

**PARK GROVE HEALTHCARE REHABILITATION CENTER LLC**  
**D/B/A GROVE PARK HEALTHCARE REHABILITATION CENTER**  
**(a limited liability company)**  
**BALANCE SHEET**  
**AT DECEMBER 31, 2023**

**ASSETS**

**Current assets**

Cash and cash equivalents (note 2)	\$ 1,437,693
Cash - restricted (patient funds) (note 2)	77,231
Accounts receivable - less allowance of \$421,600	3,981,741
Prepaid expenses and other (note 5)	<u>629,076</u>
<b>Total current assets</b>	<b>6,125,741</b>

Property and equipment - net (note 3)	2,588,892
Right-of-use asset - operating lease (note 6)	13,476,637
Notes receivable (note 5)	3,275,000
Due from realty (note 6)	59,073
Due from related entities (note 8)	<u>777,596</u>
<b>TOTAL ASSETS</b>	<b>\$ <u><u>26,302,939</u></u></b>

**LIABILITIES AND MEMBERS' EQUITY**

**Current liabilities**

Accounts payable	\$ 818,743
Operating lease liability (note 6)	75,449
Accrued expenses	433,384
Patient funds payable	77,231
Due to related entities (note 8)	647,321
Due to private and third party payors (note 13)	<u>484,023</u>
<b>Total current liabilities</b>	<b>2,536,151</b>

Operating lease liability (note 6)	<u>13,401,188</u>
<b>Total liabilities</b>	<b>15,937,339</b>

<b>Members' equity</b>	<u>10,365,600</u>
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<b>TOTAL LIABILITIES AND MEMBERS' EQUITY</b>	<b>\$ <u><u>26,302,939</u></u></b>
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**PARK GROVE HEALTHCARE REHABILITATION CENTER LLC  
D/B/A GROVE PARK HEALTHCARE REHABILITATION CENTER  
(a limited liability company)  
STATEMENTS OF EARNINGS AND MEMBERS' EQUITY  
YEAR ENDED DECEMBER 31, 2023**

Revenues	\$	19,976,754
Operating expenses		<u>16,071,890</u>
Earnings from operations		3,904,864
<b>Non-operating revenue:</b>		
Interest income (notes 5 and 14)		<u>550,206</u>
<b>NET EARNINGS</b>		4,455,070
Members' equity - December 31, 2022		<u>5,901,317</u>
		10,356,387
Net members' equity contributed		<u>9,213</u>
<b>MEMBERS' EQUITY - DECEMBER 31, 2023</b>	<b>\$</b>	<b><u><u>10,365,600</u></u></b>

**PARK GROVE HEALTHCARE REHABILITATION CENTER LLC**  
**D/B/A GROVE PARK HEALTHCARE REHABILITATION CENTER**  
**(a limited liability company)**  
**STATEMENT OF CASH FLOWS**  
**YEAR ENDED DECEMBER 31, 2023**

<b>Cash flows from operating activities</b>	
Net earnings	\$ 4,455,070
Adjustments to reconcile net earnings to net cash provided by operating activities:	
Depreciation	145,445
<b>(Increase) decrease in assets</b>	
Accounts receivable	(174,933)
Prepaid expenses and other	(617,017)
Due from realty	1,611,525
Due from prior owner	1,410
<b>Increase (decrease) in liabilities</b>	
Accounts payable	(2,232,631)
Accrued expenses	19,636
Due to private and third party payors	306,311
Patients' funds payable	(50,263)
<b>Net cash provided by operating activities</b>	<u>3,464,553</u>
 <b>Cash flows from investing activities</b>	
Purchase of equipment	<u>(1,324,022)</u>
<b>Net cash used in investing activities</b>	<u>(1,324,022)</u>
 <b>Cash flows from financing activities</b>	
Members' equity contributed	9,213
Loans to related entities	(850,000)
Net payments to landlord - related	<u>(1,042,637)</u>
<b>Net cash used in financing activities</b>	<u>(1,883,424)</u>
 <b>Net increase in cash, restricted cash, and cash equivalents</b>	 257,107
 Cash, restricted cash, and cash equivalents - December 31, 2022	 <u>1,257,817</u>
 <b>CASH, RESTRICTED CASH, AND CASH EQUIVALENTS - DECEMBER 31, 2023</b>	 <b>\$ <u>1,514,924</u></b>

**PARK GROVE HEALTHCARE REHABILITATION CENTER LLC  
D/B/A GROVE PARK HEALTHCARE REHABILITATION CENTER  
(a limited liability company)  
SUPPLEMENTARY INFORMATION  
REVENUES  
YEAR ENDED DECEMBER 31, 2023**

