

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: 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/21/2024 11:29 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report Date: 5/21/2024 Time: 11:29 am 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 SPRING HILLS MATAWAN (315463) 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	Henny Grunfeld	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name		Henny Grunfeld	2
3	Signatory Title		FINANCE SUPERVISOR	3
4	Date		(Dated when report is electronic)	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	406,355	772	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	406,355	772	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. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 11:29 am					
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 38 FRENEAU AVENUE	PO Box:				1.00			
2.00	City: MATAWAN	State: NJ	Zip Code: 07747			2.00			
3.00	County: MONMOUTH	CBSA Code: 35154	Urban/Rural: U			3.00			
3.01		CBSA Code:				3.01			
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)				
		1.00	2.00	3.00	V	XVIII	XIX		
SNF and SNF-Based Component Identification:									
4.00	SNF	SPRING HILLS MATAWAN	315463	01/03/2000	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?					Y		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					1,977,738		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					1,977,738		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			
29.00	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.					N	N	N	29.00
30.00	Skilled Nursing Facility								30.00
31.00	Nursing Facility								31.00
32.00	ICF/IID					N	N		32.00
33.00	SNF-Based HHA								33.00
34.00	SNF-Based RHC								34.00
35.00	SNF-Based FQHC						N		35.00
36.00	SNF-Based CMHC								36.00
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. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/21/2024 11:29 am
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	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:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/21/2024 11:29 am	
		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.)	Y	03/13/2024	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

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

Provider No. : 315463

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/21/2024 11:29 am

				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. : 315463

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/21/2024 11:29 am

		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.)	03/13/2024	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PREPARER	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

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

Provider No. : 315463

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/21/2024 11:29 am

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	130	47,450	0	6,466	26,084	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)	130	47,450	0	6,466	26,084	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	3,782	36,332	0	132	111	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)	3,782	36,332	0	132	111	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	199	442	0.00	48.98	234.99	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)	199	442	0.00	48.98	234.99	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	82.20	0	183	104	143	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)	82.20	0	183	104	143	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	430	114.90	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)	430	114.90	0.00	8.00		

Provider No. : 315463

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

Worksheet S-3
Part II
Date/Time Prepared:
5/21/2024 11:29 am

	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)	6,137,807	0	6,137,807	239,285.00	25.65 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	6,137,807	0	6,137,807	239,285.00	25.65 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	6,137,807	0	6,137,807	239,285.00	25.65 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	2,476,937	0	2,476,937	57,284.00	43.24 14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00 15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1,010,242	0	1,010,242		
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)	1,010,242	0	1,010,242		

SNF WAGE INDEX INFORMATION

Provider No. : 315463

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

Worksheet S-3
Part III
Date/Time Prepared:
5/21/2024 11:29 am

	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	584,615	0	584,615	18,969.00	2.00
3.00	Plant Operation, Maintenance & Repairs	131,078	0	131,078	4,264.00	3.00
4.00	Laundry & Linen Service	58,254	0	58,254	3,561.00	4.00
5.00	Housekeeping	329,692	0	329,692	20,505.00	5.00
6.00	Dietary	661,273	0	661,273	35,251.00	6.00
7.00	Nursing Administration	849,867	0	849,867	16,881.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	74,755	0	74,755	2,255.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	127,295	0	127,295	7,738.00	13.00
14.00	Total (sum lines 1 thru 13)	2,816,829	0	2,816,829	109,424.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/21/2024 11:29 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		277,346	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		30,633	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		85,067	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		415,031	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		162,484	19.00
20.00	State or Federal Unemployment Taxes		39,681	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)		1,010,242	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. : 315463

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

Worksheet S-3
Part V
Date/Time Prepared:
5/21/2024 11:29 am

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)	522,729	91,164	613,893	12,825.00	47.87	1.00
2.00	Licensed Practical Nurses (LPNs)	1,359,625	237,119	1,596,744	38,525.00	41.45	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,438,625	250,896	1,689,521	78,512.00	21.52	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,320,979	579,179	3,900,158	129,862.00	30.03	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	71,520		71,520	929.00	76.99	14.00
15.00	Licensed Practical Nurses (LPNs)	138,963		138,963	2,422.00	57.38	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,364,051		1,364,051	42,168.00	32.35	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,574,534		1,574,534	45,519.00	34.59	17.00
18.00	Physical Therapists	383,493		383,493	5,015.00	76.47	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	396,419		396,419	5,277.00	75.12	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	122,491		122,491	1,473.00	83.16	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. : 315463

