

VISTACARE LLC
(a limited liability company)
BALANCE SHEET
AT DECEMBER 31, 2023

ASSETS

Current assets

Cash and cash equivalents	\$ 1,142,778
Cash - restricted - patient funds	287,408
Accounts receivable - less allowance for doubtful accounts of \$982,200	3,192,767
Rent receivable	-
Escrow deposits	-
Prepaid expenses and other	104,464
Total current assets	<u>4,727,417</u>

Property and equipment - net	1,010,109
Due from related entity	4,343,284
Right-of-use assets - operating lease	12,418,977
Loans to members	2,500,000
Security deposits	13,911

TOTAL ASSETS **\$ 25,013,698**

LIABILITIES AND MEMBERS' DEFICIENCY

Current liabilities

Accounts payable	\$ 6,980,741
Accrued expenses	1,112,372
Accrued and withheld taxes	41,285
Operating lease payable	3,121,497
Due to private and third-party payors	179,958
Patients' funds	384,223
Total current liabilities	<u>11,820,076</u>

Loans from members	5,805,449
Due to landlord	4,245,901
Operating lease payable	9,297,480
Total liabilities	<u>31,168,906</u>

Members' deficiency **(6,155,208)**

TOTAL LIABILITIES AND MEMBERS' DEFICIENCY **\$ 25,013,698**

VISTACARE LLC
(a limited liability company)
STATEMENTS OF OPERATIONS AND MEMBERS' DEFICIENCY
YEAR ENDED DECEMBER 31, 2023

Revenues	\$ 27,310,042
Operating expenses	<u>28,068,623</u>
Loss from operations	(758,581)
Non-operating revenue (expenses)	
Interest income	20,389
Interest expense	<u>(78,485)</u>
NET LOSS	(816,677)
Members' deficiency - December 31, 2022	<u>(5,338,531)</u>
MEMBERS' DEFICIENCY - DECEMBER 31, 2023	\$ <u><u>(6,155,208)</u></u>

VISTACARE LLC
(a limited liability company)
STATEMENT OF CASH FLOWS
YEAR ENDED DECEMBER 31, 2023

Cash flows from operating activities	
Net loss	\$ (816,677)
Adjustments to reconcile net loss to net cash used in operating activities:	
Depreciation	129,703
(Increase) decrease in assets	
Accounts receivable	765,681
Prepaid expenses	1,387
Increase (decrease) in liabilities	
Accounts payable	1,341,982
Accrued expenses and withheld taxes	(343,364)
Due to private and third-party payors	55,380
Due to landlord	(1,373,182)
Patients' funds	(47,994)
Net cash used in operating activities	<u>(287,084)</u>
Cash flows from investing activities	
Purchase of property and equipment	(125,629)
Loans to member	(2,500,000)
Net cash used in investing activities	<u>(2,625,629)</u>
Cash flows from financing activities	
Loans to related entity	(2,304,788)
Loans from members	78,485
Net cash used in financing activities	<u>(2,226,303)</u>
Net decrease in cash, restricted cash, and cash equivalents	(5,139,016)
Cash, restricted cash, and cash equivalents - December 31, 2022	<u>6,569,202</u>
CASH, RESTRICTED CASH, AND CASH EQUIVALENTS - DECEMBER 31, 2023	<u>\$ 1,430,186</u>

VISTACARE LLC
(a limited liability company)
SUPPLEMENTARY INFORMATION
REVENUES
YEAR ENDED DECEMBER 31, 2023

		Per Patient Day
Current year		
Medicaid	\$ 1,740,877	\$ 247.11
Medicaid - Managed Care	18,727,167	246.01
Medicare - Part A	2,536,502	715.31
Medicare - Part A bad debts	(208,481)	(58.79)
Private	300,790	279.80
HMO	3,229,827	326.77
HMO - Lump sum	27,135	2.75
Hospice	<u>264,570</u>	246.11
Total current year	<u>26,618,387</u>	<u>\$ 269.56</u>
 Prior years		
Medicaid	(60,194)	
Medicaid - Managed Care	19,575	
Private	109,105	
HMO	<u>5,033</u>	
	<u>73,519</u>	
 Other income		
Ancillary revenue	618,070	
Other income	<u>66</u>	
	<u>618,136</u>	
TOTAL REVENUES	<u>\$ 27,310,042</u>	