		<b>Per Patient Day</b>
<b>Current year</b>		
Medicaid	\$ 830,012	\$ 241.28
Medicaid - Managed Care	12,307,360	243.06
Private	330,307	309.86
Medicare - Part A	3,273,442	720.07
Medicare - Part A bad debts	(379,306)	(83.44)
Insurance	872,043	321.91
Hospice	192,769	247.14
Optum	<u>260,980</u>	-
<b>Total current year</b>	<u>17,687,607</u>	<u>\$ 279.97</u>
 <b>Prior years</b>		
Medicaid	(36,496)	
Medicaid - Managed Care	10,228	
Private	40,892	
Medicare - Part A	9,426	
Hospice	(477)	
Insurance	<u>(53,060)</u>	
	<u>(29,487)</u>	
 <b>Other income</b>		
Ancillary revenue	679,825	
Employee retention credits	1,534,627	
Other	<u>104,182</u>	
	<u>2,318,634</u>	
 <b>TOTAL REVENUES</b>	 <u>\$ 19,976,754</u>	

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/23/2024 3:12 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____
	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GROVE PARK HEALTHCARE & REHAB CTR ( 315147 ) 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  <b>Ben Kurland</b>	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	Ben Kurland		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		
<b>PART III - SETTLEMENT SUMMARY</b>					
1.00 SKILLED NURSING FACILITY	0	197,611	0	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	197,611	0	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 3:12 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 101 NORTH GROVE STREET	PO Box:				1.00		
2.00	City: EAST ORANGE	State: NJ	Zip Code: 07017			2.00		
3.00	County: ESSEX	CBSA Code: 35084	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
					4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	GROVE PARK HEALTHCARE & REHAB CTR	315147	01/01/1974	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00
				From:	To:			
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		14.00	
					4		15.00	
					Y/N			
					1.00			
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y	18.00	
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					0	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					0	23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N	25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00	
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility				N	N	N	29.00
30.00	Nursing Facility							30.00
31.00	ICF/IID							31.00
32.00	SNF-Based HHA				N	N		32.00
33.00	SNF-Based RHC							33.00
34.00	SNF-Based FQHC							34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC							36.00
				Y/N				
				1.00	2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)			N			37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)			N			38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.						39.00	
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:			0	0	0	41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 3:12 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. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/23/2024 3:12 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	03/22/2024	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. : 315147

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/23/2024 3:12 pm

		1.00	2.00	
<b>Cost Report Preparer Contact Information</b>				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KITTY	BLISSIT	19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	KITTY.BLISSIT@HCRNJ.NET	21.00

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

Provider No. : 315147

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

Worksheet S-2  
 Part II  
 Date/Time Prepared:  
 5/23/2024 3:12 pm

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/22/2024	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	
<b>Cost Report Preparer Contact Information</b>			
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. : 315147

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

Worksheet S-3  
 Part I  
 Date/Time Prepared:  
 5/23/2024 3:12 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	185	67,525	0	4,567	54,257	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	185	67,525	0	4,567	54,257	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	3,775	62,599	0	37	19	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	3,775	62,599	0	37	19	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	179	235	0.00	123.43	2,855.63	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	179	235	0.00	123.43	2,855.63	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	266.38	0	19	15	124	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	266.38	0	19	15	124	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	158	151.00	0.00		1.00	
2.00	NURSING FACILITY	0	0.00	0.00		2.00	
3.00	ICF/IID	0	0.00	0.00		3.00	
4.00	HOME HEALTH AGENCY COST					4.00	
5.00	Other Long Term Care	0	0.00	0.00		5.00	
6.00	SNF-Based CMHC		0.00	0.00		6.00	
7.00	HOSPICE	0	0.00	0.00		7.00	
8.00	Total (Sum of lines 1-7)	158	151.00	0.00		8.00	

Provider No. : 315147

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2024 3:12 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	
<b>PART II - DIRECT SALARIES</b>						
<b>SALARIES</b>						
1.00	Total salaries (See Instructions)	8,211,878	0	8,211,878	313,880.00	26.16
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	8,211,878	0	8,211,878	313,880.00	26.16
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST					
9.00	CMHC	0	0	0	0.00	0.00
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	8,211,878	0	8,211,878	313,880.00	26.16
<b>OTHER WAGES &amp; RELATED COSTS</b>						
14.00	Contract Labor: Patient Related & Mgmt	319,005	0	319,005	2,525.00	126.34
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs core (See Part IV)	1,242,870	0	1,242,870		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,242,870	0	1,242,870		