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

Worksheet S-7

Date/Time Prepared:
5/21/2024 11:29 am

		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. : 315463

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

Worksheet S-7

Date/Time Prepared:
5/21/2024 11:29 am

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315463

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

Worksheet A
Date/Time Prepared:
5/21/2024 11:29 am

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		3,858,452	3,858,452	0	3,858,452	1.00
3.00	00300		1,070,403	1,070,403	0	1,070,403	3.00
4.00	00400	584,615	2,201,554	2,786,169	0	2,786,169	4.00
5.00	00500	131,078	443,648	574,726	0	574,726	5.00
6.00	00600	58,254	26,662	84,916	0	84,916	6.00
7.00	00700	329,692	46,325	376,017	0	376,017	7.00
8.00	00800	661,273	368,676	1,029,949	0	1,029,949	8.00
9.00	00900	849,867	122,410	972,277	0	972,277	9.00
10.00	01000	0	379,609	379,609	0	379,609	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	74,755	2,300	77,055	0	77,055	13.00
15.00	01500	127,295	40,808	168,103	0	168,103	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,320,978	1,716,809	5,037,787	0	5,037,787	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	24,426	24,426	0	24,426	40.00
41.00	04100	0	45,454	45,454	0	45,454	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	10,815	10,815	0	10,815	43.00
44.00	04400	0	407,092	407,092	0	407,092	44.00
45.00	04500	0	363,610	363,610	0	363,610	45.00
46.00	04600	0	113,590	113,590	0	113,590	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	259,084	259,084	0	259,084	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	10,635	10,635	0	10,635	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		6,137,807	11,512,362	17,650,169	0	17,650,169	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		6,137,807	11,512,362	17,650,169	0	17,650,169	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315463

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

Worksheet A
Date/Time Prepared:
5/21/2024 11:29 am

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	1,280,142	5,138,594	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,070,403	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-478,427	2,307,742	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	574,726	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	84,916	6.00
7.00	00700	HOUSEKEEPING	0	376,017	7.00
8.00	00800	DIETARY	0	1,029,949	8.00
9.00	00900	NURSING ADMINISTRATION	0	972,277	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	379,609	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	77,055	13.00
15.00	01500	PATIENT ACTIVITIES	0	168,103	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-675	5,037,112	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	24,426	40.00
41.00	04100	LABORATORY	0	45,454	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	10,815	43.00
44.00	04400	PHYSICAL THERAPY	0	407,092	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	363,610	45.00
46.00	04600	SPEECH PATHOLOGY	0	113,590	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	259,084	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	10,635	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)	801,040	18,451,209	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	801,040	18,451,209	100.00

Provider No. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/21/2024 11:29 am
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		Increases					
		Cost Center	Line #	Salary	Non Salary		
		2.00	3.00	4.00	5.00		
100.00	TOTALS	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)				0	0 100.00

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

Provider No. : 315463

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

Worksheet A-6

Date/Time Prepared:
5/21/2024 11:29 am

		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. : 315463

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

Worksheet A-7

Date/Time Prepared:
5/21/2024 11:29 am

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0	0	0	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	29,754	103,972	0	103,972	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	80,446	67,447	0	67,447	0	6.00
7.00 Subtotal (sum of lines 1-6)	110,200	171,419	0	171,419	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	110,200	171,419	0	171,419	0	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	0	0				
4.00 Building Improvements	133,726	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	147,893	0				
7.00 Subtotal (sum of lines 1-6)	281,619	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	281,619	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315463

