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: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet S Parts I, II & III Date/Time Prepared: 7/3/2024 12:21 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/3/2024 Time: 12:21 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
3.01 [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.

Contractor use only

4. [1] 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. [N] First Cost Report for this Provider CCN
8. [N] Last Cost Report for this Provider CCN
9. NPR Date: _____
10. [0] If line 4, column 1 is "4": Enter number of times reopened
11. Contractor Vendor Code _____4
12. [F] 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 MOHAWK MEADOWS (315044) for the cost reporting period beginning 01/01/2023 and ending 01/31/2024 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				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	83,590	0	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	83,590	0	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-2 Part I | Date/Time Prepared: 7/3/2024 12:21 pm

	1.00	2.00	3.00	
	Skilled Nursing Facility and Skilled Nursing Facility Complex Address:			
1.00	Street: 1 OBRIEN LANE	PO Box:		1.00
2.00	City: LAFAYETTE	State: NJ	Zip Code: 07848	2.00
3.00	County: SUSSEX	CBSA Code: 35084	Urban/Rural: U	3.00
3.01		CBSA Code:		3.01

		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
					V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:							
4.00	SNF	MOHAWK MEADOWS	315044	01/01/1970	N	P	N	4.00
5.00	Nursing Facility							5.00
6.00	ICF/IID							6.00
7.00	SNF-Based HHA							7.00
8.00	SNF-Based RHC							8.00
9.00	SNF-Based FQHC							9.00
10.00	SNF-Based CMHC							10.00
11.00	SNF-Based OLTC							11.00
12.00	SNF-Based HOSPICE							12.00
13.00	SNF-Based CORF							13.00

		From:	To:	
		1.00	2.00	
14.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	01/31/2024	14.00
15.00	Type of Control (See Instructions)	5		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	76,689	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	76,689	23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.	0	24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)	N	25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	N	26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)	N	27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)	N	28.00

		Part A	Part B	Other	
		1.00	2.00	3.00	
	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.				
29.00	Skilled Nursing Facility	N	N		29.00
30.00	Nursing Facility			N	30.00
31.00	ICF/IID				31.00
32.00	SNF-Based HHA	N	N		32.00
33.00	SNF-Based RHC				33.00
34.00	SNF-Based FQHC				34.00
35.00	SNF-Based CMHC		N		35.00
36.00	SNF-Based OLTC				36.00

		Y/N		
		1.00	2.00	
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)	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 INDENTIFICATION DATA	Provider No.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet S-2 Part I Date/Time Prepared: 7/3/2024 12:21 pm

		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	N	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.		44.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name:	Contractor's Name:	Contractor's Number:	45.00
46.00	Street:	PO Box:		46.00
47.00	City:	State:	Zip Code:	47.00

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

Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-2 Part II | Date/Time Prepared: 7/3/2024 12:21 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 Facilites			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8.00

		Y/N	
		1.00	
	Bad Debts		
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.	Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.	N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	N	11.00
	Bed Complement		
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.	N	12.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4.(see Instructions.)		N		N	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.		Y		Y	18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider No.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet S-2 Part II Date/Time Prepared: 7/3/2024 12:21 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.	CHRIS	GUILBAULT	19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	CHRIS.GUILBAULT@HCRNJ.NET	21.00

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

Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-2 Part II | Date/Time Prepared: 7/3/2024 12:21 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.)				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.: 315044

Period: From 01/01/2023 To 01/31/2024

Worksheet S-3 Part I

Date/Time Prepared: 7/3/2024 12:21 pm

	Component	Number of Beds	Bed Days Available	Inpatient Days/Visits: Title V	Inpatient Days/Visits: Title XVIII	Inpatient Days/Visits: Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	159	62,964	0	4,748	37,391	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)	159	62,964	0	4,748	37,391	8.00

	Component	Inpatient Days/Visits: Other	Inpatient Days/Visits: Total	Discharges: Title V	Discharges: Title XVIII	Discharges: Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	4,497	46,636	0	44	104	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)	4,497	46,636	0	44	104	8.00

