

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).

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: 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 8/2/2024 10:48 am
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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.	Date: _____ Time: _____
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: <u>06/21/2024</u>	6. Contractor No. <u>12001</u> 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: <u>08/12/2024</u> 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 HAMILTON PLACE AT PINES AT WHITING (315347) 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	2	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	184	61	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
7.10 SNF - BASED CORF I	0		0	0	7.10
100.00 TOTAL	0	184	61	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. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/2/2024 10:48 am					
1.00		2.00		3.00					
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:									
1.00	Street: 509 ROUTE 530	PO Box:				1.00			
2.00	City: WHITING	State: NJ	Zip Code:08759			2.00			
3.00	County: OCEAN	CBSA Code: 35154	Urban/Rural: U			3.00			
3.01		CBSA Code:				3.01			
		Component Name	Provider CCN	Date Certi fi ed	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	HAMILTON PLACE AT PINES AT WHITING	315347	08/08/1995	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 FOHC							9.00	
10.00	SNF-Based CMHC							10.00	
11.00	SNF-Based OLTC							11.00	
12.00	SNF-Based HOSPICE							12.00	
13.00	SNF-Based CORF							13.00	
				From:	To:				
				1.00	2.00				
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2023	12/31/2023		14.00		
15.00	Type of Control (See Instructions)				2		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					1,758,519		20.00	
21.00	Declining Balance					0		21.00	
22.00	Sum of the Year's Digits					0		22.00	
23.00	Sum of line 20 through 22					1,758,519		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)					Y		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 FOHC								34.00
35.00	SNF-Based CMHC						N		35.00
36.00	SNF-Based OLTC								36.00
				Y/N					
				1.00					
				2.00					
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00	
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		38.00	
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.					1		39.00	
				Premiums	Paid Losses	Self Insurance			
				1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:					77,479	0	0	41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/2/2024 10:48 am
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	N	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.		44.00
	1.00	2.00	3.00
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name:	Contractor's Name:	Contractor's Number:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 8/2/2024 10:48 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/12/2024	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.	Y			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y		9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N		10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N		11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N		12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	04/02/2024	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. : 315347

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 8/2/2024 10:48 am

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DEANDRA	FALLON	19.00
20.00	Enter the employer/company name of the cost report preparer.	BAKER TILLY		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	570.820.0301	DEANDRA.FALLON@BAKERTILLY.COM	21.00

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

Provider No. : 315347

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

Worksheet S-2
 Part II
 Date/Time Prepared:
 8/2/2024 10:48 am

		Part B		
		Date		
		4.00		
PS&R Data				
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	04/02/2024		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.			18.00
			3.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		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

VOLUNTARY CONTACT INFORMATION

Provider No. : 315347

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

Worksheet S-2
Part V
Date/Time Prepared:
8/2/2024 10:48 am

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8.00
9.00	Mailing Address 2		9.00
10.00	City		10.00
11.00	State		11.00
12.00	Zip		12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	KATHLEEN	13.00
14.00	Last Name	MILLER	14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number	7328492011	17.00
18.00	E-mail Address	kmiiler@felowshiplifenc.org	18.00
19.00	Department		19.00
20.00	Mailing Address 1	509 ROUTE 530	20.00
21.00	Mailing Address 2		21.00
22.00	City	WHITING	22.00
23.00	State		NJ 23.00
24.00	Zip	08759	24.00

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

Provider No. : 315347

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

Worksheet S-3
 Part I
 Date/Time Prepared:
 8/2/2024 10:48 am

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	66	24,090	0	2,624	5,088	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
6.10	SNF-Based CORF	0	0	0	0	0	6.10
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	66	24,090	0	2,624	5,088	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	10,303	18,015	0	98	17	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
6.10	SNF-Based CORF	0	0	0	0	0	6.10
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	10,303	18,015	0	98	17	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	128	243	0.00	26.78	299.29	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
6.10	SNF-Based CORF	0	0	0.00	0.00	0.00	6.10
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	128	243	0.00	26.78	299.29	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	74.14	0	98	20	131	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
6.10	SNF-Based CORF	0.00	0	0	0	0	6.10
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	74.14	0	98	20	131	8.00
Component		Admissions		Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	249	112.03	0.00		1.00	
2.00	NURSING FACILITY	0	0.00	0.00		2.00	
3.00	ICF/IID	0	0.00	0.00		3.00	
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00		4.00	
5.00	Other Long Term Care	0	0.00	0.00		5.00	
6.00	SNF-Based CMHC	0	0.00	0.00		6.00	
6.10	SNF-Based CORF	0	0.00	0.00		6.10	
7.00	HOSPICE	0	0.00	0.00		7.00	
8.00	Total (Sum of lines 1-7)	249	112.03	0.00		8.00	