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: 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/30/2024 2:29 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NEW VISTA NURSING & REHAB CENTER (315458) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		Title XIX	
		Part A	Part B		
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-255,513	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	-255,513	0	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:29 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 300 BROADWAY	PO Box:				1.00		
2.00	City: NEWARK	State: NJ	Zip Code: 07104			2.00		
3.00	County: ESSEX	CBSA Code: 35084	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
					4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	NEW VISTA NURSING & REHAB CENTER	315458	08/25/1999	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2023	12/31/2023		14.00	
15.00	Type of Control (See Instructions)			4			15.00	
				Y/N				
				1.00				
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y	18.00	
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					600,280	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					600,280	23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00	
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility				N	N	N	29.00
30.00	Nursing Facility							30.00
31.00	ICF/IID							31.00
32.00	SNF-Based HHA				N	N		32.00
33.00	SNF-Based RHC							33.00
34.00	SNF-Based FQHC							34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC							36.00
				Y/N				
				1.00			2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)			Y			37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)			N			38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.						39.00	
				Premiums	Paid Losses	Self Insurance		
				1.00	2.00	3.00		
41.00	List malpractice premiums and paid losses:			0	0	0	41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 2:29 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. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 2:29 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	N		N	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		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.	Y		Y	18.00

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

Provider No. : 315458

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/30/2024 2:29 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.	CHRIS	GUI LBAULT	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	CHRIS.GUI LBAULT@HCRNJ.NET	21.00

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

Provider No. : 315458

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/30/2024 2:29 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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. : 315458

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/30/2024 2:29 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	340	124,100	0	3,685	84,425	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	340	124,100	0	3,685	84,425	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	10,638	98,748	0	112	165	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	10,638	98,748	0	112	165	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	137	414	0.00	32.90	511.67	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	137	414	0.00	32.90	511.67	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	238.52	0	64	155	237	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	238.52	0	64	155	237	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	456	232.40	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	456	232.40	0.00	8.00		

Provider No. : 315458

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2024 2:29 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)	11,659,499	0	11,659,499	483,344.00	24.12
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	11,659,499	0	11,659,499	483,344.00	24.12
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00
9.00	CMHC	0	0	0	0.00	0.00
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	11,659,499	0	11,659,499	483,344.00	24.12
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	203,093	0	203,093	4,691.00	43.29
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1,993,272	0	1,993,272		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,993,272	0	1,993,272		

SNF WAGE INDEX INFORMATION

Provider No. : 315458

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2024 2:29 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	942,439	0	942,439	18,835.00	2.00
3.00	Plant Operation, Maintenance & Repairs	432,324	0	432,324	26,662.00	3.00
4.00	Laundry & Linen Service	0	0	0.00	0.00	4.00
5.00	Housekeeping	1,147,880	0	1,147,880	68,628.00	5.00
6.00	Dietary	1,044,220	0	1,044,220	62,602.00	6.00
7.00	Nursing Administration	656,433	0	656,433	23,576.00	7.00
8.00	Central Services and Supply	11,954	0	11,954	742.00	8.00
9.00	Pharmacy	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	31,867	0	31,867	2,101.00	10.00
11.00	Social Service	193,393	0	193,393	6,923.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	373,038	0	373,038	22,521.00	13.00
14.00	Total (sum lines 1 thru 13)	4,833,548	0	4,833,548	232,590.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2024 2:29 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		206,344	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)		469,957	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		222,041	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		854,813	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		240,117	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)		1,993,272	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. : 315458

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

Worksheet S-3
Part V
Date/Time Prepared:
5/30/2024 2:29 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)	1,286,349	222,024	1,508,373	29,193.00	51.67	1.00
2.00	Licensed Practical Nurses (LPNs)	2,018,530	348,398	2,366,928	62,119.00	38.10	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,854,437	492,676	3,347,113	143,880.00	23.26	3.00
4.00	Total Nursing (sum of lines 1 through 3)	6,159,316	1,063,098	7,222,414	235,192.00	30.71	4.00
5.00	Physical Therapists	398,102	68,712	466,814	9,238.00	50.53	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	185,647	32,043	217,690	4,373.00	49.78	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	82,885	14,306	97,191	1,953.00	49.76	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)	74,646		74,646	1,239.00	60.25	14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	128,447		128,447	3,452.00	37.21	16.00
17.00	Total Nursing (sum of lines 14 through 16)	203,093		203,093	4,691.00	43.29	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315458

