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: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/30/2024 12:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2024 Time: 12:52 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
3.01 [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.

Contractor use only

4. [1] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

5. Date Received: _____

6. Contractor No. _____
7. [N] First Cost Report for this Provider CCN
8. [N] Last Cost Report for this Provider CCN
9. NPR Date: _____
10. [0] If line 4, column 1 is "4": Enter number of times reopened
11. Contractor Vendor Code _____4
12. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PREFERRED CARE AT MERCER (315487) 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	Yosef Lewin		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Yosef Lewin			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-149,470	574	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	-149,470	574	0	100.00

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

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

Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2024 12:52 pm

	1.00	2.00	3.00	
	Skilled Nursing Facility and Skilled Nursing Facility Complex Address:			
1.00	Street: 1201 PARKWAY AVENUE	PO Box:		1.00
2.00	City: EWING	State: NJ	Zip Code: 08628	2.00
3.00	County: MERCER	CBSA Code: 45940	Urban/Rural: U	3.00
3.01		CBSA Code:		3.01

		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
					V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:							
4.00	SNF	PREFERRED CARE AT MERCER	315487	11/22/2004	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00

		From:	To:	
		1.00	2.00	
14.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	14.00
15.00	Type of Control (See Instructions)	5		15.00

		Y/N	
		1.00	
	Type of Freestanding Skilled Nursing Facility		
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.	Y	18.00
	Miscellaneous Cost Reporting Information		
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.	N	19.01
	Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.		
20.00	Straight Line	80,439	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	80,439	23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.	0	24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)	N	25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	N	26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)	N	27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)	N	28.00

		Part A	Part B	Other	
		1.00	2.00	3.00	
	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.				
29.00	Skilled Nursing Facility	N	N		29.00
30.00	Nursing Facility			N	30.00
31.00	ICF/IID				31.00
32.00	SNF-Based HHA	N	N		32.00
33.00	SNF-Based RHC				33.00
34.00	SNF-Based FQHC				34.00
35.00	SNF-Based CMHC		N		35.00
36.00	SNF-Based OLTC				36.00

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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX INDENTIFICATION DATA	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 12:52 pm

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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2024 12:52 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)			
	Completed by All Skilled Nursing Facilites			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8.00

		Y/N	
		1.00	
	Bad Debts		
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.	Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.	N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	N	11.00
	Bed Complement		
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.	N	12.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4.(see Instructions.)		Y	02/01/2024	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		N	18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 12:52 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.	KITTY	BLISSIT	19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	KITTY.BLISSIT@HCRNJ.NET	21.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 12:52 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.)	02/01/2024			13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.				14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.				15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.				16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:				17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18.00
			3.00		
	Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		PREPARER		19.00
20.00	Enter the employer/company name of the cost report preparer.				20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				21.00

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

Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2024 12:52 pm

	Component	Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	100	36,500	0	5,607	21,086	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	100	36,500	0	5,607	21,086	8.00

	Component	Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	5,064	31,757	0	132	39	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	5,064	31,757	0	132	39	8.00

	Component	Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	221	392	0.00	42.48	540.67	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	221	392	0.00	42.48	540.67	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	81.01	0	124	23	240	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	81.01	0	124	23	240	8.00

	Component	Admissions	Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers		
		21.00	22.00	23.00		
1.00	SKILLED NURSING FACILITY	387	84.30	0.00		1.00
2.00	NURSING FACILITY	0	0.00	0.00		2.00
3.00	ICF/IID	0	0.00	0.00		3.00
4.00	HOME HEALTH AGENCY COST					4.00
5.00	Other Long Term Care	0	0.00	0.00		5.00
6.00	SNF-Based CMHC					6.00
7.00	HOSPICE	0	0.00	0.00		7.00
8.00	Total (Sum of lines 1-7)	387	84.30	0.00		8.00

SNF WAGE INDEX INFORMATION | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2024 12:52 pm

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - DIRECT SALARIES						
	SALARIES						
1.00	Total salaries (See Instructions)	4,903,523	0	4,903,523	175,340.00	27.97	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)	4,903,523	0	4,903,523	175,340.00	27.97	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST						8.00
9.00	CMHC						9.00
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	4,903,523	0	4,903,523	175,340.00	27.97	13.00
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1,001,096	0	1,001,096	18,995.00	52.70	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)	2,216,714	0	2,216,714			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	2,216,714	0	2,216,714			22.00

