This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315044 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 01/31/2024 Date/Time Prepared: 7/3/2024 12: 21 pm PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 7/3/2024 Time: 12:21 pm use only ] Manually prepared cost report 2

[ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: 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	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
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	Si gnatory Title			3
4	Date			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	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.

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

	EX INDENTIFICATION DATA	TY HEALTH CARE	Provi der N	F	eriod: rom 01/01/	2023	Worksheet S-2 Part I		
					o 01/31/		Date/Time Pre 7/3/2024 12:2		
	1.00 Skilled Nursing Facility and Skilled Nursing	2.00 Facility Complex	 < Address:	3. 00					
00		P0 Box:						1.0	
00	3	State: NJ	Zi p Code: (					2.0	
00 01	County: SUSSEX	CBSA Code: 35084 CBSA Code:	Urban/Rura	11 : U				3. 0	
			mponent Name	Provi der	Date	Payme	nt System (P,	0.0	
				CCN	Certified		0, or N)	_	
			1. 00	2.00	3. 00	V 4. 00	XVIII XIX 5. 00 6. 00		
	SNF and SNF-Based Component Identification:	I	1.00	2.00	0.00	1.00	1 0.00   0.00		
00	SNF	MOHAWK I	MEADOWS	315044	1/01/1970	N	P N	4.0	
00	Nursing Facility   CF/  D							5. 0	
00	SNF-Based HHA							7.0	
00	SNF-Based RHC					İ		8.0	
00	SNF-Based FQHC							9.0	
00	SNF-Based CMHC SNF-Based OLTC							10.0	
00	SNF-Based HOSPI CE							12. 0	
00	SNF-Based CORF					<u> </u>		13.0	
					From:		To:	-	
00	Cost Reporting Period (mm/dd/yyyy)				1.00		2. 00 01/31/2024	14. 0	
	Type of Control (See Instructions)					5		15. 0	
							Y/N		
_	Type of Freestanding Skilled Nursing Facility	1					1. 00		
00			he requiremen	s set forth	n 42 CFR		N	16. 0	
00	Is this a composite distinct part skilled nur 42 CFR section 483.5?	in	N	17. (					
00									
00	Miscellaneous Cost Reporting Information  If this is a low Medicare utilization cost re	nort indicate	i th a "V" for	a voc. or "N"	for no		N	]   19. (	
01	If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y",	your contractor	's criteria fo			Э	N	19. 0	
	Depreciation - Enter the amount of depreciati	on reported in t	this SNF for t	ne method ind	icated on	Li nes			
	Straight Line						76, 689	1	
00	Declining Balance Sum of the Year's Digits						(	21. ( 22. (	
00	9						76, 689		
00	If depreciation is funded, enter the balance								
								24. (	
	Were there any disposal of capital assets dur	ing the cost rep	orting period		orting nor	od2	N	24. ( 25. (	
	Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a	ing the cost rep	orting period		orting per	i od?	(	24. ( 25. (	
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Health Financial Systems	MOHAWK MEADOWS			In Lieu of Form CMS-25				
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31504	4 Peri od:	Worksheet S-2				
COMPLEX INDENTIFICATION DATA			From 01/01/2023	Part I				
			To 01/31/2024	Date/Time Pre				
				7/3/2024 12: 2	1 pm			
				Y/N				
		1. 00						
42.00 Are mal practice premiums and paid loss	es reported in other than	the Administrative	and General cost	N	42. 00			
center? Enter Y or N. If yes, check bo	x, and submit supporting s	schedule listing cos	t centers and					
amounts.		-						
43.00 Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		N	43.00			
44.00 If line 43 is yes, enter the home offi	ce chain number and enter	the name and address	s of the home		44. 00			
office on lines 45, 46 and 47.								
1.00	2.00		3.00					
If this facility is part of a chain or	ganization, enter the nam	e and address of the	home office on the	lines				
below.								
45. 00 Name:	Name:   Contractor's Name:   Contractor's Number:							
46.00 Street:	PO Box:				46. 00			
47.00 City:								

\I LL:	ED NURSING FACILITY AND SKILLED NURSING FACILI	MOHAWK MEADON TY HEALTH CARE		No.: 315044 F	Peri od:	eu of Form CMS Worksheet S-	2
	X REI MBURSEMENT QUESTI ONNAI RE	THE TENTE OF THE		F	From 01/01/2023 Fo 01/31/2024	Part II	
					Y/N	7/3/2024 12: Date	
					1. 00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" foi	r Yes or "N" f	for No. For all	the date	
00	Provider Organization and Operation  Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)	ly prior to the beg the date of the cha	inning of	the cost umn 2. (see	N		1.
				Y/N 1. 00	Date 2.00	V/I 3. 00	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			N	2.00	3.33	2.
. 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)						3.
				Y/N	Туре	Date	
	Financial Data and Reports			1. 00	2. 00	3.00	
00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	" for Audited, "C" te copy or enter da no, see instructio	for te ns.	Y	С		4.
. 00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			N			5.
					Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	aal 2 (V/N) Caluma 2	lo tho	nravi dar tha	N	l N	
00		OOLE (YZN) COLUMN Z			I IV	I IN	6.
	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained duri	s? (Y/N) see instru	ctions.		N		7.
00 00		s? (Y/N) see instru ng the cost reporti	ctions.				7.
	Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) see	s? (Y/N) see instru ng the cost reporti	ctions.		N	Y/N 1.00	7.
00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad debt	s? (Y/N) see instrung the cost reportiee instructions.	ctions. ng period	for Nursing	N N	Y/N	7. 8.
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00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for battering file 9 is "Y", did the provider's bad debtering period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	s? (Y/N) see instrung the cost reportiee instructions.  d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du lived? If "Y	for Nursing  ns. ring this cost  Y", see instru  ", see instruc  Pai	N N N N N N N N N N N N N N N N N N N	Y/N 1.00  Y N N Part B	7.
000	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the second and seco	s? (Y/N) see instrung the cost reportiee instructions.  d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du lived? If "Y	for Nursing  ns. ring this cost  Y", see instru  ", see instruc  Par	N N N N N N N N N N N N N N N N N N N	Y/N 1.00  Y N N Part B Y/N	9. 10. 11.
000	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the second and seco	s? (Y/N) see instrung the cost reportiee instructions.  d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per  Description 0	instruction change du lived? If "Y	ns. ring this cost Y", see instruct Par Y/N 1.00	N N N N N N N N N N N N N N N N N N N	Y/N 1.00  Y N N  Part B Y/N 3.00	9, 10. 11. 12. 13.
00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the second and seco	s? (Y/N) see instrung the cost reportiee instructions.  d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per  Description	instruction change du lived? If "Y	ns. ring this cost Y", see instruct Par Y/N 1.00	N N N N N N N N N N N N N N N N N N N	Y/N 1.00  Y N N Part B Y/N 3.00	7. 8. 9. 10.
00 00 00 00 00 00 00 00 00 00 00 00 00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durit School and/or Allied Health Program? (Y/N) so the second and secon	s? (Y/N) see instrung the cost reportiee instructions.  d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per  Description	instruction change du lived? If "Y	ns. ring this cost Y", see instruct Par Y/N 1.00  N	N N N N N N N N N N N N N N N N N N N	Y/N 1.00  Y N N  N Part B Y/N 3.00  N	9. 10. 11. 12.
00 00 00 00 00 00 00 00 00 00 00 00 00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durity School and/or Allied Health Program? (Y/N) so the second and the provider shad deby period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  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.)  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.  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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	s? (Y/N) see instrung the cost reportiee instructions.  d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per  Description	instruction change du lived? If "Y	ns. ring this cost Y", see instruct Par Y/N 1.00  N	N N N N N N N N N N N N N N N N N N N	Y/N 1.00  Y N N N Part B Y/N 3.00  N	7. 8. 9. 10. 11. 12.

Heal th	Financial Systems MOHAWK I	MEADOW	IS	In Lieu of Form CMS-2540		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der No.: 315044	Peri od: From 01/01/2023 To 01/31/2024		pared:
			1. 00	2.	00	
	Cost Report Preparer Contact Information	_				
19.00	Enter the first name, last name and the title/position	CHRI S	5	GUI LBAULT		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
20.00	Enter the employer/company name of the cost report	HEALT	TH CARE RESOURCES			20. 00
	preparer.					
21. 00	Enter the telephone number and email address of the cost	609-9	987-1440	CHRI S. GUI LBAUL	T@HCRNJ. NET	21. 00
	report preparer in columns 1 and 2, respectively.					

Health Financial S	Systems	MOHAWK MEADOWS					In Lie	u of Form CMS-2540-10
SKILLED NURSING FA	ACILITY AND	SKILLED NURSI	IG FACILITY	' HEALTH	CARE	Provider No.: 315044	Peri od:	Worksheet S-2
COMPLEX REIMBURSEN	MENT QUESTIC	ONNAI RE					From 01/01/2023	

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 01/31/2024	
		Part B			
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R				13. 00
	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.)				
14. 00	Was the cost report prepared using the PS&R				14. 00
	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				
45.00	4.				45.00
15.00	If line 13 or 14 is "Y", were adjustments				15. 00
	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.				
14 00	If line 13 or 14 is "Y", then were				16. 00
16.00	adjustments made to PS&R data for				16.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17 00	If line 13 or 14 is "Y", then were				17. 00
17.00	adjustments made to PS&R data for Other?				17.00
	Describe the other adjustments:				
18. 00					18. 00
.0.00	provider's records? If "Y" see Instructions.				10.00
			3.00		
	Cost Report Preparer Contact Information				
19. 00	Enter the first name, last name and the title/po		PREPARER		19. 00
	held by the cost report preparer in columns 1, 2	2, and 3,			
	respecti vel y.				
20. 00	Enter the employer/company name of the cost repo	ort			20. 00
	preparer.				
21. 00	Enter the telephone number and email address of				21. 00
	report preparer in columns 1 and 2, respectively	<b>/</b> .			

MOHAWK MEADOWS In Lieu of Form CMS-2540-10

COMPLEX STATISTICAL DATA

Health Financial Systems MOHAWK M
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | Date/Time Prepared: 7/3/2024 | 12: 21 pm | Provi der No.: 315044

						7/3/2024 12: 21	l pm
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days	Title V	Title XVIII	Title XIX	
			Avai I abl e				
		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	HOSPI CE	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
		Inpatient [	ays/Vi si ts		Di scharges		
	Component	0ther	Total	Title V	Title XVIII	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	HOSPI CE	0	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	4, 497	46, 636		44	104	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1 00	OVILLED ANDROLMO FACILLETY	11.00	12.00	13.00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	30	178		107. 91	359. 53	1. 00
2.00	NURSING FACILITY	0	0	0.00		0.00	2. 00
3.00	I CF/II D	0	O			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	HOSPI CE	0	0	0.00	0.00		7. 00
8. 00	Total (Sum of lines 1-7)	30	178		107. 91	359. 53	8. 00
		Average Length		Admi s	si ons		
	Component	of Stay Total	Ti +l o V	Title XVIII	Title XIX	Other	
	Component	16. 00	Title V 17.00	18. 00	19. 00	20. 00	
1. 00	SKILLED NURSING FACILITY	262. 00	17.00		19.00	20.00	1. 00
2.00	NURSING FACILITY	0. 00	0	23	0	0	2. 00
3.00	ICF/IID	0.00	U		0	0	
4.00	HOME HEALTH AGENCY COST	0.00			U	U U	3. 00 4. 00
5.00	Other Long Term Care	0. 00				o	5. 00
6.00	SNF-Based CMHC	0.00				١	6. 00
7.00	HOSPI CE	0.00	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	262. 00	0	23	24	10	8. 00
8.00	Total (Suil of Titles 1-7)	Admi ssi ons	Full Time		24	10	6.00
		Auiii SSI UIIS	Turr irille	Lqui vai eiit			
	Component	Total	Employees on	Nonpai d			
	Component	Total	Payrol I	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				2. 00
3. 00	ICF/IID	0	0.00				3. 00
4. 00	HOME HEALTH AGENCY COST		3.00	0.00			4. 00
5. 00	Other Long Term Care	0	0. 00	0.00			5. 00
6.00	SNF-Based CMHC		3.00	0.00			6. 00
7. 00	HOSPI CE	0	0. 00	0.00			7. 00
8. 00	Total (Sum of lines 1-7)	57	149. 70				8. 00
00	1 (	1		3.00		ı	00