Provider No. : 315147

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/23/2024 3:12 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	
<b>PART III - OVERHEAD COST - DIRECT SALARIES</b>						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	707,543	0	707,543	20,137.00	2.00
3.00	Plant Operation, Maintenance & Repairs	105,067	0	105,067	5,720.00	3.00
4.00	Laundry & Linen Service	0	0	0	0.00	4.00
5.00	Housekeeping	465,721	0	465,721	30,124.00	5.00
6.00	Dietary	775,163	0	775,163	39,887.00	6.00
7.00	Nursing Administration	722,216	0	722,216	8,956.00	7.00
8.00	Central Services and Supply	29,121	0	29,121	1,355.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	104,843	0	104,843	4,120.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	169,602	0	169,602	10,841.00	13.00
14.00	Total (sum lines 1 thru 13)	3,079,276	0	3,079,276	121,140.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2024 3:12 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
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
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	259,063	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	194,741	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	789,066	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	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1,242,870	24.00
		Amount Reported	
		1.00	
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315147

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/23/2024 3:12 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	
<b>Direct Salaries</b>							
<b>Nursing Occupations</b>							
1.00	Registered Nurses (RNs)	776,691	154,422	931,113	19,889.00	46.82	1.00
2.00	Licensed Practical Nurses (LPNs)	1,069,618	212,662	1,282,280	31,632.00	40.54	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,491,671	495,396	2,987,067	123,526.00	24.18	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4,337,980	862,480	5,200,460	175,047.00	29.71	4.00
5.00	Physical Therapists	181,650	36,116	217,766	4,290.00	50.76	5.00
6.00	Physical Therapy Assistants	129,170	25,682	154,852	3,546.00	43.67	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	168,012	33,404	201,416	3,906.00	51.57	8.00
9.00	Occupational Therapy Assistants	207,364	41,228	248,592	5,255.00	47.31	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	41,419	8,235	49,654	698.00	71.14	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
<b>Contract Labor</b>							
<b>Nursing Occupations</b>							
14.00	Registered Nurses (RNs)	202,691		202,691	1,414.00	143.35	14.00
15.00	Licensed Practical Nurses (LPNs)	116,314		116,314	1,111.00	104.69	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	0		0	0.00	0.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	319,005		319,005	2,525.00	126.34	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315147

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

Worksheet S-7  
Date/Time Prepared:  
5/23/2024 3:12 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. : 315147

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

Worksheet S-7

Date/Time Prepared:  
5/23/2024 3:12 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. : 315147		Period: From 01/01/2023 To 12/31/2023		Worksheet A	
Date/Time Prepared: 5/23/2024 3:12 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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1,131,307	1,131,307	0	1,131,307	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,422,035	1,422,035	0	1,422,035	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	707,543	2,791,263	3,498,806	0	3,498,806	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	105,067	445,215	550,282	0	550,282	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	117,570	117,570	0	117,570	6.00
7.00	00700	HOUSEKEEPING	465,721	50,435	516,156	0	516,156	7.00
8.00	00800	DIETARY	775,163	520,813	1,295,976	0	1,295,976	8.00
9.00	00900	NURSING ADMINISTRATION	722,216	81	722,297	0	722,297	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	29,121	237,823	266,944	0	266,944	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	104,843	0	104,843	0	104,843	13.00
15.00	01500	PATIENT ACTIVITIES	169,602	27,884	197,486	0	197,486	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	4,337,980	483,561	4,821,541	0	4,821,541	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
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	5,302	5,302	0	5,302	40.00
41.00	04100	LABORATORY	0	14,712	14,712	0	14,712	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	2,530	2,530	0	2,530	43.00
44.00	04400	PHYSICAL THERAPY	377,827	10,867	388,694	0	388,694	44.00
45.00	04500	OCCUPATIONAL THERAPY	375,376	0	375,376	0	375,376	45.00
46.00	04600	SPEECH PATHOLOGY	41,419	0	41,419	0	41,419	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	228,064	228,064	0	228,064	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	7,840	7,840	0	7,840	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
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)	8,211,878	7,497,302	15,709,180	0	15,709,180	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	15	15	0	15	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	IDLE SPACE	0	0	0	0	0	95.00
100.00		TOTAL	8,211,878	7,497,317	15,709,195	0	15,709,195	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315147

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

Worksheet A  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-294,865	836,442	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,422,035	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-1,314,062	2,184,744	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	550,282	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	117,570	6.00
7.00	00700	HOUSEKEEPING	0	516,156	7.00
8.00	00800	DIETARY	-4,969	1,291,007	8.00
9.00	00900	NURSING ADMINISTRATION	0	722,297	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	266,944	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	104,843	13.00
15.00	01500	PATIENT ACTIVITIES	0	197,486	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	SKILLED NURSING FACILITY	-199,297	4,622,244	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
<b>ANCILLARY SERVICE COST CENTERS</b>					
40.00	04000	RADIOLOGY	0	5,302	40.00
41.00	04100	LABORATORY	0	14,712	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	2,530	43.00
44.00	04400	PHYSICAL THERAPY	0	388,694	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	375,376	45.00
46.00	04600	SPEECH PATHOLOGY	0	41,419	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	228,064	49.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
71.00	07100	AMBULANCE	0	7,840	71.00
73.00	07300	CMHC	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-1,813,193	13,895,987	89.00
<b>NONREIMBURSABLE COST CENTERS</b>					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	15	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	IDLE SPACE	0	0	95.00
100.00		TOTAL	-1,813,193	13,896,002	100.00