SNF WAGE INDEX INFORMATION | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2024 12:52 pm

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	494,015	0	494,015	6,603.00	74.82	2.00
3.00	Plant Operation, Maintenance & Repairs	77,248	0	77,248	4,191.00	18.43	3.00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4.00
5.00	Housekeeping	0	0	0	0.00	0.00	5.00
6.00	Dietary	437,670	0	437,670	26,068.00	16.79	6.00
7.00	Nursing Administration	421,517	0	421,517	23,003.00	18.32	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	41,226	0	41,226	2,120.00	19.45	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	131,228	0	131,228	7,583.00	17.31	13.00
14.00	Total (sum lines 1 thru 13)	1,602,904	0	1,602,904	69,568.00	23.04	14.00

SNF WAGE RELATED COSTS	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2024 12:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	18,781	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	145,210	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	45,934	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	144,097	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	431,061	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	1,426,083	19.00
20.00	State or Federal Unemployment Taxes	5,548	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)	2,216,714	24.00

		Amount Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2024 12:52 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)	717,259	87,004	804,263	14,431.00	55.73	1.00
2.00	Licensed Practical Nurses (LPNs)	1,193,729	144,799	1,338,528	26,153.00	51.18	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,389,631	168,562	1,558,193	65,188.00	23.90	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,300,619	400,365	3,700,984	105,772.00	34.99	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	2,800		2,800	72.00	38.89	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	88,470		88,470	2,834.00	31.22	16.00
17.00	Total Nursing (sum of lines 14 through 16)	91,270		91,270	2,906.00	31.41	17.00
18.00	Physical Therapists	144,884		144,884	2,503.00	57.88	18.00
19.00	Physical Therapy Assistants	171,599		171,599	3,557.00	48.24	19.00
20.00	Physical Therapy Aides	55,975		55,975	1,934.00	28.94	20.00
21.00	Occupational Therapists	189,698		189,698	2,858.00	66.37	21.00
22.00	Occupational Therapy Assistants	185,575		185,575	3,355.00	55.31	22.00
23.00	Occupational Therapy Aides	3,090		3,090	93.00	33.23	23.00
24.00	Speech Therapists	150,846		150,846	1,741.00	86.64	24.00
25.00	Respiratory Therapists	8,159		8,159	49.00	166.51	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-7 | Date/Time Prepared: 5/30/2024 12:52 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.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet S-7 Date/Time Prepared: 5/30/2024 12:52 pm

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

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		2,548,985	2,548,985	0	2,548,985	1.00
3.00	00300	EMPLOYEE BENEFITS	0	594,929	594,929	0	594,929	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	494,015	2,853,474	3,347,489	0	3,347,489	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	77,248	321,574	398,822	0	398,822	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	3,295	3,295	0	3,295	6.00
7.00	00700	HOUSEKEEPING	0	382,664	382,664	0	382,664	7.00
8.00	00800	DIETARY	437,670	353,554	791,224	0	791,224	8.00
9.00	00900	NURSING ADMINISTRATION	421,517	131,440	552,957	0	552,957	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	148,045	148,045	0	148,045	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	41,226	0	41,226	0	41,226	13.00
15.00	01500	PATIENT ACTIVITIES	131,228	32,286	163,514	0	163,514	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	3,300,619	214,762	3,515,381	0	3,515,381	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	23,845	23,845	0	23,845	40.00
41.00	04100	LABORATORY	0	24,510	24,510	0	24,510	41.00
42.00	04200	INTRAVENOUS THERAPY	0	1,140	1,140	0	1,140	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	8,139	8,139	0	8,139	43.00
44.00	04400	PHYSICAL THERAPY	0	372,458	372,458	0	372,458	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	378,363	378,363	0	378,363	45.00
46.00	04600	SPEECH PATHOLOGY	0	150,846	150,846	0	150,846	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	199,532	199,532	0	199,532	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	67,934	67,934	0	67,934	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE		0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	4,903,523	8,811,775	13,715,298	0	13,715,298	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	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
100.00		TOTAL	4,903,523	8,811,775	13,715,298	0	13,715,298	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/30/2024 12:52 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	-1,133,062	1,415,923		1.00
3.00	00300	EMPLOYEE BENEFITS	0	594,929		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-620,000	2,727,489		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	398,822		5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	3,295		6.00
7.00	00700	HOUSEKEEPING	0	382,664		7.00
8.00	00800	DIETARY	0	791,224		8.00
9.00	00900	NURSING ADMINISTRATION	0	552,957		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	148,045		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0		12.00
13.00	01300	SOCIAL SERVICE	0	41,226		13.00
15.00	01500	PATIENT ACTIVITIES	0	163,514		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	-12,000	3,503,381		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	23,845		40.00
41.00	04100	LABORATORY	0	24,510		41.00
42.00	04200	INTRAVENOUS THERAPY	0	1,140		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	8,139		43.00
44.00	04400	PHYSICAL THERAPY	0	372,458		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	378,363		45.00
46.00	04600	SPEECH PATHOLOGY	0	150,846		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	199,532		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS				
71.00	07100	AMBULANCE	0	67,934		71.00
		SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80.00
81.00	08100	INTEREST EXPENSE	0	0		81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0		82.00
83.00	08300	HOSPICE	0	0		83.00
89.00		SUBTOTALS (sum of lines 1-84)	-1,765,062	11,950,236		89.00
		NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0		91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0		93.00
94.00	09400	PATIENTS LAUNDRY	0	0		94.00
100.00		TOTAL	-1,765,062	11,950,236		100.00