	Component	Discharges: Other	Discharges: Total	Average Length of Stay: Title V	Average Length of Stay: Title XVIII	Average Length of Stay: Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	30	178	0.00	107.91	359.53	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)	30	178	0.00	107.91	359.53	8.00

	Component	Average Length of Stay: Total	Admissions: Title V	Admissions: Title XVIII	Admissions: Title XIX	Admissions: Other	
		16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	262.00	0	23	24	10	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)	262.00	0	23	24	10	8.00

	Component	Admissions: Total	Full Time Equivalent: Employees on Payroll	Full Time Equivalent: Nonpaid Workers		
		21.00	22.00	23.00		
1.00	SKILLED NURSING FACILITY	57	149.70	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)	57	149.70	0.00		8.00

SNF WAGE INDEX INFORMATION | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-3 Part II Date/Time Prepared: 7/3/2024 12:21 pm

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - DIRECT SALARIES						
	SALARIES						
1.00	Total salaries (See Instructions)	9,827,720	0	9,827,720	337,774.00	29.10	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	9,827,720	0	9,827,720	337,774.00	29.10	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST						8.00
9.00	CMHC						9.00
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	9,827,720	0	9,827,720	337,774.00	29.10	13.00
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	5,548	0	5,548	176.00	31.52	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	1,759,388	0	1,759,388			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	1,759,388	0	1,759,388			22.00

SNF WAGE INDEX INFORMATION | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-3 Part III Date/Time Prepared: 7/3/2024 12:21 pm

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	828,321	0	828,321	25,996.00	31.86	2.00
3.00	Plant Operation, Maintenance & Repairs	559,133	0	559,133	26,090.00	21.43	3.00
4.00	Laundry & Linen Service	44,039	0	44,039	3,647.00	12.08	4.00
5.00	Housekeeping	559,344	0	559,344	29,035.00	19.26	5.00
6.00	Dietary	822,992	0	822,992	33,163.00	24.82	6.00
7.00	Nursing Administration	673,149	0	673,149	10,891.00	61.81	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	161,375	0	161,375	4,433.00	36.40	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	446,880	0	446,880	20,856.00	21.43	13.00
14.00	Total (sum lines 1 thru 13)	4,095,233	0	4,095,233	154,111.00	26.57	14.00

SNF WAGE RELATED COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-3 Part IV Date/Time Prepared: 7/3/2024 12:21 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)	500,974	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	297,770	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	909,346	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	51,298	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1,759,388	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.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-3 Part V | Date/Time Prepared: 7/3/2024 12:21 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)	953,281	170,828	1,124,109	19,432.00	57.85	1.00
2.00	Licensed Practical Nurses (LPNs)	1,259,978	225,788	1,485,766	32,438.00	45.80	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,976,704	533,425	3,510,129	120,481.00	29.13	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5,189,963	930,041	6,120,004	172,351.00	35.51	4.00
5.00	Physical Therapists	220,229	39,465	259,694	4,229.00	61.41	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	301,167	53,969	355,136	6,806.00	52.18	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	21,128	3,786	24,914	276.00	90.27	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)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	5,548		5,548	176.00	31.52	16.00
17.00	Total Nursing (sum of lines 14 through 16)	5,548		5,548	176.00	31.52	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet S-7 | Date/Time Prepared: 7/3/2024 12:21 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.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet S-7 Date/Time Prepared: 7/3/2024 12:21 pm

