

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: 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/24/2024 1:28 pm
---	----------------------	---	--

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

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMPLETE CARE AT LAURELTON (315274) 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	1 Shalom Stein	2 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	Shalom Stein		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-20,494	1,952	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	-20,494	1,952	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. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 1:28 pm			
1.00		2.00		3.00			
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:							
1.00	Street: 475 JACK MARTIN BLVD	PO Box:				1.00	
2.00	City: BRICK	State: NJ	Zip Code: 08725			2.00	
3.00	County: OCEAN	CBSA Code: 35154	Urban/Rural: U			3.00	
3.01		CBSA Code:				3.01	
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)		
		1.00	2.00	3.00	V	XVIII	XIX
					4.00	5.00	6.00
SNF and SNF-Based Component Identification:							
4.00	SNF	COMPLETE CARE AT LAURELTON	315274	04/17/1989	N	P	P
5.00	Nursing Facility						
6.00	ICF/IID						
7.00	SNF-Based HHA						
8.00	SNF-Based RHC						
9.00	SNF-Based FQHC						
10.00	SNF-Based CMHC						
11.00	SNF-Based OLTC						
12.00	SNF-Based HOSPICE						
13.00	SNF-Based CORF						
				From:	To:		
14.00	Cost Reporting Period (mm/dd/yyyy)			1.00	2.00		
15.00	Type of Control (See Instructions)			01/01/2023	12/31/2023		
				4			
					Y/N		
					1.00		
Type of Freestanding Skilled Nursing Facility							
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y	18.00
Miscellaneous Cost Reporting Information							
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.01
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.							
20.00	Straight Line					307,734	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					307,734	23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00
				Part A	Part B	Other	
				1.00	2.00	3.00	
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.							
29.00	Skilled Nursing Facility				N	N	N
30.00	Nursing Facility						
31.00	ICF/IID						
32.00	SNF-Based HHA				N	N	
33.00	SNF-Based RHC						
34.00	SNF-Based FQHC						
35.00	SNF-Based CMHC					N	
36.00	SNF-Based OLTC						
				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			
38.00	Are you legally-required to carry malpractice insurance? (Y/N)			N			
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.						
			Premiums	Paid Losses	Self Insurance		
			1.00	2.00	3.00		
41.00	List malpractice premiums and paid losses:			0	0	0	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/24/2024 1:28 pm
				Y/N
				1.00
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.			N 42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?			N 43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			44.00
	1.00	2.00	3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.				
45.00	Name:	Contractor's Name:	Contractor's Number:	45.00
46.00	Street:	PO Box:		46.00
47.00	City:	State:	Zip Code:	47.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/24/2024 1:28 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	04/26/2024	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. : 315274

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/24/2024 1:28 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ALEXANDER	SOCHACKI	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	AL.SOCHACKI@HCRNJ.NET	21.00

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

Provider No. : 315274

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/24/2024 1:28 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	04/26/2024	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. : 315274

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/24/2024 1:28 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	180	65,700	0	4,202	26,304	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)	180	65,700	0	4,202	26,304	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	6,125	36,631	0	157	18	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)	6,125	36,631	0	157	18	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	361	536	0.00	26.76	1,461.33	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)	361	536	0.00	26.76	1,461.33	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	68.34	0	181	16	339	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)	68.34	0	181	16	339	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	536	82.30	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	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)	536	82.30	0.00	8.00		

Provider No. : 315274

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2024 1:28 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	5,177,317	0	5,177,317	170,830.00	30.31 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)	5,177,317	0	5,177,317	170,830.00	30.31 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)	5,177,317	0	5,177,317	170,830.00	30.31 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	2,303,423	0	2,303,423	60,352.00	38.17 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)	725,271	0	725,271		
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)	725,271	0	725,271		

Provider No. : 315274

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2024 1:28 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	667,241	0	667,241	15,855.00	2.00
3.00	Plant Operation, Maintenance & Repairs	114,410	0	114,410	4,102.00	3.00
4.00	Laundry & Linen Service	0	0	0.00	0.00	4.00
5.00	Housekeeping	0	0	0.00	0.00	5.00
6.00	Dietary	477,030	0	477,030	26,224.00	6.00
7.00	Nursing Administration	554,233	0	554,233	15,733.00	7.00
8.00	Central Services and Supply	43,742	0	43,742	1,876.00	8.00
9.00	Pharmacy	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	11,359	0	11,359	731.00	10.00
11.00	Social Service	119,384	0	119,384	3,125.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	212,085	0	212,085	11,757.00	13.00
14.00	Total (sum lines 1 thru 13)	2,199,484	0	2,199,484	79,403.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2024 1:28 pm
------------------------	-----------------------	---	--