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

Worksheet A-8

Date/Time Prepared:
5/21/2024 11:29 am

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line No.	
			1.00	2.00	3.00	4.00
1.00 Investment income on restricted funds (chapter 2)	B	-11,744	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	1,146,936				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-52	ADMINISTRATIVE & GENERAL		4.00	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			CAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			*** Cost Center Deleted ***		2.00	24.00
25.00 PSYCH FEES	A	-675	SKILLED NURSING FACILITY		30.00	25.00
25.01 BAD DEBT	A	-237,900	ADMINISTRATIVE & GENERAL		4.00	25.01
25.02 MISC INCOME	B	-101	ADMINISTRATIVE & GENERAL		4.00	25.02
25.03 PROMOTION & MARKETING	A	-25,544	ADMINISTRATIVE & GENERAL		4.00	25.03
25.04 DONATIONS	A	-100	ADMINISTRATIVE & GENERAL		4.00	25.04
25.05 FINES & PENALTIES	A	-59,336	ADMINISTRATIVE & GENERAL		4.00	25.05
25.06 RESIDENT REIMBURSEMENT	A	-5,065	ADMINISTRATIVE & GENERAL		4.00	25.06
25.07 CORPORATE TAX	A	-300	ADMINISTRATIVE & GENERAL		4.00	25.07
25.08 SETTLEMENT	A	-5,000	ADMINISTRATIVE & GENERAL		4.00	25.08
25.09 OTHER REV - CREDIT CARD CASH BACK	B	-283	ADMINISTRATIVE & GENERAL		4.00	25.09
25.10 OTHER REV - RESIDENT CARE FEES	B	204	ADMINISTRATIVE & GENERAL		4.00	25.10
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		801,040				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. : 315463

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/21/2024 11:29 am

	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	REALTY	1.00	
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY ADMIN COSTS	2.00	
3.00	4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT	3.00	
4.00	0.00			4.00	
5.00	0.00			5.00	
6.00	0.00			6.00	
7.00	0.00			7.00	
8.00	0.00			8.00	
9.00	0.00			9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)		
	4.00	5.00	6.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4,708,866	3,416,980	1,291,886	1.00	
2.00	6,193	0	6,193	2.00	
3.00	645,541	796,684	-151,143	3.00	
4.00	0	0	0	4.00	
5.00	0	0	0	5.00	
6.00	0	0	0	6.00	
7.00	0	0	0	7.00	
8.00	0	0	0	8.00	
9.00	0	0	0	9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	5,360,600	4,213,664	1,146,936	10.00

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

Provider No. : 315463

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/21/2024 11:29 am

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00		B	ATLAS MANAGEMENT	0.00	1.00
2.00		B	ATLAS MANAGEMENT	0.00	2.00
3.00				0.00	3.00
4.00				0.00	4.00
5.00				0.00	5.00
6.00				0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
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	ATLAS HEALTHCARE LLC	100.00	MANAGEMENT	1.00
2.00	38 FENEAU AVENUE REALTY LLC	100.00	REALTY	2.00
3.00		0.00		3.00
4.00		0.00		4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
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. : 315463

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	5,138,594	5,138,594			1.00
3.00 00300	EMPLOYEE BENEFITS	1,070,403	0	1,070,403		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,307,742	177,790	101,954	2,587,486	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	574,726	307,682	22,859	905,267	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	84,916	108,754	10,159	203,829	6.00
7.00 00700	HOUSEKEEPING	376,017	27,274	57,497	460,788	7.00
8.00 00800	DIETARY	1,029,949	165,972	115,323	1,311,244	8.00
9.00 00900	NURSING ADMINISTRATION	972,277	47,956	148,213	1,168,446	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	379,609	54,604	0	434,213	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	77,055	12,273	13,037	102,365	13.00
15.00 01500	PATIENT ACTIVITIES	168,103	39,774	22,200	230,077	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	5,037,112	3,774,113	579,161	9,390,386	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	24,426	0	0	24,426	40.00
41.00 04100	LABORATORY	45,454	0	0	45,454	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	10,815	0	0	10,815	43.00
44.00 04400	PHYSICAL THERAPY	407,092	126,425	0	533,517	44.00
45.00 04500	OCCUPATIONAL THERAPY	363,610	148,869	0	512,479	45.00
46.00 04600	SPEECH PATHOLOGY	113,590	49,093	0	162,683	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	259,084	0	0	259,084	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	10,635	0	0	10,635	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)	18,451,209	5,040,579	1,070,403	18,353,194	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	98,015	0	98,015	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	18,451,209	5,138,594	1,070,403	18,451,209	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315463