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

Worksheet S-7
Date/Time Prepared:
5/30/2024 2:29 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. : 315458

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

Worksheet S-7

Date/Time Prepared:
5/30/2024 2:29 pm

		Group	Days	
76.00		1.00	2.00	
99.00		PA1		76.00
100.00	TOTAL	AAA		99.00
				100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
<p>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)</p>				
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. : 315458

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

Worksheet A
Date/Time Prepared:
5/30/2024 2:29 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		4,427,535	4,427,535	0	4,427,535	1.00	
2.00	00200		0	0	0	0	2.00	
3.00	00300	0	2,012,182	2,012,182	0	2,012,182	3.00	
4.00	00400	942,439	4,645,251	5,587,690	0	5,587,690	4.00	
5.00	00500	432,324	1,048,855	1,481,179	0	1,481,179	5.00	
6.00	00600	0	87,310	87,310	0	87,310	6.00	
7.00	00700	1,147,880	68,429	1,216,309	0	1,216,309	7.00	
8.00	00800	1,044,220	1,723,345	2,767,565	0	2,767,565	8.00	
9.00	00900	656,433	0	656,433	0	656,433	9.00	
10.00	01000	11,954	324,343	336,297	0	336,297	10.00	
11.00	01100	0	0	0	0	0	11.00	
12.00	01200	31,867	1,676	33,543	0	33,543	12.00	
13.00	01300	193,393	4,606	197,999	0	197,999	13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	373,038	63,650	436,688	0	436,688	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	6,159,316	472,876	6,632,192	0	6,632,192	30.00	
31.00	03100	0	0	0	0	0	31.00	
32.00	03200	0	0	0	0	0	32.00	
33.00	03300	0	0	0	0	0	33.00	
ANCILLARY SERVICE COST CENTERS								
40.00	04000	0	11,000	11,000	0	11,000	40.00	
41.00	04100	0	841	841	0	841	41.00	
42.00	04200	0	2,311	2,311	0	2,311	42.00	
43.00	04300	0	13,386	13,386	0	13,386	43.00	
44.00	04400	377,098	12,415	389,513	0	389,513	44.00	
45.00	04500	130,756	91,406	222,162	0	222,162	45.00	
46.00	04600	158,781	0	158,781	0	158,781	46.00	
47.00	04700	0	0	0	0	0	47.00	
48.00	04800	0	0	0	0	0	48.00	
49.00	04900	0	318,730	318,730	0	318,730	49.00	
50.00	05000	0	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
73.00	07300	0	0	0	0	0	73.00	
SPECIAL PURPOSE COST CENTERS								
80.00	08000	0	0	0	0	0	80.00	
81.00	08100	0	0	0	0	0	81.00	
82.00	08200	0	0	0	0	0	82.00	
83.00	08300	0	0	0	0	0	83.00	
89.00	SUBTOTALS (sum of lines 1-84)		11,659,499	15,330,147	26,989,646	0	26,989,646	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	09300	0	0	0	0	0	93.00	
94.00	09400	0	0	0	0	0	94.00	
100.00	TOTAL		11,659,499	15,330,147	26,989,646	0	26,989,646	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315458

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

Worksheet A
Date/Time Prepared:
5/30/2024 2:29 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	-1,527,615	2,899,920	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	2,012,182	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-2,146,552	3,441,138	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	1,481,179	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	87,310	6.00
7.00	00700	HOUSEKEEPING	0	1,216,309	7.00
8.00	00800	DIETARY	0	2,767,565	8.00
9.00	00900	NURSING ADMINISTRATION	0	656,433	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	336,297	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	33,543	12.00
13.00	01300	SOCIAL SERVICE	0	197,999	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	436,688	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-9,000	6,623,192	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	11,000	40.00
41.00	04100	LABORATORY	0	841	41.00
42.00	04200	INTRAVENOUS THERAPY	0	2,311	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	13,386	43.00
44.00	04400	PHYSICAL THERAPY	0	389,513	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	222,162	45.00
46.00	04600	SPEECH PATHOLOGY	0	158,781	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	318,730	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
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)	-3,683,167	23,306,479	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	-3,683,167	23,306,479	100.00