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	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)	170,205	8.00
9.00	Prescription Drug Plan	462	9.00
10.00	Dental, Hearing and Vision Plan	2,580	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,468	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	100,386	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	385,652	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	64,518	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)	725,271	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. : 315274

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

Worksheet S-3
Part V
Date/Time Prepared:
5/24/2024 1:28 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	721,161	107,237	828,398	14,038.00	59.01	1.00
2.00	Licensed Practical Nurses (LPNs)	979,811	145,698	1,125,509	23,612.00	47.67	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,276,861	189,869	1,466,730	53,777.00	27.27	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,977,833	442,804	3,420,637	91,427.00	37.41	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)	220,062		220,062	4,396.00	50.06	14.00
15.00	Licensed Practical Nurses (LPNs)	790,660		790,660	21,239.00	37.23	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	661,400		661,400	24,086.00	27.46	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,672,122		1,672,122	49,721.00	33.63	17.00
18.00	Physical Therapists	137,250		137,250	2,161.00	63.51	18.00
19.00	Physical Therapy Assistants	147,356		147,356	2,321.00	63.49	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	132,620		132,620	2,369.00	55.98	21.00
22.00	Occupational Therapy Assistants	142,601		142,601	2,547.00	55.99	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	71,474		71,474	1,232.00	58.01	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. : 315274

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

Worksheet S-7
Date/Time Prepared:
5/24/2024 1:28 pm

		Group	Days	
		1. 00	2. 00	
1. 00		RUX		1. 00
2. 00		RUL		2. 00
3. 00		RVX		3. 00
4. 00		RVL		4. 00
5. 00		RHX		5. 00
6. 00		RHL		6. 00
7. 00		RMX		7. 00
8. 00		RML		8. 00
9. 00		RLX		9. 00
10. 00		RUC		10. 00
11. 00		RUB		11. 00
12. 00		RUA		12. 00
13. 00		RVC		13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31. 00
32. 00		HC1		32. 00
33. 00		HB2		33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37. 00
38. 00		LD1		38. 00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41. 00		LB2		41. 00
42. 00		LB1		42. 00
43. 00		CE2		43. 00
44. 00		CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00		CB1		50. 00
51. 00		CA2		51. 00
52. 00		CA1		52. 00
53. 00		SE3		53. 00
54. 00		SE2		54. 00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		IB2		59. 00
60. 00		IB1		60. 00
61. 00		IA2		61. 00
62. 00		IA1		62. 00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66. 00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69. 00		PD2		69. 00
70. 00		PD1		70. 00
71. 00		PC2		71. 00
72. 00		PC1		72. 00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00		PA2		75. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315274

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

Worksheet S-7

Date/Time Prepared:
5/24/2024 1:28 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315274

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

Worksheet A
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		2,389,091	2,389,091	0	2,389,091	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		0	0	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	769,714	769,714	0	769,714	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	667,241	2,244,625	2,911,866	0	2,911,866	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	114,410	331,898	446,308	0	446,308	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	42,987	42,987	0	42,987	6.00
7.00	00700	HOUSEKEEPING	0	461,472	461,472	0	461,472	7.00
8.00	00800	DIETARY	477,030	498,005	975,035	0	975,035	8.00
9.00	00900	NURSING ADMINISTRATION	554,233	0	554,233	0	554,233	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	43,742	170,407	214,149	0	214,149	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	11,359	0	11,359	0	11,359	12.00
13.00	01300	SOCIAL SERVICE	119,384	5,877	125,261	0	125,261	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	212,085	38,609	250,694	0	250,694	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	2,977,833	1,880,551	4,858,384	0	4,858,384	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	3,514	3,514	0	3,514	40.00
41.00	04100	LABORATORY	0	29,449	29,449	0	29,449	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	8,021	8,021	0	8,021	43.00
44.00	04400	PHYSICAL THERAPY	0	283,593	283,593	0	283,593	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	274,092	274,092	0	274,092	45.00
46.00	04600	SPEECH PATHOLOGY	0	71,593	71,593	0	71,593	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	264,806	264,806	0	264,806	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	12,999	12,999	0	12,999	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	5,177,317	9,781,303	14,958,620	0	14,958,620	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
100.00		TOTAL	5,177,317	9,781,303	14,958,620	0	14,958,620	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Prepared: 5/24/2024 1:28 pm
--	--	-----------------------	---	---