				T	o 01/31/2024	Date/Time Pre 7/3/2024 12:2	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		,	Worksheet A-6		Salary in col.		
					3		
		1.00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
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	HOSPI CE	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	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	9, 827, 720	0	9, 827, 720	337, 774. 00	29. 10	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	5, 548	0	5, 548			14. 00
15. 00	Contract Labor: Physician services-Part A	0	0	0	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		0	0	0			21. 00
22. 00		1, 759, 388	0	1, 759, 388			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION MOHAWK MEADOWS

				Т	o 01/31/2024	Date/Time Prep 7/3/2024 12:2	
	·	Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	C	0	0.00	0.00	1. 00
2.00	Administrative & General	828, 321	C	828, 321	25, 996. 00	31. 86	2. 00
3.00	Plant Operation, Maintenance & Repairs	559, 133	C	559, 133	26, 090. 00	21. 43	3. 00
4.00	Laundry & Linen Service	44, 039	C	44, 039	3, 647. 00	12. 08	4.00
5.00	Housekeepi ng	559, 344	C	559, 344	29, 035. 00	19. 26	5. 00
6.00	Di etary	822, 992	C	822, 992	33, 163. 00	24. 82	6. 00
7.00	Nursing Administration	673, 149	C	673, 149	10, 891. 00	61. 81	7. 00
8.00	Central Services and Supply	0	C	0	0.00	0.00	8. 00
9.00	Pharmacy	0	C	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	C	0	0.00	0.00	10.00
11. 00	Soci al Servi ce	161, 375	C	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	C	446, 880	20, 856. 00	21. 43	13. 00
14.00	Total (sum lines 1 thru 13)	4, 095, 233	C	4, 095, 233	154, 111. 00	26. 57	14. 00

Health Financial Systems	MOHAWK MEADOWS	In Lieu of Form CMS-2540-1			
SNF WAGE RELATED COSTS	Provi der No.: 315044	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 7/3/2024 12:2	pared:	
			Amount Reported		

		To 01/31/2	2024 Date/Time Pre 7/3/2024 12:2	
		<u> </u>	Amount	
			Reported	
			1.00	
	PART IV - WAGE RELATED COSTS		<u>'</u>	
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		(	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			2.00
3.00	Qualified and Non-Qualified Pension Plan Cost			3.00
4.00	Prior Year Pension Service Cost			4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		C	5. 00
6.00	Legal / Accounting / Management Fees-Pension Plan			6. 00
7.00	Employee Managed Care Program Administration Fees			7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		500, 974	8. 00
9.00	Prescription Drug Plan			9.00
10.00	Dental, Hearing and Vision Plan			10.00
11. 00	Life Insurance (If employee is owner or beneficiary)			11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			14. 00
15.00	Workers' Compensation Insurance		297, 770	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required by FASB 106	o.   C	16. 00
	Non cumulative portion)			
	TAXES			
17. 00	FICA-Employers Portion Only		909, 346	17. 00
18.00	Medicare Taxes - Employers Portion Only			18. 00
19.00	Unemployment Insurance		51, 298	19. 00
20.00	State or Federal Unemployment Taxes		C	20.00
	OTHER			
21.00	Executive Deferred Compensation		C	21.00
22. 00	Day Care Cost and Allowances		C	22. 00
23.00	Tuition Reimbursement		C	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

Provi der No.: 315044 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part V 
01/31/2024 Date/Time Prepared: 7/3/2024 12:21 pm Occupational Category Amount Fri nge Adj usted Paid Hours Average Hourly Benefits Sal ari es (col Related to Reported Wage (col. 3 col . 4) 1 + col. 2Salary in col 3.00 5.00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 953, 281 170, 828 1, 124, 109 19, 432, 00 57. 85 1.00 Licensed Practical Nurses (LPNs) 1, 259, 978 225, 788 1, 485, 766 32, 438. 00 45.80 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 2, 976, 704 533, 425 3, 510, 129 120, 481. 00 29.13 3.00 Assi stants/Ai des ̈ 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 5.00 220, 229 4, 229. 00 61. 41 5.00 Physical Therapists 39, 465 259, 694 Physical Therapy Assistants 6.00 C 0.00 0.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 301, 167 53, 969 355, 136 8.00 6, 806, 00 52.18 8.00 0.00 9.00 C 0.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 90. 27 11.00 Speech Therapists 21, 128 3, 786 24, 914 276.00 11.00 Respiratory Therapists 12.00 0.00 12 00 0 0 00 13.00 Other Medical Staff 0 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 0 00 14 00 0 0.00 15.00 Licensed Practical Nurses (LPNs) 0 0.00 0.00 15.00 Certified Nursing Assistant/Nursing 5, 548 5, 548 176.00 31.52 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 176.00 31.52 17.00 5.548 5.548 18.00 Physical Therapists 0.00 0.00 18.00 0 0 19.00 Physical Therapy Assistants 0 0 0.00 0.00 19.00 Physical Therapy Aides 20.00 000000 0 0.00 0.00 20.00 Occupational Therapists 0.00 21.00 0 0.00 21.00 Occupational Therapy Assistants 0 22.00 0.00 0.00 22.00 Occupational Therapy Aides 0 0.00 0.00 23.00 23.00 0 24.00 Speech Therapists 0.00 0.00 24.00 0 Respiratory Therapists 0.00 25.00 25.00 0.00 26.00 Other Medical Staff 0.00 0.00 26.00

From 01/01/2023 01/31/2024 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 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 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 30.00 HD1 31.00 HC<sub>2</sub> 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 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB<sub>2</sub> 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52 00 CA1 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 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 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 75. 00 PA<sub>2</sub>

Health Financial Systems	MOHAWK MEADOV	IS		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315044	Peri od: From 01/01/2023 To 01/31/2024	Worksheet S- Date/Time Pr 7/3/2024 12:	epared:
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL			_		) / / h !	100. 00
			Expenses	Percentage	Y/N	
			1.00	2. 00	3.00	
A notice published in the Federal Register payments beginning 10/01/2003. Congress ex expenses. For lines 101 through 106: Enter column 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expen (See instructions)	pected this increase t in column 1 the amour for each category to t for yes or "N" for no	to be used nt of the total SNF oif the s	for direct pexpense for expense for expense from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing						101. 00
102.00 Recruitment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)					106. 00

Health Financial Systems	MOHAWK MEA	DOWS		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2023	D-+- /T: D	
			Ţ	01/31/2024	Date/Time Pre 7/3/2024 12: 2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	. р
, , , , , , , , , , , , , , , , , , ,			+ col . 2)	ons	Trial Balance	
			ĺ	Increase/Decre	(col. 3 +-	
				ase (Fr Wkst	col . 4)	
				A-6)		
OFFICE AND A SERVICE AND A SER	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		2 012 000	2 012 000	ما	2 012 000	1 00
1.00   O0100   CAP REL COSTS - BLDGS & FIXTURES 3.00   O0300   EMPLOYEE BENEFITS		2, 812, 898		0	2, 812, 898	1. 00 3. 00
3.00   00300 EMPLOYEE BENEFITS 4.00   00400 ADMINISTRATIVE & GENERAL	0 828, 321	1, 761, 606 2, 471, 164	1, 761, 606 3, 299, 485	0	1, 761, 606 3, 299, 485	4.00
5.00   00500   PLANT OPERATION, MAINT. & REPAIRS	559, 133	435, 217	3, 299, 485 994, 350	0	3, 299, 485 994, 350	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	44, 039	13, 987	58, 026	0	58, 026	6.00
7. 00   00700   HOUSEKEEPI NG	559, 344	62, 246	621, 590	0	621, 590	7. 00
8. 00   00800 DI ETARY	822, 992	526, 264	1, 349, 256	0	1, 349, 256	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	673, 149	40, 278	713, 427	0	713, 427	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0,3,117	174, 681	174, 681	0	174, 681	10. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0	0	o	0	12. 00
13. 00   01300   SOCI AL   SERVI CE	161, 375	0	161, 375	o	161, 375	13. 00
15. 00 01500 PATIENT ACTIVITIES	446, 880	2, 079		O	448, 959	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
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 I CF/I I D	0	0	0	0	0	32.00
33.00 O3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	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   I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00   04400   PHYSI CAL THERAPY	220, 229	0	220, 229	0	220, 229	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	301, 167	0	301, 167	0	301, 167	45. 00
46. 00   04600   SPEECH PATHOLOGY	21, 128	0	21, 128	U	21, 128	46.00
47. 00   04700   ELECTROCARDI OLOGY 48. 00   04800   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	47. 00 48. 00
49. 00   04900   DRUGS CHARGED TO PATTENTS	0	251, 997	251, 997	0	251, 997	48.00
51. 00   05100   SUPPORT SURFACES	0	231, 997	251, 997	0	231, 997	51.00
OTHER REIMBURSABLE COST CENTERS	l ol		0	<u> </u>	0	31.00
71. 00 07100 AMBULANCE	O	1, 927	1, 927	0	1, 927	71. 00
SPECIAL PURPOSE COST CENTERS	٩	1, 721	1, 727	<u> </u>	1, 721	71.00
83. 00 08300 H0SPI CE	O	0	0	0	0	83. 00
89.00   SUBTOTALS (sum of lines 1-84)	9, 827, 720	8, 623, 097		o		89. 00
NONREI MBURSABLE 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	o	0	o	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	o	0	0	0	92. 00
93. 00 09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	o	0	o	0	94.00
100. 00 TOTAL	9, 827, 720	8, 623, 097	18, 450, 817	0	18, 450, 817	100. 00

Health Financial Systems MOH.
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315044

			To 01/31/2024   Date/Time Pr   7/3/2024 12:	
Cost Center Description	Adjustments to	Net Expenses	17 37 2024 12.	ZI DIII
	Expenses (Fr F			
	Wkst A-8)	(col. 5 +-		
	<b>'</b>	col. 6)		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00   00100   CAP REL COSTS - BLDGS & FLXTURES	-11, 784	2, 801, 114		1.00
3.00   00300   EMPLOYEE BENEFITS	0	1, 761, 606		3. 00
4.00   OO400   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   HOUSEKEEPI NG	0	621, 590		7. 00
8. 00   00800   DI ETARY	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	O	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   CF/IID	0	0		32. 00
33.00 03300 OTHER LONG TERM CARE	0	0		33. 00
ANCILLARY SERVICE COST CENTERS				
40. 00   04000   RADI OLOGY	0	6, 395		40. 00
41. 00   04100   LABORATORY	0	14, 095		41.00
42. 00   04200   I NTRAVENOUS THERAPY	0	0		42.00
43.00   04300   OXYGEN (INHALATION) THERAPY	0	0		43.00
44. 00   04400 PHYSI CAL THERAPY	0	220, 229		44.00
45. 00   04500 OCCUPATI ONAL THERAPY	0	301, 167		45. 00
46.00   04600   SPEECH PATHOLOGY	0	21, 128		46. 00
47. 00   04700   ELECTROCARDI OLOGY	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   HOSPI CE	0	0		83. 00
89.00 SUBTOTALS (sum of lines 1-84)	-330, 902	18, 119, 915		89. 00
NONREI MBURSABLE 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   NONPAI D WORKERS	0	0		93. 00
94. 00 09400 PATIENTS LAUNDRY	0	0		94. 00
100. 00 TOTAL	-330, 902	18, 119, 915		100. 00

Health Financial Systems	MOHAWK MEADOWS			In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS	P	Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 01/31/2024	Date/Time Pre 7/3/2024 12:2	
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5.00	
TOTALS						
100. 00	Total Reclassification	ons (Sum		0	0	100. 00
	of columns 4 and 5 mu	ust				
	equal sum of columns	8 and				
	9)					

<sup>(1)</sup> 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.

