**MED-CALC SYSTEMS** In Lieu of CMS Form 2540-10

**This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).**

**OMB NO. 0938-0463**

Expires: 12/31/2021

| **SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY** | **PROVIDER CCN:** **31-5174** | **PERIOD:** **FROM: 01/01/2023** **TO: 12/31/2023** | **WORKSHEET S** **PARTS I II & III** |
|---|---|---|---|

## PART I - COST REPORT STATUS

**Provider use only**

1. [ X ] Electronically prepared cost report — **Date:** 05/31/2024 — **Time:** 08:53:29 AM
2. [ ] Manually prepared cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report. 0
3.0.1 [ ] No Medicare Utilization Enter "Y" for yes or leave blank for no 0

**Contractor use only:**

4. [ ] Cost Report Status
   - [ 1 ] As Submitted:
   - [ 2 ] Settled without audit
   - [ 3 ] Settled with audit
   - [ 4 ] Reopened
   - [ 5 ] Amended
5. Date Received

6. Contractor No. _____
7. [ ] First Cost Report for this Provider CCN
8. [ ] Last Cost Report for this Provider CCN
9. [ ] NPR Date: _____
10. [ ] If line 4, column 1 is "4": Enter number of times reopened
11. Contractor Vendor Code _____
12. Medicare Utilization Enter "F" for full, "L" for low, or "N" for no utilization _____

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

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 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 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 DEPTFORD CTR FOR REHAB AND HLTHCR #31-5174 for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, it is a true, correct and complete statement 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.

ECR ENCRYPTION:
05/31/2024 08:53:29 AM
0SA9Mhy:wK65g03cphE11oviLNBzo0
DLT1B0uxWE.gshYyAVdkMiqG1cPDcX
lft40KMCR50J:RYx

PRINT FILE ENCRYPTION:

DO NOT SIGN UNTIL ENCRYPTION APPEARS HERE

| | SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR | | CHECKBOX | ELECTRONIC SIGNATURE STATEMENT | |
|---|---|---|---|---|---|
| | 1 | | 2 | | |
| 1 | *SIGNATURE PAGE* | | | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name | | | | 2 |
| 3 | Signatory Title | | | | 3 |
| 4 | Signature date | | | | 4 |

## PART III - SETTLEMENT SUMMARY

| | | TITLE V | TITLE XVIII A | TITLE XVIII B | TITLE XIX | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 1 | **SKILLED NURSING FACILITY** | | **(215,848)** | **3,175** | | **1** |
| 2 | **NURSING FACILITY** | | | | **0** | **2** |
| 3 | **I C F / IID** | | | | | **3** |
| 4 | **SNF - BASED HHA** | | **0** | **0** | | **4** |
| 5 | **SNF - BASED RHC** | | | **0** | | **5** |
| 6 | **SNF - BASED FQHC** | | | | | **6** |
| 7 | **SNF - BASED CMHC** | | | **0** | | **7** |
| 100 | **TOTAL** | | **(215,848)** | **3,175** | **0** | **100** |

The above amounts represent "due to" or "due from" the applicable Program for the element of the above complex indicated.
(Indicate Overpayments in Brackets.)

| MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10 | | |
|---|---|---|---|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET S-2 PART I |

**Skilled Nursing Facility and Skilled Nursing Facility Complex Address:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | Street: | 1511 CLEMENTS BRIDGE RD | P.O. Box: | | | | | 1 |
| 2 | City: | DEPTFORD | State: | NJ | Zip Code: | 08096 | | 2 |
| 3 | County: | GLOUCESTER | CBSA Code: | 15804 | Urban / Rural: | U | | 3 |

**SNF and SNF-Based Component Identification:**

| | Component | Component Name | Provider CCN: | Date Certified | | Payment System (P, O, or N) V | XVIII | XIX | |
|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | | 4 | 5 | 6 | |
| 4 | S N F | DEPTFORD CTR FOR REHAB A | 31-5174 | 01/03/2006 | | N | P | N | 4 |
| 5 | Nursing Facility | | | | | | ////////// | | 5 |
| 6 | I C F / I I D | | | | | ////////// | ////////// | | 6 |
| 7 | SNF-Based HHA | | | | | | | | 7 |
| 8 | SNF-Based RHC | | | | | | | | 8 |
| 9 | SNF-Based FQHC | | | | | | | | 9 |
| 10 | SNF-Based CMHC | | | | | | | | 10 |
| 11 | SNF-Based OLTC | | ////////// | ////////// | | ////////// | ////////// | ////////// | 11 |
| 12 | SNF-Based HOSPICE | | | | | ////////// | ////////// | ////////// | 12 |
| 13 | OTHER (specify) | | | | | ////////// | ////////// | ////////// | 13 |
| 14 | Cost Reporting Period (mm/dd/yyyy) | | | FROM: 01/01/2023 | | TO: 12/31/2023 | | | 14 |
| 15 | Type of Control | 5 | | | | | | | 15 |

| | | | |
|---|---|---|---|
| **Type of Freestanding Skilled Nursing Facility** | | Y / N | |
| 16 | Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5? | Y | 16 |
| 17 | Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5? | N | 17 |
| 18 | Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10? If yes, complete Worksheet A-8-1. | Y | 18 |
| Miscellaneous Cost Reporting information | | | |
| 19 | Is this a low Medicare utilization cost report, enter "Y" for yes, or "N" for no. | N | 19 |
| 19.01 | If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N) | | 19.01 |

**Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20-22.**

| | | | | |
|---|---|---|---|---|
| 20 | Straight Line | 402,000 | ////////// | 20 |
| 21 | Declining Balance | | ////////// | 21 |
| 22 | Sum of the Year's Digits | | ////////// | 22 |
| 23 | Sum of line 20 through 22 | 402,000 | ////////// | 23 |
| 24 | If depreciation is funded, enter the balance as of the end of the period. | | | 24 |
| 25 | Were there any disposal of capital assets during the cost reporting period? (Y/N) | | N | 25 |
| 26 | Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N) | | N | 26 |
| 27 | Did you cease to participate in the Medicare program at end of the period to which this cost report applies | | N | 27 |
| 28 | Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports | | N | 28 |

| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX | PROVIDER CCN: | PERIOD | WORKSHEET S-2 |
|---|---|---|---|
| | | FROM: 01/01/2023 | PART I (Cont.) |
| IDENTIFICATION DATA | 31-5174 | TO: 12/31/2023 | |

If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges enter "Y" for each component and type of service that qualifies for the exemption.

| | | Part A | Part B | Other | |
|---|---|---|---|---|---|
| 29 | Skilled Nursing Facility | N | N | | 29 |
| 30 | Nursing Facility | | | | 30 |
| 31 | I C F / I I D | | | | 31 |
| 32 | SNF-Based HHA | | | | 32 |
| 33 | SNF-Based RHC | | | | 33 |
| 34 | SNF-Based FQHC | | | | 34 |
| 35 | SNF-Based CMHC | | N | | 35 |
| 36 | SNF-Based OLTC | | | | 36 |

| | | Y / N | |
|---|---|---|---|
| 37 | Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients. | N | 37 |
| 38 | Are you legally-required to carry malpractice insurance? | Y | 38 |
| 39 | Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-made" enter 1. If policy is "occurence", enter 2. | 1 | 39 |

| | | Premiums | Paid Losses | Self insurance | |
|---|---|---|---|---|---|
| 41 | List malpractice premiums and paid losses: | 483,923 | | | 41 |

| | | Y / N | |
|---|---|---|---|
| | Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? | | |
| 42 | Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts. | N | 42 |
| 43 | Are there home office costs as defined in CMS Pub. 15-1, chapter 10? | N | 43 |
| 44 | If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1. | | 44 |

If this facility is part of a chain organization, enter the name and address of the home office on the lines below

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 45 | Name: | | Contractor name | | Contractor Number | | | 45 |
| 46 | Street: | | PO Box | | | | | 46 |
| 47 | City: | | State: | | Zip Code: | | | 47 |

MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10

| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET S-2 Part II |
|---|---|---|---|

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No
For all the dates responses the format will be (mm/dd/yyyy)

Completed by All Skilled Nursing Facilities

| | Provider Organization and Operation | 1 Y/N | 2 Date | | |
|---|---|---|---|---|---|
| 1 | Has the Provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions) | N | | //////////// //////////// | 1 |
| | | 1 Y/N | 2 Date | 3 V / I | |
| 2 | Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary | N | | | 2 |
| 3 | Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) | Y | //////////// | //////////// | 3 |
| | Financial Data and Reports | 1 Y/N | 2 Type | 3 Date | |
| 4 | Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. | Y | C | | 4 |
| 5 | Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation. | N | //////////// | //////////// | 5 |
| | Approved Educational Activities | | 1 Y/N | 2 Legal Oper. | |
| 6 | Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N) | | N | N | 6 |
| 7 | Were costs claimed for Allied Health Programs? (Y/N) see instructions. | | N | //////////// | 7 |
| 8 | Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions. | | N | //////////// | 8 |
| | Bad Debts | | | 1 Y/N | |
| 9 | Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. | | | Y | 9 |
| 10 | If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy. | | | N | 10 |
| 11 | If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. | | | N | 11 |
| | Bed Complement | | | | |
| 12 | Have total beds available changed from prior cost reporting period? If "Y", see instructions. | | | N | 12 |

| | PS&R Data | 1 Y/N Part A | 2 Date Part A | 3 Y/N Part B | 4 Date Part B | |
|---|---|---|---|---|---|---|
| 13 | Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4 .(see Instructions.) | Y | 04/12/2024 | Y | 04/12/2024 | 13 |
| 14 | Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. | N | | N | | 14 |
| 15 | If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. | N | //////////// | N | //////////// | 15 |
| 16 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions. | N | //////////// | N | //////////// | 16 |
| 17 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:_____ | N | //////////// | N | //////////// | 17 |
| 18 | Was the cost report prepared only using the provider's records? If "Y" see Instructions. | N | //////////// | N | //////////// | 18 |

COST REPORT PREPARER CONTACT INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 19 | First name | Abi | Last name | Goldenberg | Title | Partner | 19 |
| 20 | Employer | Martin Friedman CPA, PC | | | | | 20 |
| 21 | Phone number | 7183386900 | | Email address | agoldenberg@mfandco.com | | 21 |

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

PROVIDER CCN: 31-5174

PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET S-3 PART I

| | Component | | Number of Beds | Bed Days Available | | Inpatient Days / Visits: Title V | Title XVIII | Title XIX | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | | 3 | 4 | 5 | 6 | 7 |
| 1 | Skilled Nursing Facility | | 240 | 87,600 | | | 4,985 | 64,408 | 3,789 | 73,182 |
| 2 | Nursing Facility | | | | | | | | | 0 |
| 3 | ICF/IID | | | | | | | | | 0 |
| 4 | Home Health Agency | | | | | | | | | 0 |
| 5 | Other Long Term Care | | | | | | | | | 0 |
| 6 | SNF-Based CMHC | | | | | | | | | |
| 7 | Hospice | | | | | | | | | 0 |
| 8 | TOTAL (Sum Lines 1-7) | | 240 | 87,600 | | | 4,985 | 64,408 | 3,789 | 73,182 |

| | Component | Discharges: Title V | Title XVIII | Title XIX | Other | Total | Average Length of Stay: Title V | Title XVIII | Title XIX | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 1 | Skilled Nursing Facility | | 69 | 336 | 116 | 521 | | 72.25 | 191.69 | 140.46 |
| 2 | Nursing Facility | | | | | 0 | | | 0.00 | 0.00 |
| 3 | ICF/IID | | | | | 0 | | | 0.00 | 0.00 |
| 4 | Home Health Agency | | | | | | | | | |
| 5 | Other Long Term Care | | | | | 0 | | | | 0.00 |
| 6 | SNF-Based CMHC | | | | | | | | | |
| 7 | Hospice | | | | | 0 | | 0.00 | 0.00 | 0.00 |
| 8 | TOTAL (Sum Lines 1-7) | | 69 | 336 | 116 | 521 | | 72.25 | 191.69 | 140.46 |

| | Component | | Admissions: Title V | Title XVIII | Title XIX | Other | Total | | Full Time Equivalent: Employees on Payroll | Nonpaid Workers |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 17 | 18 | 19 | 20 | 21 | | 22 | 23 |
| 1 | Skilled Nursing Facility | | | 112 | 275 | 129 | 516 | | 144.33 | |
| 2 | Nursing Facility | | | | | | 0 | | | |
| 3 | ICF/IID | | | | | | 0 | | | |
| 4 | Home Health Agency | | | | | | | | | |
| 5 | Other Long Term Care | | | | | | 0 | | | |
| 6 | SNF-Based CMHC | | | | | | | | | |
| 7 | Hospice | | | | | | 0 | | | |
| 8 | TOTAL (Sum Lines 1-7) | | | 112 | 275 | 129 | 516 | | 144.33 | 0.00 |