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	1,052,922				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	24,609	261,684			6.00	
7.00	00700	HOUSEKEEPING	6,172	0	542,118		7.00	
8.00	00800	DIETARY	37,557	0	19,919	1,582,593	8.00	
9.00	00900	NURSING ADMINISTRATION	10,852	0	5,755	0	1,375,635	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	12,356	0	6,553	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	2,777	0	1,473	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	9,000	0	4,773	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	854,016	261,684	452,951	1,582,593	1,375,635	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	28,608	0	15,173	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	33,687	0	17,866	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	11,109	0	5,892	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
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)	1,030,743	261,684	530,355	1,582,593	1,375,635	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	22,179	0	11,763	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	1,052,922	261,684	542,118	1,582,593	1,375,635	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315463

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES		
		10.00	11.00	12.00	13.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00	
6.00	00600	LAUNDRY & LINEN SERVICE					6.00	
7.00	00700	HOUSEKEEPING					7.00	
8.00	00800	DIETARY					8.00	
9.00	00900	NURSING ADMINISTRATION					9.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	523,945				10.00	
11.00	01100	PHARMACY	0	0			11.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0		12.00	
13.00	01300	SOCIAL SERVICE	0	0	0	123,311	13.00	
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	281,377	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	311,408	0	0	123,311	281,377	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	212,537	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
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)	523,945	0	0	123,311	281,377	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER 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					98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	523,945	0	0	123,311	281,377	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315463

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description		Subtotal	Post Stepdown Adjustments	Total	
		16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
3.00	00300				3.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
15.00	01500				15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	16,165,001	0	16,165,001	30.00
31.00	03100	0	0	0	31.00
32.00	03200	0	0	0	32.00
33.00	03300	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	28,410	0	28,410	40.00
41.00	04100	52,868	0	52,868	41.00
42.00	04200	0	0	0	42.00
43.00	04300	12,579	0	12,579	43.00
44.00	04400	664,318	0	664,318	44.00
45.00	04500	647,621	0	647,621	45.00
46.00	04600	206,219	0	206,219	46.00
47.00	04700	0	0	0	47.00
48.00	04800	0	0	0	48.00
49.00	04900	513,879	0	513,879	49.00
50.00	05000	0	0	0	50.00
51.00	05100	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	0	0	0	60.00
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	0	0	0	70.00
71.00	07100	12,370	0	12,370	71.00
73.00	07300	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	83.00
89.00		18,303,265	0	18,303,265	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	0	0	0	90.00
91.00	09100	147,944	0	147,944	91.00
92.00	09200	0	0	0	92.00
93.00	09300	0	0	0	93.00
94.00	09400	0	0	0	94.00
98.00		0	0	0	98.00
99.00		0	0	0	99.00
100.00		18,451,209	0	18,451,209	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315463

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	2A	3.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	177,790	177,790	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	307,682	307,682	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	108,754	108,754	0	6.00
7.00 00700	HOUSEKEEPING	0	27,274	27,274	0	7.00
8.00 00800	DIETARY	0	165,972	165,972	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	47,956	47,956	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	54,604	54,604	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	12,273	12,273	0	13.00
15.00 01500	PATIENT ACTIVITIES	0	39,774	39,774	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	3,774,113	3,774,113	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	126,425	126,425	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	148,869	148,869	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	49,093	49,093	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC					62.00
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	5,040,579	5,040,579	0	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	98,015	98,015	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
100.00	TOTAL	0	5,138,594	5,138,594	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315463