Health Financial Systems	MOHAWK MEADOW	IS		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315044	Peri od:	Worksheet A-6	)
				From 01/01/2023		
				To 01/31/2024	Date/Time Pre	pared:
					7/3/2024 12: 2	<u>'1 pm</u>
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MOHAWK MEADOWS

					To 01/31/2024	Date/Time Prep 7/3/2024 12:2	
				Acqui si ti ons	5		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5		Т		_	
1. 00	Land	0	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	0	0		0	0	3. 00
4. 00	Building Improvements	347, 421	201, 410		0 201, 410	0	4. 00
5.00	Fixed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	176, 186	11, 346		0 11, 346		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	8. 00
9. 00	Total (line 7 minus line 8)	523, 607	212, 756		0 212, 756	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
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

Provi der No.: 315044

From 01/01/2023 To 01/31/2024 Date/Time Prepared:

				10 01/31/2024	7/3/2024 12:2	
				Expense Classification on		рш
				To/From Which the Amount is		
				TOTTO WITCH THE AMOUNT 13	to be Aujusteu	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
	bescription (1)	Adjustment	Allouit	Cost center	LITTE NO.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds	B		CAP REL COSTS - BLDGS &	1.00	1. 00
1.00		В	-11, /84		1.00	1.00
2 00	(chapter 2)			FI XTURES	0.00	2 00
2. 00	Trade, quantity, and time discounts (chapter		O	1	0.00	2. 00
0.00	8)				0.00	0.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	
4.00	Rental of provider space by suppliers		0	)	0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0	)	0.00	5. 00
	(chapter 21)					
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	A-8-2	0			8. 00
	physici an adjustment					
9.00	Home office cost (chapter 21)		0	)	0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)				0.00	10. 00
11.00	Nonallowable costs related to certain		l o		0.00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1				12. 00
	related organizations (chapter 10)					
13.00	Laundry and linen service		l o		0.00	13. 00
14.00	Revenue - Employee meals					14. 00
15. 00	Cost of meals - Guests					15. 00
16. 00	Sale of medical supplies to other than					16. 00
10.00	patients				0.00	10.00
17. 00	Sale of drugs to other than patients				0.00	17. 00
18. 00	Sale of medical records and abstracts			1	0.00	
19. 00	Vending machines				0.00	
20. 00	Income from imposition of interest, finance				0.00	
20.00	or penalty charges (chapter 21)			1	0.00	20.00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
21.00	and borrowings to repay Medicare			1	0.00	21.00
	overpayments					
22. 00				  *** Cost Center Deleted ***	02.00	22. 00
22.00	Utilization reviewphysicians' compensation		U	Cost Center Dereted	82.00	22.00
22.00	(chapter 21)			CAD DEL COSTS DIDOS	1 00	22.00
23. 00	Depreciationbuildings and fixtures		U	CAP REL COSTS - BLDGS &	1.00	23. 00
04.00				FI XTURES	0.00	04.00
24. 00	Depreciationmovable equipment			*** Cost Center Deleted ***	2.00	
25. 00	MI SC I NCOME	В		ADMI NI STRATI VE & GENERAL	4.00	
25. 02	WAGES - MARKETI NG	A		ADMI NI STRATI VE & GENERAL	4.00	
25. 03	CONTRI BUTI ONS	Α		ADMINISTRATIVE & GENERAL	4. 00	
25. 04	BAD DEBT	A		ADMINISTRATIVE & GENERAL	4.00	
25. 05	PENALTI ES	A		ADMINISTRATIVE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-330, 902			100.00
	to Worksheet A, col. 6, line 100)					
(1) Do	scription - all chapter references in this co	lumn pertain to	CMS Dub 15_1	1		

<sup>(1)</sup> 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.

MOHAWK MEADOWS

Health Financial Systems MOHAWK ME
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS Provi der No.: 315044

OFFICE COSTS				o 01/31/2024		
	Li ne No.	Cost	Center	Expense		ZI DIII
	1.00	2.	00	3. (	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
CLAIMED HOME OFFICE COSTS:						
1. 00	4. 00	ADMI NI STRATI VE	& 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						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col.	col . 5)			
		5				
	4. 00	5. 00	6. 00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:	1	,		T		
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	436, 013	436, 013	0			10. 00
6, line 100 to Worksheet A-8, column 3, line						
12.						

 			1/3/2024 12: 2	ı pm
Symbol (1)	Name	Percentage of		
		Ownershi p		
1.00	2.00	3. 00		

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

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

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

' ''			1	
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)			0.00	100.00
speci fy:				

- (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 rel ated 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.

Name Percentage of Type of Business	
Ownershi p	
4.00 5.00 6.00	

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

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

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

1.00		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)		0.00		100. 00
	speci fy:				

- (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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315044

					o 01/31/2024	Date/Time Pre	pared:
			CAPI TAL			7/3/2024 12: 2	ı piii
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FI XTURES	BENEFI TS		& GENERAL	
		Allocation					
		(from Wkst A col. 7)					
		0	1. 00	3. 00	3A	4.00	
	GENERAL SERVICE COST CENTERS	, , ,	11.00	0.00	071		
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		318, 707	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	58, 026	68, 484	7, 894			6. 00
7.00	00700 HOUSEKEEPI NG	621, 590	24, 113				7. 00
8.00	00800 DI ETARY	1, 349, 256	278, 857	147, 520			8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	713, 427	167, 970		1 ' '	1	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	174, 681	52, 163		,	1	10.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	1/1 275	11, 400		11, 100		12.00
13. 00 15. 00	O1300   SOCIAL SERVICE   O1500   PATIENT ACTIVITIES	161, 375 448, 959	0	,			13. 00 15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	440, 939	0	00, 103	529, 002	120, 000	13.00
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, 200, 220	1,012,070	700, 270	1	0	31. 00
32. 00	03200   CF/IID	0	0	ĺ	Ö	ol ol	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	d	0	o	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	6, 395	0	C	0,0,0		40. 00
41.00	04100 LABORATORY	14, 095	0	(	14, 095	3, 412	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		(	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	220, 229	45, 765		1		44.00
45. 00	04500 OCCUPATIONAL THERAPY	301, 167	0	53, 984	1		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	21, 128	0	3, 787		6, 032	46. 00 47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		47.00
48.00	04900 DRUGS CHARGED TO PATIENTS	251, 997	0		251, 997		48.00
51.00	05100 SUPPORT SURFACES	251, 447	0		1	01,008	51.00
31.00	OTHER REIMBURSABLE COST CENTERS				,		31.00
71. 00	07100 AMBULANCE	1, 927	0	(	1, 927	467	71. 00
	SPECIAL PURPOSE COST CENTERS	.,			., .,		
83.00	08300 H0SPI CE	0	0	C	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
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	_	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	14, 681	C	14, 681		91. 00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	(	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	ر ا	0	0	93.00
94. 00 98. 00	09400 PATI ENTS LAUNDRY	0	0			0	94. 00 98. 00
98.00	Cross Foot Adjustments Negative Cost Centers	0	0				98.00
100.00		18, 119, 915	2, 801, 114	1, 761, 606	18, 119, 915	1	
100.00	/ ITOTAL	10, 117, 913	2,001,114	1, 701, 000	10, 117, 913	] 3,331,791]	100.00

				To	01/31/2024	Date/Time Prep 7/3/2024 12: 2	
	Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	, pin
		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 HOUSEKEEPI NG	18, 117	0	944, 680			7. 00
8.00	00800 DI ETARY	209, 514	0	126, 423	2, 541, 451		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	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	31. 00
32. 00	03200   CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
	ANCI LLARY SERVI CE COST CENTERS	_	-	-1	-	-	
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	34, 385	0	20, 748	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0.7000	0	20,7.0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY		0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY			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
31.00	OTHER REIMBURSABLE COST CENTERS	0	0		<u> </u>	0	31.00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
71.00	SPECIAL PURPOSE COST CENTERS	0	0		<u> </u>	0	71.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 624, 106	_		2, 541, 451	1, 447, 009	89. 00
07.00	NONREI MBURSABLE COST CENTERS	1,024,100	210, 377	730, 024	2, 341, 431	1, 447, 007	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	11, 030	_	6, 656	0	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	11,030		0,030	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	94. 00 98. 00
98.00	Negative Cost Centers				0	0	98. 00 99. 00
		1 425 124	210 207	044 490	0 E41 4E1		
100.00	ITUTAL	1, 635, 136	218, 397	944, 680	2, 541, 451	1, 447, 009	100.00

				Т	o 01/31/2024	Date/Time Pre 7/3/2024 12:2	
					OTHER GENERAL	17 37 2024 12. 2	i piii
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE		Subtotal	
		SERVICES &	RECORDS &		ACTI VI TI ES		
		SUPPLY	LI BRARY				
	CENEDAL CEDIU CE COCT CENTEDO	10. 00	12. 00	13. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMI NI STRATI VE & 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 DI ETARY						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	O	·		3		13. 00
15.00	01500 PATIENT ACTIVITIES	O	C				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	C	0	0	0	31.00
32.00	03200   CF/IID	0	C	) c	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	C	) <u> </u>	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	C			7, 943	1
41.00	04100 LABORATORY	0	C	1		17, 507	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	C	C		0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	C	1	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	C		1	434, 557	44.00
46. 00	04500 SPEECH PATHOLOGY	0				441, 133 30, 947	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0			1 1	30, 947	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			1	0	48.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		1	313, 005	
51. 00	05100 SUPPORT SURFACES	0	Č	1	1	0	51.00
01.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1	<u> </u>		0 00
71. 00	07100 AMBULANCE	0	C	) C	0	2, 394	71. 00
	SPECIAL PURPOSE COST CENTERS			•			1
83.00	08300 H0SPI CE	0	C	) C	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
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		I	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	) C	0	35, 921	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	C	0	1	0	92. 00
93. 00	09300 NONPAI D WORKERS	0	C	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	C	) C	0	0	94. 00
98. 00	Cross Foot Adjustments	0	-		]	0	98.00
99.00	Negative Cost Centers	0	27 000	00000	0	10 110 015	99.00
100.00	TOTAL	344, 604	27, 893	236, 373	657, 148	18, 119, 915	1100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MOHAWK MEADOWS