Provider No. : 315458

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

Worksheet A-6

Date/Time Prepared:
5/30/2024 2:29 pm

		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Recl assi fi cations (Sum of col umns 4 and 5 must equal sum of col umns 8 and 9)				0	0 100.00

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

RECLASSIFICATIONS

Provider No. : 315458

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

Worksheet A-6

Date/Time Prepared:
5/30/2024 2:29 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315458

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

Worksheet A-7

Date/Time Prepared:
5/30/2024 2:29 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	1,306,280	55,497	0	55,497	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	418,538	78,953	0	78,953	0	6.00
7.00 Subtotal (sum of lines 1-6)	1,724,818	134,450	0	134,450	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	1,724,818	134,450	0	134,450	0	9.00
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	0	0				
4.00 Building Improvements	1,361,777	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	497,491	0				
7.00 Subtotal (sum of lines 1-6)	1,859,268	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	1,859,268	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315458

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

Worksheet A-8

Date/Time Prepared:
5/30/2024 2:29 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line No.
			1.00	2.00	3.00
1.00 Investment income on restricted funds (chapter 2)	B	-20,280	CAP REL COSTS - BLDGS & FIXTURES		1.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)		0			0.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 5.00
6.00 Television and radio service (chapter 21)		0			0.00 6.00
7.00 Parking lot (chapter 21)		0			0.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00 Home office cost (chapter 21)		0			0.00 9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00 11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-1,468,819			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Revenue - Employee meals		0			0.00 14.00
15.00 Cost of meals - Guests		0			0.00 15.00
16.00 Sale of medical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		0			0.00 18.00
19.00 Vending machines		0			0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00 22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES		1.00 23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT		2.00 24.00
25.00 Other adjustment (specify)		0			0.00 25.00
25.01 RENT INCOME	B	-30,785	CAP REL COSTS - BLDGS & FIXTURES		1.00 25.01
25.03 PENALTIES	A	-39	ADMINISTRATIVE & GENERAL		4.00 25.03
25.05 PROMOTIONAL ADVERTISING	A	-75,338	ADMINISTRATIVE & GENERAL		4.00 25.05
25.06 MANAGEMENT FEES	A	-1,500,000	ADMINISTRATIVE & GENERAL		4.00 25.06
25.07 BAD DEBTS	A	-577,486	ADMINISTRATIVE & GENERAL		4.00 25.07
25.08 PSYCH FEES	A	-9,000	SKILLED NURSING FACILITY		30.00 25.08
25.10 DONATIONS	A	-1,420	ADMINISTRATIVE & GENERAL		4.00 25.10
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-3,683,167			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. : 315458

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/30/2024 2:29 pm

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00	
2.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	DEPRECIATION	2.00	
3.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	AMORTIZATION	3.00	
4.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	INTEREST	4.00	
5.00	4.00	ADMINISTRATIVE & GENERAL	BANK CHARGES	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	0	3,400,000	-3,400,000	1.00	
2.00	470,576	0	470,576	2.00	
3.00	66,358	0	66,358	3.00	
4.00	1,386,516	0	1,386,516	4.00	
5.00	7,731	0	7,731	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.	1,931,181	3,400,000	-1,468,819	10.00

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

Provider No. : 315458

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/30/2024 2:29 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	D	BORUCH KLEIMAN	0.00	1.00
2.00	D	TZVI KLEIMAN	0.00	2.00
3.00	D	RIVKA C. KLEIMAN	55.00	3.00
4.00	D	RIVKA B. KLEIMAN	45.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00		BSD HOLDINGS LLC	55.00	REALTY	1.00
2.00		BSD HOLDINGS LLC	45.00	REALTY	2.00
3.00		VI STACARE LLC	0.00	NURSING FACILITY	3.00
4.00		VI STACARE LLC	0.00	NURSING FACILITY	4.00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315458