		Group	Days	
		1.00	2.00	
76.00		PA1		76.00
99.00		AAA		99.00
100.00	TOTAL			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.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet A | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		2,812,898	2,812,898	0	2,812,898	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,761,606	1,761,606	0	1,761,606	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	828,321	2,471,164	3,299,485	0	3,299,485	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	559,133	435,217	994,350	0	994,350	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	44,039	13,987	58,026	0	58,026	6.00
7.00	00700	HOUSEKEEPING	559,344	62,246	621,590	0	621,590	7.00
8.00	00800	DIETARY	822,992	526,264	1,349,256	0	1,349,256	8.00
9.00	00900	NURSING ADMINISTRATION	673,149	40,278	713,427	0	713,427	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	174,681	174,681	0	174,681	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	161,375	0	161,375	0	161,375	13.00
15.00	01500	PATIENT ACTIVITIES	446,880	2,079	448,959	0	448,959	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	5,189,963	48,263	5,238,226	0	5,238,226	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	6,395	6,395	0	6,395	40.00
41.00	04100	LABORATORY	0	14,095	14,095	0	14,095	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	220,229	0	220,229	0	220,229	44.00
45.00	04500	OCCUPATIONAL THERAPY	301,167	0	301,167	0	301,167	45.00
46.00	04600	SPEECH PATHOLOGY	21,128	0	21,128	0	21,128	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	251,997	251,997	0	251,997	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	1,927	1,927	0	1,927	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	9,827,720	8,623,097	18,450,817	0	18,450,817	89.00
		NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
100.00		TOTAL	9,827,720	8,623,097	18,450,817	0	18,450,817	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet A | Date/Time Prepared: 7/3/2024 12:21 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	-11,784	2,801,114		1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,761,606		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-319,118	2,980,367		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	994,350		5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	58,026		6.00
7.00	00700	HOUSEKEEPING	0	621,590		7.00
8.00	00800	DIETARY	0	1,349,256		8.00
9.00	00900	NURSING ADMINISTRATION	0	713,427		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	174,681		10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0		12.00
13.00	01300	SOCIAL SERVICE	0	161,375		13.00
15.00	01500	PATIENT ACTIVITIES	0	448,959		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	5,238,226		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	6,395		40.00
41.00	04100	LABORATORY	0	14,095		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	220,229		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	301,167		45.00
46.00	04600	SPEECH PATHOLOGY	0	21,128		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	251,997		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS				
71.00	07100	AMBULANCE	0	1,927		71.00
		SPECIAL PURPOSE COST CENTERS				
83.00	08300	HOSPICE	0	0		83.00
89.00		SUBTOTALS (sum of lines 1-84)	-330,902	18,119,915		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	-330,902	18,119,915		100.00

RECLASSIFICATIONS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet A-6 | Date/Time Prepared: 7/3/2024 12:21 pm

			Increases			
			Cost Center	Line #	Salary	Non Salary	
			2.00	3.00	4.00	5.00	
	TOTALS						
100.00		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.

RECLASSIFICATIONS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet A-6 | Date/Time Prepared: 7/3/2024 12:21 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	TOTALS					
100.00				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.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet A-7 | Date/Time Prepared: 7/3/2024 12:21 pm

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	347,421	201,410	0	201,410	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	176,186	11,346	0	11,346	0	6.00
7.00	Subtotal (sum of lines 1-6)	523,607	212,756	0	212,756	0	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	523,607	212,756	0	212,756	0	9.00

	Description	Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	548,831	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	187,532	0	6.00
7.00	Subtotal (sum of lines 1-6)	736,363	0	7.00
8.00	Reconciling Items	0	0	8.00
9.00	Total (line 7 minus line 8)	736,363	0	9.00

ADJUSTMENTS TO EXPENSES | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet A-8 | Date/Time Prepared: 7/3/2024 12:21 pm

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line No.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds (chapter 2)	B	-11,784	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	0			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)		0	*** Cost Center Deleted ***	82.00	22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciation--movable equipment		0	*** Cost Center Deleted ***	2.00	24.00
25.00	MISC INCOME	B	-13,876	ADMINISTRATIVE & GENERAL	4.00	25.00
25.02	WAGES - MARKETING	A	-83,721	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03	CONTRIBUTIONS	A	-2,490	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04	BAD DEBT	A	-193,366	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05	PENALTIES	A	-25,665	ADMINISTRATIVE & GENERAL	4.00	25.05
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-330,902			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.: 315044

Period: From 01/01/2023 To 01/31/2024

Worksheet A-8-1 Parts I-II Date/Time Prepared: 7/3/2024 12:21 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		436,013	436,013	0		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.	436,013	436,013	0		10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider No.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet A-8-1 Parts I-II Date/Time Prepared: 7/3/2024 12:21 pm

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.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
1.00		A	CHAIM SCHEINBAUM	50.00		1.00
2.00		A	LOUIS SCHWARTZ	50.00		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.

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.