Provider No. : 315147

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

Worksheet A-6  
Date/Time Prepared:  
5/23/2024 3:12 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. : 315147

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

Worksheet A-6  
Date/Time Prepared:  
5/23/2024 3:12 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. : 315147

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

Worksheet A-7

Date/Time Prepared:  
5/23/2024 3:12 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	1,295,023	457,740	0	457,740	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	51,504	17,990	0	17,990	0	6.00
7.00 Subtotal (sum of lines 1-6)	1,346,527	475,730	0	475,730	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	1,346,527	475,730	0	475,730	0	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				1.00
2.00 Land Improvements	0	0				2.00
3.00 Buildings and Fixtures	0	0				3.00
4.00 Building Improvements	1,752,763	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	69,494	0				6.00
7.00 Subtotal (sum of lines 1-6)	1,822,257	0				7.00
8.00 Reconciling Items	0	0				8.00
9.00 Total (line 7 minus line 8)	1,822,257	0				9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315147

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

Worksheet A-8

Date/Time Prepared:  
5/23/2024 3:12 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	-12,117	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	-282,748				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-73	ADMINISTRATIVE & GENERAL		4.00	18.00
19.00 Vending machines	B	-4,969	DIETARY		8.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00	22.00
23.00 Depreciation--buildings and fixtures			CAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment		0	*** Cost Center Deleted ***		2.00	24.00
25.00 Other adjustment (specify)		0			0.00	25.00
25.01 MISC INCOME	B	-199,297	SKILLED NURSING FACILITY		30.00	25.01
25.02 RESIDENT MISSING ITEMS	A	-27	ADMINISTRATIVE & GENERAL		4.00	25.02
25.05 MARKETING & ADVERTISING	A	-84,944	ADMINISTRATIVE & GENERAL		4.00	25.05
25.06 BAD DEBT	A	-283,640	ADMINISTRATIVE & GENERAL		4.00	25.06
25.07 MANAGEMENT FEE	A	-945,378	ADMINISTRATIVE & GENERAL		4.00	25.07
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,813,193				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. : 315147

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

Worksheet A-8-1  
Parts I-II  
Date/Time Prepared:  
5/23/2024 3:12 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	0.00				2.00	
3.00	0.00				3.00	
4.00	0.00				4.00	
5.00	0.00				5.00	
6.00	0.00				6.00	
7.00	0.00				7.00	
8.00	0.00				8.00	
9.00	0.00				9.00	
10.00	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	16,198	298,946	-282,748		1.00	
2.00	0	0	0		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	



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

Provider No. : 315147

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

Worksheet A-8-1  
Parts I-III  
Date/Time Prepared:  
5/23/2024 3:12 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

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

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

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

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

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

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

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

1.00	NORTH GROVE PROPERTIES LLC	100.00	REALTY	1.00
2.00		0.00		2.00
3.00		0.00		3.00
4.00		0.00		4.00
5.00		0.00		5.00
6.00		0.00		6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:	0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315147

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	836,442	836,442			1.00
3.00 00300	EMPLOYEE BENEFITS	1,422,035	0	1,422,035		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,184,744	36,018	122,524	2,343,286	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	550,282	6,225	18,194	574,701	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	117,570	13,288	0	130,858	6.00
7.00 00700	HOUSEKEEPING	516,156	3,557	80,648	600,361	7.00
8.00 00800	DIETARY	1,291,007	55,217	134,233	1,480,457	8.00
9.00 00900	NURSING ADMINISTRATION	722,297	19,722	125,065	867,084	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	266,944	12,163	5,043	284,150	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	104,843	1,308	18,155	124,306	13.00
15.00 01500	PATIENT ACTIVITIES	197,486	0	29,370	226,856	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	4,622,244	644,739	751,200	6,018,183	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	5,302	0	0	5,302	40.00
41.00 04100	LABORATORY	14,712	0	0	14,712	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	2,530	0	0	2,530	43.00
44.00 04400	PHYSICAL THERAPY	388,694	28,197	65,428	482,319	44.00
45.00 04500	OCCUPATIONAL THERAPY	375,376	0	65,003	440,379	45.00
46.00 04600	SPEECH PATHOLOGY	41,419	0	7,172	48,591	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	228,064	0	0	228,064	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	7,840	0	0	7,840	71.00
73.00 07300	CMHC	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
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)	13,895,987	820,434	1,422,035	13,879,979	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	15	0	0	15	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	IDLE SPACE	0	16,008	0	16,008	95.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	13,896,002	836,442	1,422,035	13,896,002	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315147