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	2,899,920	2,899,920			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	2,012,182	0	0	2,012,182	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,441,138	265,106	0	162,645	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,481,179	89,326	0	74,610	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	87,310	172,464	0	0	6.00
7.00 00700	HOUSEKEEPING	1,216,309	25,641	0	198,100	7.00
8.00 00800	DIETARY	2,767,565	98,021	0	180,210	8.00
9.00 00900	NURSING ADMINISTRATION	656,433	7,441	0	113,287	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	336,297	0	0	2,063	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	33,543	12,291	0	5,500	12.00
13.00 01300	SOCIAL SERVICE	197,999	22,297	0	33,376	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	436,688	0	0	64,379	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	6,623,192	2,116,002	0	1,062,965	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	11,000	0	0	0	40.00
41.00 04100	LABORATORY	841	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	2,311	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	13,386	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	389,513	48,188	0	65,079	44.00
45.00 04500	OCCUPATIONAL THERAPY	222,162	36,984	0	22,566	45.00
46.00 04600	SPEECH PATHOLOGY	158,781	0	0	27,402	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	318,730	6,159	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	23,306,479	2,899,920	0	2,012,182	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	23,306,479	2,899,920	0	2,012,182	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315458

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	3,868,889				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	327,447	1,972,562			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	51,706	133,647	445,127		6.00	
7.00	00700	HOUSEKEEPING	286,630	19,870	0	1,746,550	7.00	
8.00	00800	DIETARY	606,241	75,959	0	72,932	3,800,928	8.00
9.00	00900	NURSING ADMINISTRATION	154,688	5,767	0	5,537	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	67,348	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	10,218	9,525	0	9,145	0	12.00
13.00	01300	SOCIAL SERVICE	50,491	17,278	0	16,590	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	99,733	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,951,035	1,639,741	445,127	1,574,391	3,800,928	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	2,189	0	0	0	0	40.00
41.00	04100	LABORATORY	167	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	460	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	2,664	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	100,074	37,342	0	35,854	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	56,073	28,660	0	27,518	0	45.00
46.00	04600	SPEECH PATHOLOGY	37,058	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	64,667	4,773	0	4,583	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	3,868,889	1,972,562	445,127	1,746,550	3,800,928	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	3,868,889	1,972,562	445,127	1,746,550	3,800,928	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315458

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	943,153					9.00
10.00	01000		405,708				10.00
11.00	01100						11.00
12.00	01200				80,222		12.00
13.00	01300					338,031	13.00
14.00	01400						14.00
15.00	01500						15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	943,153	204,625		80,222	338,031	30.00
31.00	03100						31.00
32.00	03200						32.00
33.00	03300						33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000						40.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
44.00	04400						44.00
45.00	04500						45.00
46.00	04600						46.00
47.00	04700						47.00
48.00	04800						48.00
49.00	04900		201,083				49.00
50.00	05000						50.00
51.00	05100						51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000						60.00
61.00	06100						61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000						70.00
71.00	07100						71.00
73.00	07300						73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300						83.00
89.00		943,153	405,708		80,222	338,031	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
93.00	09300						93.00
94.00	09400						94.00
98.00							98.00
99.00							99.00
100.00		943,153	405,708		80,222	338,031	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315458

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		PATIENT ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	600,800			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	600,800	21,380,212	0	21,380,212 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	13,189	0	13,189 40.00
41.00 04100	LABORATORY	0	0	1,008	0	1,008 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	2,771	0	2,771 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	16,050	0	16,050 43.00
44.00 04400	PHYSICAL THERAPY	0	0	676,050	0	676,050 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	393,963	0	393,963 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	223,241	0	223,241 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	599,995	0	599,995 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	600,800	23,306,479	0	23,306,479 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	0	600,800	23,306,479	0	23,306,479 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315458