Provider No. : 315347

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

Worksheet S-3
Part II
Date/Time Prepared:
8/2/2024 10:48 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)		
	1.00	2.00	3.00	4.00	5.00		
PART II - DIRECT SALARIES							
SALARIES							
1.00	Total salaries (See Instructions)	7,051,058	0	7,051,058	291,427.00	24.19	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	7,051,058	0	7,051,058	291,427.00	24.19	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
9.10	CORF						9.10
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	1,572,719	0	1,572,719	58,407.00	26.93	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	1,572,719	0	1,572,719	58,407.00	26.93	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	5,478,339	0	5,478,339	233,020.00	23.51	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	605,423	0	605,423	14,261.00	42.45	14.00
15.00	Contract Labor: Physician services-Part A	24,000	0	24,000	360.00	66.67	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs core (See Part IV)	1,756,613	0	1,756,613			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	391,808	0	391,808			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	1,364,805	0	1,364,805			22.00

Provider No. : 315347

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

Worksheet S-3
Part III
Date/Time Prepared:
8/2/2024 10:48 am

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	733,545	0	733,545	24,127.00	2.00
3.00	Plant Operation, Maintenance & Repairs	318,123	0	318,123	10,939.00	3.00
4.00	Laundry & Linen Service	26,528	0	26,528	1,775.00	4.00
5.00	Housekeeping	475,298	0	475,298	29,184.00	5.00
6.00	Dietary	1,233,367	0	1,233,367	73,315.00	6.00
7.00	Nursing Administration	212,600	469,589	682,189	20,236.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	34,793	0	34,793	926.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	202,366	0	202,366	10,735.00	13.00
14.00	Total (sum lines 1 thru 13)	3,236,620	469,589	3,706,209	171,237.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 8/2/2024 10:48 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		827,309	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)		5,495	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		232,746	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		534,539	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		156,524	20.00
OTHER				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)		1,756,613	24.00
				Amount Reported
				1.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315347

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

Worksheet S-3
Part V
Date/Time Prepared:
8/2/2024 10:48 am

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	155,123	38,641	193,764	3,546.00	54.64	1.00
2.00	Licensed Practical Nurses (LPNs)	470,132	117,110	587,242	13,168.00	44.60	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	637,294	158,750	796,044	34,500.00	23.07	3.00
4.00	Total Nursing (sum of lines 1 through 3)	1,262,549	314,501	1,577,050	51,214.00	30.79	4.00
5.00	Physical Therapists	258,712	64,445	323,157	5,172.00	62.48	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	156,681	39,029	195,710	3,035.00	64.48	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	15,827	3,943	19,770	275.00	71.89	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	77,273		77,273	1,165.00	66.33	14.00
15.00	Licensed Practical Nurses (LPNs)	123,963		123,963	2,259.00	54.88	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	404,187		404,187	10,837.00	37.30	16.00
17.00	Total Nursing (sum of lines 14 through 16)	605,423		605,423	14,261.00	42.45	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. : 315347

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

Worksheet S-7
Date/Time Prepared:
8/2/2024 10:48 am

		Group	Days	
		1.00	2.00	
1.00		RUX		1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5.00		RHX		5.00
6.00		RHL		6.00
7.00		RMX		7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00		RUC		10.00
11.00		RUB		11.00
12.00		RUA		12.00
13.00		RVC		13.00
14.00		RVB		14.00
15.00		RVA		15.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25.00		ES2		25.00
26.00		ES1		26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30.00		HD1		30.00
31.00		HC2		31.00
32.00		HC1		32.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36.00		LE1		36.00
37.00		LD2		37.00
38.00		LD1		38.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00		CE2		43.00
44.00		CE1		44.00
45.00		CD2		45.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00		CC1		48.00
49.00		CB2		49.00
50.00		CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53.00		SE3		53.00
54.00		SE2		54.00
55.00		SE1		55.00
56.00		SSC		56.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00		IB2		59.00
60.00		IB1		60.00
61.00		IA2		61.00
62.00		IA1		62.00
63.00		BB2		63.00
64.00		BB1		64.00
65.00		BA2		65.00
66.00		BA1		66.00
67.00		PE2		67.00
68.00		PE1		68.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1		74.00
75.00		PA2		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315347

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

Worksheet S-7

Date/Time Prepared:
8/2/2024 10:48 am

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315347

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

Worksheet A
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		2,144,651	2,144,651	0	2,144,651	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300	0	1,756,613	1,756,613	0	1,756,613	3.00
4.00	00400	733,545	4,844,785	5,578,330	0	5,578,330	4.00
5.00	00500	318,123	1,129,955	1,448,078	0	1,448,078	5.00
6.00	00600	26,528	5,600	32,128	0	32,128	6.00
7.00	00700	475,298	109,178	584,476	0	584,476	7.00
8.00	00800	1,233,367	1,896,438	3,129,805	0	3,129,805	8.00
9.00	00900	212,600	12,000	224,600	469,589	694,189	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	34,793	0	34,793	0	34,793	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01501	202,366	38,125	240,491	0	240,491	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,732,138	770,206	2,502,344	-463,807	2,038,537	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	11,453	11,453	0	11,453	40.00
41.00	04100	0	19,232	19,232	0	19,232	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	5,782	5,782	-5,782	0	43.00
44.00	04400	335,917	141,679	477,596	-133,883	343,713	44.00
45.00	04500	88,213	0	88,213	119,946	208,159	45.00
46.00	04600	7,090	0	7,090	13,937	21,027	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	178,854	178,854	0	178,854	48.00
49.00	04900	0	37,007	37,007	0	37,007	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	78,361	1,145	79,506	0	79,506	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	0	0	0	0	0	80.00
81.00	08100	0	0	0	0	0	81.00
82.00	08200	0	0	0	0	0	82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
89.00		5,478,339	13,102,703	18,581,042	0	18,581,042	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	637	637	0	637	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	0	0	0	0	95.00
95.01	09501	1,572,719	966,400	2,539,119	0	2,539,119	95.01
95.02	09502	0	0	0	0	0	95.02
100.00		7,051,058	14,069,740	21,120,798	0	21,120,798	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315347