Provi der No.: 315044

Cost Center Description					To 01/31/2024   Date/Time Pro	
		Cost Center Description	Post Stepdown	Total	17072021 12.1	ET DIII
CENERAL SERVICE COST CENTRES						
1.00		T	17. 00	18. 00		
3. 0. 00300 [MINEST IVE & GENERAL   4. 00						
4. 00		1				
5. 00   00500   PLANT OPERATION, MAINT. & REPAIRS   6. 00   6. 00   00500   LAUNDRY & LINEN SERVICE   7. 00   0700   00700   0015EKEEPI NG   7. 00   0700   00700   0015EKEEPI NG   8. 00   09800   DIETARY   8. 00   09900   URSI NG ADMINISTRATION   9. 00   00100   00700   0010000   00100000   00100000   00100000   00100000   00100000   001000000   001000000   001000000   00100000000		1				1
6. 00   00600   LAUNDRY & LINEN SERVICE	4.00	00400 ADMINISTRATIVE & GENERAL				4. 00
7. 00	5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5. 00
8. 00   00800   DIETARY   9. 00   9.	6.00	00600 LAUNDRY & LINEN SERVICE				6. 00
9. 00 09900 NURSI NG ADMINI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY 12. 00 11.0 00 10100 MEDI CAL RECORDS & LIBRARY 12. 00 13. 00 01300 SOCI AL SERVI CE \$ 15. 00	7. 00	00700 HOUSEKEEPI NG				7. 00
10.00	8.00	00800 DI ETARY				8. 00
12.00   01200   NEDICAL RECORDS & LIBRARY   12.00   01300   SOCIAL SERVICE   13.00   15.00   01500   PATIENT ACTIVITIES   15.00   16.836,508   30.00   30.00   30.00   30.00   31.00   31.00   31.00   31.00   31.00   31.00   31.00   31.00   31.00   31.00   31.00   31.00   32.00   33.00   67.11   D   D   D   D   D   32.00   33.00   67.11   D   D   D   D   D   D   D   D   D	9.00	00900 NURSI NG ADMI NI STRATI ON				9. 00
13. 00   01300   SOCI AL SERVI CE   13. 00   01500   PATIENT ACTIVITIES   15. 00   116, 836, 508   30. 00   3000   SMILLED NURSI NG FACILITY   0   0   0   0   31. 00   31. 00   31. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   33. 00   34. 00   33. 00   33. 00   34. 00   33. 00   33. 00   33. 00   34. 00   33. 00   34.	10.00					10. 00
15. 00	12.00	01200 MEDI CAL RECORDS & LI BRARY				12. 00
NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.	13.00	01300 SOCIAL SERVICE				13. 00
30. 00 00 00 00 00 00 00 00 00 00 0 0 0	15.00	01500 PATIENT ACTIVITIES				15. 00
31.00   03100   NURSI NG FACILITY		INPATIENT ROUTINE SERVICE COST CENTERS				
32.00   03200   CF/I I D   0   0   0   0   33.00     33.00   03300   OTHER LONG TERM CARE   0   0   0   0     34.00   04000   RADI OLOGY   0   7,943   40.00     41.00   04100   LABORATORY   0   17,507   41.00     42.00   04200   INTRAVENOUS THERAPY   0   0   0   42.00     43.00   04300   0XYGEN (INHALATI ON) THERAPY   0   0   0   43.00     44.00   04400   PHYSI CAL THERAPY   0   43.4,557   44.00     45.00   04500   OCCUPATI ONAL THERAPY   0   441,133   45.00     46.00   04600   SPEECH PATHOLOGY   0   30,947   46.00     48.00   04600   SPEECH PATHOLOGY   0   30,947   46.00     49.00   04900   RUGS CHARGED TO PATI ENTS   0   0   47.00     51.00   05100   SUPPORT SURFACES   0   0   0     51.00   05100   SUPPORT SURFACES   0   0     51.00   05100   SUPPORT SURFACES   0   0     71.00   SPECIAL PURPOSE COST CENTERS   0   0     71.00   ONDRE IMBURSABLE COST CENTERS   0   0     71.00   OND	30.00	03000 SKILLED NURSING FACILITY	0	16, 836, 508		30. 00
33.00   03300   OTHER LONG TERM CARE   0   0   0	31.00	03100 NURSING FACILITY	0	0		31.00
ANCILLARY SERVICE COST CENTERS  40. 00 400 00 000 00 RADI OLOGY 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 42. 00 42. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 45. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 60 00 RUGS CHARGED TO PATIENTS 60 00 10 00 61. 00	32.00	03200   CF/IID	O	O		32. 00
40. 00   04000   RADI OLOGY	33.00	03300 OTHER LONG TERM CARE	O	O		33. 00
41. 00		ANCILLARY SERVICE COST CENTERS				
42. 00 04200 INTRAVENOUS THERAPY 0 0 0 0 43. 00 43. 00 04300 0XYGEN (INHALATI ON) THERAPY 0 0 0 0 43. 00 44. 00 04400 PHYSI CAL THERAPY 0 43. 00 45. 00 04500 0CCUPATI ONAL THERAPY 0 441. 133 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 30, 947 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 441, 133 45. 00 48. 00 04800 MeDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 49. 00 04800 MeDI CAL SUPPLIES CHARGED TO PATIENTS 0 313, 005 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 313, 005 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0THER REI MBURSABLE COST CENTERS  71. 00 07100   AMBULANCE 0 2, 394 51. 00 89. 00 07100   AMBULANCE 0 18, 083, 994 51. 00 89. 00 07100   AMBULANCE 0 18, 083, 994 51. 00 89. 00 07100   AMBULANCE 0 18, 083, 994 51. 00 89. 00 07100   AMBULANCE 0 18, 083, 994 51. 00 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 35, 921 91. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 35, 921 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 09400 PATIENTS LAUNDRY 0 0 0 94. 00 98. 00 Cross Foot Adjustments 0 0 0 0 99. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00	40.00	04000 RADI OLOGY	0	7, 943		40. 00
43. 00 04300 0XYGEN (INHALATION) THERAPY 0 0 434, 557 44. 00 444. 00 04400 PHYSI CAL THERAPY 0 434, 557 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 0 441, 133 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 30, 947 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 313, 005 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0THER REI MBURSABLE COST CENTERS  71. 00 07100 AMBULANCE 0 0 2, 394 71. 00 89. 00 SPECI AL PURPOSE COST CENTERS  83. 00 83300 HOSPI CE 0 0 0 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 18, 083, 994 89. 00 NONREI MBURSABLE COST CENTERS  90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 35, 921 91. 00 91. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 94. 00 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 94. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 99. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41.00	04100 LABORATORY	0	17, 507		41.00
44. 00	42.00	04200 I NTRAVENOUS THERAPY	0	0		42.00
45. 00	43.00	04300 OXYGEN (INHALATION) THERAPY	o	o		43.00
46. 00	44.00	04400 PHYSI CAL THERAPY	o	434, 557		44. 00
47. 00	45.00	04500 OCCUPATI ONAL THERAPY	0	441, 133		45. 00
48. 00	46.00	04600 SPEECH PATHOLOGY	0	30, 947		46. 00
49. 00	47.00	04700 ELECTROCARDI OLOGY	O	O		47. 00
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	O		48. 00
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0	49.00	04900 DRUGS CHARGED TO PATIENTS	O	313, 005		49. 00
71. 00    71. 00   71			O	O		51.00
SPECIAL PURPOSE COST CENTERS		OTHER REIMBURSABLE COST CENTERS				
83. 00 89. 00    SUBTOTALS (sum of lines 1-84)   0   18, 083, 994   89. 00     NONREI MBURSABLE COST CENTERS   0   0   0     90. 00   09100   BARBER AND BEAUTY SHOP   0   35, 921   91. 00     92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   0     93. 00   09300   NONPAI D WORKERS   0   0   0     94. 00   09400   PATI ENTS LAUNDRY   0   0   0     98. 00   099. 00   Negative Cost Centers   0   0     99. 00   099. 00   Negative Cost Centers   0   0     99. 00   0   0     83. 00   89. 00   90. 00     83. 00   0   0     90. 00   0   0     83. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0     90. 00   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0   0     90. 00   0     90. 00   0	71.00	07100 AMBULANCE	0	2, 394		71. 00
89. 00   SUBTOTALS (sum of lines 1-84)   0   18,083,994   89.00		SPECIAL PURPOSE COST CENTERS				
NONREI MBURSABLE COST CENTERS   90.00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0	83.00	08300 H0SPI CE	0	0		83. 00
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0	89. 00		0	18, 083, 994		89. 00
91. 00   09100   BARBER AND BEAUTY SHOP   0   35, 921   91. 00   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   94. 00   98. 00   98. 00   Negative Cost Centers   0   0   0   0   0   0   0   0   0		NONREI MBURSABLE COST CENTERS				
92. 00   99.00	90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90. 00
93. 00   93.00   93.00   93.00   94.00   94.00   94.00   94.00   98.00   Cross Foot Adjustments   0   0   99.00   Negative Cost Centers   0   0   99.00   99.00   0   0   0   0   0   0   0   0   0	91.00	09100 BARBER AND BEAUTY SHOP	0	35, 921		91.00
94.00   94.00   94.00   94.00   98.00   Cross Foot Adjustments   0   0   98.00   99.00   Negative Cost Centers   0   0   99.00   99.00	92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92.00
98.00   Cross Foot Adjustments	93.00	09300 NONPALD WORKERS	0	0		93. 00
99.00   Negative Cost Centers   0   0   99.00	94.00	09400 PATIENTS LAUNDRY	0	0		94.00
	98. 00	Cross Foot Adjustments	0	0		98. 00
100, 00 TOTAL 0 18, 119, 915 100, 00	99. 00		0	0		99. 00
	100.00	TOTAL	0	18, 119, 915		100.00

Heal th Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315044
Period: From 01/01/2023 To 01/31/2024
Part II Date/Time Prepared: 7/3/2024 12: 21 pm

Cost Center Description

Directly

BLDGS & Subtotal

EMPLOYEE

ADMINISTRATIVE

						7/3/2024 12: 2	1 pm
			CAPITAL RELATED COSTS	·			
	Cost Center Description	Di rectly	BLDGS &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New	FI XTURES		BENEFI TS	& GENERAL	
		Capi tal					
		Related Costs 0	1.00	2A	3. 00	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	ZA	3.00	4.00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3. 00	00300 EMPLOYEE BENEFITS	0	0	o	C		3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	0	402, 948		Č	1	4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	221, 855		C	36, 362	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	68, 484		C	3, 713	1
7. 00	00700 HOUSEKEEPI NG	0	24, 113		C		7. 00
8. 00	00800 DI ETARY	0	278, 857		C		8. 00
9.00	00900 NURSING ADMINISTRATION	0	167, 970		C	27, 679	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	52, 163		C	6, 266	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	11, 400	11, 400	C	315	12.00
13.00	01300 SOCIAL SERVICE	0	0	0	C	5, 256	13. 00
15.00	01500 PATIENT ACTIVITIES	0	0	0	C	14, 614	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1, 512, 878	1, 512, 878	C	212, 169	30. 00
31. 00	03100 NURSING FACILITY	0	0		C		31. 00
32. 00	03200   I CF/I I D	0	0	1	C	1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	C	0	33. 00
	ANCILLARY SERVICE COST CENTERS	_					
40.00	04000 RADI OLOGY	0	l ~		C		40. 00
41.00	04100 LABORATORY	0	0	1	C	1	41.00
42. 00 43. 00	04200   NTRAVENOUS THERAPY 04300   OXYGEN (INHALATION) THERAPY	0	0	0	C	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	45, 765	-		8, 438	44.00
45. 00	04500 OCCUPATIONAL THERAPY	0	45, 765			9, 810	
46. 00	04600 SPEECH PATHOLOGY	0	0			688	46.00
47. 00	04700 ELECTROCARDI OLOGY	0	0				47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		C	1	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		Ö		49. 00
51. 00	05100 SUPPORT SURFACES	o o	Ö		C	1 -,	51.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	0	0	C	53	71. 00
	SPECIAL PURPOSE COST CENTERS			<u> </u>		•	
83. 00	08300 HOSPI CE	0	0	0	C	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	2, 786, 433	2, 786, 433	C	402, 542	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	C	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	14, 681	14, 681	C	1	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	C	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	C	1	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	C	0	94. 00
98. 00	Cross Foot Adjustments			0			98. 00
99. 00	Negative Cost Centers	_	0	0	C	1	99. 00
100.00	TOTAL	0	2, 801, 114	2, 801, 114	C	402, 948	1100.00