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	71,499	2,460,590	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	769,714	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-486,614	2,425,252	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	446,308	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	42,987	6.00
7.00	00700	HOUSEKEEPING	0	461,472	7.00
8.00	00800	DIETARY	-4,603	970,432	8.00
9.00	00900	NURSING ADMINISTRATION	0	554,233	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	214,149	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	11,359	12.00
13.00	01300	SOCIAL SERVICE	0	125,261	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	0	250,694	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	4,858,384	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	3,514	40.00
41.00	04100	LABORATORY	0	29,449	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	8,021	43.00
44.00	04400	PHYSICAL THERAPY	0	283,593	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	274,092	45.00
46.00	04600	SPEECH PATHOLOGY	0	71,593	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	264,806	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	12,999	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)	-419,718	14,538,902	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	-419,718	14,538,902	100.00

Provider No. : 315274

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

Worksheet A-6

Date/Time Prepared:
5/24/2024 1:28 pm

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

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

Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepared: 5/24/2024 1:28 pm
-----------------------	---	---

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315274

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

Worksheet A-7

Date/Time Prepared:
5/24/2024 1:28 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	1,021,661	1,772,479	0	1,772,479	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	899,099	18,287	0	18,287	0	6.00
7.00 Subtotal (sum of lines 1-6)	1,920,760	1,790,766	0	1,790,766	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	1,920,760	1,790,766	0	1,790,766	0	9.00
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	0	0				
4.00 Building Improvements	2,794,140	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	917,386	0				
7.00 Subtotal (sum of lines 1-6)	3,711,526	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	3,711,526	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315274

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

Worksheet A-8

Date/Time Prepared:
5/24/2024 1:28 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line No.	
			1.00	2.00	3.00	4.00
1.00 Investment income on restricted funds (chapter 2)	B	-3,581	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	-86,893				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals	B	-4,603	DIETARY		8.00	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	-527	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			OCAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT		2.00	24.00
25.00		0			0.00	25.00
25.01 BAD DEBTS	A	-167,199	ADMINISTRATIVE & GENERAL		4.00	25.01
25.03 MARKETING	A	-126,939	ADMINISTRATIVE & GENERAL		4.00	25.03
25.05 FINES & PENALTIES	A	-23,989	ADMINISTRATIVE & GENERAL		4.00	25.05
25.07 RESIDENT MISSING ITEMS	A	-380	ADMINISTRATIVE & GENERAL		4.00	25.07
25.09 GOODWILL	A	-5,607	ADMINISTRATIVE & GENERAL		4.00	25.09
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-419,718				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. : 315274

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

Worksheet A-8-1
Parts I-II
Date/Time Prepared:
5/24/2024 1:28 pm

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	1.00	
2.00	4.00	ADMINISTRATIVE & GENERAL	COMPLETE CARE MANAGEMENT	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	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	1,893,495	1,818,415	75,080	1.00	
2.00	484,435	646,408	-161,973	2.00	
3.00	0	0	0	3.00	
4.00	0	0	0	4.00	
5.00	0	0	0	5.00	
6.00	0	0	0	6.00	
7.00	0	0	0	7.00	
8.00	0	0	0	8.00	
9.00	0	0	0	9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
	2,377,930	2,464,823	-86,893		

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

Provider No. : 315274

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

Worksheet A-8-1
Parts I-II
Date/Time Prepared:
5/24/2024 1:28 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	B	PEACE CAPITAL LLC	59.00	1.00
2.00	B	EEF CAPITAL LLC	40.00	2.00
3.00	B	MALKA STEIN	1.00	3.00
4.00	B	PEACE CAPITAL	100.00	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		LAURELTON REALTY	59.00	REALTY	1.00
2.00		LAURELTON REALTY	40.00	REALTY	2.00
3.00		LAURELTON REALTY	1.00	REALTY	3.00
4.00		COMPLETE CRE MANAGEMENT	100.00	MANAGEMENT COMPANY	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. : 315274