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

Worksheet A
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-284,886	1,859,765	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	0	1,756,613	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-1,567,403	4,010,927	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	-116,957	1,331,121	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	-15,844	16,284	6.00
7.00	00700	HOUSEKEEPING	0	584,476	7.00
8.00	00800	DIETARY	-31,865	3,097,940	8.00
9.00	00900	NURSING ADMINISTRATION	0	694,189	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	34,793	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01501	ACTIVITIES	0	240,491	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	2,038,537	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	11,453	40.00
41.00	04100	LABORATORY	0	19,232	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	343,713	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	208,159	45.00
46.00	04600	SPEECH PATHOLOGY	0	21,027	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	178,854	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	37,007	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	79,506	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
72.00	07200	CORF	0	0	72.00
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	-2,016,955	16,564,087	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	637	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	OTHER NONREIMBURSABLE	0	0	95.00
95.01	09501	PC/ILU	0	2,539,119	95.01
95.02	09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	95.02
100.00		TOTAL	-2,016,955	19,103,843	100.00

Provider No. : 315347

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

Worksheet A-6
Date/Time Prepared:
8/2/2024 10:48 am

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
	(1) A - RECLASS NURSING SALARIES					
1.00		NURSING ADMINISTRATION	9.00	469,589	0	1.00
	(1) B - RECLASSIFY OXYGEN COSTS					
2.00		SKILLED NURSING FACILITY	30.00	0	5,782	2.00
	(1) C - THERAPY RECLASS					
3.00		OCCUPATIONAL THERAPY	45.00	68,468	51,478	3.00
4.00		SPEECH PATHOLOGY	46.00	8,737	5,200	4.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		546,794	62,460	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. : 315347

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

Worksheet A-6
Date/Time Prepared:
8/2/2024 10:48 am

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	(1) A - RECLASS NURSING SALARIES					
1.00		SKILLED NURSING FACILITY	30.00	469,589	0	1.00
	(1) B - RECLASSIFY OXYGEN COSTS					
2.00		OXYGEN (INHALATION) THERAPY	43.00	0	5,782	2.00
	(1) C - THERAPY RECLASS					
3.00		PHYSICAL THERAPY	44.00	77,205	56,678	3.00
4.00			0.00	0	0	4.00
	TOTALS					
100.00				546,794	62,460	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. : 315347

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

Worksheet A-7

Date/Time Prepared:
8/2/2024 10:48 am

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	2,748,541	3,651,459	0	3,651,459	0	1.00
2.00 Land Improvements	398,627	2,201,374	0	2,201,374	0	2.00
3.00 Buildings and Fixtures	41,485,439	17,250,169	0	17,250,169	0	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	8,660,948	0	0	0	7,678,077	5.00
6.00 Movable Equipment	3,536,246	0	0	0	3,196,760	6.00
7.00 Subtotal (sum of lines 1-6)	56,829,801	23,103,002	0	23,103,002	10,874,837	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	56,829,801	23,103,002	0	23,103,002	10,874,837	9.00
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	6,400,000	0				
2.00 Land Improvements	2,600,001	0				
3.00 Buildings and Fixtures	58,735,608	0				
4.00 Building Improvements	0	0				
5.00 Fixed Equipment	982,871	0				
6.00 Movable Equipment	339,486	0				
7.00 Subtotal (sum of lines 1-6)	69,057,966	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	69,057,966	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315347

