

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/29/2024 6:44 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report Date: 5/29/2024 Time: 6:44 pm 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMPLETE CARE AT HARBORAGE (315307) for the cost reporting period beginning 03/16/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		Title XIX	
		Part A	Part B		
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	101,690	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	101,690	0	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 6:44 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 7600 RIVER ROAD	PO Box:				1.00		
2.00	City: NORTH BERGEN	State: NJ	Zip Code: 07047			2.00		
3.00	County: HUDSON	CBSA Code: 35614	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
					4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	COMPLETE CARE AT HARBORAGE	315307	10/02/1991	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yyyy)			03/16/2023	12/31/2023		14.00	
15.00	Type of Control (See Instructions)			2		LLC	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					5,035		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					5,035		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00
				Part A	Part B	Other		
				1.00	2.00	3.00		
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.								
29.00	Skilled Nursing Facility					N		29.00
30.00	Nursing Facility					N		30.00
31.00	ICF/IID					N		31.00
32.00	SNF-Based HHA					N		32.00
33.00	SNF-Based RHC					N		33.00
34.00	SNF-Based FQHC					N		34.00
35.00	SNF-Based CMHC					N		35.00
36.00	SNF-Based OLTC					N		36.00
				Y/N				
				1.00			2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.							39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:			0	0	0		41.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 6:44 pm
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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. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/29/2024 6:44 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	Y	03/15/2023	1.00	
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00	
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N		5.00	
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6.00	
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7.00	
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8.00	
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y	9.00	
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N	10.00	
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N	11.00	
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N	12.00	
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	05/02/2024	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. : 315307

Period:
 From 03/16/2023
 To 12/31/2023

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/29/2024 6:44 pm

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

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

Provider No. : 315307

Period:
 From 03/16/2023
 To 12/31/2023

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/29/2024 6:44 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	05/02/2024	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.	PREPARER	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

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

Provider No. : 315307

Period:
 From 03/16/2023
 To 12/31/2023

Worksheet S-3
 Part I
 Date/Time Prepared:
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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	247	71,877	0	6,791	32,486	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	247	71,877	0	6,791	32,486	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	12,338	51,615	0	202	174	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	12,338	51,615	0	202	174	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	323	699	0.00	33.62	186.70	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	323	699	0.00	33.62	186.70	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	73.84	0	288	108	326	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	73.84	0	288	108	326	8.00
Component		Admissions		Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	722	174.60	0.00		1.00	
2.00	NURSING FACILITY	0	0.00	0.00		2.00	
3.00	ICF/IID	0	0.00	0.00		3.00	
4.00	HOME HEALTH AGENCY COST					4.00	
5.00	Other Long Term Care	0	0.00	0.00		5.00	
6.00	SNF-Based CMHC					6.00	
7.00	HOSPICE	0	0.00	0.00		7.00	
8.00	Total (Sum of lines 1-7)	722	174.60	0.00		8.00	

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet S-3
Part II
Date/Time Prepared:
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	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)	9,276,139	0	9,276,139	289,186.00	32.08
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	9,276,139	0	9,276,139	289,186.00	32.08
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST					
9.00	CMHC					
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	9,276,139	0	9,276,139	289,186.00	32.08
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	3,223,628	0	3,223,628	57,296.00	56.26
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	2,094,741	0	2,094,741		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	2,094,741	0	2,094,741		

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Period:
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Worksheet S-3
Part III
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	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	555,149	0	555,149	15,192.00	2.00
3.00	Plant Operation, Maintenance & Repairs	166,759	0	166,759	6,277.00	3.00
4.00	Laundry & Linen Service	117,669	0	117,669	5,972.00	4.00
5.00	Housekeeping	813,391	0	813,391	39,098.00	5.00
6.00	Dietary	34,218	0	34,218	929.00	6.00
7.00	Nursing Administration	837,636	0	837,636	20,036.00	7.00
8.00	Central Services and Supply	35,425	0	35,425	1,338.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	33,313	0	33,313	1,625.00	10.00
11.00	Social Service	152,783	0	152,783	3,391.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	263,501	0	263,501	10,049.00	13.00
14.00	Total (sum lines 1 thru 13)	3,009,844	0	3,009,844	103,907.00	14.00