				То	01/31/2024	Date/Time Pre 7/3/2024 12:2	
	Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	, piii
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	1	1			1	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	050 047					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	258, 217	00.000				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	8, 126	· ·				6. 00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY	2, 861	0	,	2/7 257		7.00
8. 00 9. 00	00900 NURSI NG ADMI NI STRATI ON	33, 086 19, 929	1	6, 367 3, 835	367, 357 0		8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	6, 189	ŀ	1, 191	0	219, 413	10.00
12. 00	01200 MEDICAL RECORDS & LI BRARY	1, 353	0		0	0	12. 00
13. 00	01300 SOCIAL SERVICE	1, 333	0	200	0	0	13. 00
15. 00	01500 PATIENT ACTIVITIES	0	0		0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>			13.00
30. 00	03000 SKILLED NURSING FACILITY	179, 501	80, 323	34, 546	367, 357	219, 413	30.00
31. 00	03100 NURSING FACILITY	0	00,020	0.75.0	007,007	2.7,	31. 00
32. 00	03200   CF/IID	0	0	O	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 RADI OLOGY	0	0	0	0	0	40. 00
41.00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	5, 430	0	.,	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	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 OTHER REIMBURSABLE COST CENTERS	0	0	U U	0	0	51. 00
71. 00	07100 AMBULANCE	0	0	O	0	0	71. 00
71.00	SPECIAL PURPOSE COST CENTERS	0	<u> </u>	<u> </u>	0	0	71.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	256, 475		-	367, 357	_	89. 00
07.00	NONREI MBURSABLE COST CENTERS	200/1/0	007020	17,7211	0077007	2.771.0	07.00
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 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92. 00
93.00	09300 NONPALD 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	D TOTAL	258, 217	80, 323	47, 579	367, 357	219, 413	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315044

				Т	o 01/31/2024	Date/Time Pre   7/3/2024 12:2	
					OTHER GENERAL	17 37 2024 12. 2	i piii
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	PATI ENT	Subtotal	
		SERVICES &	RECORDS &		ACTI VI TI ES		
		SUPPLY	LI BRARY				
		10.00	12.00	13. 00	15. 00	16. 00	
	GENERAL SERVI CE COST CENTERS			Г	1		
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES					ļ	1. 00
3.00	00300 EMPLOYEE BENEFITS					ļ	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL					ļ	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					ļ	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE					ļ	6.00
7.00	00700 HOUSEKEEPI NG					ļ	7. 00
8.00	00800 DI ETARY					ļ	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	/F 000				ļ	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	65, 809	40.000			ļ	10.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	13, 328	1		ļ	12.00
13.00	01300 SOCIAL SERVICE	0	C	1	1	ļ	13.00
15. 00	O1500 PATIENT ACTIVITIES	U U	C	) <u> </u>	14, 614		15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	65, 809	13, 328	5, 256	14, 614	2, 705, 194	30.00
31. 00	03100 NURSING FACILITY	03, 009	•	1		2, 703, 194	
31.00	03200   CF/IID	0	C		-	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		C		1	0	
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		ή	ıl U	0	33.00
40. 00	04000 RADI OLOGY	ام	C		l ol	177	40. 00
41. 00	04100 LABORATORY		C	1	· ·	389	
42. 00	04200 I NTRAVENOUS THERAPY	o o	Č	1		0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	o o	Č	ól ő		0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	Č			60, 678	•
45. 00	04500 OCCUPATI ONAL THERAPY	0	Ċ		o	9, 810	•
46. 00	04600 SPEECH PATHOLOGY	o	C		ol	688	•
47. 00	04700 ELECTROCARDI OLOGY	o	C		ol	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C		o	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o	C		o	6, 961	49. 00
51.00	05100 SUPPORT SURFACES	0	C	) c	0	0	51.00
	OTHER REIMBURSABLE COST CENTERS			•			
71.00	07100 AMBULANCE	0	C	0	0	53	71. 00
	SPECIAL PURPOSE COST CENTERS						
83.00	08300 H0SPI CE	0	C	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
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	0	0	17, 164	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C	) C	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	C	) C	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	C	) C	0	0	94. 00
98. 00	Cross Foot Adjustments	0			0	0	98. 00
99. 00	Negative Cost Centers	0	C	) 0	0	0	99. 00
100.00	TOTAL	65, 809	13, 328	5, 256	14, 614	2, 801, 114	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MOHAWK MEADOWS

Provi der No.: 315044

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 01/31/2024 | Date/Time Prepared: | Part | Part | Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Par

				10	
	Cost Center Description	Post Step-Down	Total	77 37 2024	2. 21 piii
		Adjustments			
		17. 00	18. 00		
G	SENERAL 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 HOUSEKEEPI NG				7. 00
8.00	00800 DI ETARY				8. 00
9.00	00900 NURSING ADMINISTRATION				9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY				10.00
12.00 0	01200 MEDICAL RECORDS & LIBRARY				12. 00
13.00	01300 SOCIAL SERVICE				13. 00
15.00	01500 PATIENT ACTIVITIES				15. 00
I	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	0	2, 705, 194		30. 00
31.00	03100 NURSING FACILITY	0	o		31.00
32.00 0	03200   CF/IID	0	0		32. 00
33.00	03300 OTHER LONG TERM CARE	0	0		33. 00
	NCILLARY SERVICE COST CENTERS				
	04000 RADI OLOGY	0	177		40. 00
	04100 LABORATORY	0	389		41. 00
	04200 INTRAVENOUS THERAPY	0	0		42. 00
1	04300 OXYGEN (INHALATION) THERAPY	0	0		43. 00
1	04400 PHYSI CAL THERAPY	0	60, 678		44. 00
1	04500 OCCUPATI ONAL THERAPY	0	9, 810		45. 00
	04600 SPEECH PATHOLOGY	0	688		46. 00
1	04700 ELECTROCARDI OLOGY	0	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	6, 961		49. 00
	05100 SUPPORT SURFACES	0	0		51. 00
	OTHER REIMBURSABLE COST CENTERS	1	= 0		
	07100 AMBULANCE	0	53		71. 00
	SPECIAL PURPOSE COST CENTERS				
	08300 HOSPI CE	0	0 702 050		83. 00
89. 00	SUBTOTALS (sum of lines 1-84) IONREI MBURSABLE COST CENTERS	0	2, 783, 950		89. 00
_					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
		0	17, 164		91.00
1	09200 PHYSICIANS PRIVATE OFFICES	0	0		92.00
1	09300 NONPALD WORKERS	0	0		93. 00
	09400 PATIENTS LAUNDRY		0		94.00
98. 00	Cross Foot Adjustments	0	0		98. 00
99. 00	Negative Cost Centers	0	2 001 114		99.00
100.00	TOTAL	ı Y	2, 801, 114	I	100.00

COST A	LLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2023 To 01/31/2024	Date/Time Pre	
		CAPI TAL				7/3/2024 12: 2	1 pm
		RELATED COSTS					
	Cost Center Description	BLDGS &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	PLANT	
	p	FIXTURES	BENEFITS		& GENERAL	OPERATI ON,	
		(SQUARE FEET)	(GROSS		(ACCUM COST)	MAINT. &	
			SALARI ES)			REPAI RS	
						(SQUARE FEET)	
	GENERAL SERVICE COST CENTERS	1. 00	3. 00	4A	4. 00	5. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	34, 153		1			1. 00
3. 00	00300 EMPLOYEE BENEFITS	34, 133	9, 827, 720				3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	4, 913	828, 321	1	1 14, 588, 124		4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 705	559, 133		1, 316, 429	26, 535	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	835	44, 039	1	134, 404	835	1
7. 00	00700 HOUSEKEEPING	294	559, 344	1	745, 965	294	7. 00
8.00	00800 DI ETARY	3, 400	822, 992	1		3, 400	•
9.00	00900 NURSING ADMINISTRATION	2, 048	673, 149	1	1, 002, 058	2, 048	1
10.00	01000 CENTRAL SERVICES & SUPPLY	636	0	1	226, 844	636	1
12.00	01200 MEDICAL RECORDS & LIBRARY	139	0	) (	11, 400	139	12. 00
13.00	01300 SOCIAL SERVICE	0	161, 375	(	190, 301	0	13.00
15.00	01500 PATIENT ACTIVITIES	0	446, 880	(	529, 062	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	18, 446	5, 189, 963	(	7, 681, 397	18, 446	
31. 00	03100 NURSING FACILITY	0	0	1	0	0	
32. 00	03200   CF/IID	0	0	l .	0	0	
33. 00	03300 OTHER LONG TERM CARE	0	0	(	0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS			ı			40.00
40.00	04000 RADI OLOGY 04100 LABORATORY	0	0	1	-, -, -,	0	
41.00		0	0		14, 095	0	
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY		0			0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	558	220, 229		305, 470	558	1
45. 00	04500 OCCUPATI ONAL THERAPY	330	301, 167		355, 151	0.0	1
46. 00	04600 SPEECH PATHOLOGY	0	21, 128		24, 915	0	1
47. 00	04700 ELECTROCARDI OLOGY	0	21, 120	1	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o	0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		251, 997	0	49. 00
51.00	05100 SUPPORT SURFACES	O	0			0	51.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	C	(	1, 927	0	71. 00
	SPECIAL PURPOSE COST CENTERS			1			
83. 00	08300 H0SPI CE	0	0	1	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	33, 974	9, 827, 720	-3, 531, 79°	1 14, 573, 443	26, 356	89. 00
00 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN			J		0	00.00
90. 00 91. 00	09100 BARBER AND BEAUTY SHOP	0 179	0	1	14 401	0 179	
91.00	09200 PHYSI CLANS PRI VATE OFFI CES	1/9	0		14, 681	0	
	09300 NONPAID WORKERS		0			0	ı
	09400 PATIENTS LAUNDRY		0	]		0	1
98. 00	Cross Foot Adjustments		O	`		O	98. 00
99. 00	Negative Cost Centers						99.00
102.00	9	2, 801, 114	1, 761, 606		3, 531, 791	1, 635, 136	1
	Part I)	_,,	., ,		3, 331, 111	.,,	
103.00		82. 016631	0. 179249		0. 242100	61. 621858	103. 00
104.00	Cost to be allocated (per Wkst. B,		0		402, 948	258, 217	
	Part II)						
105.00	The state of the s		0. 000000		0. 027622	9. 731185	105. 00
	11)	1		1			l