RECLASSIFICATIONS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 12:52 pm

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

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

RECLASSIFICATIONS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/30/2024 12:52 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	TOTALS					
100.00				0	0	100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 | Date/Time Prepared: 5/30/2024 12:52 pm

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	113,083	22,226	0	22,226	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	397,075	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	510,158	22,226	0	22,226	0	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	510,158	22,226	0	22,226	0	9.00

	Description	Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	135,309	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	397,075	0	6.00
7.00	Subtotal (sum of lines 1-6)	532,384	0	7.00
8.00	Reconciling Items	0	0	8.00
9.00	Total (line 7 minus line 8)	532,384	0	9.00

ADJUSTMENTS TO EXPENSES | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/30/2024 12:52 pm

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line No.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds (chapter 2)	B	-6,029	ADMINISTRATIVE & GENERAL	4.00	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	-1,133,062			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0		0.00	14.00
15.00	Cost of meals - Guests		0		0.00	15.00
16.00	Sale of medical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	82.00	22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciation--movable equipment		0	*** Cost Center Deleted ***	2.00	24.00
25.00	PATIENT REIMBURSEMENT	A	-129	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01	MARKETING	A	-131,143	ADMINISTRATIVE & GENERAL	4.00	25.01
25.04	PSYCHIATRIC EVAL/NON-REIM	A	-12,000	SKILLED NURSING FACILITY	30.00	25.04
25.05	BAD DEBTS	A	-352,521	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06	NJ PTE BAIT TAX EXPENSE	A	-130,178	ADMINISTRATIVE & GENERAL	4.00	25.06
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,765,062			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.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 Parts I-II Date/Time Prepared: 5/30/2024 12:52 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		4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT	1.00
2.00		4.00	ADMINISTRATIVE & GENERAL	CLINICAL AND ADMIN CONSULTING	2.00
3.00		1.00	CAP REL COSTS - BLDGS & FIXTURES	MORTGAGE INTEREST	3.00
4.00		0.00			4.00
5.00		0.00			5.00
6.00		0.00			6.00
7.00		0.00			7.00
8.00		0.00			8.00
9.00		0.00			9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.				10.00

		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)		
		4.00	5.00	6.00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		762,869	762,869	0		1.00
2.00		248,000	248,000	0		2.00
3.00		16,938	1,150,000	-1,133,062		3.00
4.00		0	0	0		4.00
5.00		0	0	0		5.00
6.00		0	0	0		6.00
7.00		0	0	0		7.00
8.00		0	0	0		8.00
9.00		0	0	0		9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1,027,807	2,160,869	-1,133,062		10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Parts I-II Date/Time Prepared: 5/30/2024 12:52 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		0.00	1.00
2.00		A		0.00	2.00
3.00		A		0.00	3.00
4.00		A		0.00	4.00
5.00		A		0.00	5.00
6.00				0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	100.00