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	2,460,590	2,460,590			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	769,714	18,179	0	787,893	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,425,252	117,002	0	101,542	2,643,796
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	446,308	35,455	0	17,411	499,174
6.00 00600	LAUNDRY & LINEN SERVICE	42,987	47,445	0	0	90,432
7.00 00700	HOUSEKEEPING	461,472	14,053	0	0	475,525
8.00 00800	DIETARY	970,432	178,888	0	72,595	1,221,915
9.00 00900	NURSING ADMINISTRATION	554,233	31,587	0	84,344	670,164
10.00 01000	CENTRAL SERVICES & SUPPLY	214,149	15,085	0	6,657	235,891
11.00 01100	PHARMACY	0	0	0	0	0
12.00 01200	MEDICAL RECORDS & LIBRARY	11,359	9,283	0	1,729	22,371
13.00 01300	SOCIAL SERVICE	125,261	15,729	0	18,168	159,158
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00 01500	PATIENT ACTIVITIES	250,694	93,150	0	32,276	376,120
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	4,858,384	1,773,598	0	453,171	7,085,153
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	3,514	0	0	0	3,514
41.00 04100	LABORATORY	29,449	0	0	0	29,449
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00 04300	OXYGEN (INHALATION) THERAPY	8,021	0	0	0	8,021
44.00 04400	PHYSICAL THERAPY	283,593	45,125	0	0	328,718
45.00 04500	OCCUPATIONAL THERAPY	274,092	28,364	0	0	302,456
46.00 04600	SPEECH PATHOLOGY	71,593	7,478	0	0	79,071
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	264,806	0	0	0	264,806
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	FQHC	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	12,999	0	0	0	12,999
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)	14,538,902	2,430,421	0	787,893	14,508,733
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00 09100	BARBER AND BEAUTY SHOP	0	18,179	0	0	18,179
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	11,990	0	0	11,990
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	14,538,902	2,460,590	0	787,893	14,538,902

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315274

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	2,643,796				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	110,946	610,120			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	20,099	12,641	123,172		6.00	
7.00	00700	HOUSEKEEPING	105,690	3,744	0	584,959	7.00	
8.00	00800	DIETARY	271,582	47,662	0	46,957	1,588,116	8.00
9.00	00900	NURSING ADMINISTRATION	148,950	8,416	0	8,292	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	52,429	4,019	0	3,960	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	4,972	2,473	0	2,437	0	12.00
13.00	01300	SOCIAL SERVICE	35,374	4,191	0	4,129	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	83,596	24,818	0	24,452	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,574,740	472,546	123,172	465,560	1,588,116	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	781	0	0	0	0	40.00
41.00	04100	LABORATORY	6,545	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	1,783	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	73,061	12,023	0	11,845	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	67,224	7,557	0	7,445	0	45.00
46.00	04600	SPEECH PATHOLOGY	17,574	1,992	0	1,963	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	58,856	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	2,889	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)	2,637,091	602,082	123,172	577,040	1,588,116	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	4,040	4,843	0	4,772	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	2,665	3,195	0	3,147	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	2,643,796	610,120	123,172	584,959	1,588,116	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315274

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	835,822					9.00
10.00	01000	0	296,299				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	32,253		12.00
13.00	01300	0	0	0	0	202,852	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	835,822	116,015	0	32,253	202,852	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	180,284	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		835,822	296,299	0	32,253	202,852	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00	TOTAL	835,822	296,299	0	32,253	202,852	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315274

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		PATIENT ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	508,986			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	508,986	13,005,215	0	13,005,215
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	4,295	0	4,295
41.00 04100	LABORATORY	0	0	35,994	0	35,994
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	9,804	0	9,804
44.00 04400	PHYSICAL THERAPY	0	0	425,647	0	425,647
45.00 04500	OCCUPATIONAL THERAPY	0	0	384,682	0	384,682
46.00 04600	SPEECH PATHOLOGY	0	0	100,600	0	100,600
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	503,946	0	503,946
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	15,888	0	15,888
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	508,986	14,486,071	0	14,486,071
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	31,834	0	31,834
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	20,997	0	20,997
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	0	508,986	14,538,902	0	14,538,902