| Provider No.: 315044 | Period: | Worksheet B-1 | From 01/01/2023 | To 01/31/2024 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					To	o 01/31/2024	Date/Time Pre 7/3/2024 12:2	
		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	
			LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	SERVICES &	
			(PATI ENT			<b>/</b>	SUPPLY	
			CENSUS)			(DI RECT	(COSTED	
			4 00	7. 00	8. 00	NURSI NG)	REQUI S. ) 10. 00	
	GENER	AL SERVICE COST CENTERS	6. 00	7.00	8.00	9. 00	10.00	
1.00		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		LAUNDRY & LINEN SERVICE	46, 636					6. 00
7.00		HOUSEKEEPI NG	0	25, 406				7. 00
8.00		DI ETARY	0	3, 400				8. 00
9.00		NURSING ADMINISTRATION	0	2, 048		,		9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	636		- 1	174, 681	10.00
12. 00		MEDICAL RECORDS & LIBRARY	0	139		- 1	0	
13.00		SOCIAL SERVICE	0	0			0	
15. 00		PATIENT ACTIVITIES	0	0	0	0	0	15. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	4/ /2/	10 444	120,000	170 50/	174 (01	20.00
30. 00 31. 00	1	SKILLED NURSING FACILITY NURSING FACILITY	46, 636	18, 446 0			174, 681 0	30. 00 31. 00
31.00		ICF/IID	0	0			0	1
33. 00		OTHER LONG TERM CARE	0	0			0	
33.00		LARY SERVICE COST CENTERS	U	U	U	U <sub>I</sub>		33.00
40. 00		RADI OLOGY	0	0	0	0	0	40. 00
41. 00		LABORATORY	0	0			0	
42. 00		I NTRAVENOUS THERAPY	0	0			0	
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0		- 1	0	1
44. 00		PHYSI CAL THERAPY	0	558	0	0	0	44.00
45.00		OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700	ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		- 1	0	
49. 00		DRUGS CHARGED TO PATIENTS	0	0			0	1
51. 00		SUPPORT SURFACES	0	0	0	0	0	51. 00
74 00		REIMBURSABLE COST CENTERS	1					
71. 00		AMBULANCE	0	0	0	0	0	71. 00
02.00		AL PURPOSE COST CENTERS		0		O	0	02.00
83. 00 89. 00	08300	HOSPICE SUBTOTALS (sum of lines 1-84)	0 46, 636	0 25, 227			-	
69.00	NONDE	IMBURSABLE COST CENTERS	40, 030	25, 227	139, 900	172, 520	174, 681	09.00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	O	0	90.00
91. 00		BARBER AND BEAUTY SHOP	0	179			0	
92. 00		PHYSICIANS PRIVATE OFFICES	0	0		-	0	
93. 00		NONPALD WORKERS	0	0	o o	0	0	
94. 00		PATI ENTS 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,	218, 397	944, 680	2, 541, 451	1, 447, 009	344, 604	102. 00
		Part I)						
103.00	1	Unit cost multiplier (Wkst. B, Part I)	4. 683013	37. 183343			1. 972762	
104.00	P	Cost to be allocated (per Wkst. B,	80, 323	47, 579	367, 357	219, 413	65, 809	104. 00
405.00		Part II)	4 700000	4 0767.7	0 (0570)	4 074710	0 07/700	105.00
105.00	וי	Unit cost multiplier (Wkst. B, Part	1. 722339	1. 872747	2. 625704	1. 271768	0. 376738	105.00
	1	[11]						I

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315044 Period:

Peri od: Worksheet B-1 From 01/01/2023 To 01/31/2024 Date/Ti me Prepared:

7/3/2024 12: 21 pm OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCIAL SERVICE PATI ENT ACTI VI TI ES RECORDS & LI BRARY (PATI ENT (PATIENT (PATI ENT CENSUS) CENSUS) CENSUS) 12.00 13.00 15.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS - BLDGS & FLXTURES 1 00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 01200 MEDICAL RECORDS & LIBRARY 12.00 46,636 12.00 01300 SOCIAL SERVICE 13.00 13.00 46,636 01500 PATIENT ACTIVITIES 46, 636 15.00 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 46,636 46, 636 46, 636 30.00 03100 NURSING FACILITY 31.00 31.00 0 32 00 03200 | CF/IID 0 C 0 32 00 33.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 0 41.00 04100 LABORATORY C 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 000000 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 44.00 0 0 44.00 0 45.00 04500 OCCUPATIONAL THERAPY 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 C 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 49.00 05100 SUPPORT SURFACES 51.00 0 51.00 OTHER REIMBURSABLE COST CENTERS 71.00 07100 AMBULANCE 0 0 0 71.00 SPECIAL PURPOSE COST CENTERS 83.00 08300 HOSPI CE 83.00 0 0 SUBTOTALS (sum of lines 1-84) 46, 636 89.00 46, 636 46, 636 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 09100 BARBER AND BEAUTY SHOP 0 0 91 00 C 91 00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 C 92.00 93.00 09300 NONPALD WORKERS 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 C 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, 27, 893 236, 373 657, 148 102.00 Part I) 14.091003 103.00 103.00 Unit cost multiplier (Wkst. B, Part I) 0.598100 5. 068466 104.00 Cost to be allocated (per Wkst. B, 13, 328 5, 256 14,614 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0. 285788 0.112703 0.313363 105.00 H)

Health Financial Systems MOHAWK MEADO	WS		In Lie	eu of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der		eri od:	Worksheet C	
			rom 01/01/2023		aanad.
		'	o 01/31/2024	Date/Time Prep 7/3/2024 12:2	
Cost Center Description		Total (from	Total Charges	Ratio (col. 1	-
		Wkst. B, Pt I,		di vi ded by	
		col . 18)		col. 2	
		1. 00	2. 00	3.00	
ANCILLARY SERVICE COST CENTERS					
40. 00   04000   RADI OLOGY		7, 943		0. 000000	40. 00
41. 00  04100  LABORATORY		17, 507	637	27. 483516	41.00
42. 00   04200   I NTRAVENOUS THERAPY		C	0	0.000000	42.00
43.00   04300   OXYGEN (INHALATION) THERAPY		C	0	0.000000	43.00
44. 00   04400   PHYSI CAL THERAPY		434, 557	546, 423	0. 795276	44.00
45. 00   04500   OCCUPATI ONAL 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   ELECTROCARDI OLOGY		C	0	0.000000	47.00
48.00  04800   MEDICAL SUPPLIES CHARGED TO PATIENTS		C	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		C	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

Uselith Financial Costana	MOLLANIK M	EADOWC		1- 11-	£ F CMC	25.4010
Health Financial Systems	MOHAWK M				eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2023	Worksheet D Part I	
					Date/Time Pre	nared:
				10 01/31/2024	7/3/2024 12: 2	
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pi	rogram Charges	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	,	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Col umn 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					1
ANCILLARY SERVICE COST CENTERS	T	_	Г		_	
40. 00   04000   RADI OLOGY	0. 000000			0	0	
41. 00   04100   LABORATORY	27. 483516			0	0	
42.00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43.00 O4300 OXYGEN (INHALATION) THERAPY	0. 000000			0	0	
44. 00 O4400 PHYSI CAL THERAPY	0. 795276	, , , , , , , , , , , , , , , , , , , ,		0 174, 243	<b>l</b>	
45. 00   04500   OCCUPATI ONAL THERAPY	0. 533896			0 194, 053	0	45. 00
46.00 04600 SPEECH PATHOLOGY	0. 699193	27, 047		0 18, 911	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	-		0	0	
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	0	10.00
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	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 VIV use columns 1 2 and 4 only						

<sup>(1)</sup> For title V and XIX use columns 1, 2, and 4 only.

<sup>(2)</sup> Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

Heal th Financial	I Systems	MOHAWK M	IEADOWS		In Lie	u of Form CMS-2	2540-10
	OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315044	Peri od: From 01/01/2023 To 01/31/2024	Worksheet D Parts II-III Date/Time Pre 7/3/2024 12:2	pared:
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cos	st Center Description					1. 00	
PART II -	- APPORTIONMENT OF VACCINE COST						
1.00 Dru	ugs charged to patients - ratio of co			t C, column 3	, line 49)	1. 797237 0	1. 00 2. 00
	ogram costs (Line 1 x line 2) (Title Part I, line 18)	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
Cos	st Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
			(From Wkst. B,			Heal th Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col . 2 / Col	•	3 x Col. 4)	
		1, 00	2.00	3, 00	4. 00	5. 00	
PART III	- CALCULATION OF PASS THROUGH COSTS			3.00	4.00	3.00	
	Y SERVICE COST CENTERS	TOK NOKSTNO &	ALLIED HEALTH				
40. 00 04000 RAD		7, 943	(	0.0000	00	0	40. 00
41. 00 04100 LAB	BORATORY	17, 507		0. 00000		0	41.00
42. 00 04200 I NT	TRAVENOUS THERAPY	0		0. 00000	00 0	0	42.00
43. 00 04300 0XY	YGEN (INHALATION) THERAPY	0	l c	0. 00000	00	0	43. 00
44.00 04400 PHY	YSI CAL THERAPY	434, 557	(	0. 00000	174, 243	0	44. 00
45. 00 04500 0CC	CUPATIONAL THERAPY	441, 133	(	0. 00000	194, 053	0	45. 00
46. 00 04600 SPE	EECH PATHOLOGY	30, 947	C	0.0000	18, 911	0	46. 00
47. 00 04700 ELE	ECTROCARDI OLOGY	0	C	0. 00000	00	0	47. 00
48.00 04800 MED	DICAL SUPPLIES CHARGED TO PATIENTS	0	(	0. 00000		0	48. 00
	JGS CHARGED TO PATIENTS	313, 005	(	0.0000		0	49. 00
51. 00  05100 SUP		0	(	0.0000		0	51.00
100. 00   Tot	tal (Sum of lines 40 - 52)	1, 245, 092	(	P	684, 971	0	100. 00

eal th	Financial Systems	MOHAWK MEADOWS	In Lie	eu of Form CMS-2	2540-1
OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315044	Peri od: From 01/01/2023 To 01/31/2024		pared:
		Title XVIII	Skilled Nursing Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
. 00	Inpatient days including private room days			46, 636	
. 00	Private room days			0	
. 00	Inpatient days including private room days applicab			4, 748	1
. 00	Medically necessary private room days applicable to	the Program		0	
. 00	Total general inpatient routine service cost			16, 836, 508	5.0
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			14, 278, 969	6.0
. 00	General inpatient routine service charges	(line 5 divided by line 6)		1. 179112	
. 00	Enter private room charges from your records	(Erric o di vi ded by Time o)		0	1
00	Average private room per diem charge (Private room	charges line 8 divided by private	e room davs. line	0.00	
	2)	311	, , , , , , , , , , , , , , , , , , ,		
0. 00	Enter semi-private room charges from your records			0.00	
1. 00	00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by				
	semi -pri vate room days)	(1. 0 . 1. 44)			100
2.00	Average per diem private room charge differential (			0.00	12. (
3. 00 4. 00	Average per diem private room cost differential (Li Private room cost differential adjustment (Line 2 t			0.00	•
5. 00	General inpatient routine service cost net of priva	· ·	minus line 14)	16, 836, 508	
3. 00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	THE FORM COST OF FIRE CONTROL	minas irric iri	10,000,000	10. \
6. 00	Adjusted general inpatient service cost per diem (L	ine 15 divided by line 1)		361.02	16. (
7. 00	Program routine service cost (Line 3 times line 16	5)		1, 714, 123	17. (
3. 00	Medically necessary private room cost applicable to	program (line 4 times line 13)		0	18. (
9. 00	Total program general inpatient routine service cos			1, 714, 123	1
0. 00	Capital related cost allocated to inpatient routine		art II column 18,	2, 705, 194	20. (
1 00	line 30 for SNF; line 31 for NF, or line 32 for ICF	•		F0 01	21 /
1. 00 2. 00	Per diem capital related costs (Line 20 divided by Program capital related cost (Line 3 times line 21	·		58. 01 275, 431	1
3. 00	Inpatient routine service cost (Line 19 minus line			1, 438, 692	
. 00	Aggregate charges to beneficiaries for excess costs			1, 438, 092	1
. 00	Total program routine service costs for comparison		ninus Line 24)	1, 438, 692	
. 00	Enter the per diem limitation (1)	22.00 20 1	,		26.
7. 00	Inpatient routine service cost limitation (Line 3 t	imes the per diem limitation line	26) (1)		27.
3. 00	Reimbursable inpatient routine service costs (Line		line 27)		28.
	(Transfer to Worksheet E, Part II, line 4) (See ins nes 26 and 27 are not applicable for title XVIII, bu	•		l	