		Related Organization(s) and/or Home Office				
		Name	Percentage of Ownership	Type of Business		
		4.00	5.00	6.00		
1.00		ANDOVER MANAGEMENT	50.00	MANAGEMENT		1.00
2.00		ANDOVER MANAGEMENT	50.00	MANAGEMENT		2.00
3.00			0.00			3.00
4.00			0.00			4.00
5.00			0.00			5.00
6.00			0.00			6.00
7.00			0.00			7.00
8.00			0.00			8.00
9.00			0.00			9.00
10.00			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.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part I | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDGS & FIXTURES	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	3.00	3A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	2,801,114	2,801,114				1.00
3.00	00300	EMPLOYEE BENEFITS	1,761,606	0	1,761,606			3.00
4.00	00400	ADMINISTRATIVE & GENERAL	2,980,367	402,948	148,476	3,531,791	3,531,791	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	994,350	221,855	100,224	1,316,429	318,707	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	58,026	68,484	7,894	134,404	32,539	6.00
7.00	00700	HOUSEKEEPING	621,590	24,113	100,262	745,965	180,598	7.00
8.00	00800	DIETARY	1,349,256	278,857	147,520	1,775,633	429,881	8.00
9.00	00900	NURSING ADMINISTRATION	713,427	167,970	120,661	1,002,058	242,598	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	174,681	52,163	0	226,844	54,919	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	11,400	0	11,400	2,760	12.00
13.00	01300	SOCIAL SERVICE	161,375	0	28,926	190,301	46,072	13.00
15.00	01500	PATIENT ACTIVITIES	448,959	0	80,103	529,062	128,086	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	5,238,226	1,512,878	930,293	7,681,397	1,859,674	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	6,395	0	0	6,395	1,548	40.00
41.00	04100	LABORATORY	14,095	0	0	14,095	3,412	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	220,229	45,765	39,476	305,470	73,954	44.00
45.00	04500	OCCUPATIONAL THERAPY	301,167	0	53,984	355,151	85,982	45.00
46.00	04600	SPEECH PATHOLOGY	21,128	0	3,787	24,915	6,032	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	251,997	0	0	251,997	61,008	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	1,927	0	0	1,927	467	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	18,119,915	2,786,433	1,761,606	18,105,234	3,528,237	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	14,681	0	14,681	3,554	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	18,119,915	2,801,114	1,761,606	18,119,915	3,531,791	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part I | Date/Time Prepared: 7/3/2024 12:21 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	1,635,136					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	51,454	218,397				6.00
7.00	00700	HOUSEKEEPING	18,117	0	944,680			7.00
8.00	00800	DIETARY	209,514	0	126,423	2,541,451		8.00
9.00	00900	NURSING ADMINISTRATION	126,202	0	76,151	0	1,447,009	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	39,192	0	23,649	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	8,565	0	5,168	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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	1,136,677	218,397	685,885	2,541,451	1,447,009	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	34,385	0	20,748	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	1,624,106	218,397	938,024	2,541,451	1,447,009	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	11,030	0	6,656	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	1,635,136	218,397	944,680	2,541,451	1,447,009	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part I | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
			10.00	12.00	13.00	15.00	16.00	
		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	344,604					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	27,893				12.00
13.00	01300	SOCIAL SERVICE	0	0	236,373			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	657,148		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	344,604	27,893	236,373	657,148	16,836,508	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	7,943	40.00
41.00	04100	LABORATORY	0	0	0	0	17,507	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	434,557	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	441,133	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	30,947	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	313,005	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	2,394	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	344,604	27,893	236,373	657,148	18,083,994	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	35,921	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	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	344,604	27,893	236,373	657,148	18,119,915	100.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part I Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	Post Stepdown Adjustments	Total		
			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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	16,836,508		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	7,943		40.00
41.00	04100	LABORATORY	0	17,507		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	434,557		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	441,133		45.00
46.00	04600	SPEECH PATHOLOGY	0	30,947		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	313,005		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS				
71.00	07100	AMBULANCE	0	2,394		71.00
		SPECIAL PURPOSE COST CENTERS				
83.00	08300	HOSPICE	0	0		83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	18,083,994		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	35,921		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
98.00		Cross Foot Adjustments	0	0		98.00
99.00		Negative Cost Centers	0	0		99.00
100.00		TOTAL	0	18,119,915		100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part II Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
			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	0		3.00
4.00	00400	ADMINISTRATIVE & GENERAL	0	402,948	402,948	0	402,948	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	221,855	221,855	0	36,362	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	68,484	68,484	0	3,713	6.00
7.00	00700	HOUSEKEEPING	0	24,113	24,113	0	20,605	7.00
8.00	00800	DIETARY	0	278,857	278,857	0	49,047	8.00
9.00	00900	NURSING ADMINISTRATION	0	167,970	167,970	0	27,679	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	52,163	52,163	0	6,266	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	11,400	11,400	0	315	12.00
13.00	01300	SOCIAL SERVICE	0	0	0	0	5,256	13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	0	14,614	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	1,512,878	1,512,878	0	212,169	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	177	40.00
41.00	04100	LABORATORY	0	0	0	0	389	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	45,765	45,765	0	8,438	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	9,810	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	688	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,961	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	53	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	2,786,433	2,786,433	0	402,542	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	14,681	14,681	0	406	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments			0			98.00