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315274

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	18,179	0	18,179	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	117,002	0	117,002	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	35,455	0	35,455	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	47,445	0	47,445	6.00
7.00 00700	HOUSEKEEPING	0	14,053	0	14,053	7.00
8.00 00800	DIETARY	0	178,888	0	178,888	8.00
9.00 00900	NURSING ADMINISTRATION	0	31,587	0	31,587	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	15,085	0	15,085	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	9,283	0	9,283	12.00
13.00 01300	SOCIAL SERVICE	0	15,729	0	15,729	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	0	93,150	0	93,150	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	1,773,598	0	1,773,598	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	45,125	0	45,125	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	28,364	0	28,364	45.00
46.00 04600	SPEECH PATHOLOGY	0	7,478	0	7,478	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	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	2,430,421	0	2,430,421	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	18,179	0	18,179	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	11,990	0	11,990	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments				0	98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	2,460,590	0	2,460,590	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315274		Period: From 01/01/2023 To 12/31/2023		Worksheet B Part II Date/Time Prepared: 5/24/2024 1:28 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	119,345				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5,008	40,865			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	907	847	49,199		6.00	
7.00	00700	HOUSEKEEPING	4,771	251	0	19,075	7.00	
8.00	00800	DIETARY	12,259	3,192	0	1,531	197,545	8.00
9.00	00900	NURSING ADMINISTRATION	6,724	564	0	270	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	2,367	269	0	129	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	224	166	0	79	0	12.00
13.00	01300	SOCIAL SERVICE	1,597	281	0	135	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	3,774	1,662	0	797	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	71,089	31,651	49,199	15,182	197,545	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	35	0	0	0	0	40.00
41.00	04100	LABORATORY	295	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	80	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	3,298	805	0	386	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	3,035	506	0	243	0	45.00
46.00	04600	SPEECH PATHOLOGY	793	133	0	64	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	2,657	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						62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	130	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)	119,043	40,327	49,199	18,816	197,545	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	182	324	0	156	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	120	214	0	103	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments			0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	119,345	40,865	49,199	19,075	197,545	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315274

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	41,091					9.00
10.00	01000	0	18,004				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	9,792		12.00
13.00	01300	0	0	0	0	18,161	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	41,091	7,049	0	9,792	18,161	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	10,955	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		41,091	18,004	0	9,792	18,161	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00	TOTAL	41,091	18,004	0	9,792	18,161	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315274

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		PATIENT ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	PATIENT ACTIVITIES	0	100,128			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	100,128	2,324,940	0	2,324,940
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	35	0	35
41.00 04100	LABORATORY	0	0	295	0	295
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	80	0	80
44.00 04400	PHYSICAL THERAPY	0	0	49,614	0	49,614
45.00 04500	OCCUPATIONAL THERAPY	0	0	32,148	0	32,148
46.00 04600	SPEECH PATHOLOGY	0	0	8,468	0	8,468
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	13,612	0	13,612
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	130	0	130
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	100,128	2,429,322	0	2,429,322
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	18,841	0	18,841
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	12,427	0	12,427
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	0	100,128	2,460,590	0	2,460,590

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315274

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

Worksheet B-1
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	38,170					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	282	0	5,177,317			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,815	0	667,241	-2,643,796	11,895,106	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	550	0	114,410	0	499,174	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	736	0	0	0	90,432	6.00
7.00 00700	HOUSEKEEPING	218	0	0	0	475,525	7.00
8.00 00800	DIETARY	2,775	0	477,030	0	1,221,915	8.00
9.00 00900	NURSING ADMINISTRATION	490	0	554,233	0	670,164	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	234	0	43,742	0	235,891	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	144	0	11,359	0	22,371	12.00
13.00 01300	SOCIAL SERVICE	244	0	119,384	0	159,158	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	PATIENT ACTIVITIES	1,445	0	212,085	0	376,120	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	27,513	0	2,977,833	0	7,085,153	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	3,514	40.00
41.00 04100	LABORATORY	0	0	0	0	29,449	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	8,021	43.00
44.00 04400	PHYSICAL THERAPY	700	0	0	0	328,718	44.00
45.00 04500	OCCUPATIONAL THERAPY	440	0	0	0	302,456	45.00
46.00 04600	SPEECH PATHOLOGY	116	0	0	0	79,071	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	264,806	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	12,999	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)	37,702	0	5,177,317	-2,643,796	11,864,937	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	282	0	0	0	18,179	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	186	0	0	0	11,990	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,460,590	0	787,893		2,643,796	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	64.463977	0.000000	0.152182		0.222259	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			18,179		119,345	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.003511		0.010033	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315274