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	317,827				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	7,428	118,466			6.00
7.00	00700	HOUSEKEEPING	1,863	0	34,301		7.00
8.00	00800	DIETARY	11,337	0	1,260	193,264	8.00
9.00	00900	NURSING ADMINISTRATION	3,276	0	364	0	64,691
10.00	01000	CENTRAL SERVICES & SUPPLY	3,730	0	415	0	0
11.00	01100	PHARMACY	0	0	0	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
13.00	01300	SOCIAL SERVICE	838	0	93	0	0
15.00	01500	PATIENT ACTIVITIES	2,717	0	302	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	257,787	118,466	28,660	193,264	64,691
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	0
41.00	04100	LABORATORY	0	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00	04400	PHYSICAL THERAPY	8,635	0	960	0	0
45.00	04500	OCCUPATIONAL THERAPY	10,168	0	1,130	0	0
46.00	04600	SPEECH PATHOLOGY	3,353	0	373	0	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00	06200	FOHC	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00	07100	AMBULANCE	0	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
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
89.00		SUBTOTALS (sum of lines 1-84)	311,132	118,466	33,557	193,264	64,691
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	6,695	0	744	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
98.00		Cross Foot Adjustments	0	0	0	0	0
99.00		Negative Cost Centers	0	0	0	0	0
100.00		TOTAL	317,827	118,466	34,301	193,264	64,691

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315463

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES		
		10.00	11.00	12.00	13.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00	
6.00	00600	LAUNDRY & LINEN SERVICE					6.00	
7.00	00700	HOUSEKEEPING					7.00	
8.00	00800	DIETARY					8.00	
9.00	00900	NURSING ADMINISTRATION					9.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	63,615				10.00	
11.00	01100	PHARMACY	0	0			11.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0		12.00	
13.00	01300	SOCIAL SERVICE	0	0	0	14,351	13.00	
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	45,371	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	37,810	0	0	14,351	45,371	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	25,805	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
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)	63,615	0	0	14,351	45,371	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	63,615	0	0	14,351	45,371	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315463

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

Worksheet B
Part II
Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description		Subtotal	Post Step-Down Adjustments	Total	
		16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
3.00	00300				3.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
15.00	01500				15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,639,759	0	4,639,759	30.00
31.00	03100	0	0	0	31.00
32.00	03200	0	0	0	32.00
33.00	03300	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	274	0	274	40.00
41.00	04100	509	0	509	41.00
42.00	04200	0	0	0	42.00
43.00	04300	121	0	121	43.00
44.00	04400	141,999	0	141,999	44.00
45.00	04500	165,910	0	165,910	45.00
46.00	04600	54,642	0	54,642	46.00
47.00	04700	0	0	0	47.00
48.00	04800	0	0	0	48.00
49.00	04900	28,709	0	28,709	49.00
50.00	05000	0	0	0	50.00
51.00	05100	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	0	0	0	60.00
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	0	0	0	70.00
71.00	07100	119	0	119	71.00
73.00	07300	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	83.00
89.00		5,032,042	0	5,032,042	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	0	0	0	90.00
91.00	09100	106,552	0	106,552	91.00
92.00	09200	0	0	0	92.00
93.00	09300	0	0	0	93.00
94.00	09400	0	0	0	94.00
98.00		0	0	0	98.00
99.00		0	0	0	99.00
100.00		5,138,594	0	5,138,594	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315463

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

Worksheet B-1

Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	90,436				1.00
3.00 00300	EMPLOYEE BENEFITS	0	6,137,807			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,129	584,615	-2,587,486	15,863,723	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	5,415	131,078	0	905,267	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,914	58,254	0	203,829	6.00
7.00 00700	HOUSEKEEPING	480	329,692	0	460,788	7.00
8.00 00800	DIETARY	2,921	661,273	0	1,311,244	8.00
9.00 00900	NURSING ADMINISTRATION	844	849,867	0	1,168,446	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	961	0	0	434,213	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	216	74,755	0	102,365	13.00
15.00 01500	PATIENT ACTIVITIES	700	127,295	0	230,077	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	66,422	3,320,978	0	9,390,386	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	24,426	40.00
41.00 04100	LABORATORY	0	0	0	45,454	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	10,815	43.00
44.00 04400	PHYSICAL THERAPY	2,225	0	0	533,517	44.00
45.00 04500	OCCUPATIONAL THERAPY	2,620	0	0	512,479	45.00
46.00 04600	SPEECH PATHOLOGY	864	0	0	162,683	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	259,084	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	10,635	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)	88,711	6,137,807	-2,587,486	15,765,708	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	1,725	0	0	98,015	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)	5,138,594	1,070,403		2,587,486	1,052,922
103.00	Unit cost multiplier (Wkst. B, Part I)	56.820226	0.174395		0.163107	12.857446
104.00	Cost to be allocated (per Wkst. B, Part II)		0		177,790	317,827
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.011207	3.881051