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	265,106	0	265,106	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	89,326	0	89,326	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	172,464	0	172,464	6.00
7.00 00700	HOUSEKEEPING	0	25,641	0	25,641	7.00
8.00 00800	DIETARY	0	98,021	0	98,021	8.00
9.00 00900	NURSING ADMINISTRATION	0	7,441	0	7,441	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	12,291	0	12,291	12.00
13.00 01300	SOCIAL SERVICE	0	22,297	0	22,297	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	2,116,002	0	2,116,002	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	48,188	0	48,188	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	36,984	0	36,984	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	6,159	0	6,159	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	2,899,920	0	2,899,920	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments				0	98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	2,899,920	0	2,899,920	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315458

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	265,106					4.00
5.00	00500	22,438	111,764				5.00
6.00	00600	3,543	7,572	183,579			6.00
7.00	00700	19,641	1,126	0	46,408		7.00
8.00	00800	41,542	4,304	0	1,938	145,805	8.00
9.00	00900	10,600	327	0	147	0	9.00
10.00	01000	4,615	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	700	540	0	243	0	12.00
13.00	01300	3,460	979	0	441	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	6,834	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	133,688	92,906	183,579	41,833	145,805	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	150	0	0	0	0	40.00
41.00	04100	11	0	0	0	0	41.00
42.00	04200	32	0	0	0	0	42.00
43.00	04300	183	0	0	0	0	43.00
44.00	04400	6,857	2,116	0	953	0	44.00
45.00	04500	3,842	1,624	0	731	0	45.00
46.00	04600	2,539	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	4,431	270	0	122	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		265,106	111,764	183,579	46,408	145,805	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00		0	0	0	0	0	99.00
100.00		265,106	111,764	183,579	46,408	145,805	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315458

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	18,515					9.00
10.00	01000	0	4,615				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	13,774		12.00
13.00	01300	0	0	0	0	27,177	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,515	2,328	0	13,774	27,177	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	2,287	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		18,515	4,615	0	13,774	27,177	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00	TOTAL	18,515	4,615	0	13,774	27,177	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315458

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total	
		14.00 15.00 16.00 17.00 18.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	6,834			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	6,834	2,782,441	0	2,782,441 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	150	0	150 40.00
41.00 04100	LABORATORY	0	0	11	0	11 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	32	0	32 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	183	0	183 43.00
44.00 04400	PHYSICAL THERAPY	0	0	58,114	0	58,114 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	43,181	0	43,181 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	2,539	0	2,539 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	13,269	0	13,269 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	6,834	2,899,920	0	2,899,920 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	0	6,834	2,899,920	0	2,899,920 100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315458

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

Worksheet B-1
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	104,049				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0			2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	11,659,499		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	9,512	0	942,439	-3,868,889	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	3,205	0	432,324	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	6,188	0	0	1,645,115	6.00
7.00 00700	HOUSEKEEPING	920	0	1,147,880	0	7.00
8.00 00800	DIETARY	3,517	0	1,044,220	0	8.00
9.00 00900	NURSING ADMINISTRATION	267	0	656,433	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	11,954	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	441	0	31,867	0	12.00
13.00 01300	SOCIAL SERVICE	800	0	193,393	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	0	373,038	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	75,922	0	6,159,316	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	11,000	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	841	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	2,311	43.00
44.00 04400	PHYSICAL THERAPY	1,729	0	377,098	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	1,327	0	130,756	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	158,781	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	221	0	0	324,889	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	104,049	0	11,659,499	-3,868,889	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,899,920	0	2,012,182	3,868,889	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	27.870715	0.000000	0.172579	0.199042	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0	265,106	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.013639	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315458

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

Worksheet B-1

Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS HRS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	91,332					6.00
7.00	00700	6,188	98,748				7.00
8.00	00800	920		84,224			8.00
9.00	00900	3,517		3,517	296,244		9.00
10.00	01000	267		267		239,883	10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	75,922	98,748	75,922	296,244	239,883	30.00
31.00	03100						31.00
32.00	03200						32.00
33.00	03300						33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000						40.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
44.00	04400	1,729		1,729			44.00
45.00	04500	1,327		1,327			45.00
46.00	04600						46.00
47.00	04700						47.00
48.00	04800						48.00
49.00	04900	221		221			49.00
50.00	05000						50.00
51.00	05100						51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000						60.00
61.00	06100						61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000						70.00
71.00	07100						71.00
73.00	07300						73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300						83.00
89.00		91,332	98,748	84,224	296,244	239,883	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
93.00	09300						93.00
94.00	09400						94.00
98.00							98.00
99.00							99.00
102.00		1,972,562	445,127	1,746,550	3,800,928	943,153	102.00
103.00		21.597709	4.507706	20.736963	12.830397	3.931721	103.00
104.00		111,764	183,579	46,408	145,805	18,515	104.00
105.00		1.223711	1.859066	0.551007	0.492179	0.077183	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315458