SNF WAGE RELATED COSTS		Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2024 6:44 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)	831,361		8.00
9.00	Prescription Drug Plan	0		9.00
10.00	Dental, Hearing and Vision Plan	35,093		10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,090		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	251,415		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	714,156		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	245,626		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)	2,094,741		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. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2024 6:44 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	1,558,582	355,980	1,914,562	28,023.00	68.32	1.00
2.00	Licensed Practical Nurses (LPNs)	1,623,918	370,903	1,994,821	36,054.00	55.33	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,924,589	667,976	3,592,565	116,917.00	30.73	3.00
4.00	Total Nursing (sum of lines 1 through 3)	6,107,089	1,394,859	7,501,948	180,994.00	41.45	4.00
5.00	Physical Therapists	78,626	17,958	96,584	1,981.00	48.76	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	59,706	13,637	73,343	1,697.00	43.22	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	20,874	4,768	25,642	608.00	42.17	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)	328,169		328,169	3,883.00	84.51	14.00
15.00	Licensed Practical Nurses (LPNs)	979,879		979,879	14,297.00	68.54	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,106,545		1,106,545	20,937.00	52.85	16.00
17.00	Total Nursing (sum of lines 14 through 16)	2,414,593		2,414,593	39,117.00	61.73	17.00
18.00	Physical Therapists	263,014		263,014	5,719.00	45.99	18.00
19.00	Physical Therapy Assistants	128,090		128,090	3,064.00	41.80	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	248,410		248,410	5,467.00	45.44	21.00
22.00	Occupational Therapy Assistants	64,583		64,583	1,564.00	41.29	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	104,938		104,938	2,365.00	44.37	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. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet S-7
Date/Time Prepared:
5/29/2024 6:44 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet S-7

Date/Time Prepared:
5/29/2024 6:44 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315307		Period: From 03/16/2023 To 12/31/2023		Worksheet A	
Date/Time Prepared: 5/29/2024 6:44 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		854,260	854,260	0	854,260	1.00
3.00	00300		2,118,289	2,118,289	0	2,118,289	3.00
4.00	00400	555,149	2,928,502	3,483,651	0	3,483,651	4.00
5.00	00500	166,759	476,937	643,696	0	643,696	5.00
6.00	00600	117,669	34,488	152,157	0	152,157	6.00
7.00	00700	813,391	80,767	894,158	0	894,158	7.00
8.00	00800	34,218	2,180,836	2,215,054	0	2,215,054	8.00
9.00	00900	837,636	0	837,636	0	837,636	9.00
10.00	01000	35,425	619,048	654,473	0	654,473	10.00
12.00	01200	33,313	0	33,313	0	33,313	12.00
13.00	01300	152,783	0	152,783	0	152,783	13.00
15.00	01500	263,501	46,633	310,134	0	310,134	15.00
15.10	01510	0	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,107,089	2,668,484	8,775,573	0	8,775,573	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	20,068	20,068	0	20,068	40.00
41.00	04100	0	64,282	64,282	0	64,282	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	78,626	913,428	992,054	0	992,054	44.00
45.00	04500	59,706	312,964	372,670	0	372,670	45.00
46.00	04600	20,874	104,936	125,810	0	125,810	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	498,545	498,545	0	498,545	49.00
51.00	05100	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS							
71.00	07100	0	25,818	25,818	0	25,818	71.00
SPECIAL PURPOSE COST CENTERS							
82.00	08200	0	0	0	0	0	82.00
83.00	08300	0	0	0	0	0	83.00
89.00		9,276,139	13,948,285	23,224,424	0	23,224,424	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
100.00		9,276,139	13,948,285	23,224,424	0	23,224,424	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-11,961	842,299	1.00
3.00	00300	EMPLOYEE BENEFITS	0	2,118,289	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-837,978	2,645,673	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	643,696	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	152,157	6.00
7.00	00700	HOUSEKEEPING	0	894,158	7.00
8.00	00800	DIETARY	0	2,215,054	8.00
9.00	00900	NURSING ADMINISTRATION	0	837,636	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	654,473	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	33,313	12.00
13.00	01300	SOCIAL SERVICE	0	152,783	13.00
15.00	01500	PATIENT ACTIVITIES	0	310,134	15.00
15.10	01510	REHAB TECH	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	8,775,573	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	20,068	40.00
41.00	04100	LABORATORY	0	64,282	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	992,054	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	372,670	45.00
46.00	04600	SPEECH PATHOLOGY	0	125,810	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	498,545	49.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OTHER REIMBURSABLE COST CENTERS					
71.00	07100	AMBULANCE	0	25,818	71.00
SPECIAL PURPOSE COST CENTERS					
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-849,939	22,374,485	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
100.00		TOTAL	-849,939	22,374,485	100.00