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

Worksheet A-8

Date/Time Prepared:
8/2/2024 10:48 am

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line No.
			3.00	4.00
1.00	2.00	3.00	4.00	
1.00 Investment income on restricted funds (chapter 2)	B	-284,886	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)	B	-63,748	ADMINISTRATIVE & GENERAL	4.00 5.00
6.00 Television and radio service (chapter 21)	A	-110,043	PLANT OPERATION, MAINT. & REPAIRS	5.00 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	-89,656		12.00
13.00 Laundry and linen service	B	-15,844	LAUNDRY & LINEN SERVICE	6.00 13.00
14.00 Revenue - Employee meals	B	-2,916	DIETARY	8.00 14.00
15.00 Cost of meals - Guests		0		0.00 15.00
16.00 Sale of medical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts		0		0.00 18.00
19.00 Vending machines		0		0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW	82.00 22.00
23.00 Depreciation--buildings and fixtures			CAP REL COSTS - BLDGS & FIXTURES	1.00 23.00
24.00 Depreciation--movable equipment			CAP REL COSTS - MOVABLE EQUIPMENT	2.00 24.00
25.00 MISC INCOME	B	-98,816	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01 GIFTS	A	-721	ADMINISTRATIVE & GENERAL	4.00 25.01
25.02 CARE TO SHARE INVESTORS PROGRAM	B	-523	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03 BAD DEBT EXPENSE	A	-45,000	ADMINISTRATIVE & GENERAL	4.00 25.03
25.04 ADVERTISING	A	-261,503	ADMINISTRATIVE & GENERAL	4.00 25.04
25.05 TRAVEL	A	-410	ADMINISTRATIVE & GENERAL	4.00 25.05
25.06 EVENTS	A	-25,541	ADMINISTRATIVE & GENERAL	4.00 25.06
25.07 HOUSEKEEPING	B	-6,914	PLANT OPERATION, MAINT. & REPAIRS	5.00 25.07
25.08 EMPLOYEE RECOGNITION	A	-25,841	ADMINISTRATIVE & GENERAL	4.00 25.08
25.09 CAFE/BISTRO INCOME	B	-28,949	DIETARY	8.00 25.09
25.10 GIFT SHOP REVENUE	B	-2,161	ADMINISTRATIVE & GENERAL	4.00 25.10
25.11 FINANCE CHARGES	B	-2,521	ADMINISTRATIVE & GENERAL	4.00 25.11
25.12 DONATIONS	A	-575	ADMINISTRATIVE & GENERAL	4.00 25.12
25.13 BANK AND TRUSTEE CHARGES	A	-950,387	ADMINISTRATIVE & GENERAL	4.00 25.13
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-2,016,955		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. : 315347

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

Worksheet A-8-1
Parts 1-11
Date/Time Prepared:
8/2/2024 10:48 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	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		703,314	792,970	-89,656	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.	703,314	792,970	-89,656	10.00

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

Provider No. : 315347

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

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
8/2/2024 10:48 am

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	B	0.00	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	FELLOWSHIP LIFE, INC.	100.00	MANAGEMENT COMPANY	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. : 315347

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,859,765	1,859,765			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	1,756,613	0	0	1,756,613	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	4,010,927	37,962	0	182,747	4,231,636 4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,331,121	58,552	0	79,253	1,468,926 5.00
6.00 00600	LAUNDRY & LINEN SERVICE	16,284	22,267	0	6,609	45,160 6.00
7.00 00700	HOUSEKEEPING	584,476	19,926	0	118,410	722,812 7.00
8.00 00800	DIETARY	3,097,940	106,514	0	307,266	3,511,720 8.00
9.00 00900	NURSING ADMINISTRATION	694,189	2,142	0	169,952	866,283 9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 10.00
11.00 01100	PHARMACY	0	0	0	0	0 11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 12.00
13.00 01300	SOCIAL SERVICE	34,793	598	0	8,668	44,059 13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0 14.00
15.00 01501	ACTIVITIES	240,491	22,282	0	50,415	313,188 15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	2,038,537	104,956	0	314,536	2,458,029 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	11,453	1,049	0	0	12,502 40.00
41.00 04100	LABORATORY	19,232	1,049	0	0	20,281 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	343,713	4,350	0	64,452	412,515 44.00
45.00 04500	OCCUPATIONAL THERAPY	208,159	4,225	0	39,034	251,418 45.00
46.00 04600	SPEECH PATHOLOGY	21,027	0	0	3,943	24,970 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,854	1,078	0	0	179,932 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	37,007	0	0	0	37,007 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	79,506	0	0	19,522	99,028 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
72.00 07200	CORF	0	0	0	0	0 72.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 84.00
89.00	SUBTOTALS (sum of lines 1-84)	16,564,087	386,950	0	1,364,807	14,699,466 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	2,171	0	0	2,171 90.00
91.00 09100	BARBER AND BEAUTY SHOP	637	6,403	0	0	7,040 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	OTHER NONREIMBURSABLE	0	1,464,241	0	0	1,464,241 95.00
95.01 09501	PC/ILU	2,539,119	0	0	391,806	2,930,925 95.01
95.02 09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 95.02
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	19,103,843	1,859,765	0	1,756,613	19,103,843 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315347

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4,231,636				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	417,958	1,886,884			5.00
6.00	00600	LAUNDRY & LINEN SERVICE	12,850	23,829	81,839		6.00
7.00	00700	HOUSEKEEPING	205,664	21,323	0	949,799	7.00
8.00	00800	DIETARY	999,201	113,983	0	0	4,624,904
9.00	00900	NURSING ADMINISTRATION	246,486	2,292	0	1,260	0
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
11.00	01100	PHARMACY	0	0	0	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
13.00	01300	SOCIAL SERVICE	12,536	640	0	352	0
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00	01501	ACTIVITIES	89,112	23,844	0	13,108	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	699,390	112,315	59,882	61,743	1,200,440
31.00	03100	NURSING FACILITY	0	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	3,557	1,122	0	617	0
41.00	04100	LABORATORY	5,771	1,122	0	617	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	117,374	4,655	0	2,559	0
45.00	04500	OCCUPATIONAL THERAPY	71,537	4,521	0	2,485	0
46.00	04600	SPEECH PATHOLOGY	7,105	0	0	0	0
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,197	1,154	0	634	0
49.00	04900	DRUGS CHARGED TO PATIENTS	10,530	0	0	0	0
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0	0
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	CLINIC	28,177	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00	06200	FOHC	0	0	0	0	0
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00	07100	AMBULANCE	0	0	0	0	0
72.00	07200	CORF	0	0	0	0	0
73.00	07300	CMHC	0	0	0	0	0
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100	INTEREST EXPENSE					81.00
82.00	08200	UTILIZATION REVIEW					82.00
83.00	08300	HOSPICE	0	0	0	0	0
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	2,978,445	310,800	59,882	83,375	1,200,440
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	618	2,324	0	1,277	0
91.00	09100	BARBER AND BEAUTY SHOP	2,003	6,852	0	3,767	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	OTHER NONREIMBURSABLE	416,625	1,566,908	21,957	861,380	3,424,464
95.01	09501	PC/ILLU	833,945	0	0	0	0
95.02	09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
98.00		Cross Foot Adjustments	0	0	0	0	0
99.00		Negative Cost Centers	0	0	0	0	0
100.00		TOTAL	4,231,636	1,886,884	81,839	949,799	4,624,904