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315463

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

Worksheet B-1

Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	36,332				6.00
7.00	00700	HOUSEKEEPING	0	79,498			7.00
8.00	00800	DIETARY	0	2,921	108,996		8.00
9.00	00900	NURSING ADMINISTRATION	0	844	0	175,382	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	961	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	216	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	700	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	36,332	66,422	108,996	175,382	379,609
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	0
41.00	04100	LABORATORY	0	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00	04400	PHYSICAL THERAPY	0	2,225	0	0	0
45.00	04500	OCCUPATIONAL THERAPY	0	2,620	0	0	0
46.00	04600	SPEECH PATHOLOGY	0	864	0	0	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	259,084
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	0	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00	06200	FOHC	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00	07100	AMBULANCE	0	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
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
89.00		SUBTOTALS (sum of lines 1-84)	36,332	77,773	108,996	175,382	638,693
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	1,725	0	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
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)	261,684	542,118	1,582,593	1,375,635	523,945
103.00		Unit cost multiplier (Wkst. B, Part I)	7.202576	6.819266	14.519735	7.843650	0.820339
104.00		Cost to be allocated (per Wkst. B, Part II)	118,466	34,301	193,264	64,691	63,615
105.00		Unit cost multiplier (Wkst. B, Part II)	3.260652	0.431470	1.773129	0.368858	0.099602

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315463

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

Worksheet B-1

Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE		
	11.00	12.00	13.00	PATIENT ACTIVITIES (PATIENT CENSUS)	15.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPING						7.00
8.00 00800 DIETARY						8.00
9.00 00900 NURSING ADMINISTRATION						9.00
10.00 01000 CENTRAL SERVICES & SUPPLY						10.00
11.00 01100 PHARMACY	0					11.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00 01300 SOCIAL SERVICE	0	0	36,332			13.00
15.00 01500 PATIENT ACTIVITIES	0	0	0	36,332		15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	0	0	36,332	36,332		30.00
31.00 03100 NURSING FACILITY	0	0	0	0		31.00
32.00 03200 ICF/IID	0	0	0	0		32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	0		33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000 RADIOLOGY	0	0	0	0		40.00
41.00 04100 LABORATORY	0	0	0	0		41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	0		42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0		43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	0		44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	0		45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	0		46.00
47.00 04700 ELECTROCARDIOLOGY	0	0	0	0		47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0		49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0		50.00
51.00 05100 SUPPORT SURFACES	0	0	0	0		51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000 CLINIC		0	0	0		60.00
61.00 06100 RURAL HEALTH CLINIC	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		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	0	36,332	36,332		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)	0	0	123,311	281,377		102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	3.394005	7.744605		103.00
104.00 Cost to be allocated (per Wkst. B, Part II)	0	0	14,351	45,371		104.00
105.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.394996	1.248789		105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315463