		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

Health Financial Systems	MOHAWK MEADOW	VS	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provi der No.: 315044	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 7/3/2024 12:21 pm

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT					7/3/2024 12: 2	1 pm
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT			Title XVIII	Skilled Nursing	PPS	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT   3,789,790   1.00				Facility		
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT   3,789,790   1.00						
1.00					1.00	
2.00   Nursing and Allied Heal th Education Activities (pass through payments)   0   2   00			EMENT			
Subtotal ( Sum of lines 1 and 2)   3.09   4.00   7.00   4.00   7.00   7.00   4.00   7.00   7.00   4.00   7.00   7.00   4.00   7.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   4.00   7.00   7.00   4.00   7.00			_			
A 0.0   Primary payor amounts		1 3 1	yments)			
5. 00   Coin surance   290, 389   5. 00						
A lowable bad debts (From your records)   131, 225   6, 00		, , ,			-	
1.   Nowable   Bad debts   for dual   eligible   beneficiaries   (See instructions)   88, 296   8, 00     Nowable   Bad debts   for statistical records only   0, 00     Nowable   Recovery of bad debts   for statistical records only   0, 00     Nowable   Ililization review   0, 10, 00     Nowable   Ililization   Ililization   1, 10, 00     Nowable   Ililiz					· ·	
8. 00					· ·	
9.00			ctions)			
10.00   Utilization review   0   0.00   0.						
11.00   Subtotal (See instructions)   3,584,697   11.00   1.00	9. 00	Recovery of bad debts - for statistical records only			0	9. 00
12.00   Interim payments (See instructions)   3, 430, 441   12.00   13.00   13.00   14.00   15.00					-	10. 00
13. 00   Tentative adjustment   0   13. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 50   14. 55   14. 55   14. 55   15. 00   14. 55   14. 55   15. 00   14. 55   15. 00   15. 00   15. 00   15. 00   15. 00   16. 00   1	11. 00	Subtotal (See instructions)			3, 584, 697	11. 00
14. 00       OTHER adjustment (See instructions)       0       14. 00         14. 50       Demonstration payment adjustment amount before 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. 75         15. 00       Bal ance due provider/program (see Instructions)       83. 590       15. 00         16. 00       Protested amounts (Nonal lowable cost report items in accordance with CMS Pub. 15-2, section 115. 2)       0       16. 00         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       18. 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       22. 00         24. 01       All lowable bad debts (From your records)       0       24. 02	12.00	Interim payments (See instructions)			3, 430, 441	12. 00
14. 50       Demonstration payment adjustment amount before sequestration       0       14. 55         14. 75       Demonstration payment adjustment amount after sequestration       0       14. 55         14. 75       Sequestration por non-claims based amounts (see instructions)       14. 75         14. 99       Sequestration amount (see instructions)       68, 960       14. 99         15. 00       Bal ance due provi der/program (see Instructions)       83, 590       15. 00         16. 00       Portested amounts (Nonall owable 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         17. 00       Ancillary services Part B       0       17. 00         18. 00       Vaccine cost (From Wist D, Part III, 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       Primary payor amounts       0       20. 00         22. 00       Primary payor amounts       0       22. 00         23. 00       Coinsurance and deductibles       0       23. 00         24. 01 <td>13.00</td> <td>Tentati ve adjustment</td> <td></td> <td></td> <td>0</td> <td>13.00</td>	13.00	Tentati ve adjustment			0	13.00
14.55   Demonstration payment adjustment amount after sequestration   14.55   Sequestration for non-claims based amounts (see instructions)   1,706   14.75   14.75   Sequestration for non-claims based amounts (see instructions)   68,960   14.99   15.00   Bal ance due provider/program (see Instructions)   83,590   15.00   Protested amounts (Nonaliowable 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   1	14.00	OTHER adjustment (See instructions)			0	14. 00
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       Bal ance due provider/program (see Instructions)       83, 590       15. 00         16. 00       Protested amounts (Nonal lowable 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       18. 00       17. 00       18. 00       19. 00	14.50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 99 Sequestration amount (see instructions) 15. 00 Bal ance due provider/program (see Instructions) 16. 00 Protested amounts (Nonall owable cost report items in accordance with CMS Pub. 15-2, section 115. 2) 16. 00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY  17. 00 Ancillary services Part B 18. 00 Vaccine cost (From Wkst D, Part II, line 3) 19. 00 Total reasonable costs (Sum of lines 17 and 18) 19. 00 Medicare Part B ancillary charges (See instructions) 20. 00 Medicare Part B ancillary charges (See instructions) 21. 00 Cost of covered services (Lesser of line 19 or line 20) 22. 00 Primary payor amounts 23. 00 Coinsurance and deductibles 24. 00 Allowable bad debts (From your records) 24. 01 Allowable Bad debts (From quarrecords) 24. 02 Adjusted reimbursable bad debts (see instructions) 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26. 00 Interim payments (See instructions) 27. 00 Tentative adjustment 28. 00 Other Adjustments (See instructions) Specify 29. 00 Demonstration payment adjustment amount before sequestration 29. 00 Demonstration payment adjustment amount before sequestration 29. 00 Demonstration payment adjustment amount after sequestra	14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
15.00 Balance due provider/program (see Instructions) 16.00 Protested amounts (Nonal Lowable cost report items in accordance with CMS Pub. 15-2, section 115.2)  PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY  17.00 Ancillary services Part B  18.00 Vaccine cost (From Wkst D, Part II, line 3) 19.00 Total reasonable costs (Sum of lines 17 and 18) 20.00 Medicare Part B ancillary charges (See instructions) 21.00 Cost of covered services (Lesser of line 19 or line 20) 22.00 Primary payor amounts 23.00 Coinsurance and deductibles 24.00 Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.50 Demonstration payment adjustment amount before sequestration 29.00 Demonstration payment adjustment amount after sequestration 29.00 Demonstration payment adjustment amo	14. 75	Sequestration for non-claims based amounts (see instructions)			1, 706	14. 75
16.00   Protested amounts (Nonal Lowable 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   18.00   Vaccine cost (From Wkst D, Part II, line 3)   0   18.00   18.00   19.00   1	14. 99	Sequestration amount (see instructions)			68, 960	14. 99
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY  17. 00 Ancillary services Part B  18. 00 Vaccine cost (From Wkst D, Part II, line 3) 19. 00 Total reasonable costs (Sum of lines 17 and 18) 20. 00 Medicare Part B ancillary charges (See instructions) 21. 00 Cost of covered services (Lesser of line 19 or line 20) 22. 00 Primary payor amounts 23. 00 Coinsurance and deductibles 24. 00 Allowable bad debts (From your records) 24. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26. 00 Interim payments (See instructions) 27. 00 Tentative adjustment 28. 00 Other Adjustments (See instructions) Specify 28. 50 Demonstration payment adjustment amount before sequestration 28. 50 Demonstration payment adjustment amount after sequestration 29. 00 Demonstration	15.00	Balance due provider/program (see Instructions)			83, 590	15. 00
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. 01       Allowable bad debts (From your records)       0       24. 01         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       25. 00         27. 00       Tentative adjustment       0       26. 00         28. 50       Demonstration payment adjustment amount before sequestration       0       28. 50         28. 99       Sequestration amount (see instructions)	16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	0	16. 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       24.02         26.00       Interim payments (See instructions)       0       26.00         27.00       Tentative adjustment       0       28.00         28.50       Demonstration payment adjustment amount before sequestration       0       28.50         28.50       Demonstration payment adjustment amount after sequestration       0       28.55         28.99       Sequestration amount (see instructions)		PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (	OF COST OR CHARGES -	TITLE XVIII ONLY		
Total reasonable costs (Sum of lines 17 and 18)  20.00 Medicare Part B ancillary charges (See instructions)  Cost of covered services (Lesser of line 19 or line 20)  Primary payor amounts  Coi nsurance and deductibles  4.00 Allowable bad debts (From your records)  4.11 Allowable Bad debts for dual eligible beneficiaries (see instructions)  24.01 Allowable Bad debts (see instructions)  24.02 Adjusted reimbursable bad debts (see instructions)  25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  1 Interim payments (See instructions)  26.00 Interim payments (See instructions)  27.00 Tentative adjustment  Other Adjustments (See instructions) Specify  Demonstration payment adjustment amount before sequestration  28.50 Demonstration payment adjustment amount after sequestration  28.55 Sequestration amount (see instructions)  29.00 Balance due provider/program (see instructions)  0 29.00	17.00	Ancillary services Part B			0	17. 00
20.00 Medicare Part B ancillary charges (See instructions)  21.00 Cost of covered services (Lesser of line 19 or line 20)  22.00 Primary payor amounts  23.00 Coi nsurance and deductibles  24.00 Allowable bad debts (From your records)  24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions)  24.02 Adjusted reimbursable bad debts (see instructions)  25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  26.00 Interim payments (See instructions)  27.00 Tentative adjustment  28.00 Uther Adjustments (See instructions) Specify  28.00 Demonstration payment adjustment amount before sequestration  28.50 Demonstration payment adjustment amount after sequestration  29.00 Balance due provider/program (see instructions)  0 20.00  21.00  22.00  23.00  24.01  24.01  25.00  26.00  27.00  28.00  29.00	18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
21.00 Cost of covered services (Lesser of line 19 or line 20)  22.00 Primary payor amounts  Coinsurance and deductibles  Allowable bad debts (From your records)  24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions)  24.02 Adjusted reimbursable bad debts (see instructions)  Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  1nterim payments (See instructions)  1nterim payments (See instructions)  Tentative adjustment  28.00 Other Adjustments (See instructions) Specify  Demonstration payment adjustment amount before sequestration  28.50 Demonstration payment adjustment amount after sequestration  Sequestration amount (see instructions)  29.00 Balance due provider/program (see instructions)  0 21.00  22.00  23.00  24.00  24.01  24.01  25.00  26.00  27.00  28.00  29.00	19.00	Total reasonable costs (Sum of Lines 17 and 18)			0	19. 00
22.00 Primary payor amounts  Coinsurance and deductibles  Allowable bad debts (From your records)  Allowable Bad debts for dual eligible beneficiaries (see instructions)  Adjusted reimbursable bad debts (see instructions)  Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  Interim payments (See instructions)  Interim payments (See instructions)  Tentative adjustment  See instructions) Specify  Demonstration payment adjustment amount before sequestration  Sequestration amount (see instructions)  Sequestration amount (see instructions)  Sequestration amount (see instructions)  Balance due provider/program (see instructions)  O 22.00  23.00  24.00  24.01  25.00  24.01  26.00  27.00  28.00  29.00	20.00	Medicare Part B ancillary charges (See instructions)			0	20. 00
23.00 Coinsurance and deductibles 24.00 Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.57 Sequestration amount (see instructions) 29.00 Balance due provider/program (see instructions) 20.23.00 24.00 24.01 25.00 26.00 27.00 28.00 29.00	21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
24.00 Allowable bad debts (From your records)  24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions)  24.02 Adjusted reimbursable bad debts (see instructions)  25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  26.00 Interim payments (See instructions)  27.00 Tentative adjustment  28.00 Other Adjustments (See instructions) Specify  28.50 Demonstration payment adjustment amount before sequestration  28.55 Demonstration payment adjustment amount after sequestration  28.55 Sequestration amount (see instructions)  29.00 Balance due provider/program (see instructions)  0 24.02  24.01  24.02  25.00  25.00  26.00  27.00  28.50  28.50  28.51	22.00	Primary payor amounts			0	22. 00
24. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions)  24. 02 Adjusted reimbursable bad debts (see instructions)  25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  26. 00 Interim payments (See instructions)  70 Tentative adjustment  10 Other Adjustments (See instructions) Specify  10 Demonstration payment adjustment amount before sequestration  28. 50 Demonstration payment adjustment amount before sequestration  28. 55 Demonstration payment adjustment amount after sequestration  28. 55 Sequestration amount (see instructions)  29. 00 Balance due provider/program (see instructions)  0 24. 01  24. 02  25. 00  26. 00  27. 00  28. 00  28. 50  29. 00	23.00	Coinsurance and deductibles			0	23. 00
24.02 Adjusted reimbursable bad debts (see instructions)  25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  26.00 Interim payments (See instructions)  7.00 Tentative adjustment  8.00 Other Adjustments (See instructions) Specify  9.00 Demonstration payment adjustment amount before sequestration  9.28.50 Demonstration payment adjustment amount before sequestration  9.28.50 Demonstration payment adjustment amount after sequestration  9.28.50 Sequestration amount (see instructions)  9.28.50 Sequestration amount (see instructions)  9.28.50 Ozerostration amount (see instructions)  9.28.50 Ozerostration amount (see instructions)  9.29.00 Balance due provider/program (see instructions)	24.00	Allowable bad debts (From your records)			0	24. 00
25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)  26.00 Interim payments (See instructions)  7.00 Tentative adjustment  8.00 Other Adjustments (See instructions) Specify  9.00 Demonstration payment adjustment amount before sequestration  9.28.50 Demonstration payment adjustment amount before sequestration  9.28.50 Demonstration payment adjustment amount after sequestration  9.28.50 Sequestration amount (see instructions)  9.28.99 Sequestration amount (see instructions)  9.28.90 Demonstration payment adjustment amount after sequestration  9.28.90 Occurrence (see instructions)  9.29.00 Demonstration payment adjustment amount after sequestration  9.28.90 Occurrence (see instructions)  9.29.00 Demonstration payment adjustment amount after sequestration  9.29.00 Occurrence (see instructions)	24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
26.00 Interim payments (See instructions)  7 Intative adjustment  8.00 Other Adjustments (See instructions) Specify  9 Demonstration payment adjustment amount before sequestration  10 28.50 Demonstration payment adjustment amount after sequestration  10 28.50 Other Adjustments  10 28.50 Other Adjustments  10 28.50 Other Adjustments  11 28.50 Other Adjustments  12 28.50 Other Adjustments  13 28.50 Other Adjustments  14 28.50 Other Adjustments  15 28.50 Other Adjustments  16 28.50 Other Adjustments  17 28.50 Other Adjustments  18 28.50 Other Adjustments  18 28.50 Other Adjustments  28 50 Other Adjustments  29 50 Other Adjustments  20 50 Other Adjustments  20 50 Oth	24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
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	25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 28.57 Sequestration amount (see instructions) 28.59 Sequestration amount (see instructions) 28.50 Occurrence 28.50 Demonstration payment adjustment amount after sequestration 28.50 Occurrence 28.50 Occ	26.00	Interim payments (See instructions)			0	26. 00
28. 50 Demonstration payment adjustment amount before sequestration 28. 50 Demonstration payment adjustment amount after sequestration 28. 50 Demonstration payment adjustment amount before sequestration 28. 50 Demonstration payment adjustment amount before sequestration 29. 50 Demonstration payment adjustment amount before sequestration 29. 50 Demonstration payment adjustment amount before sequestration 29. 50 Demonstration payment adjustment amount after sequestration payment adjustment amount after sequestration payment adjustment amount after sequestration paymen	27.00	Tentati ve adjustment			0	27. 00
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	28.00	Other Adjustments (See instructions) Specify			0	28. 00
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	28. 50				0	28. 50
28.99 Sequestration amount (see instructions) 0 28.99 29.00 Balance due provider/program (see instructions) 0 29.00					0	
29.00 Balance due provider/program (see instructions) 0 29.00					0	
					0	
			e with CMS Pub.15-2,	section 115.2	0	