99.00		Negative Cost Centers		0	0	0	0	99.00
100.00		TOTAL	0	2,801,114	2,801,114	0	402,948	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part II Date/Time Prepared: 7/3/2024 12:21 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	258,217					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	8,126	80,323				6.00
7.00	00700	HOUSEKEEPING	2,861	0	47,579			7.00
8.00	00800	DIETARY	33,086	0	6,367	367,357		8.00
9.00	00900	NURSING ADMINISTRATION	19,929	0	3,835	0	219,413	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	6,189	0	1,191	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	1,353	0	260	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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	179,501	80,323	34,546	367,357	219,413	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	5,430	0	1,045	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		OTHER REIMBURSABLE COST CENTERS						
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	256,475	80,323	47,244	367,357	219,413	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	1,742	0	335	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	0	99.00
100.00		TOTAL	258,217	80,323	47,579	367,357	219,413	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part II | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PATIENT ACTIVITIES	Subtotal	
			10.00	12.00	13.00	15.00	16.00	
		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	65,809					10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	13,328				12.00
13.00	01300	SOCIAL SERVICE	0	0	5,256			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	0	14,614		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	65,809	13,328	5,256	14,614	2,705,194	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	177	40.00
41.00	04100	LABORATORY	0	0	0	0	389	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	60,678	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	9,810	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	688	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,961	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	53	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	65,809	13,328	5,256	14,614	2,783,950	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	17,164	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	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	65,809	13,328	5,256	14,614	2,801,114	100.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B Part II | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	Post Step-Down Adjustments	Total		
			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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	2,705,194		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	177		40.00
41.00	04100	LABORATORY	0	389		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	60,678		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	9,810		45.00
46.00	04600	SPEECH PATHOLOGY	0	688		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	6,961		49.00
51.00	05100	SUPPORT SURFACES	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS				
71.00	07100	AMBULANCE	0	53		71.00
		SPECIAL PURPOSE COST CENTERS				
83.00	08300	HOSPICE	0	0		83.00
89.00		SUBTOTALS (sum of lines 1-84)	0	2,783,950		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	17,164		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
98.00		Cross Foot Adjustments	0	0		98.00
99.00		Negative Cost Centers	0	0		99.00
100.00		TOTAL	0	2,801,114		100.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B-1 | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	
			1.00	3.00	4A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	34,153					1.00
3.00	00300	EMPLOYEE BENEFITS	0	9,827,720				3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4,913	828,321	-3,531,791	14,588,124		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	2,705	559,133	0	1,316,429	26,535	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	835	44,039	0	134,404	835	6.00
7.00	00700	HOUSEKEEPING	294	559,344	0	745,965	294	7.00
8.00	00800	DIETARY	3,400	822,992	0	1,775,633	3,400	8.00
9.00	00900	NURSING ADMINISTRATION	2,048	673,149	0	1,002,058	2,048	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	636	0	0	226,844	636	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	139	0	0	11,400	139	12.00
13.00	01300	SOCIAL SERVICE	0	161,375	0	190,301	0	13.00
15.00	01500	PATIENT ACTIVITIES	0	446,880	0	529,062	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	18,446	5,189,963	0	7,681,397	18,446	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	6,395	0	40.00
41.00	04100	LABORATORY	0	0	0	14,095	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	558	220,229	0	305,470	558	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	301,167	0	355,151	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	21,128	0	24,915	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	251,997	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	1,927	0	71.00
		SPECIAL PURPOSE COST CENTERS						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	33,974	9,827,720	-3,531,791	14,573,443	26,356	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	179	0	0	14,681	179	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)	2,801,114	1,761,606		3,531,791	1,635,136	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	82.016631	0.179249		0.242100	61.621858	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)		0		402,948	258,217	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.027622	9.731185	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B-1 | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			6.00	7.00	8.00	9.00	10.00	
		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	46,636					6.00
7.00	00700	HOUSEKEEPING	0	25,406				7.00
8.00	00800	DIETARY	0	3,400	139,908			8.00
9.00	00900	NURSING ADMINISTRATION	0	2,048	0	172,526		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	636	0	0	174,681	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	139	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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	46,636	18,446	139,908	172,526	174,681	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	558	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	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						
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	46,636	25,227	139,908	172,526	174,681	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	179	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)	218,397	944,680	2,541,451	1,447,009	344,604	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	4.683013	37.183343	18.165159	8.387194	1.972762	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	80,323	47,579	367,357	219,413	65,809	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	1.722339	1.872747	2.625704	1.271768	0.376738	105.00