SNF WAGE INDEX INFORMATION | **PROVIDER CCN:** 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET S-3 PARTS II & III**

| | **PART II DIRECT SALARIES** | Amount Reported | Reclass.of Salaries from Wkst A-6 | Adjusted Salaries | Paid Hrs Related to col.3 | Average Hrly Wage | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | Total salary (See Instructions) | 6,838,113 | 0 | 6,838,113 | 300,199.64 | 22.78 | 1 |
| 2 | Physician salaries-Part A | | | 0 | | 0.00 | 2 |
| 3 | Physician salaries-Part B | | | 0 | | 0.00 | 3 |
| 4 | Home office personnel | | | 0 | | 0.00 | 4 |
| 5 | Sum of lines 2 thru 4 | 0 | 0 | 0 | 0.00 | 0.00 | 5 |
| 6 | Revised wages (line 1 minus line 5) | 6,838,113 | 0 | 6,838,113 | 300,199.64 | 22.78 | 6 |
| 7 | Other Long Term Care | 0 | 0 | 0 | | 0.00 | 7 |
| 8 | HHA | 0 | 0 | 0 | | 0.00 | 8 |
| 9 | CMHC | 0 | 0 | 0 | | 0.00 | 9 |
| 10 | Hospice | 0 | 0 | 0 | | 0.00 | 10 |
| 11 | Other excluded areas | 0 | 0 | 0 | | 0.00 | 11 |
| 12 | Subtotal Excluded salary (Sum of lines 7-11) | 0 | 0 | 0 | 0.00 | 0.00 | 12 |
| 13 | Total Adjusted Salaries (line 6 minus line | 6,838,113 | 0 | 6,838,113 | 300,199.64 | 22.78 | 13 |
| | OTHER WAGES AND RELATED COSTS | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | |
| 14 | Contract Labor: Patient Related & Mgmt | 5,149,588 | | 5,149,588 | 88,117.91 | 58.44 | 14 |
| 15 | Contract Labor: Physician services-Part A | | | 0 | | 0.00 | 15 |
| 16 | Home office salaries & wage related costs | | | 0 | | 0.00 | 16 |
| | WAGE RELATED COSTS | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | |
| 17 | Wage related costs core. (See Part IV) | 1,145,909 | | 1,145,909 | //////////////////////// | //////////////////////// | 17 |
| 18 | Wage related costs other (See Part IV) | 0 | | 0 | //////////////////////// | //////////////////////// | 18 |
| 19 | Wage related costs (excluded units) | | | 0 | //////////////////////// | //////////////////////// | 19 |
| 20 | Physicians Part A - WRC | | | 0 | //////////////////////// | //////////////////////// | 20 |
| 21 | Physicians Part B - WRC | | | 0 | //////////////////////// | //////////////////////// | 21 |
| 22 | Total Adj. Wage Related costs (see instructior | 1,145,909 | 0 | 1,145,909 | //////////////////////// | //////////////////////// | 22 |

| | **PART III - OVERHEAD COST - DIRECT SALARIES** | Amount Reported | Reclass. of Salaries from Wkst. A-6 | Adjusted Salaries (col. 1 ± col. 2) | Paid Hours Related to Salary in col. 3 | Average Hourly Wage (col. 3 ÷ col. 4) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | Employee Benefits | 0 | 0 | 0 | | 0.00 | 1 |
| 2 | Administrative & General | 149,420 | 0 | 149,420 | 7,278.52 | 20.53 | 2 |
| 3 | Plant Operation, Maintenance & Repairs | 207,112 | 0 | 207,112 | 8,876.98 | 23.33 | 3 |
| 4 | Laundry & Linen Service | 48,043 | 0 | 48,043 | 3,253.08 | 14.77 | 4 |
| 5 | Housekeeping | 610,437 | 0 | 610,437 | 37,904.89 | 16.10 | 5 |
| 6 | Dietary | 933,289 | 0 | 933,289 | 48,934.38 | 19.07 | 6 |
| 7 | Nursing Administration | 1,234,337 | 0 | 1,234,337 | 29,884.11 | 41.30 | 7 |
| 8 | Central Services and Supply | 34,618 | 0 | 34,618 | 2,076.54 | 16.67 | 8 |
| 9 | Pharmacy | 0 | 0 | 0 | | 0.00 | 9 |
| 10 | Medical Records & Medical Records Library | 31,346 | 0 | 31,346 | 1,954.25 | 16.04 | 10 |
| 11 | Social Service | 173,247 | 0 | 173,247 | 6,629.64 | 26.13 | 11 |
| 12 | Nursing and Allied Health Education Activities | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | 12 |
| 13 | Other General Service Cost | 249,073 | 0 | 249,073 | 13,317.35 | 18.70 | 13 |
| 14 | Total (sum lines 1 thru 13) | 3,670,922 | 0 | 3,670,922 | 160,109.74 | **22.93** | 14 |

| **SNF WAGE RELATED COSTS** | **PROVIDER CCN:** **31-5174** | **PERIOD:** **FROM: 01/01/2023** **TO: 12/31/2023** | **WORKSHEET** **S-3** **PART IV** |
|---|---|---|---|

**PART IV - Wage Related Cost**

**Part A - Core List**

| | | Amount Reported | |
|---|---|---|---|
| | **RETIREMENT COST** | | |
| 1 | 401K Employer Contributions | | 1 |
| 2 | Tax Sheltered Annuity (TSA) Employer Contribution | | 2 |
| 3 | Qualified and Non-Qualified Pension Plan Cost | 29,421 | 3 |
| 4 | Prior Year Pension Service Cost | | 4 |
| | **PLAN ADMINISTRATIVE COSTS (Paid to External Organization):** | | |
| 5 | 401K/TSA Plan Administration fees | | 5 |
| 6 | Legal/Accounting/Management Fees-Pension Plan | | 6 |
| 7 | Employee Managed Care Program Administration Fees | | 7 |
| | **HEALTH AND INSURANCE COST** | | |
| 8 | Health Insurance (Purchased or Self Funded) | 267,102 | 8 |
| 9 | Prescription Drug Plan | | 9 |
| 10 | Dental, Hearing and Vision Plan | | 10 |
| 11 | Life Insurance (If employee is owner or beneficiary) | | 11 |
| 12 | Accidental Insurance (If employee is owner or beneficiary) | | 12 |
| 13 | Disability Insurance (If employee is owner or beneficiary) | | 13 |
| 14 | Long-Term Care Insurance (If employee is owner or beneficiary) | | 14 |
| 15 | Workers' Compensation Insurance | 162,992 | 15 |
| 16 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion) | | 16 |
| | **TAXES** | | |
| 17 | FICA-Employers Portion Only | 531,441 | 17 |
| 18 | Medicare Taxes - Employers Portion Only | | 18 |
| 19 | Unemployment Insurance | (301) | 19 |
| 20 | State or Federal Unemployment Taxes | 117,858 | 20 |
| | **OTHER** | | |
| 21 | Executive Deferred Compensation | | 21 |
| 22 | Day Care Cost and Allowances | | 22 |
| 23 | Tuition Reimbursement | 37,396 | 23 |
| 24 | Total Wage Related cost (Sum of lines 1 -23) | 1,145,909 | 24 |

| **Part B Other than Core Related Cost** | | **Amount Reported** | |
|---|---|---|---|
| 25 | | | 25 |

MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10

| SNF REPORTING OF DIRECT CARE EXPENDITURES | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET S-3 PART V |
|---|---|---|---|

| | Occupational Category | Amount Reported | Fringe Benefits | Adjusted Salaries (col. 1 + col. 2) | Paid Hours Related to Salary in col. 3 | Average Hourly Wage (col. 3 ÷ col. 4) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| | **Direct Salaries** | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | ////// |
| | **Nursing Occupations** | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | ////// |
| 1 | Registered Nurses (RNs) | 243,212 | 40,757 | 283,969 | 8,738.98 | 32.49 | 1 |
| 2 | Licensed Practical Nurses (LPNs) | 412,850 | 69,184 | 482,034 | 11,608.73 | 41.52 | 2 |
| 3 | Certified Nursing Assistants/Nursing Assistants/Aides | 2,180,320 | 365,371 | 2,545,691 | 113,308.27 | 22.47 | 3 |
| 4 | Total Nursing (sum of lines 1 through 3) | 2,836,382 | 475,312 | 3,311,694 | 133,655.98 | 24.78 | 4 |
| 5 | Physical Therapists | | | - | | 0.00 | 5 |
| 6 | Physical Therapy Assistants | 21,381 | 3,583 | 24,964 | 1,187.86 | 21.02 | 6 |
| 7 | Physical Therapy Aides | | | - | | 0.00 | 7 |
| 8 | Occupational Therapists | | | - | | 0.00 | 8 |
| 9 | Occupational Therapy Assistants | | | - | | 0.00 | 9 |
| 10 | Occupational Therapy Aides | | | - | | 0.00 | 10 |
| 11 | Speech Therapists | | | - | | 0.00 | 11 |
| 12 | Respiratory Therapists | | | - | | 0.00 | 12 |
| 13 | Other Medical Staff | | | - | | 0.00 | 13 |
| | **Contract Labor** | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | / |
| | **Nursing Occupations** | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | / |
| 14 | Registered Nurses (RNs) | 413,647 | //////////////////////// | 413,647 | 1,010.10 | 409.51 | 14 |
| 15 | Licensed Practical Nurses (LPNs) | 2,111,300 | //////////////////////// | 2,111,300 | 38,218.02 | 55.24 | 15 |
| 16 | Certified Nursing Assistants/Nursing Assistants/Aides | 1,301,097 | //////////////////////// | 1,301,097 | 24,959.62 | 52.13 | 16 |
| 17 | Total Nursing (sum of lines 14 through 16) | 3,826,044 | //////////////////////// | 3,826,044 | 64,187.74 | 59.61 | 17 |
| 18 | Physical Therapists | 554,202 | //////////////////////// | 554,202 | 10,961.25 | 50.56 | 18 |
| 19 | Physical Therapy Assistants | | //////////////////////// | - | | 0.00 | 19 |
| 20 | Physical Therapy Aides | | //////////////////////// | - | | 0.00 | 20 |
| 21 | Occupational Therapists | 604,158 | //////////////////////// | 604,158 | 10,160.17 | 59.46 | 21 |
| 22 | Occupational Therapy Assistants | | //////////////////////// | - | | 0.00 | 22 |
| 23 | Occupational Therapy Aides | | //////////////////////// | - | | 0.00 | 23 |
| 24 | Speech Therapists | 165,183 | //////////////////////// | 165,183 | 2,808.76 | 58.81 | 24 |
| 25 | Respiratory Therapists | | //////////////////////// | - | | 0.00 | 25 |
| 26 | Other Medical Staff | | //////////////////////// | - | | 0.00 | 26 |

MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET A

| | | COST CENTER (Omit Cents) | SALARIES | OTHER | TOTAL ( Col 1 + Col 2 ) | RECLASSI-FICATIONS Increase/Decrease ( Fr Wkst A-6 ) | RECLASSIFIED TRIAL BALANCE ( Col 3 +/- Col 4 ) | ADJUSTMENTS TO EXPENSES Increase/Decrease ( Fr Wkst A-8 ) | NET EXPENSES FOR COST ALLOCATION ( Col 5 +/- Col 6 ) |
|---|---|---|---|---|---|---|---|---|---|
| A | B | C | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | 0100 | Capital-Related Costs - Building & Fixture | | 5,828,359 | **5,828,359** | 0 | **5,828,359** | 0 | **5,828,359** |
| 2 | 0200 | Capital-Related Costs - Movable Equipment | | 0 | **0** | 0 | **0** | 0 | **0** |
| 3 | 0300 | Employee Benefits | 0 | 1,145,909 | **1,145,909** | 0 | **1,145,909** | 0 | **1,145,909** |
| 4 | 0400 | Administrative and General | 149,420 | 5,413,378 | **5,562,798** | 0 | **5,562,798** | (2,090,992) | **3,471,806** |
| 5 | 0500 | Plant Operation, Maintenance and Repairs | 207,112 | 724,471 | **931,583** | 0 | **931,583** | 0 | **931,583** |
| 6 | 0600 | Laundry and Linen Service | 48,043 | 103,581 | **151,624** | 0 | **151,624** | 0 | **151,624** |
| 7 | 0700 | Housekeeping | 610,437 | 65,512 | **675,949** | 0 | **675,949** | 0 | **675,949** |
| 8 | 0800 | Dietary | 933,289 | 646,779 | **1,580,068** | 0 | **1,580,068** | 0 | **1,580,068** |
| 9 | 0900 | Nursing Administration | 1,234,337 | 25,470 | **1,259,807** | 0 | **1,259,807** | 0 | **1,259,807** |
| 10 | 1000 | Central Services and Supply | 34,618 | 283,503 | **318,121** | 0 | **318,121** | 0 | **318,121** |
| 11 | 1100 | Pharmacy | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 12 | 1200 | Medical Records and Library | 31,346 | 21,454 | **52,800** | 0 | **52,800** | 0 | **52,800** |
| 13 | 1300 | Social Service | 173,247 | 75 | **173,322** | 0 | **173,322** | 0 | **173,322** |
| 14 | 1400 | Nursing and Allied Health Education Activities | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 15 | 1500 | Other General Service Cost | 249,073 | 54,767 | **303,840** | 0 | **303,840** | 0 | **303,840** |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | 3000 | Skilled Nursing Facility | 3,145,796 | 3,973,509 | **7,119,305** | 0 | **7,119,305** | 0 | **7,119,305** |
| 31 | 3100 | Nursing Facility | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 32 | 3200 | ICF/IID | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 33 | 3300 | Other Long Term Care | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 40 | 4000 | Radiology | 0 | 14,522 | **14,522** | 0 | **14,522** | 0 | **14,522** |
| 41 | 4100 | Laboratory | 0 | 104,299 | **104,299** | 0 | **104,299** | 0 | **104,299** |
| 42 | 4200 | Intravenous Therapy | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 43 | 4300 | Oxygen (Inhalation) Therapy | 0 | 32,583 | **32,583** | 0 | **32,583** | 0 | **32,583** |
| 44 | 4400 | Physical Therapy | 21,381 | 554,202 | **575,583** | 0 | **575,583** | 0 | **575,583** |
| 45 | 4500 | Occupational Therapy | 14 | 604,158 | **604,172** | 0 | **604,172** | 0 | **604,172** |
| 46 | 4600 | Speech Pathology | 0 | 165,183 | **165,183** | 0 | **165,183** | 0 | **165,183** |
| 47 | 4700 | Electrocardiology | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 48 | 4800 | Medical Supplies Charged to Patients | 0 | 25,474 | **25,474** | 29,000 | **54,474** | 0 | **54,474** |
| 49 | 4900 | Drugs Charged to Patients | 0 | 269,971 | **269,971** | (29,000) | **240,971** | 0 | **240,971** |
| 50 | 5000 | Dental Care - Title XIX only | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 51 | 5100 | Support Surfaces | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 52 | 5200 | Other Ancillary Service Cost Center | 0 | 0 | **0** | 0 | **0** | 0 | **0** |

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET A

| | | COST CENTER (Omit Cents) | SALARIES | OTHER | TOTAL ( Col 1 + Col 2 ) | RECLASSI-FICATIONS Increase/Decrease ( Fr Wkst A-6 ) | RECLASSIFIED TRIAL BALANCE ( Col 3 +/- Col 4 ) | ADJUSTMENTS TO EXPENSES Increase/Decrease ( Fr Wkst A-8 ) | NET EXPENSES FOR COST ALLOCATION ( Col 5 +/- Col 6 ) |
|---|---|---|---|---|---|---|---|---|---|
| A | B | C | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 52.01 | 5201 | Other Ancillary Service Cost Center II | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 52.02 | 5202 | Other Ancillary Service Cost Center III | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| OUTPATIENT SERVICE COST CENTERS | | | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// |
| 60 | 6000 | Clinic | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 61 | 6100 | Rural Health Clinic | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 62 | 6200 | FQHC | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 63 | 6300 | Other Outpatient Service Cost | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| OTHER REIMBURSABLE COST CENTERS | | | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// |
| 70 | 7000 | Home Health Agency Cost | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 71 | 7100 | Ambulance | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 72 | 7200 | Outpatient Rehabilitation | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 73 | 7300 | CMHC | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 74 | 7400 | Other Reimbursable Cost | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| SPECIAL PURPOSE COST CENTERS | | | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// |
| 80 | 8000 | Malpractice Premiums & Paid Losses | //////////////////////// | 0 | **0** | 0 | **0** | 0 | **-0-** |
| 81 | 8100 | Interest Expense | //////////////////////// | 0 | **0** | 0 | **0** | 0 | **-0-** |
| 82 | 8200 | Utilization Review -- SNF | 0 | 0 | **0** | 0 | **0** | 0 | **-0-** |
| 83 | 8300 | Hospice | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 84 | 8400 | Other Special Purpose Cost I | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 84.01 | 8401 | Other Special Purpose Cost II | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 89 | | SUBTOTALS (sum of lines 1 through 84) | 6,838,113 | 20,057,159 | **26,895,272** | 0 | **26,895,272** | (2,090,992) | **24,804,280** |
| NON REIMBURSABLE COST CENTERS | | | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// |
| 90 | 9000 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 91 | 9100 | Barber and Beauty Shop | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 92 | 9200 | Physicians' Private Offices | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 93 | 9300 | Nonpaid Workers | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 94 | 9400 | Patients Laundry | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 95 | 9500 | Other Nonreimbursable Cost | 0 | 0 | **0** | 0 | **0** | 0 | **0** |
| 100 | | TOTAL | **6,838,113** | **20,057,159** | **26,895,272** | **0** | **26,895,272** | **(2,090,992)** | **24,804,280** |

RECLASSIFICATIONS | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET A-6

| | | INCREASE | | | | | DECREASE | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | EXPLANATION OF RECLASSIFICATION ENTRY | CODE (1) | COST CENTER | LINE NO. | SALARY | NON-SALARY | COST CENTER | LINE NO. | SALARY | NON-SALARY |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1 | | | | | | | | | | |
| 2 | RECLASS MED SUPP | A | Medical Supplies Charged to | 48 | | 29,000 | Drugs Charged to Pati | 49 | | 29,000 |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
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| 69 | | | | | | | | | | |
| 70 | | | | | | | | | | |
| 71 | | | | | | | | | | |
| 72 | | | | | | | | | | |
| 100 | **TOTAL RECLASSIFICATIONS** | ////////// | ////////////////////////////////////// | ////////// | 0 | 29,000 | ////////////////////////////// | ////////// | 0 | 29,000 |

(1) A LETTER (A, B, etc.) MUST BE ENTERED ON EACH LINE TO IDENTIFY EACH RECLASSIFICATION ENTRY.
(2) TRANSFER TO WORKSHEET A, COLUMN 4, LINE AS APPROPRIATE.

| | PROVIDER CCN: | PERIOD: | |
|---|---|---|---|
| | | FROM: 01/01/2023 | WORKSHEET A-7 |
| | 31-5174 | TO: 12/31/2023 | |

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

ASSET BALANCES

| | Description | Beginning Balances | Acquisitions | | | Disposals and Retirements | Ending Balance | Fully Depreciated Assets |
|---|---|---|---|---|---|---|---|---|
| | | | Purchases | Donation | Total | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 1 | Land | | | | **0** | | **0** | |
| 2 | Land Improvements | | | | **0** | | **0** | |
| 3 | Buildings and Fixtures | | | | **0** | | **0** | |
| 4 | Building Improvements | 1,494,545 | 152,750 | | **152,750** | | **1,647,295** | |
| 5 | Fixed Equipment | | | | **0** | | **0** | |
| 6 | Movable Equipment | 2,208,674 | 53,651 | | **53,651** | | **2,262,325** | |
| 7 | Subtotal (sum of lines 1-6) | **3,703,219** | **206,401** | **0** | **206,401** | **0** | **3,909,620** | 0 |
| 8 | Reconciling Items | | | | **0** | | **0** | |
| 9 | Total (line 7 minus line 8) | 3,703,219 | 206,401 | 0 | 206,401 | 0 | 3,909,620 | 0 |

| ADJUSTMENTS TO EXPENSES | PROVIDER CCN 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 |
|---|---|---|

WORKSHEET A-8

| | (1) DESCRIPTION | (2) BASIS* FOR ADJ | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | |
|---|---|---|---|---|---|
| | | | AMOUNT | COST CENTER | LINE # |
| 1 | Investment income on restricted funds (Chapter 2) | B | (287,805) | Administrative and General | 4 |
| 2 | Trade, quantity and time discounts on purchases (Chapter 8) | | | | |
| 3 | Refunds and rebates of expenses (Chapter 8) | | | | |
| 4 | Rental of provider space by suppliers (Chapter 8) | | | | |
| 5 | Telephone services (pay stations excluded) (Chapter 21) | | | | |
| 6 | Television and radio service (Chapter 21) | | | | |
| 7 | Parking lot (Chapter 21) | | | | |
| 8 | Remuneration applicable to provider- | //////////////// | //////////////////// | //////////////////////////////////////////////////////////// | //////////////////// |
| | based physician adjustment | A-8-2 | 0 | //////////////////////////////////////////////////////////// | //////////////////// |
| 9 | Home office costs (Chapter 21) | | | | |
| 10 | Sale of scrap, waste, etc. (Chapter23) | | | | |
| 11 | Nonallowable costs related to certain | //////////////// | //////////////////// | //////////////////////////////////////////////////////////// | //////////////////// |
| | Capital expenditures (Chapter 24) | | | | |
| 12 | Adjustment resulting from transactions | //////////////// | //////////////////// | //////////////////////////////////////////////////////////// | //////////////////// |
| | with related organizations (Chapter 10) | A-8-1 | (13,858) | //////////////////////////////////////////////////////////// | //////////////////// |
| 13 | Laundry and Linen service | | | | |
| 14 | Revenue - Employee meals | | | | |
| 15 | Cost of meals - Guests | | | | |
| 16 | Sale of medical supplies to other than patients | | | | |
| 17 | Sale of drugs to other than patients | | | | |
| 18 | Sale of medical records and abstracts | | | | |
| 19 | Vending machines | | | | |
| 20 | Income from imposition of interest, | //////////////// | //////////////////// | //////////////////////////////////////////////////////////// | //////////////////// |
| | finance or penalty charges (Chapter 21) | | | | |
| 21 | Interest expense on Medicare overpayments | //////////////// | //////////////////// | //////////////////////////////////////////////////////////// | //////////////////// |
| | and borrowings to repay Medicare overpayments | | | | |
| 22 | Utilization review--physicians' compensation (chapter 21) | | | Utilization Review -- SNF | 82 |
| 23 | Depreciation--buildings and fixtures | | | Capital-Related Costs - Building & Fixture | 1 |
| 24 | Depreciation--movable equipment | | | Capital-Related Costs - Moveable Equipment | 2 |
| 25 | Don,Misc,ProAds,Pens | A | (1,789,329) | Administrative and General | 4 |
| 25.01 | | | | | |
| 25.02 | | | | | |
| 25.03 | | | | | |
| 25.04 | | | | | |
| | A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW) | //////////////// | 0 | //////////////////////////////////////////////////////////// | //////////////////// |
| 100 | TOTAL | //////////////// | (2,090,992) | //////////////////////////////////////////////////////////// | //////////////////// |

| ADJUSTMENTS TO EXPENSES | PROVIDER CCN 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 |
|---|---|---|

WORKSHEET A-8

| | (1) DESCRIPTION | (2) BASIS* FOR ADJ | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED AMOUNT | COST CENTER | LINE # |
|---|---|---|---|---|---|
| | **ADDITIONAL ADJUSTMENTS** | | | | |
| 25.05 | | | | | |
| 25.06 | | | | | |
| 25.07 | | | | | |
| 25.08 | | | | | |
| 25.09 | | | | | |
| 25.10 | | | | | |
| 25.11 | | | | | |
| 25.12 | | | | | |
| 25.13 | | | | | |
| 25.14 | | | | | |
| 25.15 | | | | | |
| 25.16 | | | | | |
| 25.17 | | | | | |
| 25.18 | | | | | |
| 25.19 | | | | | |
| 25.20 | | | | | |
| 25.21 | | | | | |
| 25.22 | | | | | |
| 25.23 | | | | | |
| 25.24 | | | | | |
| 25.25 | | | | | |

SUBTOTAL OF ADDITIONAL ADJUSTMENTS 0

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

| STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET A-8-1** |
|---|---|---|---|

PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

| | | Line No. | Cost Center | Expense Items | Amount Allowable In Cost | Amount Included in Wkst. A. , col. 5 | Adjustments (Col 4 minus Col 5) |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 |
| 1 | | 4 | Administrative and General | Software | 181,044 | 194,902 | (13,858) |
| 2 | | | | | | | 0 |
| 3 | | | | | | | 0 |
| 4 | | | | | | | 0 |
| 5 | | | | | | | 0 |
| 6 | | | | | | | 0 |
| 7 | | | | | | | 0 |
| 8 | | | | | | | 0 |
| 9 | | | | | | | 0 |
| 9.01 | | | | | | | 0 |
| 9.02 | | | | | | | 0 |
| 9.03 | | | | | | | 0 |
| 9.04 | | | | | | | 0 |
| 9.05 | | | | | | | 0 |
| 9.06 | | | | | | | 0 |
| 9.07 | | | | | | | 0 |
| 9.08 | | | | | | | 0 |
| 9.09 | | | | | | | 0 |
| 9.10 | | | | | | | 0 |
| **10 TOTAL** | | | | | 181,044 | 194,902 | (13,858) |

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 II 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

| | | | | | Related Organization(s) | | |
|---|---|---|---|---|---|---|---|
| | Description | (1) Symbol | Name | Percentage of Ownership | Name | Percentage of Ownership | Type of Business |
| | | 1 | 2 | 3 | 4 | 5 | 6 |
| 1 | | A | Deptford | 100.00 | BIS Funding Capital | 100.00 | Software |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
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| 9 | | | | | | | |
| 10 | | | | | | | |
| 10.01 | | | | | | | |
| 10.02 | | | | | | | |
| 10.03 | | | | | | | |
| 10.04 | | | | | | | |
| 10.05 | | | | | | | |

(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 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.
G. Other (financial or non-financial) specify

PROVIDER-BASED PHYSICIAN ADJUSTMENTS | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET A-8-2**

| | Wkst A Line No. | Cost Center / Physician Identifier | Total Remuneration | Professional Component | Provider Component | R C E Amount | Physician / Provider Component Hrs | Unadjusted R C E Limit | 5 Percent of Unadjusted R C E Limit |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1 | | | | | | | | 0 | 0 |
| 2 | | | | | | | | 0 | 0 |
| 3 | | | | | | | | 0 | 0 |
| 4 | | | | | | | | 0 | 0 |
| 5 | | | | | | | | 0 | 0 |
| 6 | | | | | | | | 0 | 0 |
| 7 | | | | | | | | 0 | 0 |
| 8 | | | | | | | | 0 | 0 |
| 9 | | | | | | | | 0 | 0 |
| 10 | | | | | | | | 0 | 0 |
| 11 | | | | | | | | 0 | 0 |
| | | | | | | | | | |
| 100 | **TOTAL** | | **0** | **0** | **0** | //////////////////////////// | **0** | **0** | **0** |

| | Wkst A Line No. | Cost Center / Physician Identifier | Cost of Memberships & Continuing Education | Provider Component Share of Col 12 | Physician Cost of Malpractice Insurance | Provider Component Share of Column 14 | Adjusted R C E Limit | R C E Disallowance | Adjustment |
|---|---|---|---|---|---|---|---|---|---|
| | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 1 | | | | 0 | | 0 | 0 | 0 | **0** |
| 2 | | | | 0 | | 0 | 0 | 0 | **0** |
| 3 | | | | 0 | | 0 | 0 | 0 | **0** |
| 4 | | | | 0 | | 0 | 0 | 0 | **0** |
| 5 | | | | 0 | | 0 | 0 | 0 | **0** |
| 6 | | | | 0 | | 0 | 0 | 0 | **0** |
| 7 | | | | 0 | | 0 | 0 | 0 | **0** |
| 8 | | | | 0 | | 0 | 0 | 0 | **0** |
| 9 | | | | 0 | | 0 | 0 | 0 | **0** |
| 10 | | | | 0 | | 0 | 0 | 0 | **0** |
| 11 | | | | 0 | | 0 | 0 | 0 | **0** |
| | | | | | | | | | |
| 100 | **TOTAL** | | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5174

PERIOD:
FROM: 01/01/2023
TO: 12/31/2023

**WORKSHEET B**
**PART I**

| | COST CENTER | NET EXPENSES FOR COST ALLOCATION | CAP.REL. BLDGS & FIXTURES | CAP.REL. MOVABLE EQUIPMENT | EMPLOYEE BENEFITS | SUBTOTAL | OTHER ADMIN & GENERAL | PLANT OP. MAINT & REPAIRS | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 3a | 4.00 | 5 | 6 | 7 | 8 |
| GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital-Related Costs - Building & Fixture | 5,828,359 | 5,828,359 | | | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | 0 | ////////////////////// | 0 | | | | | | | |
| 3 | Employee Benefits | 1,145,909 | 0 | 0 | 1,145,909 | | | | | | |
| 4 | Administrative and General | 3,471,806 | 0 | 0 | 25,039 | 3,496,845 | 3,496,845 | | | | |
| 5 | Plant Operation, Maintenance and Repairs | 931,583 | 0 | 0 | 34,707 | 966,290 | 158,582 | 1,124,872 | | | |
| 6 | Laundry and Linen Service | 151,624 | 0 | 0 | 8,051 | 159,675 | 26,205 | 0 | 185,880 | | |
| 7 | Housekeeping | 675,949 | 0 | 0 | 102,295 | 778,244 | 127,721 | 0 | 0 | 905,965 | |
| 8 | Dietary | 1,580,068 | 0 | 0 | 156,398 | 1,736,466 | 284,978 | 0 | 0 | 0 | 2,021,444 |
| 9 | Nursing Administration | 1,259,807 | 0 | 0 | 206,846 | 1,466,653 | 240,698 | 0 | 0 | 0 | 0 |
| 10 | Central Services and Supply | 318,121 | 0 | 0 | 5,801 | 323,922 | 53,160 | 0 | 0 | 0 | 0 |
| 11 | Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 12 | Medical Records and Library | 52,800 | 0 | 0 | 5,253 | 58,053 | 9,527 | 0 | 0 | 0 | 0 |
| 13 | Social Service | 173,322 | 0 | 0 | 29,032 | 202,354 | 33,209 | 0 | 0 | 0 | 0 |
| 14 | Nursing and Allied Health Education Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 15 | Other General Service Cost | 303,840 | 0 | 0 | 41,739 | 345,579 | 56,714 | 0 | 0 | 0 | 0 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Skilled Nursing Facility | 7,119,305 | 5,828,359 | 0 | 527,163 | 13,474,827 | 2,211,406 | 1,124,872 | 185,880 | 905,965 | 2,021,444 |
| 31 | Nursing Facility | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 32 | ICF/IID | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 33 | Other Long Term Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | |
| 40 | Radiology | 14,522 | 0 | 0 | 0 | 14,522 | 2,383 | 0 | 0 | 0 | 0 |
| 41 | Laboratory | 104,299 | 0 | 0 | 0 | 104,299 | 17,117 | 0 | 0 | 0 | 0 |
| 42 | Intravenous Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 43 | Oxygen (Inhalation) Therapy | 32,583 | 0 | 0 | 0 | 32,583 | 5,347 | 0 | 0 | 0 | 0 |
| 44 | Physical Therapy | 575,583 | 0 | 0 | 3,583 | 579,166 | 95,049 | 0 | 0 | 0 | 0 |
| 45 | Occupational Therapy | 604,172 | 0 | 0 | 2 | 604,174 | 99,153 | 0 | 0 | 0 | 0 |
| 46 | Speech Pathology | 165,183 | 0 | 0 | 0 | 165,183 | 27,109 | 0 | 0 | 0 | 0 |
| 47 | Electrocardiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 48 | Medical Supplies Charged to Patients | 54,474 | 0 | 0 | 0 | 54,474 | 8,940 | 0 | 0 | 0 | 0 |
| 49 | Drugs Charged to Patients | 240,971 | 0 | 0 | 0 | 240,971 | 39,547 | 0 | 0 | 0 | 0 |
| 50 | Dental Care - Title XIX only | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 51 | Support Surfaces | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 52 | Other Ancillary Service Cost Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5174

PERIOD:
FROM: 01/01/2023
TO: 12/31/2023

**WORKSHEET B**
**PART I**

| | COST CENTER | NET EXPENSES FOR COST ALLOCATION | CAP.REL. BLDGS & FIXTURES | CAP.REL. MOVABLE EQUIPMENT | EMPLOYEE BENEFITS | SUBTOTAL | OTHER ADMIN & GENERAL | PLANT OP. MAINT & REPAIRS | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 3a | 4.00 | 5 | 6 | 7 | 8 |
| 52.01 | Other Ancillary Service Cost Center II | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 52.02 | Other Ancillary Service Cost Center III | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | |
| 60 | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| 61 | Rural Health Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 62 | FQHC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 63 | Other Outpatient Service Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 70 | Home Health Agency Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 71 | Ambulance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 72 | Outpatient Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 73 | CMHC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 74 | Other Reimbursable Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | | | |
| 83 | Hospice | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 84 | Other Special Purpose Cost I | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 84.01 | Other Special Purpose Cost II | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 89 | SUBTOTALS (sum of lines 1 through 84) | 24,804,280 | 5,828,359 | 0 | 1,145,909 | 24,804,280 | 3,496,845 | 1,124,872 | 185,880 | 905,965 | 2,021,444 |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 91 | Barber and Beauty Shop | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 92 | Physicians' Private Offices | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 93 | Nonpaid Workers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 94 | Patients Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 95 | Other Nonreimbursable Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 98 | Cross Foot Adjustments | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// |
| 99 | Negative Cost Center | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 100 | TOTAL | 24,804,280 | 5,828,359 | 0 | 1,145,909 | 24,804,280 | 3,496,845 | 1,124,872 | 185,880 | 905,965 | 2,021,444 |

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5174

PERIOD:
FROM: 01/01/2023
TO: 12/31/2023

WORKSHEET B
PART I
(cont.)

| | COST CENTER | NURSING ADMIN. | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | NURSING & ALLIED HEALTH | OTHER GEN. SERVICE | SUBTOTAL | POST STEPDOWN ADJUSTMENTS | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital-Related Costs - Building & Fixture | | | | | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | | | | | | | | | | |
| 3 | Employee Benefits | | | | | | | | | | |
| 4 | Administrative and General | | | | | | | | | | |
| 5 | Plant Operation, Maintenance and Repairs | | | | | | | | | | |
| 6 | Laundry and Linen Service | | | | | | | | | | |
| 7 | Housekeeping | | | | | | | | | | |
| 8 | Dietary | | | | | | | | | | |
| 9 | Nursing Administration | 1,707,351 | | | | | | | | | |
| 10 | Central Services and Supply | 0 | 377,082 | | | | | | | | |
| 11 | Pharmacy | 0 | 0 | 0 | | | | | | | |
| 12 | Medical Records and Library | 0 | 0 | 0 | 67,580 | | | | | | |
| 13 | Social Service | 0 | 0 | 0 | 0 | 235,563 | | | | | |
| 14 | Nursing and Allied Health Education Activities | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| 15 | Other General Service Cost | 0 | 0 | 0 | 0 | 0 | 0 | 402,293 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Skilled Nursing Facility | 1,707,351 | 377,082 | 0 | 67,580 | 235,563 | 0 | 402,293 | 22,714,263 | 0 | 22,714,263 |
| 31 | Nursing Facility | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 32 | ICF/IID | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 33 | Other Long Term Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | |
| 40 | Radiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 16,905 | 0 | 16,905 |
| 41 | Laboratory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 121,416 | 0 | 121,416 |
| 42 | Intravenous Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 43 | Oxygen (Inhalation) Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 37,930 | 0 | 37,930 |
| 44 | Physical Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 674,215 | 0 | 674,215 |
| 45 | Occupational Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 703,327 | 0 | 703,327 |
| 46 | Speech Pathology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 192,292 | 0 | 192,292 |
| 47 | Electrocardiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 48 | Medical Supplies Charged to Patients | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 63,414 | 0 | 63,414 |
| 49 | Drugs Charged to Patients | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 280,518 | 0 | 280,518 |
| 50 | Dental Care - Title XIX only | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 51 | Support Surfaces | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 52 | Other Ancillary Service Cost Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5174

PERIOD:
FROM: 01/01/2023
TO: 12/31/2023

WORKSHEET B
PART I
(cont.)