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

Worksheet B-1

Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	643,073					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	98,748			12.00
13.00	01300	0	0	0	98,748		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	324,343	0	98,748	98,748	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	318,730	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		643,073	0	98,748	98,748	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		405,708	0	80,222	338,031	0	102.00
103.00		0.630889	0.000000	0.812391	3.423168	0.000000	103.00
104.00		4,615	0	13,774	27,177	0	104.00
105.00		0.007176	0.000000	0.139486	0.275216	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315458

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

Worksheet B-1
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description		OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT_DAYS)	
		15.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	PATIENT ACTIVITIES	98,748
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	98,748
31.00	03100	NURSING FACILITY	0
32.00	03200	ICF/IID	0
33.00	03300	OTHER LONG TERM CARE	0
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	0
41.00	04100	LABORATORY	0
42.00	04200	INTRAVENOUS THERAPY	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0
44.00	04400	PHYSICAL THERAPY	0
45.00	04500	OCCUPATIONAL THERAPY	0
46.00	04600	SPEECH PATHOLOGY	0
47.00	04700	ELECTROCARDIOLOGY	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0
51.00	05100	SUPPORT SURFACES	0
OUTPATIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	0
61.00	06100	RURAL HEALTH CLINIC	0
62.00	06200	FOHC	0
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0
71.00	07100	AMBULANCE	0
73.00	07300	CMHC	0
SPECIAL PURPOSE COST CENTERS			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0
81.00	08100	INTEREST EXPENSE	0
82.00	08200	UTILIZATION REVIEW - SNF	0
83.00	08300	HOSPICE	0
89.00		SUBTOTALS (sum of lines 1-84)	98,748
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0
91.00	09100	BARBER AND BEAUTY SHOP	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0
93.00	09300	NONPAID WORKERS	0
94.00	09400	PATIENTS LAUNDRY	0
98.00		Cross Foot Adjustments	0
99.00		Negative Cost Centers	0
102.00		Cost to be allocated (per Wkst. B, Part I)	600,800
103.00		Unit cost multiplier (Wkst. B, Part I)	6.084174
104.00		Cost to be allocated (per Wkst. B, Part II)	6,834
105.00		Unit cost multiplier (Wkst. B, Part II)	0.069206

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315458

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

Worksheet C
Date/Time Prepared:
5/30/2024 2:29 pm

Cost Center Description			Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	13,189	0	0.000000	40.00
41.00	04100	LABORATORY	1,008	0	0.000000	41.00
42.00	04200	INTRAVENOUS THERAPY	2,771	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	16,050	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	676,050	397,326	1.701500	44.00
45.00	04500	OCCUPATIONAL THERAPY	393,963	296,105	1.330484	45.00
46.00	04600	SPEECH PATHOLOGY	223,241	211,628	1.054875	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	599,995	302,280	1.984898	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FQHC				62.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	1,926,267	1,207,339		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Provider No. : 315458

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

Worksheet D
Part I
Date/Time Prepared:
5/30/2024 2:29 pm

Title XVIII (1)