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	691,270				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	11,566	168,966			6.00	
7.00	00700	HOUSEKEEPING	3,096	0	725,231		7.00	
8.00	00800	DIETARY	48,061	0	51,515	1,880,320	8.00	
9.00	00900	NURSING ADMINISTRATION	17,166	0	18,400	0	1,078,524	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10,587	0	11,347	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	1,138	0	1,220	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	SKILLED NURSING FACILITY	561,180	168,966	601,508	1,880,320	1,078,524	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
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	24,543	0	26,306	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
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)	677,337	168,966	710,296	1,880,320	1,078,524	89.00
<b>NONREIMBURSABLE COST CENTERS</b>								
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
95.00	09500	IDLE SPACE	13,933	0	14,935	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	691,270	168,966	725,231	1,880,320	1,078,524	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315147

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	12.00	13.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPING						7.00
8.00 00800 DIETARY						8.00
9.00 00900 NURSING ADMINISTRATION						9.00
10.00 01000 CENTRAL SERVICES & SUPPLY	363,719					10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00 01300 SOCIAL SERVICE	0	0	151,877			13.00
15.00 01500 PATIENT ACTIVITIES	0	0	0	272,870		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 SKILLED NURSING FACILITY	185,669	0	151,877	272,870	12,139,793	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000 RADIOLOGY	0	0	0	0	6,377	40.00
41.00 04100 LABORATORY	0	0	0	0	17,696	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	3,043	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	0	630,999	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	0	529,703	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	0	58,447	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	178,050	0	0	0	452,373	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100 AMBULANCE	0	0	0	0	9,430	71.00
73.00 07300 CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
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)	363,719	0	151,877	272,870	13,847,861	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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	18	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500 IDLE SPACE	0	0	0	0	48,123	95.00
98.00 Cross Foot Adjustments	0	0	0	0	0	98.00
99.00 Negative Cost Centers	0	0	0	0	0	99.00
100.00 TOTAL	363,719	0	151,877	272,870	13,896,002	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315147

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		Post Stepdown Adjustments	Total	
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	SKILLED NURSING FACILITY	12,139,793	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
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00	04000	RADIOLOGY	6,377	40.00
41.00	04100	LABORATORY	17,696	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	3,043	43.00
44.00	04400	PHYSICAL THERAPY	630,999	44.00
45.00	04500	OCCUPATIONAL THERAPY	529,703	45.00
46.00	04600	SPEECH PATHOLOGY	58,447	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	452,373	49.00
51.00	05100	SUPPORT SURFACES	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00	07100	AMBULANCE	9,430	71.00
73.00	07300	CMHC	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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)	13,847,861	89.00
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	18	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
95.00	09500	IDLE SPACE	48,123	95.00
98.00		Cross Foot Adjustments	0	98.00
99.00		Negative Cost Centers	0	99.00
100.00		TOTAL	13,896,002	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315147

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		0	BLDGS & FIXTURES				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
3.00	00300	0	0	0	0		3.00
4.00	00400	0	36,018	36,018	0	36,018	4.00
5.00	00500	0	6,225	6,225	0	1,792	5.00
6.00	00600	0	13,288	13,288	0	408	6.00
7.00	00700	0	3,557	3,557	0	1,872	7.00
8.00	00800	0	55,217	55,217	0	4,616	8.00
9.00	00900	0	19,722	19,722	0	2,704	9.00
10.00	01000	0	12,163	12,163	0	886	10.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	1,308	1,308	0	388	13.00
15.00	01500	0	0	0	0	707	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	644,739	644,739	0	18,760	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
40.00	04000	0	0	0	0	17	40.00
41.00	04100	0	0	0	0	46	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	8	43.00
44.00	04400	0	28,197	28,197	0	1,504	44.00
45.00	04500	0	0	0	0	1,373	45.00
46.00	04600	0	0	0	0	152	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	0	0	0	711	49.00
51.00	05100	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	0	0	0	0	24	71.00
73.00	07300	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
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		0	820,434	820,434	0	35,968	89.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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
95.00	09500	0	16,008	16,008	0	50	95.00
98.00				0			98.00
99.00				0		0	99.00
100.00		0	836,442	836,442	0	36,018	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315147

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	8,017				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	134	13,830			6.00
7.00	00700	HOUSEKEEPING	36	0	5,465		7.00
8.00	00800	DIETARY	557	0	388	60,778	8.00
9.00	00900	NURSING ADMINISTRATION	199	0	139	0	22,764
10.00	01000	CENTRAL SERVICES & SUPPLY	123	0	86	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
13.00	01300	SOCIAL SERVICE	13	0	9	0	0
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	6,508	13,830	4,532	60,778	22,764
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
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	285	0	198	0	0
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
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)	7,855	13,830	5,352	60,778	22,764
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0
95.00	09500	IDLE SPACE	162	0	113	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	8,017	13,830	5,465	60,778	22,764