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

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

1.00		GSS MANAGEMENT LLC	0.00	MANAGEMENT	1.00
2.00		GSS MANAGEMENT LLC	0.00	MANAGEMENT	2.00
3.00		GSS MANAGEMENT LLC	0.00	MANAGEMENT	3.00
4.00		PC CONSULTING	0.00	CILNICAL SERVICES	4.00
5.00		MERCER REALTY	0.00	LANDLORD	5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDGS & FIXTURES	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	3.00	3A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1,415,923	1,415,923				1.00
3.00	00300	EMPLOYEE BENEFITS	594,929	0	594,929			3.00
4.00	00400	ADMINISTRATIVE & GENERAL	2,727,489	226,606	59,937	3,014,032	3,014,032	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	398,822	56,611	9,372	464,805	156,771	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	3,295	70,825	0	74,120	24,999	6.00
7.00	00700	HOUSEKEEPING	382,664	14,132	0	396,796	133,833	7.00
8.00	00800	DIETARY	791,224	113,303	53,101	957,628	322,992	8.00
9.00	00900	NURSING ADMINISTRATION	552,957	14,132	50,133	617,222	208,178	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	148,045	0	0	148,045	49,933	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	14,132	0	14,132	4,766	12.00
13.00	01300	SOCIAL SERVICE	41,226	2,859	5,002	49,087	16,556	13.00
15.00	01500	PATIENT ACTIVITIES	163,514	0	15,921	179,435	60,520	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	3,503,381	863,785	400,455	4,767,621	1,608,040	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	23,845	0	0	23,845	8,043	40.00
41.00	04100	LABORATORY	24,510	0	0	24,510	8,267	41.00
42.00	04200	INTRAVENOUS THERAPY	1,140	0	0	1,140	385	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	8,139	0	0	8,139	2,745	43.00
44.00	04400	PHYSICAL THERAPY	372,458	14,132	0	386,590	130,390	44.00
45.00	04500	OCCUPATIONAL THERAPY	378,363	5,637	0	384,000	129,517	45.00
46.00	04600	SPEECH PATHOLOGY	150,846	5,637	0	156,483	52,779	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	199,532	14,132	0	213,664	72,065	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	67,934	0	0	67,934	22,913	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	11,950,236	1,415,923	593,921	11,949,228	3,013,692	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	1,008	1,008	340	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	11,950,236	1,415,923	594,929	11,950,236	3,014,032	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 12:52 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	621,576					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	38,865	137,984				6.00
7.00	00700	HOUSEKEEPING	7,755	0	538,384			7.00
8.00	00800	DIETARY	62,176	0	58,221	1,401,017		8.00
9.00	00900	NURSING ADMINISTRATION	7,755	0	7,262	0	840,417	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	7,755	0	7,262	0	0	12.00
13.00	01300	SOCIAL SERVICE	1,569	0	1,469	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	474,005	137,984	443,854	1,401,017	840,417	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	7,755	0	7,262	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	3,093	0	2,896	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	3,093	0	2,896	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	7,755	0	7,262	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	621,576	137,984	538,384	1,401,017	840,417	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	621,576	137,984	538,384	1,401,017	840,417	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
			10.00	12.00	13.00	15.00	16.00	
		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	197,978					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	33,915				12.00
13.00	01300	SOCIAL SERVICE	0	0	68,681			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	239,955		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	84,326	33,915	68,681	239,955	10,099,815	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	31,888	40.00
41.00	04100	LABORATORY	0	0	0	0	32,777	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	1,525	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	10,884	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	531,997	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	519,506	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	215,251	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	113,652	0	0	0	414,398	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	90,847	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	197,978	33,915	68,681	239,955	11,948,888	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	1,348	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0			0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	197,978	33,915	68,681	239,955	11,950,236	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/30/2024 12:52 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
12.00	01200	MEDICAL RECORDS & LIBRARY				12.00
13.00	01300	SOCIAL SERVICE				13.00
15.00	01500	PATIENT ACTIVITIES				15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	10,099,815		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	31,888		40.00
41.00	04100	LABORATORY	0	32,777		41.00
42.00	04200	INTRAVENOUS THERAPY	0	1,525		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	10,884		43.00
44.00	04400	PHYSICAL THERAPY	0	531,997		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	519,506		45.00
46.00	04600	SPEECH PATHOLOGY	0	215,251		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	414,398		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS				
71.00	07100	AMBULANCE	0	90,847		71.00
		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		83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	11,948,888		89.00
		NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	1,348		91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0		93.00
94.00	09400	PATIENTS LAUNDRY	0	0		94.00
98.00		Cross Foot Adjustments	0	0		98.00
99.00		Negative Cost Centers	0	0		99.00
100.00		TOTAL	0	11,950,236		100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	3.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300	EMPLOYEE BENEFITS	0	0	0	0		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	226,606	226,606	0	226,606	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	56,611	56,611	0	11,787	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	70,825	70,825	0	1,880	6.00
7.00	00700	HOUSEKEEPING	0	14,132	14,132	0	10,062	7.00
8.00	00800	DIETARY	0	113,303	113,303	0	24,284	8.00
9.00	00900	NURSING ADMINISTRATION	0	14,132	14,132	0	15,652	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	3,754	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	14,132	14,132	0	358	12.00
13.00	01300	SOCIAL SERVICE	0	2,859	2,859	0	1,245	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	4,550	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	863,785	863,785	0	120,897	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	605	40.00
41.00	04100	LABORATORY	0	0	0	0	622	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	29	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	206	43.00
44.00	04400	PHYSICAL THERAPY	0	14,132	14,132	0	9,803	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	5,637	5,637	0	9,737	45.00
46.00	04600	SPEECH PATHOLOGY	0	5,637	5,637	0	3,968	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	14,132	14,132	0	5,418	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	1,723	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	1,415,923	1,415,923	0	226,580	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	26	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments			0			98.00
99.00		Negative Cost Centers		0	0	0	0	99.00
100.00		TOTAL	0	1,415,923	1,415,923	0	226,606	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 12:52 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	68,398					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	4,277	76,982				6.00
7.00	00700	HOUSEKEEPING	853	0	25,047			7.00
8.00	00800	DIETARY	6,842	0	2,709	147,138		8.00