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A-6
Date/Time Prepared:
5/29/2024 6:44 pm

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

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

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/29/2024 6:44 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A-7

Date/Time Prepared:
5/29/2024 6:44 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	0	81,701	0	81,701	4.00
5.00	Fixed Equipment	0	42,918	0	42,918	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	0	124,619	0	124,619	7.00
8.00	Reconciling Items	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	0	124,619	0	124,619	9.00
Description		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	81,701	0			4.00
5.00	Fixed Equipment	42,918	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	Subtotal (sum of lines 1-6)	124,619	0			7.00
8.00	Reconciling Items	0	0			8.00
9.00	Total (line 7 minus line 8)	124,619	0			9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/29/2024 6:44 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line No.
			1.00	2.00
1.00 Investment income on restricted funds (chapter 2)	B	-11,961	CAP REL COSTS - BLDGS & FIXTURES	1.00 1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 2.00
3.00 Refunds and rebates of expenses (chapter 8)		0		0.00 3.00
4.00 Rental of provider space by suppliers (chapter 8)		0		0.00 4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 5.00
6.00 Television and radio service (chapter 21)		0		0.00 6.00
7.00 Parking lot (chapter 21)		0		0.00 7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0		8.00
9.00 Home office cost (chapter 21)		0		0.00 9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00 11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-418,560		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Revenue - Employee meals		0		0.00 14.00
15.00 Cost of meals - Guests		0		0.00 15.00
16.00 Sale of medical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts		0		0.00 18.00
19.00 Vending machines		0		0.00 19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	82.00 22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES	1.00 23.00
24.00 Depreciation--movable equipment			0*** Cost Center Deleted ***	2.00 24.00
25.00 MISC REVENUE	B	-7	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01 RENT REVENUE	B	-1,635	ADMINISTRATIVE & GENERAL	4.00 25.01
25.02 OTHER REVENUE - CARRYOVER PTO	B	-119,578	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03 RESIDENT MISSING ITEMS	A	-1,775	ADMINISTRATIVE & GENERAL	4.00 25.03
25.04 FINES & PENALTIES	A	-100	ADMINISTRATIVE & GENERAL	4.00 25.04
25.05 DONATIONS/CHARITY	A	-1,000	ADMINISTRATIVE & GENERAL	4.00 25.05
25.06 MARKETING	A	-29,836	ADMINISTRATIVE & GENERAL	4.00 25.06
25.07 BAD DEBT	A	-265,487	ADMINISTRATIVE & GENERAL	4.00 25.07
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-849,939		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. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/29/2024 6:44 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT	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		600,310	1,018,870	-418,560	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.	600,310	1,018,870	-418,560	10.00