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315147

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
	10.00	12.00	13.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPING						7.00
8.00 00800 DIETARY						8.00
9.00 00900 NURSING ADMINISTRATION						9.00
10.00 01000 CENTRAL SERVICES & SUPPLY	13,258					10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00 01300 SOCIAL SERVICE	0	0	1,718			13.00
15.00 01500 PATIENT ACTIVITIES	0	0	0	707		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 SKILLED NURSING FACILITY	6,768	0	1,718	707	781,104	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000 RADIOLOGY	0	0	0	0	17	40.00
41.00 04100 LABORATORY	0	0	0	0	46	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	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	0	30,184	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	0	1,373	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	0	152	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	6,490	0	0	0	7,201	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100 AMBULANCE	0	0	0	0	24	71.00
73.00 07300 CMHC	0	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
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)	13,258	0	1,718	707	820,109	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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
95.00 09500 IDLE SPACE	0	0	0	0	16,333	95.00
98.00 Cross Foot Adjustments	0	0	0	0	0	98.00
99.00 Negative Cost Centers	0	0	0	0	0	99.00
100.00 TOTAL	13,258	0	1,718	707	836,442	100.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315147

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		Post Step-Down Adjustments	Total	
		17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
15.00	01500	PATIENT ACTIVITIES		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	SKILLED NURSING FACILITY	781,104	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
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00	04000	RADIOLOGY	17	40.00
41.00	04100	LABORATORY	46	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	8	43.00
44.00	04400	PHYSICAL THERAPY	30,184	44.00
45.00	04500	OCCUPATIONAL THERAPY	1,373	45.00
46.00	04600	SPEECH PATHOLOGY	152	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	7,201	49.00
51.00	05100	SUPPORT SURFACES	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00	07100	AMBULANCE	24	71.00
73.00	07300	CMHC	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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)	820,109	89.00
<b>NONREIMBURSABLE COST CENTERS</b>				
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
95.00	09500	IDLE SPACE	16,333	95.00
98.00		Cross Foot Adjustments	0	98.00
99.00		Negative Cost Centers	0	99.00
100.00		TOTAL	836,442	100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315147

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

Worksheet B-1  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	31,978				1.00
3.00 00300	EMPLOYEE BENEFITS	0	8,211,878			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	1,377	707,543	-2,343,286	11,552,716	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	238	105,067	0	574,701	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	508	0	0	130,858	6.00
7.00 00700	HOUSEKEEPING	136	465,721	0	600,361	7.00
8.00 00800	DIETARY	2,111	775,163	0	1,480,457	8.00
9.00 00900	NURSING ADMINISTRATION	754	722,216	0	867,084	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	465	29,121	0	284,150	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	50	104,843	0	124,306	13.00
15.00 01500	PATIENT ACTIVITIES	0	169,602	0	226,856	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	SKILLED NURSING FACILITY	24,649	4,337,980	0	6,018,183	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
40.00 04000	RADIOLOGY	0	0	0	5,302	40.00
41.00 04100	LABORATORY	0	0	0	14,712	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	2,530	43.00
44.00 04400	PHYSICAL THERAPY	1,078	377,827	0	482,319	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	375,376	0	440,379	45.00
46.00 04600	SPEECH PATHOLOGY	0	41,419	0	48,591	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	228,064	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
71.00 07100	AMBULANCE	0	0	0	7,840	71.00
73.00 07300	CMHC	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
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)	31,366	8,211,878	-2,343,286	11,536,693	89.00
<b>NONREIMBURSABLE COST CENTERS</b>						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	15	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	IDLE SPACE	612	0	0	16,008	95.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	836,442	1,422,035		2,343,286	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	26.156795	0.173168		0.202834	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		36,018	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.003118	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315147

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	62,599				6.00
7.00	00700	HOUSEKEEPING	0	29,719			7.00
8.00	00800	DIETARY	0	2,111	187,797		8.00
9.00	00900	NURSING ADMINISTRATION	0	754	0	177,572	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	465	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	465,887	12.00
13.00	01300	SOCIAL SERVICE	0	50	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	SKILLED NURSING FACILITY	62,599	24,649	187,797	177,572	237,823
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
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	1,078	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	228,064	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
71.00	07100	AMBULANCE	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
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)	62,599	29,107	187,797	177,572	465,887
<b>NONREIMBURSABLE COST CENTERS</b>							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00	09500	IDLE SPACE	0	612	0	0	95.00
98.00		Cross Foot Adjustments					98.00
99.00		Negative Cost Centers					99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	168,966	725,231	1,880,320	1,078,524	363,719
103.00		Unit cost multiplier (Wkst. B, Part I)	2.699180	24.402941	10.012514	6.073728	0.780702
104.00		Cost to be allocated (per Wkst. B, Part II)	13,830	5,465	60,778	22,764	13,258
105.00		Unit cost multiplier (Wkst. B, Part II)	0.220930	0.183889	0.323637	0.128196	0.028458