Form 01/01/2023 To 01/31/2024 Date/Time Prepared: 7/3/2024 12: 21 pm

Title XVIII Skilled Nursing PPS

		11 (1	e Aviii	Facility	FF3	
		Inpatien	t Part A		t 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	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provi der to Program		_1		T -	
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			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		0		0	
3. 99	- 3.98)		U		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 430, 441		0	4. 00
1. 00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		0, 100, 111			1.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		_		_	
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5.03	Provider to Program		U		0	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		0		0	
5. 52			0		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		Ö	
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		83, 590		0	
6.02	PROVI DER TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		3, 514, 031		0	7. 00
			Contract	or Name	Contractor	
			1	20	Number	
8. 00	Name of Contractor		1. (	JU	2.00	8. 00
0.00	Intalic of contractor				I	1 0.00

<sup>(1)</sup> 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.

Health Financial Systems

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 01/01/2

Peri od: Worksheet G From 01/01/2023 To 01/31/2024 Date/Time Prepared: 7/3/2024 12:21 pm

onl y)			10 0	7/3/	/2024 12: 21	
		General Fund			nt Fund	·
		1.00	Purpose Fund 2.00	3.00	4. 00	
	Assets					
1. 00	CURRENT ASSETS  Cash on hand and in banks	23, 483	0		0	1. 00
2.00	Temporary investments	23, 483	0	0	0	2. 00
3.00	Notes receivable			ol	0	3. 00
4. 00	Accounts recei vabl e	7, 234, 300	o o	o	ő	4. 00
5.00	Other recei vabl es	0	0	O	0	5. 00
6.00	Less: allowances for uncollectible notes and accounts	-766, 017	0	О	0	6.00
	recei vabl e	_	_		_	
7.00	Inventory	(0.04)	0	0	0	7. 00
8. 00 9. 00	Prepaid expenses Other current assets	68, 946 3, 796		O O	0	8. 00 9. 00
10. 00	Due from other funds	3, 740			0	10.00
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	6, 564, 508		o	ő	11. 00
	FIXED ASSETS	27 22 17 22 2		-1		
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	Bui I di ngs	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	17.00
18.00	Less: Accumulated Amortization	-288, 418		0	0	18.00
19.00	Fixed equipment	0	0	O O	0	19.00
20.00	Less: Accumulated depreciation	0		0	0	20.00
21. 00 22. 00	Automobiles and trucks Less: Accumulated depreciation	0			0	21. 00 22. 00
23. 00	Major movable equipment	187, 532			0	23. 00
24. 00	Less: Accumulated depreciation	107, 552			0	24. 00
25. 00	Mi nor equipment - Depreciable			ol	0	25. 00
26. 00	Mi nor equipment nondepreciable	0		o	ő	26. 00
27. 00	Other fixed assets	0	l öl	ol	ō	27. 00
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	447, 945	0	O	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	1	0	0	31. 00
32. 00	Other assets	1, 113, 870	1	0	0	32.00
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	4, 283, 771		0	0	33.00
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	11, 296, 224	0	0	0	34. 00
	CURRENT LIABILITIES					
35. 00	Accounts payable	12, 405, 358	0	0	0	35. 00
36. 00	Salaries, wages, and fees payable	304, 143		o	ō	36. 00
37.00	Payroll taxes payable	25, 729	1	O	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	Accel erated payments	0				40. 00
41. 00		0	1	0		41.00
42.00	Other current liabilities	68, 351		0	0	42.00
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	13, 017, 480	0	0	0	43. 00
44.00	LONG TERM LIABILITIES		0	ol		44.00
44. 00 45. 00	Mortgage payable Notes payable	3, 885, 481		0	0	44. 00 45. 00
46. 00	Unsecured Loans	3,000,481	0		0	46. 00
47. 00	Loans from owners:	0			0	47. 00
48. 00	Other long term liabilities	0		ol	ő	48. 00
49. 00	OTHER (SPECIFY)	o o	o o	ol	ő	49. 00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	3, 885, 481	0	O	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			٥		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				٥	58. 00
59 00		-5 606 737				59. 00
			1	ol	- 1	60.00
55. 66		, 2,0, 224		Ĭ	ĭ	55. 50
59. 00 60. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	-5, 606, 737 11, 296, 224	1	0		0

In Lieu of Form CMS-2540-10 Health Financial Systems MOHAWK MEADOWS Provi der No.: 315044

STATEMENT OF CHANGES IN FUND BALANCES

sheet (Line 11 - line 18)

Peri od: Worksheet G-1 From 01/01/2023

01/31/2024 Date/Time Prepared: 7/3/2024 12:21 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5.00 2 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 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 -5, 606, 737 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 0000 14.00 0 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance -5, 606, 737 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 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 5.00 0 6.00 6.00 7.00 0 7 00 8.00 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 14.00 0 14.00 15.00 0 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00

Heal th	Financial Systems MOHAWK MEADO	DWS		In lie	eu of Form CMS-:	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES			Period: From 01/01/2023 To 01/31/2024	Worksheet G-2 Parts I-II Date/Time Pre 7/3/2024 12:2	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
	DART I DATI ENT DEVENUES		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES					-
1. 00	General Inpatient Routine Care Services SKILLED NURSING FACILITY		14 270 04		14 070 0/0	1 00
	NURSING FACILITY		14, 278, 96	2	14, 278, 969 0	1.00
2. 00 3. 00	INDESTING FACILITY				0	2.00
4. 00	OTHER LONG TERM CARE				0	3. 00 4. 00
5. 00			14, 278, 96		14 270 060	
5.00	Total general inpatient care services (Sum of lines 1 - 4) All Other Care Services		14, 270, 90	7	14, 278, 969	3.00
6. 00	ANCI LLARY SERVICES		1, 591, 73:	2 0	1, 591, 732	6. 00
7. 00	CLINIC		1, 371, 73.	2	1, 371, 732	1
8.00	HOME HEALTH AGENCY COST				0	
9. 00	AMBULANCE				0	1
10.00	RURAL HEALTH CLINIC			0	o o	1
10. 10	FOHC			0	o o	
11. 00	CMHC			0	o o	1
12. 00	HOSPI CE		1	n 0	ő	1
	OTHER (SPECIFY)			0	Ō	1
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	3 to	15, 870, 70	1 0	15, 870, 701	14. 00
	Worksheet G-3, Line 1)					
	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	7			0		7. 00

8.00

9. 00

10.00

11.00

12.00

13. 00 0 14. 00

18, 450, 817 15. 00

8. 00 9. 00

10.00

11.00

12.00

Total Additions (Sum of lines 2 - 7)

15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

13.00 14.00 Total Deductions (Sum of lines 9 - 13)

Deduct (Specify)

	lealth Financial Systems MOHAWK MEADOWS			u of Form CMS-2	
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315044	Peri od:	Worksheet G-3	
			From 01/01/2023 To 01/31/2024	Date/Time Pre 7/3/2024 12:2	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, li			15, 870, 701	
2.00	Less: contractual allowances and discounts on patients acco	ounts		1, 342, 706	
3.00	Net patient revenues (Line 1 minus line 2)			14, 527, 995	
4.00	Less: total operating expenses (From Worksheet G-2, Part II	, line 15)		18, 450, 817	
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	
7. 00	Income from investments	_		11, 784	
8. 00	Revenues from communications (Telephone and Internet servi	ce)		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	
				0	
	Revenue from rental of living quarters			0	10.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	
17. 00	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flower, coffee shops, canteen			0	
21. 00	Rental of vending machines			0	
	Rental of skilled nursing space			0	
23.00	Governmental appropriations			0	23. 00
24.00	NON PATIENT REVENUE			13, 876	24. 00
24. 01	BARBER BEAUTY			1, 017	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (Sum of lines 6 - 24)				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	
29.00				0	29. 00

0 29.00 0 30.00

-3, 896, 145 31. 00

29. 00

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)