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

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet A-8-1
Parts I-II
Date/Time Prepared:
5/29/2024 6:44 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	B	PEACE CAPITAL LLC	100.00	1.00
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00	COMPLETE CARE MANAGEMENT	100.00	MANAGEMENT OF FACILITY	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. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	3.00	3A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	842,299	842,299			1.00
3.00 00300	EMPLOYEE BENEFITS	2,118,289	0	2,118,289		3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,645,673	260,822	126,773	3,033,268	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	643,696	7,768	38,081	689,545	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	152,157	19,784	26,871	198,812	6.00
7.00 00700	HOUSEKEEPING	894,158	22,891	185,745	1,102,794	7.00
8.00 00800	DIETARY	2,215,054	37,740	7,814	2,260,608	8.00
9.00 00900	NURSING ADMINISTRATION	837,636	21,819	191,282	1,050,737	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	654,473	0	8,090	662,563	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	33,313	0	7,607	40,920	12.00
13.00 01300	SOCIAL SERVICE	152,783	0	34,889	187,672	13.00
15.00 01500	PATIENT ACTIVITIES	310,134	0	60,173	370,307	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	8,775,573	442,549	1,394,608	10,612,730	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	20,068	0	0	20,068	40.00
41.00 04100	LABORATORY	64,282	0	0	64,282	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	992,054	15,110	17,955	1,025,119	44.00
45.00 04500	OCCUPATIONAL THERAPY	372,670	4,083	13,634	390,387	45.00
46.00 04600	SPEECH PATHOLOGY	125,810	4,619	4,767	135,196	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	962	0	962	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	498,545	0	0	498,545	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS						
71.00 07100	AMBULANCE	25,818	0	0	25,818	71.00
SPECIAL PURPOSE COST CENTERS						
82.00 08200	UTILIZATION REVIEW - SNF	0	0	0	0	82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	22,374,485	838,147	2,118,289	22,370,333	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	4,152	0	4,152	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	22,374,485	842,299	2,118,289	22,374,485	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	797,686				5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	27,508	257,499			6.00	
7.00	00700	HOUSEKEEPING	31,828	0	1,307,572		7.00	
8.00	00800	DIETARY	52,473	0	92,926	2,760,536	8.00	
9.00	00900	NURSING ADMINISTRATION	30,337	0	53,725	0	1,299,585	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	0	15.00
15.10	01510	REHAB TECH	0	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	615,321	257,499	1,089,694	2,760,536	1,299,585	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	21,008	0	37,204	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	5,677	0	10,054	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	6,423	0	11,375	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,338	0	2,370	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS								
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	791,913	257,499	1,297,348	2,760,536	1,299,585	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	5,773	0	10,224	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	797,686	257,499	1,307,572	2,760,536	1,299,585	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE		
				PATIENT ACTIVITIES	REHAB TECH	
				10.00	12.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINISTRATIVE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7.00 00700 HOUSEKEEPING						7.00
8.00 00800 DIETARY						8.00
9.00 00900 NURSING ADMINISTRATION						9.00
10.00 01000 CENTRAL SERVICES & SUPPLY	766,472					10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	47,337				12.00
13.00 01300 SOCIAL SERVICE	0	0	217,104			13.00
15.00 01500 PATIENT ACTIVITIES	0	0	0	428,382		15.00
15.10 01510 REHAB TECH	0	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	424,558	47,337	217,104	428,382	0	30.00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200 ICF/IID	0	0	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000 RADIOLOGY	0	0	0	0	0	40.00
41.00 04100 LABORATORY	0	0	0	0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400 PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00 04500 OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00 04700 ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	341,914	0	0	0	0	49.00
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS						
71.00 07100 AMBULANCE	0	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS						
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83.00 08300 HOSPICE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	766,472	47,337	217,104	428,382	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300 NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	766,472	47,337	217,104	428,382	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part I
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		Subtotal	Post Stepdown Adjustments	Total	
		16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
3.00	00300	EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPING			7.00
8.00	00800	DIETARY			8.00
9.00	00900	NURSING ADMINISTRATION			9.00
10.00	01000	CENTRAL SERVICES & SUPPLY			10.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
15.00	01500	PATIENT ACTIVITIES			15.00
15.10	01510	REHAB TECH			15.10
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	19,417,136	0	19,417,136
31.00	03100	NURSING FACILITY	0	0	0
32.00	03200	ICF/IID	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	23,215	0	23,215
41.00	04100	LABORATORY	74,363	0	74,363
42.00	04200	INTRAVENOUS THERAPY	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0
44.00	04400	PHYSICAL THERAPY	1,244,099	0	1,244,099
45.00	04500	OCCUPATIONAL THERAPY	467,342	0	467,342
46.00	04600	SPEECH PATHOLOGY	174,197	0	174,197
47.00	04700	ELECTROCARDIOLOGY	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,821	0	4,821
49.00	04900	DRUGS CHARGED TO PATIENTS	918,645	0	918,645
51.00	05100	SUPPORT SURFACES	0	0	0
OTHER REIMBURSABLE COST CENTERS					
71.00	07100	AMBULANCE	29,867	0	29,867
SPECIAL PURPOSE COST CENTERS					
82.00	08200	UTILIZATION REVIEW - SNF			82.00
83.00	08300	HOSPICE	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	22,353,685	0	22,353,685
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	20,800	0	20,800
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0
98.00		Cross Foot Adjustments	0	0	0
99.00		Negative Cost Centers	0	0	0
100.00		TOTAL	22,374,485	0	22,374,485