| | COST CENTER | NURSING ADMIN. | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | NURSING & ALLIED HEALTH | OTHER GEN. SERVICE | SUBTOTAL | POST STEPDOWN ADJUSTMENTS | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 52.01 | Other Ancillary Service Cost Center II | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 52.02 | Other Ancillary Service Cost Center III | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | |
| 60 | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 61 | Rural Health Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 62 | FQHC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 63 | Other Outpatient Service Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | 0 | | |
| 70 | Home Health Agency Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 71 | Ambulance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 72 | Outpatient Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 73 | CMHC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 74 | Other Reimbursable Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | | | |
| 83 | Hospice | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 84 | Other Special Purpose Cost I | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 84.01 | Other Special Purpose Cost II | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 89 | SUBTOTALS (sum of lines 1 through 84) | 1,707,351 | 377,082 | 0 | 67,580 | 235,563 | 0 | 402,293 | 24,804,280 | 0 | 24,804,280 |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 91 | Barber and Beauty Shop | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 92 | Physicians' Private Offices | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 93 | Nonpaid Workers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 94 | Patients Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 95 | Other Nonreimbursable Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 98 | Cross Foot Adjustments | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// |
| 99 | Negative Cost Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| 100 | TOTAL | 1,707,351 | 377,082 | 0 | 67,580 | 235,563 | 0 | 402,293 | 24,804,280 | 0 | 24,804,280 |

ALLOCATION OF CAPITAL-RELATED COSTS | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | PROVIDER CCN: 31-5174 | **WORKSHEET B PART II**

| | COST CENTER | DIRECTLY ASSIGNED | CAP.REL. BLDGS & FIXTURES | CAP.REL. MOVABLE EQUIPMENT | SUBTOTAL | EMPLOYEE BENEFITS | ADMIN & GENERAL | PLANT OP. MAINT & REPAIRS | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 2a | 3 | 4 | 5 | 6 | 7 | |
| GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital-Related Costs - Building & Fixture | //////////////////// | //////////////////// | //////////////////// | //////////////////// | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | //////////////////// | //////////////////// | //////////////////// | //////////////////// | | | | | | |
| 3 | Employee Benefits | | 0 | 0 | 0 | 0 | | | | | |
| 4 | Administrative and General | | 0 | 0 | 0 | 0 | 0 | | | | |
| 5 | Plant Operation, Maintenance and Repairs | | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| 6 | Laundry and Linen Service | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| 7 | Housekeeping | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 8 | Dietary | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 9 | Nursing Administration | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 10 | Central Services and Supply | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 11 | Pharmacy | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 12 | Medical Records and Library | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 13 | Social Service | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 14 | Nursing and Allied Health Education Activities | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 15 | Other General Service Cost | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Skilled Nursing Facility | | 5,828,359 | 0 | 5,828,359 | 0 | 0 | 0 | 0 | 0 | |
| 31 | Nursing Facility | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 32 | ICF/IID | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 33 | Other Long Term Care | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | |
| 40 | Radiology | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 41 | Laboratory | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 42 | Intravenous Therapy | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 43 | Oxygen (Inhalation) Therapy | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 44 | Physical Therapy | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 45 | Occupational Therapy | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 46 | Speech Pathology | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 47 | Electrocardiology | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 48 | Medical Supplies Charged to Patients | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 49 | Drugs Charged to Patients | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 50 | Dental Care - Title XIX only | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 51 | Support Surfaces | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52 | Other Ancillary Service Cost Center | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52.01 | Other Ancillary Service Cost Center II | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

ALLOCATION OF CAPITAL-RELATED COSTS | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | PROVIDER CCN: 31-5174 | **WORKSHEET B PART II**

| | COST CENTER | DIRECTLY ASSIGNED | CAP.REL. BLDGS & FIXTURES | CAP.REL. MOVABLE EQUIPMENT | SUBTOTAL | EMPLOYEE BENEFITS | ADMIN & GENERAL | PLANT OP. MAINT & REPAIRS | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 2a | 3 | 4 | 5 | 6 | 7 | |
| 52.02 | Other Ancillary Service Cost Center III | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | |
| 60 | Clinic | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 61 | Rural Health Clinic | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 62 | FQHC | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 63 | Other Outpatient Service Cost | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 70 | Home Health Agency Cost | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 71 | Ambulance | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 72 | Outpatient Rehabilitation | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 73 | CMHC | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 74 | Other Reimbursable Cost | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | | | |
| 83 | Hospice | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 84 | Other Special Purpose Cost I | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 84.01 | Other Special Purpose Cost II | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 89 | SUBTOTALS (sum of lines 1 through 84) | 0 | 5,828,359 | 0 | 5,828,359 | 0 | 0 | 0 | 0 | 0 | |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 91 | Barber and Beauty Shop | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 92 | Physicians' Private Offices | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 93 | Nonpaid Workers | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 94 | Patients Laundry | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 95 | Other Nonreimbursable Cost | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 98 | Cross Foot Adjustments | | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | ////////// |
| 99 | Negative Cost Center | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 100 | TOTAL | 0 | 5,828,359 | 0 | 5,828,359 | 0 | 0 | 0 | 0 | 0 | |

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5174

PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSH PAF (cont.)

| | COST CENTER | NURSING ADMIN. | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | NURSING & ALLIED HEALTH | OTHER GEN. SERVICE | SUBTOTAL | POST STEPDOWN ADJUSTMENTS | TOT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital-Related Costs - Building & Fixture | | | | | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | | | | | | | | | | |
| 3 | Employee Benefits | | | | | | | | | | |
| 4 | Administrative and General | | | | | | | | | | |
| 5 | Plant Operation, Maintenance and Repairs | | | | | | | | | | |
| 6 | Laundry and Linen Service | | | | | | | | | | |
| 7 | Housekeeping | | | | | | | | | | |
| 8 | Dietary | | | | | | | | | | |
| 9 | Nursing Administration | 0 | | | | | | | | | |
| 10 | Central Services and Supply | 0 | 0 | | | | | | | | |
| 11 | Pharmacy | 0 | 0 | 0 | | | | | | | |
| 12 | Medical Records and Library | 0 | 0 | 0 | 0 | | | | | | |
| 13 | Social Service | 0 | 0 | 0 | 0 | 0 | | | | | |
| 14 | Nursing and Allied Health Education Activities | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| 15 | Other General Service Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Skilled Nursing Facility | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5,828,359 | 0 | 5, |
| 31 | Nursing Facility | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 32 | ICF/IID | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 33 | Other Long Term Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | |
| 40 | Radiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 41 | Laboratory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 42 | Intravenous Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 43 | Oxygen (Inhalation) Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 44 | Physical Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 45 | Occupational Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 46 | Speech Pathology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 47 | Electrocardiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 48 | Medical Supplies Charged to Patients | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 49 | Drugs Charged to Patients | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 50 | Dental Care - Title XIX only | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 51 | Support Surfaces | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52 | Other Ancillary Service Cost Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52.01 | Other Ancillary Service Cost Center II | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

ALLOCATION OF CAPITAL-RELATED COSTS | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSH PAF (cont.)

| | COST CENTER | NURSING ADMIN. | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | NURSING & ALLIED HEALTH | OTHER GEN. SERVICE | SUBTOTAL | POST STEPDOWN ADJUSTMENTS | TOT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 1 |
| 52.02 | Other Ancillary Service Cost Center III | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | |
| 60 | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 61 | Rural Health Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 62 | FQHC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 63 | Other Outpatient Service Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 70 | Home Health Agency Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 71 | Ambulance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 72 | Outpatient Rehabilitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 73 | CMHC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 74 | Other Reimbursable Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | | | |
| 83 | Hospice | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 84 | Other Special Purpose Cost I | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 84.01 | Other Special Purpose Cost II | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 89 | SUBTOTALS (sum of lines 1 through 84) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5,828,359 | 0 | 5, |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 91 | Barber and Beauty Shop | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 92 | Physicians' Private Offices | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 93 | Nonpaid Workers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 94 | Patients Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 95 | Other Nonreimbursable Cost | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 98 | Cross Foot Adjustments | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | //////////////////////// | ////////////// |
| 99 | Negative Cost Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| 100 | TOTAL | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5,828,359 | 0 | 5, |

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-1

| | COST CENTER | | CAP.REL. BLDG/FIX (SQUARE FEET) | CAP.REL. MOV.EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS GROSS SALARIES | RECONCI-LIATION * | ADMIN & GENERAL (ACCUM COST) | PLANT OP. MAINT/REP. (SQUARE FEET) | LNDRY/LIN SERVICE (PATIENT DAYS) | HOUSE-KEEPING (SQUARE FEET) | DIETARY (MEALS SERVED) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4.00a | 4.00 | 5 | 6 | 7 | 8 |
| GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital-Related Costs - Building & Fixture | | 100 | | | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | | | 0 | | | | | | | |
| 3 | Employee Benefits | | | 0 | 6,838,113 | | | | | | |
| 4 | Administrative and General | | | 0 | 149,420 | (3,496,845) | 21,307,435 | | | | |
| 5 | Plant Operation, Maintenance and Repairs | | | 0 | 207,112 | | 966,290 | 100 | | | |
| 6 | Laundry and Linen Service | | | 0 | 48,043 | | 159,675 | 0 | 73,182 | | |
| 7 | Housekeeping | | | 0 | 610,437 | | 778,244 | 0 | | 100 | |
| 8 | Dietary | | | 0 | 933,289 | | 1,736,466 | 0 | | 0 | 219,546 |
| 9 | Nursing Administration | | | 0 | 1,234,337 | | 1,466,653 | 0 | | 0 | |
| 10 | Central Services and Supply | | | 0 | 34,618 | | 323,922 | 0 | | 0 | |
| 11 | Pharmacy | | | 0 | 0 | | 0 | 0 | | 0 | |
| 12 | Medical Records and Library | | | 0 | 31,346 | | 58,053 | 0 | | 0 | |
| 13 | Social Service | | | 0 | 173,247 | | 202,354 | 0 | | 0 | |
| 14 | Nursing and Allied Health Education Activities | | | 0 | 0 | | 0 | 0 | | 0 | |
| 15 | Other General Service Cost | | | 0 | 249,073 | | 345,579 | 0 | | 0 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Skilled Nursing Facility | | 100 | 0 | 3,145,796 | | 13,474,827 | 100 | 73,182 | 100 | 219,546 |
| 31 | Nursing Facility | | | 0 | 0 | | 0 | 0 | 0 | 0 | 0 |
| 32 | ICF/IID | | | 0 | 0 | | 0 | 0 | 0 | 0 | 0 |
| 33 | Other Long Term Care | | | 0 | 0 | | 0 | 0 | 0 | 0 | 0 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | |
| 40 | Radiology | | | 0 | 0 | | 14,522 | 0 | | 0 | |
| 41 | Laboratory | | | 0 | 0 | | 104,299 | 0 | | 0 | |
| 42 | Intravenous Therapy | | | 0 | 0 | | 0 | 0 | | 0 | |
| 43 | Oxygen (Inhalation) Therapy | | | 0 | 0 | | 32,583 | 0 | | 0 | |
| 44 | Physical Therapy | | | 0 | 21,381 | | 579,166 | 0 | | 0 | |
| 45 | Occupational Therapy | | | 0 | 14 | | 604,174 | 0 | | 0 | |
| 46 | Speech Pathology | | | 0 | 0 | | 165,183 | 0 | | 0 | |
| 47 | Electrocardiology | | | 0 | 0 | | 0 | 0 | | 0 | |
| 48 | Medical Supplies Charged to Patients | | | 0 | 0 | | 54,474 | 0 | | 0 | |
| 49 | Drugs Charged to Patients | | | 0 | 0 | | 240,971 | 0 | | 0 | |
| 50 | Dental Care - Title XIX only | | | 0 | 0 | | 0 | 0 | | 0 | |
| 51 | Support Surfaces | | | 0 | 0 | | 0 | 0 | | 0 | |
| 52 | Other Ancillary Service Cost Center | | | 0 | 0 | | 0 | 0 | | 0 | |
| 52.01 | Other Ancillary Service Cost Center II | | | 0 | 0 | | 0 | 0 | | 0 | |
| 52.02 | Other Ancillary Service Cost Center III | | | 0 | 0 | | 0 | 0 | | 0 | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | |

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-1

| | COST CENTER | | CAP.REL. BLDG/FIX (SQUARE FEET) | CAP.REL. MOV.EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS GROSS SALARIES | RECONCI-LIATION * | ADMIN & GENERAL (ACCUM COST) | PLANT OP. MAINT/REP. (SQUARE FEET) | LNDRY/LIN SERVICE (PATIENT DAYS) | HOUSE-KEEPING (SQUARE FEET) | DIETARY (MEALS SERVED) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4.00a | 4.00 | 5 | 6 | 7 | 8 |
| 60 | Clinic | //////////// | | 0 | 0 | | 0 | 0 | | 0 | //////////// |
| 61 | Rural Health Clinic | //////////// | | | | | 0 | | | | |
| 62 | FQHC | //////////// | | | | | 0 | | | | |
| 63 | Other Outpatient Service Cost | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| OTHER REIMBURSABLE COST CENTERS | | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 70 | Home Health Agency Cost | //////////// | | 0 | 0 | | 0 | 0 | 0 | 0 | 0 |
| 71 | Ambulance | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 72 | Outpatient Rehabilitation | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 73 | CMHC | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 74 | Other Reimbursable Cost | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| SPECIAL PURPOSE COST CENTERS | | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 83 | Hospice | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 84 | Other Special Purpose Cost I | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 84.01 | Other Special Purpose Cost II | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 89 | SUBTOTALS (sum of lines 1 through 84) | //////////// | 100 | 0 | 6,838,113 | (3,496,845) | 21,307,435 | 100 | 73,182 | 100 | 219,546 |
| NON REIMBURSABLE COST CENTERS | | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 90 | Gift, Flower, Coffee Shop & Canteen | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 91 | Barber and Beauty Shop | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 92 | Physicians' Private Offices | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 93 | Nonpaid Workers | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 94 | Patients Laundry | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 95 | Other Nonreimbursable Cost | //////////// | | 0 | 0 | | 0 | 0 | | 0 | |
| 98 | Cross Foot Adjustment | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 99 | Negative Cost Center | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 102 | Cost to Be Allocated (Per Worksheet B, Part I) | //////////// | 5,828,359 | 0 | 1,145,909 | //////////// | 3,496,845 | 1,124,872 | 185,880 | 905,965 | 2,021,444 |
| 103 | Unit Cost Multiplier (Worksheet B, Part I) | //////////// | 58283.590000 | 0.000000 | 0.167577 | //////////// | 0.164114 | 11248.720000 | 2.539969 | 9059.650000 | 9.207383 |
| 104 | Cost to Be Allocated (Per Worksheet B, Part II) | //////////// | //////////// | //////////// | 0 | //////////// | 0 | 0 | 0 | 0 | 0 |
| 105 | Unit Cost Multiplier (Worksheet B, Part II) | //////////// | //////////// | //////////// | 0.000000 | //////////// | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 0.000000 |

* may zero out accum.cost stat at col.4 instead of using reconcil.

COST ALLOCATION
STATISTICAL BASIS

PROVIDER CCN: 31-5174

PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET B-1 (cont.)

| | COST CENTER | NURSING ADMIN. (PATIENT DAYS) | CENTRAL SVC & SUPP (PATIENT DAYS) | PHARMACY (COSTED REQUIS.) | MEDICAL REC & LIB (PATIENT DAYS) | SOCIAL SERVICE (PATIENT DAYS) | NURSING & ALLIED HEALTH (ASSIGNED TIME) | OTHER GEN. SERVICE (PATIENT DAYS) | SUBTOTAL | POST STEPDOWN ADJUSTMENTS | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital-Related Costs - Building & Fixture | | | | | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | | | | | | | | | | |
| 3 | Employee Benefits | | | | | | | | | | |
| 4 | Administrative and General | | | | | | | | | | |
| 5 | Plant Operation, Maintenance and Repairs | | | | | | | | | | |
| 6 | Laundry and Linen Service | | | | | | | | | | |
| 7 | Housekeeping | | | | | | | | | | |
| 8 | Dietary | | | | | | | | | | |
| 9 | Nursing Administration | 73,182 | | | | | | | | | |
| 10 | Central Services and Supply | | 73,182 | | | | | | | | |
| 11 | Pharmacy | | | 0 | | | | | | | |
| 12 | Medical Records and Library | | | | 73,182 | | | | | | |
| 13 | Social Service | | | | | 73,182 | | | | | |
| 14 | Nursing and Allied Health Education Activities | | | | | | 0 | | | | |
| 15 | Other General Service Cost | | | | | | | 73,182 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Skilled Nursing Facility | 73,182 | 73,182 | 0 | 73,182 | 73,182 | | 73,182 | | | |
| 31 | Nursing Facility | 0 | 0 | 0 | 0 | 0 | | 0 | | | |
| 32 | ICF/IID | 0 | 0 | 0 | 0 | 0 | | 0 | | | |
| 33 | Other Long Term Care | 0 | 0 | 0 | 0 | 0 | | 0 | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | |
| 40 | Radiology | | | | | | | | | | |
| 41 | Laboratory | | | | | | | | | | |
| 42 | Intravenous Therapy | | | | | | | | | | |
| 43 | Oxygen (Inhalation) Therapy | | | | | | | | | | |
| 44 | Physical Therapy | | | | | | | | | | |
| 45 | Occupational Therapy | | | | | | | | | | |
| 46 | Speech Pathology | | | | | | | | | | |
| 47 | Electrocardiology | | | | | | | | | | |
| 48 | Medical Supplies Charged to Patients | | | | | | | | | | |
| 49 | Drugs Charged to Patients | | | | | | | | | | |
| 50 | Dental Care - Title XIX only | | | | | | | | | | |
| 51 | Support Surfaces | | | | | | | | | | |
| 52 | Other Ancillary Service Cost Center | | | | | | | | | | |
| 52.01 | Other Ancillary Service Cost Center II | | | | | | | | | | |
| 52.02 | Other Ancillary Service Cost Center III | | | | | | | | | | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | |

COST ALLOCATION
STATISTICAL BASIS

PROVIDER CCN: 31-5174

PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET B-1 (cont.)

| | COST CENTER | NURSING ADMIN. (PATIENT DAYS) | CENTRAL SVC & SUPP (PATIENT DAYS) | PHARMACY (COSTED REQUIS.) | MEDICAL REC & LIB (PATIENT DAYS) | SOCIAL SERVICE (PATIENT DAYS) | NURSING & ALLIED HEALTH (ASSIGNED TIME) | OTHER GEN. SERVICE (PATIENT DAYS) | SUBTOTAL | POST STEPDOWN ADJUSTMENTS | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 60 | Clinic | | | | | | | | | | |
| 61 | Rural Health Clinic | | | | | | | | | | |
| 62 | FQHC | | | | | | | | | | |
| 63 | Other Outpatient Service Cost | | | | | | | | | | |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 70 | Home Health Agency Cost | 0 | 0 | 0 | 0 | 0 | | 0 | | | |
| 71 | Ambulance | | | | | | | | | | |
| 72 | Outpatient Rehabilitation | | | | | | | | | | |
| 73 | CMHC | | | | | | | | | | |
| 74 | Other Reimbursable Cost | | | | | | | | | | |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | | | |
| 83 | Hospice | | | | | | | | | | |
| 84 | Other Special Purpose Cost I | | | | | | | | | | |
| 84.01 | Other Special Purpose Cost II | | | | | | | | | | |
| 89 | SUBTOTALS (sum of lines 1 through 84) | 73,182 | 73,182 | 0 | 73,182 | 73,182 | 0 | 73,182 | | | |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | | | | | | | | | | |
| 91 | Barber and Beauty Shop | | | | | | | | | | |
| 92 | Physicians' Private Offices | | | | | | | | | | |
| 93 | Nonpaid Workers | | | | | | | | | | |
| 94 | Patients Laundry | | | | | | | | | | |
| 95 | Other Nonreimbursable Cost | | | | | | | | | | |
| 98 | Cross Foot Adjustment | | | | | | | | | | |
| 99 | Negative Cost Center | | | | | | | | | | |
| 102 | Cost to Be Allocated (Per Worksheet B, Part I) | 1,707,351 | 377,082 | 0 | 67,580 | 235,563 | 0 | 402,293 | | | |
| 103 | Unit Cost Multiplier (Worksheet B, Part I) | 23.330204 | 5.152660 | 0.000000 | 0.923451 | 3.218865 | 0.000000 | 5.497158 | | | |
| 104 | Cost to Be Allocated (Per Worksheet B, Part II) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| 105 | Unit Cost Multiplier (Worksheet B, Part II) | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 0.000000 | | | |

| POST STEP DOWN ADJUSTMENTS | PROVIDER CCN: 31-5174 | PERIOD: **FROM: 01/01/2023 TO: 12/31/2023** | **WORKSHEET B-2** |
|---|---|---|---|

| | DESCRIPTION | WORKSHEET B PART NO. (1 or 2) | LINE NO. | AMOUNT |
|---|---|---|---|---|
| | -1- | -2- | -3- | -4- |
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| | | | | 0 |

| RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | PROVIDER CCN: 31-5174 | PERIOD : FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET C |
|---|---|---|---|

| | Cost Center | TOTAL (From Wkst B, Pt. I, Col. 18) | Total Charges | Ratio (col. 1 divided by col. 2) |
|---|---|---|---|---|
| | | 1 | 2 | 3 |
| ANCILLARY SERVICE COST CENTERS: | | | | |
| 40 | Radiology | 16,905 | 14,522 | 1.164096 |
| 41 | Laboratory | 121,416 | 129,773 | 0.935603 |
| 42 | Intravenous Therapy | 0 | 0 | 0.000000 |
| 43 | Oxygen ( Inhalation ) Therapy | 37,930 | 32,583 | 1.164104 |
| 44 | Physical Therapy | 674,215 | 683,829 | 0.985941 |
| 45 | Occupational Therapy | 703,327 | 775,711 | 0.906687 |
| 46 | Speech Pathology | 192,292 | 335,144 | 0.573759 |
| 47 | Electrocardiology | 0 | 0 | 0.000000 |
| 48 | Medical Supplies Charged | 63,414 | 29,000 | 2.186690 |
| 49 | Drugs Charged to Patients | 280,518 | 253,927 | 1.104719 |
| 50 | Dental Care - Title XIX only | 0 | 0 | 0.000000 |
| 51 | Support Surfaces | 0 | 0 | 0.000000 |
| 52 | Other Ancillary Service Cost Center | 0 | 0 | 0.000000 |
| 52.01 | Other Ancillary Service Cost Center II | 0 | 0 | 0.000000 |
| 52.02 | Other Ancillary Service Cost Center III | 0 | 0 | 0.000000 |
| | | | | |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 60 | Clinic | 0 | 0 | 0.000000 |
| 61 | Rural Health Clinic | 00000000000000000 | 0000000000000000 | 0000000000000000 |
| 62 | FQHC | 00000000000000000 | 0000000000000000 | 0000000000000000 |
| 63 | Other Outpatient Service Cost | 0 | 0 | 0.000000 |
| 71 | Ambulance | 0 | 0 | 0.000000 |
| | | | | |
| 100 | TOTAL | 2,090,017 | 2,254,489 | //////////////////////////////// |

| MED-CALC SYSTEMS | | | In Lieu of CMS Form 2540-10 | | | |
|---|---|---|---|---|---|---|
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST | | | PROVIDER CCN<br>31-5174 | PERIOD :<br>FROM: 01/01/2023<br>TO: 12/31/2023 | WORKSHEET D | |
| Check One: [ ] Title V (1)<br>[ X ] Title XVIII<br>[ ] Title XIX (1) | | Check One: | [ X ] SNF [ ] NF [ ] ICF/IID [ ] Other<br>[ ] PPS - Must also complete Part II | | | |
| PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST | | RATIO OF COST TO CHARGES | HEALTH CARE PROGRAM CHARGES | | HEALTH CARE PROGRAM COST | |
| | | (WS C, col 3) | PART A | PART B | PART A | PART B |
| | | 1 | 2 | 3 | 4 | 5 |
| ANCILLARY SERVICE COST CENTERS: | | | | | | |
| 40 | Radiology | 1.164096 | 0 | | 0 | 0 |
| 41 | Laboratory | 0.935603 | 0 | | 0 | 0 |
| 42 | Intravenous Therapy | 0.000000 | 0 | | 0 | 0 |
| 43 | Oxygen ( Inhalation ) Therapy | 1.164104 | 0 | | 0 | 0 |
| 44 | Physical Therapy | 0.985941 | 222,944 | | 219,810 | 0 |
| 45 | Occupational Therapy | 0.906687 | 244,542 | | 221,723 | 0 |
| 46 | Speech Pathology | 0.573759 | 143,982 | | 82,611 | 0 |
| 47 | Electrocardiology | 0.000000 | 0 | | 0 | 0 |
| 48 | Medical Supplies Charged | 2.186690 | 0 | | 0 | 0 |
| 49 | Drugs Charged to Patients | 1.104719 | 0 | | 0 | 0 |
| 50 | Dental Care - Title XIX only | 0.000000 | //////////////////////////// | //////////////////////////// | 0 | //////////////// |
| 51 | Support Surfaces | 0.000000 | 0 | | 0 | 0 |
| 52 | Other Ancillary Service Cost Center | 0.000000 | 0 | | 0 | 0 |
| 52.01 | Other Ancillary Service Cost Center II | 0.000000 | 0 | | 0 | 0 |
| 52.02 | Other Ancillary Service Cost Center III | 0.000000 | 0 | | 0 | 0 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60 | Clinic | 0.000000 | 0 | | 0 | 0 |
| 61 | Rural Health Clinic | 0.000000 | | | 0 | 0 |
| 62 | FQHC | 0.000000 | | | 0 | 0 |
| 63 | Other Outpatient Service Cost | 0.000000 | 0 | | 0 | 0 |
| 71 | Ambulance | 0.000000 | //////////////////////////// | //////////////////////////// | | |
| | (2) | | | | | |
| 100 | Total (Sum of lines 40 - 71) | | 611,468 | 0 | 524,144 | 0 |

( 1 ) For titles V and XIX use columns 1, 2 and 4 only.