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315347

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	1,116,321					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	57,587	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01501	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,116,321	0	0	0	57,587	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
89.00		1,116,321	0	0	0	57,587	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
95.01	09501	0	0	0	0	0	95.01
95.02	09502	0	0	0	0	0	95.02
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		1,116,321	0	0	0	57,587	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315347

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

Worksheet B
Part I
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01501	ACTIVITIES	0	439,252			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	439,252	6,204,959	0	6,204,959 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	17,798	0	17,798 40.00
41.00 04100	LABORATORY	0	0	27,791	0	27,791 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	537,103	0	537,103 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	329,961	0	329,961 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	32,075	0	32,075 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	232,917	0	232,917 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	47,537	0	47,537 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	127,205	0	127,205 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
72.00 07200	CORF	0	0	0	0	0 72.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	439,252	7,557,346	0	7,557,346 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	6,390	0	6,390 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	19,662	0	19,662 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	OTHER NONREIMBURSABLE	0	0	7,755,575	0	7,755,575 95.00
95.01 09501	PC/ILU	0	0	3,764,870	0	3,764,870 95.01
95.02 09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 95.02
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	439,252	19,103,843	0	19,103,843 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315347

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

Worksheet B
Part II
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDGS & FIXTURES	MOVABLE EQUIPMENT		
		0	2.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	37,962	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	58,552	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	22,267	0	6.00
7.00 00700	HOUSEKEEPING	0	19,926	0	7.00
8.00 00800	DIETARY	0	106,514	0	8.00
9.00 00900	NURSING ADMINISTRATION	0	2,142	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	598	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	14.00
15.00 01501	ACTIVITIES	0	22,282	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	SKILLED NURSING FACILITY	0	104,956	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00 04000	RADIOLOGY	0	1,049	0	40.00
41.00 04100	LABORATORY	0	1,049	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	4,350	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	4,225	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	1,078	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00 06000	CLINIC	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00 06200	FQHC	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	71.00
72.00 07200	CORF	0	0	0	72.00
73.00 07300	CMHC	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00 08100	INTEREST EXPENSE				81.00
82.00 08200	UTILIZATION REVIEW				82.00
83.00 08300	HOSPICE	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	386,950	0	89.00
NONREIMBURSABLE COST CENTERS					
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	2,171	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	6,403	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	OTHER NONREIMBURSABLE	0	1,464,241	0	95.00
95.01 09501	PC/ILLU	0	0	0	95.01
95.02 09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	95.02
98.00	Cross Foot Adjustments				98.00
99.00	Negative Cost Centers		0	0	99.00
100.00	TOTAL	0	1,859,765	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315347

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

Worksheet B
Part II
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	37,962					4.00
5.00	00500	3,750	62,302				5.00
6.00	00600	115	787	23,169			6.00
7.00	00700	1,845	704	0	22,475		7.00
8.00	00800	8,959	3,764	0	0	119,237	8.00
9.00	00900	2,212	76	0	30	0	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	112	21	0	8	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01501	800	787	0	310	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,275	3,708	16,953	1,461	30,949	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	32	37	0	15	0	40.00
41.00	04100	52	37	0	15	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,053	154	0	61	0	44.00
45.00	04500	642	149	0	59	0	45.00
46.00	04600	64	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	459	38	0	15	0	48.00
49.00	04900	94	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	253	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
89.00		26,717	10,262	16,953	1,974	30,949	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	6	77	0	30	0	90.00
91.00	09100	18	226	0	89	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	3,738	51,737	6,216	20,382	88,288	95.00
95.01	09501	7,483	0	0	0	0	95.01
95.02	09502	0	0	0	0	0	95.02
98.00							98.00
99.00							99.00
100.00		37,962	62,302	23,169	22,475	119,237	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315347