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

Worksheet C

Date/Time Prepared:
5/21/2024 11:29 am

Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
			Wkst. B, Pt 1, col. 18)		divided by col. 2	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	28,410	6,450	4.404651	40.00
41.00	04100	LABORATORY	52,868	22,694	2.329603	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	12,579	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	664,318	585,479	1.134657	44.00
45.00	04500	OCCUPATIONAL THERAPY	647,621	553,589	1.169859	45.00
46.00	04600	SPEECH PATHOLOGY	206,219	289,275	0.712882	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	513,879	135,912	3.780969	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	12,370	0	0.000000	71.00
100.00		Total	2,138,264	1,593,399		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/21/2024 11:29 am
		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	4.404651	1,398	0	6,158	0 40.00
41.00	04100 LABORATORY	2.329603	18,427	0	42,928	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	1.134657	270,803	0	307,269	0 44.00
45.00	04500 OCCUPATIONAL THERAPY	1.169859	246,367	0	288,215	0 45.00
46.00	04600 SPEECH PATHOLOGY	0.712882	150,893	0	107,569	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	3.780969	112,722	0	426,198	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)		800,610	0	1,178,337	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. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/21/2024 11:29 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	3.780969	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	3,030	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)	11,456	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	28,410	0	0.000000	6,158	0	40.00
41.00	04100	LABORATORY	52,868	0	0.000000	42,928	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	12,579	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	664,318	0	0.000000	307,269	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	647,621	0	0.000000	288,215	0	45.00
46.00	04600	SPEECH PATHOLOGY	206,219	0	0.000000	107,569	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	513,879	0	0.000000	426,198	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)	2,125,894	0		1,178,337	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-III Date/Time Prepared: 5/21/2024 11:29 am
	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		36,332	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		6,466	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		16,165,001	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		15,507,675	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		1.042387	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		16,165,001	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		444.92	16.00
17.00	Program routine service cost (Line 3 times line 16)		2,876,853	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)		2,876,853	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)		4,639,759	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		127.70	21.00
22.00	Program capital related cost (Line 3 times line 21)		825,708	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		2,051,145	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		2,051,145	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		36,332	1.00
2.00	Program inpatient days (see instructions)		6,466	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)		0.177970	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 XVIIII		Provider No. : 315463	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/21/2024 11:29 am
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		5,202,804	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		5,202,804	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		952,800	5.00
6.00	Allowable bad debts (From your records)		742,907	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		332,791	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		482,890	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		4,732,894	11.00
12.00	Interim payments (See instructions)		4,231,881	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)		9,658	14.75
14.99	Sequestration amount (see instructions)		85,000	14.99
15.00	Balance due provider/program (see Instructions)		406,355	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		11,456	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		11,456	19.00
20.00	Medicare Part B ancillary charges (See instructions)		3,030	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		3,030	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)		3,030	25.00
26.00	Interim payments (See instructions)		2,197	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)		61	28.99
29.00	Balance due provider/program (see instructions)		772	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. : 315463

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

Worksheet E-1

Date/Time Prepared:
5/21/2024 11:29 am

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					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		4,195,967		2,197	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		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/31/2023	35,914		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)		35,914		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		4,231,881		2,197	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		406,355		772	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,638,236		2,969	7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					8.00

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

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

Provider No. : 315463

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

Worksheet G

Date/Time Prepared:
5/21/2024 11:29 am

		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	612,924	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,007,861	0	0	0	4.00
5.00	Other receivables	379,028	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-101,546	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	70,988	0	0	0	8.00
9.00	Other current assets	27,074	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4,996,329	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	133,726	0	0	0	17.00
18.00	Less: Accumulated Amortization	-9,105	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	147,894	0	0	0	23.00
24.00	Less: Accumulated depreciation	-27,964	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)	244,551	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	133,432	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)	133,432	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5,374,312	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	745,539	0	0	0	35.00
36.00	Salaries, wages, and fees payable	380,050	0	0	0	36.00
37.00	Payroll taxes payable	27,084	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	773,710	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	4,380,064	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	6,306,447	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	0	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	6,306,447	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-932,135	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)	-932,135	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	5,374,312	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315463

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

Worksheet G-1

Date/Time Prepared:
5/21/2024 11:29 am

		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		769,218			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-1,701,353				2.00
3.00	Total (sum of line 1 and line 2)		-932,135			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		-932,135			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-932,135			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)						4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315463

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/21/2024 11:29 am

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	15,507,675		15,507,675	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	15,507,675		15,507,675	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,593,399	0	1,593,399	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD	50,897	0	50,897	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	17,151,971	0	17,151,971	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			17,650,169	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)			17,650,169	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315463

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

Worksheet G-3

Date/Time Prepared:
5/21/2024 11:29 am

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17,151,971	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,216,928	2.00
3.00	Net patient revenues (Line 1 minus line 2)	15,935,043	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17,650,169	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,715,126	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,744	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	52	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	NON PATIENT REVENUE	1,977	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	13,773	25.00
26.00	Total (Line 5 plus line 25)	-1,701,353	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)	-1,701,353	31.00