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315147

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

Worksheet B-1

Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT CENSUS)	
	12.00	13.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
3.00 00300 EMPLOYEE BENEFITS				3.00
4.00 00400 ADMINISTRATIVE & GENERAL				4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 00600 LAUNDRY & LINEN SERVICE				6.00
7.00 00700 HOUSEKEEPING				7.00
8.00 00800 DIETARY				8.00
9.00 00900 NURSING ADMINISTRATION				9.00
10.00 01000 CENTRAL SERVICES & SUPPLY				10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	62,599			12.00
13.00 01300 SOCIAL SERVICE	0	62,599		13.00
15.00 01500 PATIENT ACTIVITIES	0	0	62,599	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000 SKILLED NURSING FACILITY	62,599	62,599	62,599	30.00
31.00 03100 NURSING FACILITY	0	0	0	31.00
32.00 03200 ICF/IID	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	33.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
40.00 04000 RADIOLOGY	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	46.00
47.00 04700 ELECTROCARDIOLOGY	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	51.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
71.00 07100 AMBULANCE	0	0	0	71.00
73.00 07300 CMHC	0	0	0	73.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100 INTEREST EXPENSE				81.00
82.00 08200 UTILIZATION REVIEW - SNF				82.00
83.00 08300 HOSPICE	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	62,599	62,599	62,599	89.00
<b>NONREIMBURSABLE COST CENTERS</b>				
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	94.00
95.00 09500 IDLE SPACE	0	0	0	95.00
98.00 Cross Foot Adjustments				98.00
99.00 Negative Cost Centers				99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	0	151,877	272,870	102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	2.426189	4.359015	103.00
104.00 Cost to be allocated (per Wkst. B, Part II)	0	1,718	707	104.00
105.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.027445	0.011294	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315147

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

Worksheet C  
Date/Time Prepared:  
5/23/2024 3:12 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	6,377	0	0.000000	40.00
41.00	04100	LABORATORY	17,696	0	0.000000	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	3,043	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	630,999	812,546	0.776570	44.00
45.00	04500	OCCUPATIONAL THERAPY	529,703	749,192	0.707032	45.00
46.00	04600	SPEECH PATHOLOGY	58,447	91,423	0.639303	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	452,373	228,064	1.983535	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS						
71.00	07100	AMBULANCE	9,430	0	0.000000	71.00
100.00		Total	1,708,068	1,881,225		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/23/2024 3:12 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
			1.00	2.00	3.00	4.00		5.00
<b>PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST</b>								
<b>ANCILLARY SERVICE COST CENTERS</b>								
40.00	04000	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	04100	LABORATORY	0.000000	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.776570	624,423	0	484,908	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.707032	257,235	0	181,873	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.639303	73,891	0	47,239	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	1.983535	1,050	0	2,083	0	49.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
71.00	07100	AMBULANCE (2)	0.000000		0		0	71.00
100.00		Total (Sum of lines 40 - 71)		956,599	0	716,103	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. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/23/2024 3:12 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)				1.983535	1.00
2.00		Program vaccine charges (From your records, or the PS&R)				0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)				0	3.00
Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH							
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	6,377	0	0.000000	0	0 40.00
41.00	04100	LABORATORY	17,696	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	3,043	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	630,999	0	0.000000	484,908	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	529,703	0	0.000000	181,873	0 45.00
46.00	04600	SPEECH PATHOLOGY	58,447	0	0.000000	47,239	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	452,373	0	0.000000	2,083	0 49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0 51.00
100.00		Total (Sum of lines 40 - 52)	1,698,638	0		716,103	0 100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-III Date/Time Prepared: 5/23/2024 3:12 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
<b>PART I CALCULATION OF INPATIENT ROUTINE COSTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days including private room days		62,599	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		4,567	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		12,139,793	5.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
6.00	General inpatient routine service charges		18,146,707	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.668980	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)		12,139,793	15.00
<b>PROGRAM INPATIENT ROUTINE SERVICE COSTS</b>				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		193.93	16.00
17.00	Program routine service cost (Line 3 times line 16)		885,678	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)		885,678	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)		781,104	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		12.48	21.00
22.00	Program capital related cost (Line 3 times line 21)		56,996	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		828,682	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)		828,682	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	
<b>PART II CALCULATION OF INPATIENT NURSING &amp; ALLIED HEALTH COSTS FOR PPS PASS-THROUGH</b>				
1.00	Total SNF inpatient days		62,599	1.00
2.00	Program inpatient days (see instructions)		4,567	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)		0.072956	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. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/23/2024 3:12 pm
		Title XVIII	Skilled Nursing Facility	PPS