Skilled Nursing
Facility

PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
			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	0.000000	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1.701500	165,116	0	280,945	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1.330484	88,861	0	118,228	0	45.00
46.00	04600	SPEECH PATHOLOGY	1.054875	147,972	0	156,092	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1.984898	302,280	0	599,995	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0.000000	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC						61.00
62.00	06200	FQHC						62.00
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		704,229	0	1,155,260	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. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/30/2024 2:29 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description						1.00	
PART II - APPORTIONMENT OF VACCINE COST							
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)				1.984898	1.00
2.00		Program vaccine charges (From your records, or the PS&R)				0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)				0	3.00
Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH							
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	13,189	0	0.000000	0	0 40.00
41.00	04100	LABORATORY	1,008	0	0.000000	0	0 41.00
42.00	04200	INTRAVENOUS THERAPY	2,771	0	0.000000	0	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	16,050	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	676,050	0	0.000000	280,945	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	393,963	0	0.000000	118,228	0 45.00
46.00	04600	SPEECH PATHOLOGY	223,241	0	0.000000	156,092	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	599,995	0	0.000000	599,995	0 49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0 50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0 51.00
100.00		Total (Sum of lines 40 - 52)	1,926,267	0		1,155,260	0 100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/30/2024 2:29 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		98,748	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		3,685	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		21,380,212	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		27,046,988	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.790484	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)		21,380,212	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		216.51	16.00
17.00	Program routine service cost (Line 3 times line 16)		797,839	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)		797,839	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)		2,782,441	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		28.18	21.00
22.00	Program capital related cost (Line 3 times line 21)		103,843	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		693,996	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)		693,996	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		98,748	1.00
2.00	Program inpatient days (see instructions)		3,685	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)		0.037317	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. : 315458	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/30/2024 2:29 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)		2,598,637	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)		2,598,637	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		303,001	5.00
6.00	Allowable bad debts (From your records)		94,489	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		61,418	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		2,357,054	11.00
12.00	Interim payments (See instructions)		2,559,366	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)		1,228	14.75
14.99	Sequestration amount (see instructions)		51,973	14.99
15.00	Balance due provider/program (see Instructions)		-255,513	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315458

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

Worksheet E-1

Date/Time Prepared:
5/30/2024 2:29 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		2,523,463			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)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/01/2023	35,903			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)		35,903			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		2,559,366			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 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)					0 6.00
6.01	PROGRAM TO PROVIDER		0			0 6.01
6.02	PROVIDER TO PROGRAM		255,513			0 6.02
7.00	Total Medicare program liability (see instructions)		2,303,853			0 7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					0 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. : 315458

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

Worksheet G

Date/Time Prepared:
5/30/2024 2:29 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	1,244,014	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	5,711,106	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-1,416,156	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	99,637	0	0	0	8.00
9.00	Other current assets	0	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)	5,638,601	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	1,361,777	0	0	0	17.00
18.00	Less: Accumulated Amortization	-492,861	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	497,491	0	0	0	23.00
24.00	Less: Accumulated depreciation	-356,299	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)	1,010,108	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	13,911	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	13,911	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	6,662,620	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	6,829,543	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,062,372	0	0	0	36.00
37.00	Payroll taxes payable	41,285	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	488,698	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	17,097	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	8,438,995	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:	5,482,209	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)	5,482,209	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	13,921,204	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-7,258,584	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-7,258,584	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	6,662,620	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315458

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

Worksheet G-1

Date/Time Prepared:
5/30/2024 2:29 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		-5,338,465			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		579,879				2.00
3.00	Total (sum of line 1 and line 2)		-4,758,586			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING	2		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)		2			0	10.00
11.00	Subtotal (line 3 plus line 10)		-4,758,584			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	RETURN OF CAPITAL	2,500,000		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)		2,500,000			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-7,258,584			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	ROUNDING		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	RETURN OF CAPITAL		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. : 315458

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/30/2024 2:29 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	27,046,988		27,046,988	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)	27,046,988		27,046,988	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,207,339	0	1,207,339	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	28,254,327	0	28,254,327	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			26,989,646	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)			26,989,646	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315458

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

Worksheet G-3

Date/Time Prepared:
5/30/2024 2:29 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	28,254,327	1.00
2.00	Less: contractual allowances and discounts on patients accounts	809,387	2.00
3.00	Net patient revenues (Line 1 minus line 2)	27,444,940	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	26,989,646	4.00
5.00	Net income from service to patients (Line 3 minus 4)	455,294	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	20,280	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	73,520	24.00
24.01	NON PATIENT REVENUE	30,785	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	124,585	25.00
26.00	Total (Line 5 plus line 25)	579,879	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)	579,879	31.00