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

Worksheet B
Part II
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	4,460					9.00
10.00	01000		0				10.00
11.00	01100		0	0			11.00
12.00	01200		0	0	0		12.00
13.00	01300		0	0	0	739	13.00
14.00	01400		0	0	0	0	14.00
15.00	01501		0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,460	0	0	0	739	30.00
31.00	03100		0	0	0	0	31.00
32.00	03200		0	0	0	0	32.00
33.00	03300		0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000		0	0	0	0	40.00
41.00	04100		0	0	0	0	41.00
42.00	04200		0	0	0	0	42.00
43.00	04300		0	0	0	0	43.00
44.00	04400		0	0	0	0	44.00
45.00	04500		0	0	0	0	45.00
46.00	04600		0	0	0	0	46.00
47.00	04700		0	0	0	0	47.00
48.00	04800		0	0	0	0	48.00
49.00	04900		0	0	0	0	49.00
50.00	05000		0	0	0	0	50.00
51.00	05100		0	0	0	0	51.00
52.00	05200		0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000		0	0	0	0	60.00
61.00	06100		0	0	0	0	61.00
62.00	06200						62.00
63.00	06300		0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000		0	0	0	0	70.00
71.00	07100		0	0	0	0	71.00
72.00	07200		0	0	0	0	72.00
73.00	07300		0	0	0	0	73.00
74.00	07400		0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300		0	0	0	0	83.00
84.00	08400		0	0	0	0	84.00
89.00		4,460	0	0	0	739	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000		0	0	0	0	90.00
91.00	09100		0	0	0	0	91.00
92.00	09200		0	0	0	0	92.00
93.00	09300		0	0	0	0	93.00
94.00	09400		0	0	0	0	94.00
95.00	09500		0	0	0	0	95.00
95.01	09501		0	0	0	0	95.01
95.02	09502		0	0	0	0	95.02
98.00			0	0	0	0	98.00
99.00			0	0	0	0	99.00
100.00		4,460	0	0	0	739	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315347

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

Worksheet B
Part II
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01501	ACTIVITIES	0	24,179			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	24,179	193,680	0	193,680 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	1,133	0	1,133 40.00
41.00 04100	LABORATORY	0	0	1,153	0	1,153 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	5,618	0	5,618 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	5,075	0	5,075 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	64	0	64 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,590	0	1,590 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	94	0	94 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	253	0	253 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
72.00 07200	CORF	0	0	0	0	0 72.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	24,179	208,660	0	208,660 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	2,284	0	2,284 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	6,736	0	6,736 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	OTHER NONREIMBURSABLE	0	0	1,634,602	0	1,634,602 95.00
95.01 09501	PC/ILU	0	0	7,483	0	7,483 95.01
95.02 09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 95.02
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	24,179	1,859,765	0	1,859,765 100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315347

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

Worksheet B-1

Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	251,812				1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		251,812			2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	7,051,058		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	5,140	5,140	733,545	-4,231,636	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	7,928	7,928	318,123	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	3,015	3,015	26,528	0	6.00
7.00 00700	HOUSEKEEPING	2,698	2,698	475,298	0	7.00
8.00 00800	DIETARY	14,422	14,422	1,233,367	0	8.00
9.00 00900	NURSING ADMINISTRATION	290	290	682,189	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	81	81	34,793	0	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01501	ACTIVITIES	3,017	3,017	202,366	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	14,211	14,211	1,262,549	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	142	142	0	0	40.00
41.00 04100	LABORATORY	142	142	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	589	589	258,712	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	572	572	156,681	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	15,827	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	146	146	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	78,361	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FQHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	52,393	52,393	5,478,339	-4,231,636	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	294	294	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	867	867	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	OTHER NONREIMBURSABLE	198,258	198,258	0	0	95.00
95.01 09501	PC/ILLU	0	0	1,572,719	0	95.01
95.02 09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	95.02
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1,859,765	0	1,756,613	4,231,636	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	7.385530	0.000000	0.249128	0.284533	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0	37,962	104.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315347

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

Worksheet B-1
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)			
	1.00	2.00	3.00			
105.00 Unit cost multiplier (Wkst. B, Part II)			0.000000	4A	0.002553	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315347

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

Worksheet B-1

Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	238,744				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	3,015	298,480			6.00	
7.00	00700	HOUSEKEEPING	2,698	0	218,609		7.00	
8.00	00800	DIETARY	14,422	0	0	190,168	8.00	
9.00	00900	NURSING ADMINISTRATION	290	0	290	0	9.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00	
11.00	01100	PHARMACY	0	0	0	0	11.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00	
13.00	01300	SOCIAL SERVICE	81	0	81	0	13.00	
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00	
15.00	01501	ACTIVITIES	3,017	0	3,017	0	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	14,211	218,400	14,211	49,360	51,214	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	142	0	142	0	0	40.00
41.00	04100	LABORATORY	142	0	142	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	589	0	589	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	572	0	572	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	146	0	146	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	39,325	218,400	19,190	49,360	51,214	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	294	0	294	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	867	0	867	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	OTHER NONREIMBURSABLE	198,258	80,080	198,258	140,808	0	95.00
95.01	09501	PC/ILU	0	0	0	0	0	95.01
95.02	09502	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95.02
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	1,886,884	81,839	949,799	4,624,904	1,116,321	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	7.903378	0.274186	4.344739	24.320096	21.797184	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	62,302	23,169	22,475	119,237	4,460	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.260957	0.077623	0.102809	0.627009	0.087086	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315347