		1.00	
<b>PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT</b>			
1.00	Inpatient PPS amount (See Instructions)	3,363,733	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)	3,363,733	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	0	5.00
6.00	Allowable bad debts (From your records)	807,296	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	582,881	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	552,719	8.00
9.00	Recovery of bad debts - for statistical records only	378,873	9.00
10.00	Utilization review	0	10.00
11.00	Subtotal (See instructions)	0	11.00
12.00	Interim payments (See instructions)	2,935,310	12.00
13.00	Tentative adjustment	2,678,993	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)	7,577	14.75
14.99	Sequestration amount (see instructions)	51,129	14.99
15.00	Balance due provider/program (see Instructions)	197,611	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
<b>PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY</b>			
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315147	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/23/2024 3:12 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0
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		2,671,436		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/01/2023	7,557		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		0		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)		7,557		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)		2,678,993		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
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)				0
6.01	PROGRAM TO PROVIDER		197,611		0
6.02	PROVIDER TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,876,604		0
			Contractor Name		Contractor Number
			1.00		2.00
8.00	Name of Contractor				0

(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. : 315147

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

Worksheet G

Date/Time Prepared:  
5/23/2024 3:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>Assets</b>						
<b>CURRENT ASSETS</b>						
1.00	Cash on hand and in banks	1,414,431	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	4,781,831	0	0	0	4.00
5.00	Other receivables	854,198	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-372,431	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	23,963	0	0	0	8.00
9.00	Other current assets	77,231	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	<b>TOTAL CURRENT ASSETS (Sum of lines 1 - 10)</b>	<b>6,779,223</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,752,763	0	0	0	17.00
18.00	Less: Accumulated Amortization	-6,324	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	69,494	0	0	0	23.00
24.00	Less: Accumulated depreciation	-2,384	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	2,865	0	0	0	27.00
28.00	<b>TOTAL FIXED ASSETS (Sum of lines 12 - 27)</b>	<b>1,816,414</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28.00</b>
<b>OTHER ASSETS</b>						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	45,000	0	0	0	30.00
31.00	Due from owners/officers	1,186,010	0	0	0	31.00
32.00	Other assets	1,004,115	0	0	0	32.00
33.00	<b>TOTAL OTHER ASSETS (Sum of lines 29 - 32)</b>	<b>2,235,125</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33.00</b>
34.00	<b>TOTAL ASSETS (Sum of lines 11, 28, and 33)</b>	<b>10,830,762</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34.00</b>
<b>Liabilities and Fund Balances</b>						
<b>CURRENT LIABILITIES</b>						
35.00	Accounts payable	4,200,281	0	0	0	35.00
36.00	Salaries, wages, and fees payable	7,365	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	557,922	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	778,015	0	0	0	42.00
43.00	<b>TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)</b>	<b>5,543,583</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43.00</b>
<b>LONG TERM LIABILITIES</b>						
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:	-2,425,000	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	<b>TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)</b>	<b>-2,425,000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>TOTAL LIABILITIES (Sum of lines 43 and 50)</b>	<b>3,118,583</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	7,712,179	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	<b>TOTAL FUND BALANCES (Sum of lines 52 thru 58)</b>	<b>7,712,179</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)</b>	<b>10,830,762</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315147

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

Worksheet G-1

Date/Time Prepared:  
5/23/2024 3:12 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		2,928,156			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		4,784,024				2.00
3.00	Total (sum of line 1 and line 2)		7,712,180			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		7,712,180			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING	1		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)		1			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		7,712,179			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)						4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING		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. : 315147

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

Worksheet G-2  
Parts I-III  
Date/Time Prepared:  
5/23/2024 3:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	18,146,707		18,146,707	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)	18,146,707		18,146,707	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,881,225	0	1,881,225	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD	36,730	0	36,730	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	20,064,662	0	20,064,662	14.00
Cost Center Description			1.00	2.00	
<b>PART II - OPERATING EXPENSES</b>					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			15,709,195	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)			15,709,195	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315147

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

Worksheet G-3

Date/Time Prepared:  
5/23/2024 3:12 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	20,064,662	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,339,978	2.00
3.00	Net patient revenues (Line 1 minus line 2)	18,724,684	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	15,709,195	4.00
5.00	Net income from service to patients (Line 3 minus 4)	3,015,489	5.00
<b>Other income:</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	12,117	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	73	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	4,969	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	NON PATIENT REVENUE	199,297	24.00
24.50	COVID-19 PHE Funding	1,552,079	24.50
25.00	Total other income (Sum of lines 6 - 24)	1,768,535	25.00
26.00	Total (Line 5 plus line 25)	4,784,024	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)	4,784,024	31.00