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	ADM NI STRATI VE & GENERAL	
		BLDGS & FIXTURES				
	0	1.00	2A	3.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0		3.00
4.00 00400	ADM NI STRATI VE & GENERAL	0	260,822	260,822	0	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	7,768	7,768	0	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	19,784	19,784	0	6.00
7.00 00700	HOUSEKEEPING	0	22,891	22,891	0	7.00
8.00 00800	DI ETARY	0	37,740	37,740	0	8.00
9.00 00900	NURSI NG ADM NI STRATI ON	0	21,819	21,819	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
12.00 01200	MEDI CAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCI AL SERVI CE	0	0	0	0	13.00
15.00 01500	PATI ENT ACTI VI TI ES	0	0	0	0	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKI LLED NURSI NG FACI LI TY	0	442,549	442,549	0	30.00
31.00 03100	NURSI NG FACI LI TY	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
ANCI LLARY SERVICE COST CENTERS						
40.00 04000	RADI OLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSI CAL THERAPY	0	15,110	15,110	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	4,083	4,083	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	4,619	4,619	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	962	962	0	48.00
49.00 04900	DRUGS CHARGED TO PATI ENTS	0	0	0	0	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OTHER REI MBURSABLE COST CENTERS						
71.00 07100	AMBULANCE	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS						
82.00 08200	UTI LI ZATI ON REVI EW - SNF					82.00
83.00 08300	HOSPI CE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	838,147	838,147	0	89.00
NONREI MBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	4,152	4,152	0	91.00
92.00 09200	PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATI ENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
100.00	TOTAL	0	842,299	842,299	0	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300	EMPLOYEE BENEFITS					3.00
4.00	00400	ADMINISTRATIVE & GENERAL					4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	17,067				5.00
6.00	00600	LAUNDRY & LINEN SERVICE	589	23,054			6.00
7.00	00700	HOUSEKEEPING	681	0	38,443		7.00
8.00	00800	DIETARY	1,123	0	2,732	72,079	8.00
9.00	00900	NURSING ADMINISTRATION	649	0	1,580	0	38,217
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00
15.10	01510	REHAB TECH	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	SKILLED NURSING FACILITY	13,165	23,054	32,036	72,079	38,217
31.00	03100	NURSING FACILITY	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	449	0	1,094	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	121	0	296	0	45.00
46.00	04600	SPEECH PATHOLOGY	137	0	334	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	29	0	70	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS							
71.00	07100	AMBULANCE	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS							
82.00	08200	UTILIZATION REVIEW - SNF					82.00
83.00	08300	HOSPICE	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	16,943	23,054	38,142	72,079	38,217
NONREIMBURSABLE COST CENTERS							
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	124	0	301	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	99.00
100.00		TOTAL	17,067	23,054	38,443	72,079	38,217

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE		
				PATIENT ACTIVITIES	REHAB TECH	
				10.00	12.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	8,935				10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	552			12.00
13.00 01300	SOCIAL SERVICE	0	0	2,531		13.00
15.00 01500	PATIENT ACTIVITIES	0	0	0	4,994	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	4,949	552	2,531	4,994	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	3,986	0	0	0	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS						
71.00 07100	AMBULANCE	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS						
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	8,935	552	2,531	4,994	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0			0	98.00
99.00	Negative Cost Centers	0			0	99.00
100.00	TOTAL	8,935	552	2,531	4,994	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B
Part II
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		Subtotal	Post Step-Down Adjustments	Total	
		16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
3.00	00300	EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPING			7.00
8.00	00800	DIETARY			8.00
9.00	00900	NURSING ADMINISTRATION			9.00
10.00	01000	CENTRAL SERVICES & SUPPLY			10.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
15.00	01500	PATIENT ACTIVITIES			15.00
15.10	01510	REHAB TECH			15.10
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	777,243	0	777,243
31.00	03100	NURSING FACILITY	0	0	0
32.00	03200	ICF/IID	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	271	0	271
41.00	04100	LABORATORY	867	0	867
42.00	04200	INTRAVENOUS THERAPY	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0
44.00	04400	PHYSICAL THERAPY	30,477	0	30,477
45.00	04500	OCCUPATIONAL THERAPY	9,764	0	9,764
46.00	04600	SPEECH PATHOLOGY	6,913	0	6,913
47.00	04700	ELECTROCARDIOLOGY	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,074	0	1,074
49.00	04900	DRUGS CHARGED TO PATIENTS	10,709	0	10,709
51.00	05100	SUPPORT SURFACES	0	0	0
OTHER REIMBURSABLE COST CENTERS					
71.00	07100	AMBULANCE	348	0	348
SPECIAL PURPOSE COST CENTERS					
82.00	08200	UTILIZATION REVIEW - SNF			82.00
83.00	08300	HOSPICE	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	837,666	0	837,666
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	4,633	0	4,633
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0
98.00		Cross Foot Adjustments	0	0	0
99.00		Negative Cost Centers	0	0	0
100.00		TOTAL	842,299	0	842,299