**MEADOWBROOK RESPIRATORY AND NURSING CENTER
SUPPLEMENTARY INFORMATION
YEAR ENDED 2023**

BALANCE SHEET

Assets

Current Assets	
Cash and Cash Equivalents	\$ 639,997.90
Accounts Receivable, Net	\$3,906,315.33
Prepaid Expenses	\$ 70,987.72
Other Current Assets	\$ 379,028.30
Total Current Assets	<u>\$4,996,329.25</u>
Fixed Assets, Net	
Fixed Assets	\$ 281,619.45
Accumulated Depreciation	\$ 37,068.94
Total Fixed Assets, Net	<u>\$ 244,550.51</u>
Other Assets	
Other Assets	\$ 23,537.61
Total Other Assets	<u>\$ 23,537.61</u>
Total Assets	<u><u>\$5,264,417.37</u></u>

Liabilities and Equity

Current Liabilities	
Accounts Payable	\$ 463,131.62
Accrued Liabilities	\$ 638,091.77
Accrued Taxes	\$ 27,084.38
Intercompany Payable	\$4,270,169.41
Other Current Liabilities	\$ 24,365.40
Total Current Liabilities	<u>\$5,422,842.58</u>
Other Liabilities	
Other Liabilities	\$ 773,709.96
Total Other Liabilities	<u>\$ 773,709.96</u>
Stockholders Equity	<u>\$ (932,135.17)</u>
Total Liabilities and Equity	<u><u>\$5,264,417.37</u></u>

**MEADOWBROOK RESPIRATORY AND NURSING CENTER
SUPPLEMENTARY INFORMATION
YEAR ENDED 2023**

STATEMENT OF CASH FLOWS

Cash flows from Operating activities	
Net Gain (Loss)	\$ (1,701,352.91)
Depreciation & Amortization	\$ 32,463.25
Changes In:	
Accounts Receivable	\$ 122,322.42
Prepaid Expenses	\$ (5,475.67)
Operating Assets	\$ (353,782.96)
Accounts payable	\$ (268,852.73)
Accrued Expenses	\$ (29,585.53)
Accrued Taxes & Withholdings	\$ 423.49
Changes in Other Current Payables	\$ (41,251.19)
Due To/From Third Party Payors	\$ 649,989.53
Net cash provided by Operating activities	<u>\$ (1,595,102.30)</u>
Cash flows from Investing activities	
Purchase of Property and Equipment	\$ (171,418.90)
Net cash provided by Investing activities	<u>\$ (171,418.90)</u>
Cash flows from Financing activities	
Dues to Affiliate	\$ 738,588.25
Net cash provided by Financing activities	<u>\$ 738,588.25</u>
Cash and Cash Equivalents-Beginning of year	<u>\$ 1,667,930.85</u>
CASH & CASH EQUIVALENTS - END OF PERIOD	<u>\$ 639,997.90</u>

**MEADOWBROOK RESPIRATORY AND NURSING CENTER
SUPPLEMENTARY INFORMATION
YEAR ENDED 2023**

REVENUES

Income

Medicare	\$ 3,909,570.01
Medicare HMO	\$ 370,427.11
Private	\$ 714,706.24
Medicaid	\$ 5,729,023.21
Medicaid HMO	\$ 48,055.26
Commercial	\$ 112,437.13
Hospice	\$ 314,780.45
Total Income	<u>\$11,198,999.41</u>

Vent Income

Medicare Vent	\$ 1,363,689.68
Medicare HMO Vent	\$ 149,544.69
Private Vent	\$ 175,158.32
Medicaid Vent	\$ 2,128,318.49
Medicaid HMO Vent	\$ 246,812.04
Commercial Vent	\$ 158,933.00
Total Vent Income	<u>\$ 4,222,456.22</u>

Other Income

Revenue- Ancillary	\$ 463,812.36
Other Income	\$ 63,548.21
Total Other Income	<u>\$ 527,360.57</u>

TO TAL REVENUES

\$15,948,816.20

**MEADOWBROOK RESPIRATORY AND NURSING CENTER
SUPPLEMENTARY INFORMATION
YEAR ENDED 2023**

STATEMENT OF CHANGES IN NET ASSETS

Stockholders Equity Beg	\$769,217.74
INCOME/NET INCOME	\$(1,701,352.91)
Stockholders Equity	\$(932,135.17)