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

Worksheet B-1
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (TOTAL PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	18,015					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	18,015			12.00
13.00	01300	0	0	0	18,015		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01501	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,015	0	18,015	18,015	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
89.00		18,015	0	18,015	18,015	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
95.01	09501	0	0	0	0	0	95.01
95.02	09502	0	0	0	0	0	95.02
98.00							98.00
99.00							99.00
102.00		0	0	0	57,587	0	102.00
103.00		0.000000	0.000000	0.000000	3.196614	0.000000	103.00
104.00		0	0	0	739	0	104.00
105.00		0.000000	0.000000	0.000000	0.041021	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315347

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

Worksheet B-1
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		OTHER GENERAL SERVICE ACTIVITIES (TOTAL PATIENT DAYS)	
		15.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01501	ACTIVITIES	15.00
		18,015	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	30.00
31.00	03100	NURSING FACILITY	31.00
32.00	03200	ICF/IID	32.00
33.00	03300	OTHER LONG TERM CARE	33.00
		0	
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	40.00
41.00	04100	LABORATORY	41.00
42.00	04200	INTRAVENOUS THERAPY	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	43.00
44.00	04400	PHYSICAL THERAPY	44.00
45.00	04500	OCCUPATIONAL THERAPY	45.00
46.00	04600	SPEECH PATHOLOGY	46.00
47.00	04700	ELECTROCARDIOLOGY	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	50.00
51.00	05100	SUPPORT SURFACES	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	52.00
		0	
OUTPATIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	60.00
61.00	06100	RURAL HEALTH CLINIC	61.00
62.00	06200	FOHC	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	63.00
		0	
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	70.00
71.00	07100	AMBULANCE	71.00
72.00	07200	CORF	72.00
73.00	07300	CMHC	73.00
74.00	07400	OTHER REIMBURSABLE COST	74.00
		0	
SPECIAL PURPOSE COST CENTERS			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	80.00
81.00	08100	INTEREST EXPENSE	81.00
82.00	08200	UTILIZATION REVIEW	82.00
83.00	08300	HOSPICE	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	84.00
89.00		SUBTOTALS (sum of lines 1-84)	89.00
		18,015	
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	90.00
91.00	09100	BARBER AND BEAUTY SHOP	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	92.00
93.00	09300	NONPAID WORKERS	93.00
94.00	09400	PATIENTS LAUNDRY	94.00
95.00	09500	OTHER NONREIMBURSABLE	95.00
95.01	09501	PC/ILU	95.01
95.02	09502	OTHER NONREIMBURSABLE COST CENTERS	95.02
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)	102.00
		439,252	
103.00		Unit cost multiplier (Wkst. B, Part I)	103.00
		24.382570	
104.00		Cost to be allocated (per Wkst. B, Part II)	104.00
		24,179	
105.00		Unit cost multiplier (Wkst. B, Part II)	105.00
		1.342159	

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 8/2/2024 10:48 am
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Cost Center Description			Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	17,798	11,453	1.554003	40.00
41.00	04100	LABORATORY	27,791	19,232	1.445040	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	04400	PHYSICAL THERAPY	537,103	610,666	0.879536	44.00
45.00	04500	OCCUPATIONAL THERAPY	329,961	410,650	0.803509	45.00
46.00	04600	SPEECH PATHOLOGY	32,075	30,534	1.050468	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,917	178,854	1.302274	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	47,537	63,522	0.748355	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	127,205	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FOHC				62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	63.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	1,352,387	1,324,911		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 8/2/2024 10:48 am
		Title XVIII (1)	Skilled Nursing Facility	PPS

	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost	
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)
		2.00	3.00	4.00	5.00

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	1.554003	6,165	0	9,580	0	40.00
41.00	04100	LABORATORY	1.445040	10,908	0	15,762	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	0.879536	411,450	0	361,885	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.803509	410,650	0	329,961	0	45.00
46.00	04600	SPEECH PATHOLOGY	1.050468	20,550	0	21,587	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.302274	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0.748355	62,247	0	46,583	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0.000000	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC						61.00
62.00	06200	FOHC						62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	63.00
71.00	07100	AMBULANCE (2)	0.000000					71.00
100.00		Total (Sum of lines 40 - 71)		921,970	0	785,358	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. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 8/2/2024 10:48 am
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description				1.00
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PART II - APPORTIONMENT OF VACCINE COST					
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		0.748355	1.00
2.00		Program vaccine charges (From your records, or the PS&R)		1,275	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)		954	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	17,798	0	0.000000	9,580	0	40.00
41.00	04100	LABORATORY	27,791	0	0.000000	15,762	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	537,103	0	0.000000	361,885	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	329,961	0	0.000000	329,961	0	45.00
46.00	04600	SPEECH PATHOLOGY	32,075	0	0.000000	21,587	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,917	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	47,537	0	0.000000	46,583	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	52.00
100.00		Total (Sum of lines 40 - 52)	1,225,182	0		785,358	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS		Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-III Date/Time Prepared: 8/2/2024 10:48 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		18,015	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		2,624	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		6,204,959	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		7,000,316	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.886383	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		7,000,316	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		388.58	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)		6,204,959	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		344.43	16.00
17.00	Program routine service cost (Line 3 times line 16)		903,784	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)		903,784	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)		193,680	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		10.75	21.00
22.00	Program capital related cost (Line 3 times line 21)		28,208	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		875,576	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)		875,576	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00
(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX				
				1.00
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		18,015	1.00
2.00	Program inpatient days (see instructions)		2,624	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)		0.145656	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 XVII I		Provider No. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 8/2/2024 10:48 am
		Title XVII I	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		1,832,349	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)		1,832,349	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinurance		185,000	5.00
6.00	Allowable bad debts (From your records)		289	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		188	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		1,647,537	11.00
12.00	Interim payments (See instructions)		1,614,402	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		4	14.75
14.99	Sequestration amount (see instructions)		32,947	14.99
15.00	Balance due provider/program (see Instructions)		184	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCI LLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVII I ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		954	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		954	19.00
20.00	Medicare Part B ancillary charges (See instructions)		1,275	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		954	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinurance 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)		954	25.00
26.00	Interim payments (See instructions)		874	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)		19	28.99
29.00	Balance due provider/program (see instructions)		61	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. : 315347	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 8/2/2024 10:48 am	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				874 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		1,614,402		0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1,614,402		874 4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0 5.01
5.02			0		0 5.02
5.03			0		0 5.03
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0 5.50
5.51			0		0 5.51
5.52			0		0 5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	PROGRAM TO PROVIDER		184		61 6.01
6.02	PROVIDER TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		1,614,586		935 7.00
		Contractor Name		Contractor Number	
		1.00		2.00	
8.00	Name of Contractor	Novitas Solutions		12001 8.00	