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B-1
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
	BLDGS & FIXTURES (SQUARE FEET)					
	1.00	3.00	4A	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	61,265				1.00
3.00 00300	EMPLOYEE BENEFITS	0	9,276,139			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	18,971	555,149	-3,033,268	19,341,217	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	565	166,759	0	689,545	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,439	117,669	0	198,812	6.00
7.00 00700	HOUSEKEEPING	1,665	813,391	0	1,102,794	7.00
8.00 00800	DIETARY	2,745	34,218	0	2,260,608	8.00
9.00 00900	NURSING ADMINISTRATION	1,587	837,636	0	1,050,737	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	35,425	0	662,563	10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	33,313	0	40,920	12.00
13.00 01300	SOCIAL SERVICE	0	152,783	0	187,672	13.00
15.00 01500	PATIENT ACTIVITIES	0	263,501	0	370,307	15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	32,189	6,107,089	0	10,612,730	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	20,068	40.00
41.00 04100	LABORATORY	0	0	0	64,282	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	1,099	78,626	0	1,025,119	44.00
45.00 04500	OCCUPATIONAL THERAPY	297	59,706	0	390,387	45.00
46.00 04600	SPEECH PATHOLOGY	336	20,874	0	135,196	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	70	0	0	962	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	498,545	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS						
71.00 07100	AMBULANCE	0	0	0	25,818	71.00
SPECIAL PURPOSE COST CENTERS						
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	60,963	9,276,139	-3,033,268	19,337,065	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	302	0	0	4,152	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	842,299	2,118,289		3,033,268	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	13.748453	0.228359		0.156829	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		260,822	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.013485	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)		
		6.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL					4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS					5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	51,615				6.00	
7.00	00700	HOUSEKEEPING	0	38,625			7.00	
8.00	00800	DIETARY	0	2,745	154,845		8.00	
9.00	00900	NURSING ADMINISTRATION	0	1,587	0	220,110	9.00	
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00	
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00	
13.00	01300	SOCIAL SERVICE	0	0	0	0	13.00	
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	15.00	
15.10	01510	REHAB TECH	0	0	0	0	15.10	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	51,615	32,189	154,845	220,110	619,048	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	1,099	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	297	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	336	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	498,545	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS								
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS								
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	51,615	38,323	154,845	220,110	1,117,593	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	302	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	257,499	1,307,572	2,760,536	1,299,585	766,472	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	4.988840	33.852997	17.827737	5.904252	0.685824	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	23,054	38,443	72,079	38,217	8,935	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.446653	0.995288	0.465491	0.173627	0.007995	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	OTHER GENERAL SERVICE			
			PATIENT ACTIVITIES (PATIENT DAYS)	REHAB TECH (ACTUAL COST)		
			12.00	13.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
12.00 01200	MEDICAL RECORDS & LIBRARY	51,615				12.00
13.00 01300	SOCIAL SERVICE	0	51,615			13.00
15.00 01500	PATIENT ACTIVITIES	0	0	51,615		15.00
15.10 01510	REHAB TECH	0	0	0	0	15.10
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	51,615	51,615	51,615	0	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	0	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS						
71.00 07100	AMBULANCE	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS						
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	51,615	51,615	51,615	0	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	47,337	217,104	428,382	0	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	0.917117	4.206219	8.299564	0.000000	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	552	2,531	4,994	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.010695	0.049036	0.096755	0.000000	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet C Date/Time Prepared: 5/29/2024 6:44 pm	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	23,215	0	0.000000 40.00
41.00	04100	LABORATORY	74,363	9,414	7.899193 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	1,244,099	992,054	1.254064 44.00
45.00	04500	OCCUPATIONAL THERAPY	467,342	726,527	0.643255 45.00
46.00	04600	SPEECH PATHOLOGY	174,197	346,056	0.503378 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,821	0	0.000000 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	918,645	498,545	1.842652 49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000 51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	07100	AMBULANCE	29,867	0	0.000000 71.00
100.00		Total	2,936,549	2,572,596	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/29/2024 6:44 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost		
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1.00	2.00	3.00	4.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST						
ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADIOLOGY	0.000000	0	0	0	0 40.00
41.00	04100 LABORATORY	7.899193	9,043	0	71,432	0 41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0 42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0 43.00
44.00	04400 PHYSICAL THERAPY	1.254064	395,529	0	496,019	0 44.00
45.00	04500 OCCUPATIONAL THERAPY	0.643255	335,426	0	215,764	0 45.00
46.00	04600 SPEECH PATHOLOGY	0.503378	137,836	0	69,384	0 46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.842652	139,548	0	257,138	0 49.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
71.00	07100 AMBULANCE (2)	0.000000		0		0 71.00
100.00	Total (Sum of lines 40 - 71)		1,017,382	0	1,109,737	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. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prepared: 5/29/2024 6:44 pm				
		Title XVIII	Skilled Nursing Facility	PPS				
Cost Center Description					1.00			
PART II - APPORTIONMENT OF VACCINE COST								
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		1.842652	1.00			
2.00		Program vaccine charges (From your records, or the PS&R)		0	2.00			
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		0	3.00			
Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)		
		1.00	2.00	3.00	4.00	5.00		
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	23,215	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	74,363	0	0.000000	71,432	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	1,244,099	0	0.000000	496,019	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	467,342	0	0.000000	215,764	0	45.00
46.00	04600	SPEECH PATHOLOGY	174,197	0	0.000000	69,384	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,821	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	918,645	0	0.000000	257,138	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	2,906,682	0		1,109,737	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/29/2024 6:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		51,615	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		6,791	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		19,417,136	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		19,609,951	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.990167	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		19,417,136	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		376.19	16.00
17.00	Program routine service cost (Line 3 times line 16)		2,554,706	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		2,554,706	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)		777,243	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		15.06	21.00
22.00	Program capital related cost (Line 3 times line 21)		102,272	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		2,452,434	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		2,452,434	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		51,615	1.00
2.00	Program inpatient days (see instructions)		6,791	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)		0.131570	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/29/2024 6:44 pm
		Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		5,719,471	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		5,719,471	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		679,600	5.00
6.00	Allowable bad debts (From your records)		173,302	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		157,379	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		112,646	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)		5,152,517	11.00
12.00	Interim payments (See instructions)		4,947,777	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		2,253	14.75
14.99	Sequestration amount (see instructions)		100,797	14.99
15.00	Balance due provider/program (see Instructions)		101,690	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 315307	Period: From 03/16/2023 To 12/31/2023	Worksheet E-1 Date/Time Prepared: 5/29/2024 6:44 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		4,939,074		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/20/2023	8,703		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		8,703		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		4,947,777		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	PROGRAM TO PROVIDER		101,690		0
6.02	PROVIDER TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		5,049,467		0
			Contractor Name		Contractor Number
			1.00	2.00	
8.00	Name of Contractor				0