9.00	00900	NURSING ADMINISTRATION	853	0	338	0	30,975	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	853	0	338	0	0	12.00
13.00	01300	SOCIAL SERVICE	173	0	68	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	52,161	76,982	20,648	147,138	30,975	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	853	0	338	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	340	0	135	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	340	0	135	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	853	0	338	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	68,398	76,982	25,047	147,138	30,975	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments		0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	68,398	76,982	25,047	147,138	30,975	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
			10.00	12.00	13.00	15.00	16.00	
		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	3,754					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	15,681				12.00
13.00	01300	SOCIAL SERVICE	0	0	4,345			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	4,550		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	1,599	15,681	4,345	4,550	1,338,761	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	605	40.00
41.00	04100	LABORATORY	0	0	0	0	622	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	29	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	206	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	25,126	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	15,849	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	10,080	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	2,155	0	0	0	22,896	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	1,723	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	3,754	15,681	4,345	4,550	1,415,897	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	26	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0			0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	3,754	15,681	4,345	4,550	1,415,923	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/30/2024 12:52 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
12.00	01200	MEDICAL RECORDS & LIBRARY				12.00
13.00	01300	SOCIAL SERVICE				13.00
15.00	01500	PATIENT ACTIVITIES				15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	1,338,761		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	605		40.00
41.00	04100	LABORATORY	0	622		41.00
42.00	04200	INTRAVENOUS THERAPY	0	29		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	206		43.00
44.00	04400	PHYSICAL THERAPY	0	25,126		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	15,849		45.00
46.00	04600	SPEECH PATHOLOGY	0	10,080		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	22,896		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS				
71.00	07100	AMBULANCE	0	1,723		71.00
		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		83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	1,415,897		89.00
		NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	26		91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0		93.00
94.00	09400	PATIENTS LAUNDRY	0	0		94.00
98.00		Cross Foot Adjustments	0	0		98.00
99.00		Negative Cost Centers	0	0		99.00
100.00		TOTAL	0	1,415,923		100.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
			1.00	3.00	4A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	17,333					1.00
3.00	00300	EMPLOYEE BENEFITS	0	4,903,523				3.00
4.00	00400	ADMINISTRATIVE & GENERAL	2,774	494,015	-3,014,032	8,936,204		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	693	77,248	0	464,805	13,866	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	867	0	0	74,120	867	6.00
7.00	00700	HOUSEKEEPING	173	0	0	396,796	173	7.00
8.00	00800	DIETARY	1,387	437,670	0	957,628	1,387	8.00
9.00	00900	NURSING ADMINISTRATION	173	413,209	0	617,222	173	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	148,045	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	173	0	0	14,132	173	12.00
13.00	01300	SOCIAL SERVICE	35	41,226	0	49,087	35	13.00
15.00	01500	PATIENT ACTIVITIES	0	131,228	0	179,435	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	10,574	3,300,619	0	4,767,621	10,574	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	23,845	0	40.00
41.00	04100	LABORATORY	0	0	0	24,510	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	1,140	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	8,139	0	43.00
44.00	04400	PHYSICAL THERAPY	173	0	0	386,590	173	44.00
45.00	04500	OCCUPATIONAL THERAPY	69	0	0	384,000	69	45.00
46.00	04600	SPEECH PATHOLOGY	69	0	0	156,483	69	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	173	0	0	213,664	173	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	67,934	0	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	17,333	4,895,215	-3,014,032	8,935,196	13,866	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	8,308	0	1,008	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	1,415,923	594,929		3,014,032	621,576	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	81.689436	0.121327		0.337283	44.827347	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)		0		226,606	68,398	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.025358	4.932785	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			6.00	7.00	8.00	9.00	10.00	
		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	31,757					6.00
7.00	00700	HOUSEKEEPING	0	12,826				7.00
8.00	00800	DIETARY	0	1,387	95,271			8.00
9.00	00900	NURSING ADMINISTRATION	0	173	0	108,679		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	347,577	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	173	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	35	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	31,757	10,574	95,271	108,679	148,045	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	173	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	69	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	69	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	173	0	0	199,532	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
		SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	31,757	12,826	95,271	108,679	347,577	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	137,984	538,384	1,401,017	840,417	197,978	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	4.344995	41.975986	14.705598	7.733021	0.569595	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	76,982	25,047	147,138	30,975	3,754	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	2.424095	1.952830	1.544415	0.285014	0.010800	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT CENSUS)		
			12.00	13.00	15.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE					6.00
7.00	00700	HOUSEKEEPING					7.00
8.00	00800	DIETARY					8.00
9.00	00900	NURSING ADMINISTRATION					9.00
10.00	01000	CENTRAL SERVICES & SUPPLY					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	31,757				12.00
13.00	01300	SOCIAL SERVICE	0	31,757			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	31,757		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	31,757	31,757	31,757		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
51.00	05100	SUPPORT SURFACES	0	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS					
71.00	07100	AMBULANCE	0	0	0		71.00
		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
89.00		SUBTOTALS (sum of lines 1-84)	31,757	31,757	31,757		89.00
		NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0		91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0	0		93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0		94.00
98.00		Cross Foot Adjustments					98.00
99.00		Negative Cost Centers					99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	33,915	68,681	239,955		102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	1.067954	2.162704	7.555972		103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	15,681	4,345	4,550		104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.493781	0.136820	0.143275		105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C | Date/Time Prepared: 5/30/2024 12:52 pm

		Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2	
			1.00	2.00	3.00	
		ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	31,888	0	0.000000	40.00
41.00	04100	LABORATORY	32,777	180	182.094444	41.00
42.00	04200	INTRAVENOUS THERAPY	1,525	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	10,884	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	531,997	721,495	0.737354	44.00
45.00	04500	OCCUPATIONAL THERAPY	519,506	672,714	0.772254	45.00
46.00	04600	SPEECH PATHOLOGY	215,251	292,811	0.735119	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	414,398	199,532	2.076850	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
		OUTPATIENT SERVICE COST CENTERS				
71.00	07100	AMBULANCE	90,847	0	0.000000	71.00
100.00		Total	1,849,073	1,886,732		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I Date/Time Prepared: 5/30/2024 12:52 pm

Title XVIII (1) | Skilled Nursing Facility | PPS

				Health Care Program Charges		Health Care Program Cost		
			Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
			1.00	2.00	3.00	4.00	5.00	
	PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
	ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	04100	LABORATORY	182.094444	180	0	32,777	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.737354	202,826	0	149,555	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.772254	209,186	0	161,545	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.735119	117,562	0	86,422	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	2.076850	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS							
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		529,754	0	430,299	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.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/30/2024 12:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	1.00	
		PART II - APPORTIONMENT OF VACCINE COST		
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	2.076850	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	1,170	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)	2,430	3.00

		Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH						
		ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	31,888	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	32,777	0	0.000000	32,777	0	41.00
42.00	04200	INTRAVENOUS THERAPY	1,525	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	10,884	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	531,997	0	0.000000	149,555	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	519,506	0	0.000000	161,545	0	45.00
46.00	04600	SPEECH PATHOLOGY	215,251	0	0.000000	86,422	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	414,398	0	0.000000	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	1,758,226	0		430,299	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/30/2024 12:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		
	INPATIENT DAYS		
1.00	Inpatient days including private room days	31,757	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	5,607	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	10,099,815	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	12,307,035	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.820654	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	10,099,815	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	318.03	16.00
17.00	Program routine service cost (Line 3 times line 16)	1,783,194	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	1,783,194	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	1,338,761	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	42.16	21.00
22.00	Program capital related cost (Line 3 times line 21)	236,391	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,546,803	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,546,803	25.00
26.00	Enter the per diem limitation (1)		26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00

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

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	31,757	1.00
2.00	Program inpatient days (see instructions)	5,607	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.176559	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/30/2024 12:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1.00	Inpatient PPS amount (See Instructions)	4,451,008	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)	4,451,008	3.00
4.00	Primary payor amounts	6,325	4.00
5.00	Coinsurance	741,800	5.00
6.00	Allowable bad debts (From your records)	684,812	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	44,508	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	445,128	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)	4,148,011	11.00
12.00	Interim payments (See instructions)	4,214,520	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)	8,903	14.75
14.99	Sequestration amount (see instructions)	74,058	14.99
15.00	Balance due provider/program (see Instructions)	-149,470	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	2,430	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	2,430	19.00
20.00	Medicare Part B ancillary charges (See instructions)	1,170	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	1,170	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	1,170	25.00
26.00	Interim payments (See instructions)	573	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)	23	28.99
29.00	Balance due provider/program (see instructions)	574	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.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 | Date/Time Prepared: 5/30/2024 12:52 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		4,130,722		573	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	07/13/2023	83,798		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)		83,798		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		4,214,520		573	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		574	6.01
6.02	PROVIDER TO PROGRAM		149,470		0	6.02
7.00	Total Medicare program liability (see instructions)		4,065,050		1,147	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.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/30/2024 12:52 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	2,342,888	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,978,998	0	0	0	4.00
5.00	Other receivables	835,457	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-654,908	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	256,388	0	0	0	8.00
9.00	Other current assets	193,465	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4,952,288	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	135,309	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	397,075	0	0	0	23.00
24.00	Less: Accumulated depreciation	-220,620	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)	311,764	0	0	0	28.00
	OTHER ASSETS					
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	247,005	0	0	0	30.00
31.00	Due from owners/officers	196,653	0	0	0	31.00
32.00	Other assets	3	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	443,661	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5,707,713	0	0	0	34.00
	Liabilities and Fund Balances					
	CURRENT LIABILITIES					
35.00	Accounts payable	969,916	0	0	0	35.00
36.00	Salaries, wages, and fees payable	216,588	0	0	0	36.00
37.00	Payroll taxes payable	23,543	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	1,479,781	0	0	0	39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	1,025,894	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3,715,722	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	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	3,715,722	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,991,991				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	1,991,991	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	5,707,713	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider No.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/30/2024 12:52 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		2,631,331		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		5,660				2.00
3.00	Total (sum of line 1 and line 2)		2,636,991		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		2,636,991		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00	DIVDENDS	645,000		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		645,000		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		1,991,991		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	DIVDENDS		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.: 315487 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I-II | Date/Time Prepared: 5/30/2024 12:52 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	12,307,035		12,307,035	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)	12,307,035		12,307,035	5.00
	All Other Care Services				
6.00	ANCILLARY SERVICES	1,886,732	0	1,886,732	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD	353,612	0	353,612	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	14,547,379	0	14,547,379	14.00

	Cost Center Description			
		1.00	2.00	
	PART II - OPERATING EXPENSES			
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		13,715,298	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)		13,715,298	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315487	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/30/2024 12:52 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	14,547,379	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,800,860	2.00
3.00	Net patient revenues (Line 1 minus line 2)	12,746,519	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	13,715,298	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-968,779	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	112,097	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	PRIOR YEAR	7,878	24.00
24.01	NON PATIENT REVENUE	-4,252	24.01
24.50	COVID-19 PHE Funding	858,716	24.50
25.00	Total other income (Sum of lines 6 - 24)	974,439	25.00
26.00	Total (Line 5 plus line 25)	5,660	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	5,660	31.00