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

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

Provider No. : 315347

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

Worksheet G

Date/Time Prepared:
8/2/2024 10:48 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	1,383,541	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	900,051	0	0	0	4.00
5.00	Other receivables	-615,170	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-27,014	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	130,663	0	0	0	8.00
9.00	Other current assets	93,451	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1,865,522	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,400,000	0	0	0	12.00
13.00	Land improvements	2,600,001	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	58,735,608	0	0	0	15.00
16.00	Less Accumulated depreciation	-732,326	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	982,871	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	339,486	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	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	718,657	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	69,044,297	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	1,748,765	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	1,238,072	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2,986,837	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	73,896,656	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,712,832	0	0	0	35.00
36.00	Salaries, wages, and fees payable	931,173	0	0	0	36.00
37.00	Payroll taxes payable	37,279	0	0	0	37.00
38.00	Notes & loans payable (Short term)	1,402,804	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4,084,088	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	7,649,476	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	9,470,247	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	17,119,723	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	21,203,811	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	52,692,845	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	52,692,845	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	73,896,656	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315347

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

Worksheet G-1

Date/Time Prepared:
8/2/2024 10:48 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		645,930			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-1,293,303				2.00
3.00	Total (sum of line 1 and line 2)		-647,373			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	INHERENT CONTRIBUTION	53,568,417			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)		53,568,417			0	10.00
11.00	Subtotal (line 3 plus line 10)		52,921,044			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	OPENING BALANCE ADJUSTMENT	228,199			0	0	13.00
14.00	ROUNDING	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)		228,199			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		52,692,845			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	INHERENT CONTRIBUTION		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	OPENING BALANCE ADJUSTMENT		0				13.00
14.00	ROUNDING		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. : 315347

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

Worksheet G-2
Parts I-11
Date/Time Prepared:
8/2/2024 10:48 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	7,000,316		7,000,316	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)	7,000,316		7,000,316	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,121,409	0	1,121,409	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
11.10	CORF		0	0	11.10
12.00	HOSPICE	0	0	0	12.00
13.00	ASSISTED AND INDEPENDENT LIVING	11,792,274	0	11,792,274	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	19,913,999	0	19,913,999	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			21,120,798	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)			21,120,798	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315347

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

Worksheet G-3

Date/Time Prepared:
8/2/2024 10:48 am

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	19,913,999	1.00
2.00	Less: contractual allowances and discounts on patients accounts	771,831	2.00
3.00	Net patient revenues (Line 1 minus line 2)	19,142,168	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	21,120,798	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,978,630	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	416	6.00
7.00	Income from investments	284,886	7.00
8.00	Revenues from communications (Telephone and Internet service)	63,748	8.00
9.00	Revenue from television and radio service	116,027	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	15,844	13.00
14.00	Revenue from meals sold to employees and guests	2,916	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	31,110	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	0	24.00
24.01	BARBER AND BEAUTY	28,308	24.01
24.02	FINANCE CHARGES	0	24.02
24.03	OTHER MISCELLANEOUS	98,816	24.03
24.04	TRANSPORTATION	6,032	24.04
24.05	RESTRICTED INVESTMENT INCOME	0	24.05
24.06	GAIN / LOSS ON ASSET DISPOSAL	1,000	24.06
24.07	NET ASSETS RELEASED	0	24.07
24.08	CARE TO SHARE INVESTORS REVENUE	523	24.08
24.09	INTEREST ON PROMISSORY NOTE	0	24.09
24.10	HOUSEKEEPING	6,914	24.10
24.12	INSURANCE RECOVERY	26,266	24.12
24.13	OTHER	0	24.13
24.14	FINANCE CHARGES	2,521	24.14
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	685,327	25.00
26.00	Total (Line 5 plus line 25)	-1,293,303	26.00
27.00	RESTRICTED INVESTMENT LOSS	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-1,293,303	31.00