COST ALLOCATION - STATISTICAL BASIS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet B-1 | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	OTHER GENERAL SERVICE PATIENT ACTIVITIES (PATIENT CENSUS)		
			12.00	13.00	15.00		
		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	46,636				12.00
13.00	01300	SOCIAL SERVICE	0	46,636			13.00
15.00	01500	PATIENT ACTIVITIES	0	0	46,636		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	46,636	46,636	46,636		30.00
31.00	03100	NURSING FACILITY	0	0	0		31.00
32.00	03200	ICF/IID	0	0	0		32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0		33.00
		ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	0		40.00
41.00	04100	LABORATORY	0	0	0		41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0		42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0		43.00
44.00	04400	PHYSICAL THERAPY	0	0	0		44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0		45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0		46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0		47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0		49.00
51.00	05100	SUPPORT SURFACES	0	0	0		51.00
		OTHER REIMBURSABLE COST CENTERS					
71.00	07100	AMBULANCE	0	0	0		71.00
		SPECIAL PURPOSE COST CENTERS					
83.00	08300	HOSPICE	0	0	0		83.00
89.00		SUBTOTALS (sum of lines 1-84)	46,636	46,636	46,636		89.00
		NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0		91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0		92.00
93.00	09300	NONPAID WORKERS	0	0	0		93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0		94.00
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)	27,893	236,373	657,148		102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	0.598100	5.068466	14.091003		103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	13,328	5,256	14,614		104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.285788	0.112703	0.313363		105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet C | Date/Time Prepared: 7/3/2024 12:21 pm

		Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2	
			1.00	2.00	3.00	
		ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	7,943	0	0.000000	40.00
41.00	04100	LABORATORY	17,507	637	27.483516	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	434,557	546,423	0.795276	44.00
45.00	04500	OCCUPATIONAL THERAPY	441,133	826,252	0.533896	45.00
46.00	04600	SPEECH PATHOLOGY	30,947	44,261	0.699193	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	313,005	174,159	1.797237	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
		OUTPATIENT SERVICE COST CENTERS				
71.00	07100	AMBULANCE	2,394	0	0.000000	71.00
100.00		Total	1,247,486	1,591,732		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	Provider No.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet D Part I Date/Time Prepared: 7/3/2024 12:21 pm
	Title XVIII (1)	Skilled Nursing Facility	PPS

			Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost		
				Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
			1.00	2.00	3.00	4.00	5.00	
	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	27.483516	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0.795276	219,097	0	174,243	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0.533896	363,466	0	194,053	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.699193	27,047	0	18,911	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	1.797237	165,679	0	297,764	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)		775,289	0	684,971	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.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet D Parts II-III Date/Time Prepared: 7/3/2024 12:21 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)	1.797237	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	7,943	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	17,507	0	0.000000	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	434,557	0	0.000000	174,243	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	441,133	0	0.000000	194,053	0	45.00
46.00	04600	SPEECH PATHOLOGY	30,947	0	0.000000	18,911	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	313,005	0	0.000000	297,764	0	49.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	1,245,092	0		684,971	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet D-1 Parts I-II Date/Time Prepared: 7/3/2024 12:21 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	46,636	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	4,748	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	16,836,508	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	14,278,969	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1.179112	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	16,836,508	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	361.02	16.00
17.00	Program routine service cost (Line 3 times line 16)	1,714,123	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	1,714,123	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	2,705,194	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	58.01	21.00
22.00	Program capital related cost (Line 3 times line 21)	275,431	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,438,692	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,438,692	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	46,636	1.00
2.00	Program inpatient days (see instructions)	4,748	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)	0.101810	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.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet E Part I Date/Time Prepared: 7/3/2024 12:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1.00	Inpatient PPS amount (See Instructions)	3,789,790	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	3,789,790	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	290,389	5.00
6.00	Allowable bad debts (From your records)	131,225	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	58,282	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	85,296	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)	3,584,697	11.00
12.00	Interim payments (See instructions)	3,430,441	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)	1,706	14.75
14.99	Sequestration amount (see instructions)	68,960	14.99
15.00	Balance due provider/program (see Instructions)	83,590	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.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet E-1 Date/Time Prepared: 7/3/2024 12:21 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		3,430,441		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3,430,441		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		83,590		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,514,031		0	7.00

		Contractor Name	Contractor Number	
		1.00	2.00	
8.00	Name of Contractor			8.00

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

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

Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet G | Date/Time Prepared: 7/3/2024 12:21 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	23,483	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	7,234,300	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	-766,017	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	68,946	0	0	0	8.00
9.00	Other current assets	3,796	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)	6,564,508	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	548,831	0	0	0	17.00
18.00	Less: Accumulated Amortization	-288,418	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	187,532	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	447,945	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	3,169,901	0	0	0	31.00
32.00	Other assets	1,113,870	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	4,283,771	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	11,296,224	0	0	0	34.00
	Liabilities and Fund Balances					
	CURRENT LIABILITIES					
35.00	Accounts payable	12,405,358	0	0	0	35.00
36.00	Salaries, wages, and fees payable	304,143	0	0	0	36.00
37.00	Payroll taxes payable	25,729	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	213,899	0	0	0	39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	68,351	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	13,017,480	0	0	0	43.00
	LONG TERM LIABILITIES					
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	3,885,481	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	3,885,481	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	16,902,961	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-5,606,737				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-5,606,737	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	11,296,224	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider No.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet G-1 | Date/Time Prepared: 7/3/2024 12:21 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		-1,710,592		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-3,896,145				2.00
3.00	Total (sum of line 1 and line 2)		-5,606,737		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-5,606,737		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-5,606,737		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.: 315044 | Period: From 01/01/2023 To 01/31/2024 | Worksheet G-2 Parts I-II | Date/Time Prepared: 7/3/2024 12:21 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	14,278,969		14,278,969	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)	14,278,969		14,278,969	5.00
	All Other Care Services				
6.00	ANCILLARY SERVICES	1,591,732	0	1,591,732	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)	15,870,701	0	15,870,701	14.00

	Cost Center Description				
			1.00	2.00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			18,450,817	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)			18,450,817	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315044	Period: From 01/01/2023 To 01/31/2024	Worksheet G-3 Date/Time Prepared: 7/3/2024 12:21 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	15,870,701	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,342,706	2.00
3.00	Net patient revenues (Line 1 minus line 2)	14,527,995	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	18,450,817	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-3,922,822	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,784	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	0	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	13,876	24.00
24.01	BARBER BEAUTY	1,017	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	26,677	25.00
26.00	Total (Line 5 plus line 25)	-3,896,145	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)	-3,896,145	31.00