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

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

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet G

Date/Time Prepared:
5/29/2024 6:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	555,512	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	6,411,294	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-221,257	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	108,802	0	0	0	8.00
9.00	Other current assets	46,370	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)	6,900,721	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	81,701	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	42,918	0	0	0	23.00
24.00	Less: Accumulated depreciation	-5,035	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	119,584	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	148,878	0	0	0	31.00
32.00	Other assets	10,532	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	159,410	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	7,179,715	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	6,639,319	0	0	0	35.00
36.00	Salaries, wages, and fees payable	15,452	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	361,212	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)	7,015,983	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	603,880	0	0	0	47.00
48.00	Other long term liabilities	2,406,880	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)	3,010,760	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	10,026,743	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-2,847,028	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)	-2,847,028	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	7,179,715	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet G-1

Date/Time Prepared:
5/29/2024 6:44 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		0		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-2,847,028			2.00
3.00	Total (sum of line 1 and line 2)		-2,847,028		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-2,847,028		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-2,847,028		0	19.00
		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/29/2024 6:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	19,609,951		19,609,951	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)	19,609,951		19,609,951	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	2,572,597	0	2,572,597	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	22,182,548	0	22,182,548	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			23,224,424	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)			23,224,424	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315307

Period:
From 03/16/2023
To 12/31/2023

Worksheet G-3

Date/Time Prepared:
5/29/2024 6:44 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	22,182,548	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,939,017	2.00
3.00	Net patient revenues (Line 1 minus line 2)	20,243,531	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	23,224,424	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2,980,893	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,961	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	-16	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	NON PATIENT REVENUE	2,342	24.00
24.01	FEMA RELIEF	119,578	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	133,865	25.00
26.00	Total (Line 5 plus line 25)	-2,847,028	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-2,847,028	31.00