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	35,523				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	736	36,631			6.00
7.00	00700	HOUSEKEEPING	218	0	34,569		7.00
8.00	00800	DIETARY	2,775	0	2,775	109,893	8.00
9.00	00900	NURSING ADMINISTRATION	490	0	490	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	234	0	234	0	10.00
11.00	01100	PHARMACY	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	144	0	144	0	12.00
13.00	01300	SOCIAL SERVICE	244	0	244	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	1,445	0	1,445	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	27,513	36,631	27,513	109,893	141,148
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	700	0	700	0	0
45.00	04500	OCCUPATIONAL THERAPY	440	0	440	0	0
46.00	04600	SPEECH PATHOLOGY	116	0	116	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)	35,055	36,631	34,101	109,893	141,148
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	282	0	282	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	186	0	186	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)	610,120	123,172	584,959	1,588,116	835,822
103.00		Unit cost multiplier (Wkst. B, Part I)	17.175351	3.362507	16.921490	14.451476	5.921600
104.00		Cost to be allocated (per Wkst. B, Part II)	40,865	49,199	19,075	197,545	41,091
105.00		Unit cost multiplier (Wkst. B, Part II)	1.150381	1.343097	0.551795	1.797612	0.291120

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315274

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

Worksheet B-1

Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	435,213					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	36,631			12.00
13.00	01300	0	0	0	36,631		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	170,407	0	36,631	36,631	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	264,806	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		435,213	0	36,631	36,631	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		296,299	0	32,253	202,852	0	102.00
103.00		0.680814	0.000000	0.880484	5.537714	0.000000	103.00
104.00		18,004	0	9,792	18,161	0	104.00
105.00		0.041368	0.000000	0.267315	0.495782	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315274

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

Worksheet B-1
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		OTHER GENERAL SERVICE	PATIENT ACTIVITIES (PATIENT CENSUS)	
			15.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500	PATIENT ACTIVITIES	36,631	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	36,631	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	0	51.00
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FOHC	0	62.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
73.00	07300	CMHC	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	83.00
89.00		SUBTOTALS (sum of lines 1-84)	36,631	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
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)	508,986	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	13.894952	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	100,128	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	2.733423	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/24/2024 1:28 pm	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	4,295	3,514	1.222254 40.00
41.00	04100	LABORATORY	35,994	29,449	1.222249 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	9,804	8,021	1.222291 43.00
44.00	04400	PHYSICAL THERAPY	425,647	453,667	0.938237 44.00
45.00	04500	OCCUPATIONAL THERAPY	384,682	428,609	0.897513 45.00
46.00	04600	SPEECH PATHOLOGY	100,600	174,718	0.575785 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	503,946	264,806	1.903076 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	15,888	12,999	1.222248 71.00
100.00		Total	1,480,856	1,375,783	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/24/2024 1:28 pm			
		Title XVIII (1)	Skilled Nursing Facility	PPS			
		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)		
Ratio of Cost to Charges (Fr. Wkst. C Column 3)							
1.00		2.00	3.00	4.00	5.00		
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADIOLOGY	1.222254	864	0	1,056	0	40.00
41.00	04100 LABORATORY	1.222249	0	0	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1.222291	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0.938237	148,443	0	139,275	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.897513	156,604	0	140,554	0	45.00
46.00	04600 SPEECH PATHOLOGY	0.575785	85,039	0	48,964	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.903076	115,005	0	218,863	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)	1.222248		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		505,955	0	548,712	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. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/24/2024 1:28 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description			1.00	
-------------------------	--	--	------	--

PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.903076	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	9,961	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)	18,957	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	4,295	0	0.000000	1,056	0 40.00
41.00	04100	LABORATORY	35,994	0	0.000000	0	0 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	9,804	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	425,647	0	0.000000	139,275	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	384,682	0	0.000000	140,554	0 45.00
46.00	04600	SPEECH PATHOLOGY	100,600	0	0.000000	48,964	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	503,946	0	0.000000	218,863	0 49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0 50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0 51.00
100.00		Total (Sum of lines 40 - 52)	1,464,968	0		548,712	0 100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/24/2024 1:28 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		36,631	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		4,202	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		13,005,215	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		12,858,674	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		1.011396	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)		13,005,215	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		355.03	16.00
17.00	Program routine service cost (Line 3 times line 16)		1,491,836	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		1,491,836	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		2,324,940	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		63.47	21.00
22.00	Program capital related cost (Line 3 times line 21)		266,701	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		1,225,135	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		1,225,135	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		36,631	1.00
2.00	Program inpatient days (see instructions)		4,202	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)		0.114712	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/24/2024 1:28 pm
		Title XVIII	Skilled Nursing Facility	PPS

		1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT			
1.00	Inpatient PPS amount (See Instructions)	3,245,494	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)	3,245,494	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	445,400	5.00
6.00	Allowable bad debts (From your records)	174,748	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	37,438	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	113,586	8.00
9.00	Recovery of bad debts - for statistical records only	0	9.00
10.00	Utilization review	0	10.00
11.00	Subtotal (See instructions)	2,913,680	11.00
12.00	Interim payments (See instructions)	2,875,900	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)	2,272	14.75
14.99	Sequestration amount (see instructions)	56,002	14.99
15.00	Balance due provider/program (see Instructions)	-20,494	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY			
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	18,957	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	18,957	19.00
20.00	Medicare Part B ancillary charges (See instructions)	9,961	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	9,961	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)	9,961	25.00
26.00	Interim payments (See instructions)	7,810	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)	199	28.99
29.00	Balance due provider/program (see instructions)	1,952	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part II Date/Time Prepared: 5/24/2024 1:28 pm
		Title XIX	Skilled Nursing Facility	PPS
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		0	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		0	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		0	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		0	10.00
REASONABLE CHARGES				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315274	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/24/2024 1:28 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		2,884,904		7,810
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/01/2023	9,004		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-9,004		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		2,875,900		7,810
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	PROGRAM TO PROVIDER		0		1,952
6.02	PROVIDER TO PROGRAM		20,494		0
7.00	Total Medicare program liability (see instructions)		2,855,406		9,762
			Contractor Name		Contractor Number
			1.00	2.00	
8.00	Name of Contractor				

(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. : 315274

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

Worksheet G

Date/Time Prepared:
5/24/2024 1:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	209,700	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	4,461,805	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-354,868	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	61,036	0	0	0	8.00
9.00	Other current assets	23,284	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)	4,400,957	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	2,794,141	0	0	0	17.00
18.00	Less: Accumulated Amortization	-31,304	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	917,386	0	0	0	23.00
24.00	Less: Accumulated depreciation	-1,155,603	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)	2,524,620	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	-434,664	0	0	0	31.00
32.00	Other assets	56,398	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-378,266	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	6,547,311	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	2,257,026	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,184,470	0	0	0	36.00
37.00	Payroll taxes payable	993	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	618,681	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4,061,170	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	8,611,457	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)	8,611,457	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	12,672,627	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-6,125,316	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)	-6,125,316	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	6,547,311	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315274

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

Worksheet G-1

Date/Time Prepared:
5/24/2024 1:28 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-4,094,850			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-2,030,470				2.00
3.00	Total (sum of line 1 and line 2)		-6,125,320			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING	4			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)		4			0	10.00
11.00	Subtotal (line 3 plus line 10)		-6,125,316			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)		-6,125,316			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)						4.00
5.00	ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00			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. : 315274

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

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/24/2024 1:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	12,858,674		12,858,674	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	12,858,674		12,858,674	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,375,783	0	1,375,783	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	14,234,457	0	14,234,457	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			14,958,620	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)			14,958,620	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315274

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

Worksheet G-3

Date/Time Prepared:
5/24/2024 1:28 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	14,234,457	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,315,018	2.00
3.00	Net patient revenues (Line 1 minus line 2)	12,919,439	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	14,958,620	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2,039,181	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,581	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	527	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	4,603	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other miscellaneous revenue (specify)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	8,711	25.00
26.00	Total (Line 5 plus line 25)	-2,030,470	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)	-2,030,470	31.00