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

| MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10 | | |
|---|---|---|---|
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST | PROVIDER CCN<br>31-5174 | PERIOD :<br>FROM: 01/01/2023<br>TO: 12/31/2023 | WORKSHEET D |

Check One: [ ] Title V (1) [ ] Title XIX (1) [X] Title XVIII

Check One: [X] SNF [ ] NF [ ] ICF/IID [ ] Other [ ] PPS - Must also complete Part II

PART II - APPORTIONMENT OF VACCINE COST

| | | |
|---|---|---|
| 1 | Drugs charged to patients - ratio of cost to charges ( From Worksheet C, column 3, line 49) | 1.104719 |
| 2 | Program vaccine charges ( From your records, or the P S & R.) ---> | 12,956 |
| 3 | Program costs ( Line 1 X line 2) ( Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) | 14,313 |

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

| | | Total Cost (From Worksheet B, Part I, Col 18) | Nursing & Allied Health (From Wkst. B, Part I, Column 14) | Ratio of Nursing & Allied Health Costs To Total Costs - Part A (Col. 2 / Col.. 1) | Program Part A Cost (From Wkst. D. Part I, Col. 4) | Part A ursing & Allie ealth Costs f Pass Through (Col. 3 X Col. |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| ANCILLARY SERVICE COST CENTERS | | //////////////////////////// | //////////////////////////// | //////////////////////////// | //////////////////////////// | ////////////////// |
| 40 | Radiology | 16,905 | 0 | 0.000000 | 0 | 0 |
| 41 | Laboratory | 121,416 | 0 | 0.000000 | 0 | 0 |
| 42 | Intravenous Therapy | 0 | 0 | 0.000000 | 0 | 0 |
| 43 | Oxygen ( Inhalation ) Therapy | 37,930 | 0 | 0.000000 | 0 | 0 |
| 44 | Physical Therapy | 674,215 | 0 | 0.000000 | 219,810 | 0 |
| 45 | Occupational Therapy | 703,327 | 0 | 0.000000 | 221,723 | 0 |
| 46 | Speech Pathology | 192,292 | 0 | 0.000000 | 82,611 | 0 |
| 47 | Electro cardiology | 0 | 0 | 0.000000 | 0 | 0 |
| 48 | Medical Supplies | 63,414 | 0 | 0.000000 | 0 | 0 |
| 49 | Drugs Charged to Patients | 280,518 | 0 | 0.000000 | 0 | 0 |
| 50 | Dental Care - Title XIX only | 0 | 0 | 0.000000 | 0 | 0 |
| 51 | Support Surfaces | 0 | 0 | 0.000000 | 0 | 0 |
| 52 | Other Ancillary Service Cost Center | 0 | 0 | 0.000000 | 0 | 0 |
| 52.01 | Other Ancillary Service Cost Center II | 0 | 0 | 0.000000 | 0 | 0 |
| 52.02 | Other Ancillary Service Cost Center III | 0 | 0 | 0.000000 | 0 | 0 |
| | | | | | | |
| 100 | Total ( Sum of lines 40 - 52) | 2,090,017 | 0 | //////////////////////////// | 524,144 | 0 |

| MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10 | | |
|---|---|---|---|
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST | PROVIDER CCN<br>31-5174 | PERIOD :<br>FROM: 01/01/2023<br>TO: 12/31/2023 | WORKSHEET D |

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

Check One: [ ] Title V (1) [ ] Title XVIII **[ X ] Title XIX (1)**

Check One: [ ] SNF **[ X ] NF** [ ] ICF/IID [ ] Other [ ] PPS - Must also complete Part II

| | PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST | RATIO OF COST TO CHARGES | HEALTH CARE PROGRAM INPATIENT CHARGES | | HEALTH CARE PROGRAM INPATIENT COST | |
|---|---|---|---|---|---|---|
| | | | PART A | PART B | PART A | PART B |
| | | 1 | 2 | 3 | 4 | 5 |
| | ANCILLARY SERVICE COST CENTERS: | ////////// | ////////// | ////////// | ////////// | ////////// |
| 40 | Radiology | 1.164096 | | ////////// | 0 | ////////// |
| 41 | Laboratory | 0.935603 | | ////////// | 0 | ////////// |
| 42 | Intravenous Therapy | 0.000000 | | ////////// | 0 | ////////// |
| 43 | Oxygen ( Inhalation ) Therapy | 1.164104 | | ////////// | 0 | ////////// |
| 44 | Physical Therapy | 0.985941 | | ////////// | 0 | ////////// |
| 45 | Occupational Therapy | 0.906687 | | ////////// | 0 | ////////// |
| 46 | Speech Pathology | 0.573759 | | ////////// | 0 | ////////// |
| 47 | Electro cardiology | 0.000000 | | ////////// | 0 | ////////// |
| 48 | Medical Supplies Charged | 2.186690 | | ////////// | 0 | ////////// |
| 49 | Drugs Charged to Patients | 1.104719 | | ////////// | 0 | ////////// |
| 50 | Dental Care - Title XIX only | 0.000000 | | ////////// | 0 | ////////// |
| 51 | Support Surfaces | 0.000000 | | ////////// | 0 | ////////// |
| 52 | Other Ancillary Service Cost Center | 0.000000 | | ////////// | 0 | ////////// |
| 52.01 | Other Ancillary Service Cost Center II | 0.000000 | | ////////// | 0 | ////////// |
| 52.02 | Other Ancillary Service Cost Center III | 0.000000 | | ////////// | 0 | ////////// |
| | OUTPATIENT SERVICE COST CENTERS | ////////// | ////////// | ////////// | ////////// | ////////// |
| 60 | Clinic | 0.000000 | | ////////// | 0 | ////////// |
| 61 | Rural Health Clinic | 0.000000 | | ////////// | 0 | ////////// |
| 62 | FQHC | 0.000000 | | ////////// | 0 | ////////// |
| 63 | Other Outpatient Service Cost | 0.000000 | | ////////// | 0 | ////////// |
| 71 | Ambulance | 0.000000 | | ////////// | 0 | ////////// |
| | | | | ////////// | | ////////// |
| 100 | Total (Sum of lines 40 - 71) | | **0** | ////////// | **0** | ////////// |

( 1 ) For titles V and XIX use columns 1, 2 and 4 only.
( 2 ) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

| MED-CALC SYSTEMS | In Lieu of CMS Form 2540-10 | | |
|---|---|---|---|
| COMPUTATION OF INPATIENT ROUTINE COSTS | PROVIDER CCN : 31-5174 | PERIOD : FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET D-1 PARTS I & II |
| Check One: | [ ] Title V [ X ] Title XVI [ ] Title XIX | | |
| Check One: | [ X ] SNF [ ] NF [ ] ICF/IID | | |

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

| | | |
|---|---|---|
| 1 | Inpatient days including private room days | 73,182 |
| 2 | Private room days | |
| 3 | Inpatient days including private room days applicable to the Program | 4,985 |
| 4 | Medically necessary private room days applicable to the Program | |
| 5 | Total general inpatient routine service cost | 22,714,263 |
| | | |

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

| | | |
|---|---|---|
| 6 | General inpatient routine service charges | 23,660,768 |
| 7 | General inpatient routine service cost/charge ratio (Line 5 divided by line 6) | 0.959997 |
| 8 | Enter private room charges from your records | |
| 9 | Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) | 0.00 |
| 10 | Enter semi-private room charges from your records | |
| 11 | Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) | 0.00 |
| 12 | Average per diem private room charge differential (Line 9 minus line 11) | 0.00 |
| 13 | Average per diem private room cost differential ( Line 7 times line 12 ) | 0.00 |
| 14 | Private room cost differential adjustment (Line 2 times line 13) | 0 |
| 15 | General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) | 22,714,263 |

PROGRAM INPATIENT ROUTINE SERVICE COSTS

| | | |
|---|---|---|
| 16 | Adjusted general inpatient service cost per diem (Line 15 divided by line 1) | 310.38 |
| 17 | Program routine service cost (Line 3 times line 16) | 1,547,244 |
| 18 | Medically necessary private room cost applicable to program (line 4 times line 13) | 0 |
| 19 | Total program general inpatient routine service cost (Line 17 plus line 18) | 1,547,244 |
| 20 | Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 30 for SNF; line 31 for NF,or line 32 for ICF/MR) | 5,828,359 |
| 21 | Per diem capital related costs (Line 20 divided by line 1) | 79.64 |
| 22 | Program capital related cost (Line 3 times line 21) | 397,005 |
| 23 | Inpatient routine service cost (Line 19 minus line 22) | 1,150,239 |
| 24 | Aggregate charges to beneficiaries for excess costs (From provider records) | |
| 25 | Total program routine service costs for comparison to the cost limitation ( Line 23 minus line 24 ) | 1,150,239 |
| 26 | Enter the per diem limitation (1) | N/A |
| 27 | Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) | N/A |
| 28 | Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) | |
| | (Transfer to Worksheet E, Part II, line 4) (See instructions) | |
| | (1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX | |

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

| | | |
|---|---|---|
| 1 | Total inpatient days | 73,182 |
| 2 | Program inpatient days. (see instructions) | 4,985 |
| 3 | 'Total Nursing & Allied Health costs. ( see instructions) | 0 |
| 4 | Nursing & Allied Health ratio. (Line 2 divided by line 1) | 0.068118 |
| 5 | Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4) | 0 |

| COMPUTATION OF INPATIENT ROUTINE COSTS | PROVIDER CCN : 31-5174 | PERIOD : FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET D-1 PARTS I & II |
|---|---|---|---|
| Check One: | [ ] Title XVIII | **[ X ] Title XIX** | |
| Check One: | **[ X ] NF** | [ ] ICF/IID | |

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

| | | |
|---|---|---|
| 1 | Inpatient days including private room days | 0 |
| 2 | Private room days | |
| 3 | Inpatient days including private room days applicable to the Program | 0 |
| 4 | Medically necessary private room days applicable to the Program | |
| 5 | Total general inpatient routine service cost | 0 |

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

| | | |
|---|---|---|
| 6 | General inpatient routine service charges | |
| 7 | General inpatient routine service cost/charge ratio (Line 5 divided by line 6) | 0.000000 |
| 8 | Enter private room charges from your records | |
| 9 | Average private room per diem charge (Private room charges line 8 divided by private room days, lir | 0.00 |
| 10 | Enter semi-private room charges from your records | |
| 11 | Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-pr | 0.00 |
| 12 | Average per diem private room charge differential (Line 9 minus line 11) | 0.00 |
| 13 | Average per diem private room cost differential ( Line 7 times line 12 ) | 0.00 |
| 14 | Private room cost differential adjustment (Line 2 times line 13) | 0 |
| 15 | General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) | 0 |

PROGRAM INPATIENT ROUTINE SERVICE COSTS

| | | |
|---|---|---|
| 16 | Adjusted general inpatient service cost per diem (Line 15 divided by line 1) | 0.00 |
| 17 | Program routine service cost (Line 3 times line 16) | 0 |
| 18 | Medically necessary private room cost applicable to program (line 4 times line 13) | 0 |
| 19 | Total program general inpatient routine service cost (Line 17 plus line 18) | 0 |
| 20 | Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 30 for SNF; line 31 for NF,or line 32 for ICF/MR) | 0 |
| 21 | Per diem capital related costs (Line 20 divided by line 1) | 0.00 |
| 22 | Program capital related cost (Line 3 times line 21) | 0 |
| 23 | Inpatient routine service cost (Line 19 minus line 22) | 0 |
| 24 | Aggregate charges to beneficiaries for excess costs (From provider records) | |
| 25 | Total program routine service costs for comparison to the cost limitation ( Line 23 minus line 24 ) | 0 |
| 26 | Enter the per diem limitation (1) | |
| 27 | Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) | 0 |
| 28 | Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) | 0 |
| | (Transfer to Worksheet E, Part II, line 4) (See instructions) | |
| | (1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX | |

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

| | | |
|---|---|---|
| 1 | Total inpatient days | |
| 2 | Program inpatient days. (see instructions) | |
| 3 | 'Total Nursing & Allied Health costs. ( see instructions) | |
| 4 | Nursing & Allied Health ratio. (Line 2 divided by line 1) | |
| 5 | Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4) | |

| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII | PROVIDER CCN : 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET E PART I** |
|---|---|---|---|

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

| | | |
|---|---|---|
| 1 | Inpatient PPS amount (See Instructions) | 3,294,038 |
| 2 | Nursing and Allied Health Education Activities (pass through payments) | 0 |
| 3 | Subtotal ( Sum of lines 1 and 2) | 3,294,038 |
| 4 | Primary payor amounts | ( 0 ) |
| 5 | Coinsurance | ( 675,200 ) |
| 6 | Allowable bad debts (from your records) | 460,801 |
| 7 | Allowable Bad debts for dual eligible beneficiaries (see instructions) | 367,149 |
| 8 | Adjusted reimbursable bad debts. (See instructions) | 299,521 |
| 9 | Recovery of bad debts - for statistical records only | |
| 10 | Utilization review | 0 |
| 11 | Subtotal (See instructions) | 2,918,359 |
| 12 | Interim payments (See instructions) | 3,075,840 |
| 13 | Tentative adjustment | |
| 14 | Other Adjustments (See Instructions) | |
| 14.50 | Demonstration payment adjustment amount before sequestration | 0 |
| 14.55 | Demonstration payment adjustment amount after sequestration | 0 |
| 14.75 | Sequestration for non-claims based amounts (see instructions) | 5,990 |
| 14.99 | Sequestration amount (see instructions) | 52,377 |
| 15 | Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14) | **(215,848)** |
| | (Indicate overpayment in parentheses) (See Instructions) | |
| 16 | Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) | |

PART B - ANCILLARY SERVICES COMPUTATION OF REIMBURSEMENT - LESSER OF COST OR CHARGES, TITLE XVIII ONLY

| | | |
|---|---|---|
| 17 | Ancillary services Part B | 0 |
| 18 | Vaccine cost (From Wkst D, Part II, line 3) | 14,313 |
| 19 | Total reasonable costs (Sum of lines 17 and 18) | 14,313 |
| 20 | Medicare Part B ancillary charges (See instructions) | 12,956 |
| 21 | Cost of covered services (Lesser of line 19 or line 20) | 12,956 |
| 22 | Primary payor amounts | ( 0 ) |
| 23 | Coinsurance and deductibles | ( 0 ) |
| 24 | Allowable bad debts (from your records) | |
| 24.01 | Allowable Bad debts for dual eligible beneficiaries (see instructions) | |
| 24.02 | Reimbursable bad debts (see instructions) | 0 |
| 25 | Subtotal (Sum of lines 21 and 24.02, minus lines 22 and 23) | 12,956 |
| 26 | Interim payments (See instructions) | 9,522 |
| 27 | Tentative adjustment | |
| 28 | Other Adjustments (See Instructions) | |
| 28.50 | Demonstration payment adjustment amount before sequestration | 0 |
| 28.55 | Demonstration payment adjustment amount after sequestration | 0 |
| 28.99 | Sequestration amount (see instructions) | 259 |
| 29 | Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28) | **3,175** |
| | (Indicate overpayments in parentheses) (See Instructions) | |
| 30 | Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2 | |

| ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET E-1** |
|---|---|---|---|

| | Description | | | Inpatient Part A | | Part B | |
|---|---|---|---|---|---|---|---|
| | | | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount |
| | | | | 1 | 2 | 3 | 4 |
| 1 | Total interim payments paid to provider | | | ////////// | 2,566,461 | ////////// | 9,522 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero. | | | ////////// | 507,135 | ////////// | |
| 3 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1) | | .01 | 07/19/23 | 2,244 | | |
| | | | .02 | | | | |
| | | Program to | .03 | | | | |
| | | Provider | .04 | | | | |
| | | | .05 | | | | |
| | | | .50 | | | | |
| | | Provider to | .51 | | | | |
| | | Program | .52 | | | | |
| | | * | .53 | | | | |
| | | | .54 | | | | |
| | SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) | | .99 | ////////// | 2,244 | ////////// | 0 |
| 4 | TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) Transfer to Wkst E, Part I line 12 for Part A, and line 26 for Part B.) | | | ////////// | 3,075,840 | ////////// | 9,522 |
| | | | | ////////// | | ////////// | |

TO BE COMPLETED BY CONTRACTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 5 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1) | | .01 | | | | |
| | | Program to | .02 | | | | |
| | | Provider | .03 | | | | |
| | | | .50 | | | | |
| | | Provider to | .51 | | | | |
| | | Program | .52 | | | | |
| | SUBTOTAL (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98) | | .99 | ////////// | | ////////// | |
| 6 | Determine net settlement amount (balance due) based on the cost report. (1) | Program to provider | .01 | | | | |
| | | Provider to program | .50 | | | | |
| 7 | TOTAL MEDICARE PROGRAM LIABILITY (See Instructions) | | | ////////// | | ////////// | |
| 8 | Name of Contractor | Contractor Number | | | | | |

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET E PART II TITLE XIX** |
|---|---|---|---|

Check one: [ ] Title V **[ X ] Title XIX**

Check one: [ ] SNF **[ X ] NF** [ ] ICF/IID

COMPUTATION OF NET COST OF COVERED PART A - INPATIENT SERVICES

| | | |
|---|---|---|
| 1 | Inpatient ancillary services (see Instructions) | 0 |
| 2 | Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) | 0 |
| 3 | Outpatient services | 0 |
| 4 | Inpatient routine services (see instructions) | 0 |
| 5 | Utilization review--physicians' compensation (from provider records) | |
| 6 | Cost of covered services (Sum of lines 1 - 5) | 0 |
| 7 | Differential in charges between semiprivate accommodations and less than semiprivate accommodations | |
| 8 | SUBTOTAL (Line 6 minus line 7) | 0 |
| 9 | Primary payor amounts | |
| 10 | Total Reasonable Cost (Line 8 minus line 9) | 0 |

REASONABLE CHARGES

| | | |
|---|---|---|
| 11 | Inpatient ancillary service charges | 0 |
| 12 | Outpatient service charges | 0 |
| 13 | Inpatient routine service charges | |
| 14 | Differential in charges between semiprivate accommodations and less than semiprivate accommodations | |
| 15 | Total reasonable charges | 0 |

CUSTOMARY CHARGES:

| | | |
|---|---|---|
| 16 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | |
| 17 | Amounts that would have been realized from patients liable for payment for serviceson a charge basis had such payment been made in accordance with 42 CFR 413.13(e) | |
| 18 | Ratio of line 16 to line 17 (not to exceed 1.000000) | 1.000000 |
| 19 | Total customary charges (see instructions) | 0 |

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

| | | |
|---|---|---|
| 20 | Cost of covered services (see Instructions) | 0 |
| 21 | Deductibles | |
| 22 | Subtotal (Line 20 minus line 21) | 0 |
| 23 | Coinsurance | |
| 24 | Subtotal (Line 22 minus line 23) | 0 |
| 25 | Allowable bad debts (from your records) | |
| 26 | Subtotal (sum of lines 24 and 25) | 0 |
| 27 | Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit | |
| 28 | Recovery of excess depreciation resulting from provider termination or a decrease in program utilization | |
| 29 | | |
| 30 | Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( if minus, enter amount in parentheses) | |
| 31 | Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) | 0 |
| 32 | Interim payments | |
| 33 | Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions) | 0 |

| BALANCE SHEET | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET G** |
|---|---|---|---|

ASSETS

| | | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 |
| | CURRENT ASSETS | | | | |
| 1 | Cash on hand and in banks | 8,007,830 | | | |
| 2 | Temporary investments | 0 | | | |
| 3 | Notes receivable | 0 | | | |
| 4 | Accounts receivable | 3,944,966 | | | |
| 5 | Other receivables | 0 | | | |
| 6 | Less: allowances for uncollectible notes and A/R | 0 | | | |
| 7 | Inventory | 0 | | | |
| 8 | Prepaid expenses | 0 | | | |
| 9 | Other current assets | 2,096,466 | | | |
| 10 | Due from other funds | 0 | | | |
| 11 | TOTAL CURRENT ASSETS | 14,049,262 | 0 | 0 | 0 |
| | (Sum of lines 1 - 10) | | | | |
| | FIXED ASSETS | | | | |
| 12 | Land | 0 | | | |
| 13 | Land improvements | 0 | | | |
| 14 | Less: Accumulated depreciation | 0 | | | |
| 15 | Buildings | 0 | | | |
| 16 | Less Accumulated depreciation | 0 | | | |
| 17 | Leasehold improvements | 1,647,295 | | | |
| 18 | Less: Accumulated Amortization | 0 | | | |
| 19 | Fixed equipment | 0 | | | |
| 20 | Less: Accumulated depreciation | 0 | | | |
| 21 | Automobiles and trucks | 0 | | | |
| 22 | Less: Accumulated depreciation | 0 | | | |
| 23 | Major movable equipment | 2,262,325 | | | |
| 24 | Less: Accumulated depreciation | (3,413,145) | | | |
| 25 | Minor equipment - Depreciable | 0 | | | |
| 26 | Minor equipment nondepreciable | 0 | | | |
| 27 | Other fixed assets | 0 | | | |
| 28 | TOTAL FIXED ASSETS | 496,475 | 0 | 0 | 0 |
| | (Sum of lines 12 - 27) | | | | |
| | OTHER ASSETS | | | | |
| 29 | Investments | 0 | | | |
| 30 | Deposits on leases | 0 | | | |
| 31 | Due from owners/officers | 0 | | | |
| 32 | Other assets | 15,298,004 | | | |
| 33 | TOTAL OTHER ASSETS | 15,298,004 | 0 | 0 | 0 |
| | (Sum of lines 29 - 32) | | | | |
| 34 | TOTAL ASSETS | 29,843,741 | 0 | 0 | 0 |
| | (Sum of lines 11, 28 and 33) | | | | |

| BALANCE SHEET | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | | WORKSHEET G (cont'd) |
|---|---|---|---|---|
| LIABILITIES & FUND BALANCES | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND |
| | 1 | 2 | 3 | 4 |
| | CURRENT LIABILITIES | | | |
| 35 | Accounts payable | 1,923,357 | | | |
| 36 | Salaries, wages & fees payable | 259,759 | | | |
| 37 | Payroll taxes payable | 873,365 | | | |
| 38 | Notes & loans payable (Short term) | 0 | | | |
| 39 | Deferred income | 42,429 | | | |
| 40 | Accelerated payments | 0 | //////////////////// | //////////////////// | //////////////////// |
| 41 | Due to other funds | 0 | | | |
| 42 | Other current liabilities | 13,423,438 | | | |
| 43 | TOTAL CURRENT LIABILITIES | 16,522,348 | 0 | 0 | 0 |
| | (Sum of lines 35 - 42) | | | | |
| | LONG TERM LIABILITIES | | | | |
| 44 | Mortgage payable | 15,042,397 | | | |
| 45 | Notes payable | 1,185,050 | | | |
| 46 | Unsecured loans | 0 | | | |
| 47 | Loans from owners: | 0 | | | |
| 48 | Other long term liabilities | 0 | | | |
| 49 | Other (Specify) | 0 | | | |
| 50 | TOTAL LONG TERM LIABILITIES | 16,227,447 | 0 | 0 | 0 |
| | (Sum of lines 44 - 49) | | | | |
| 51 | TOTAL LIABILITIES | 32,749,795 | 0 | 0 | 0 |
| | (Sum of lines 43 and 50) | | | | |
| | CAPITAL ACCOUNTS | | | | |
| 52 | General fund balance | (2,906,054) | //////////////////// | //////////////////// | //////////////////// |
| 53 | Specific purpose fund | //////////////////// | 0 | //////////////////// | //////////////////// |
| 54 | Donor created - EFB restricted | //////////////////// | //////////////////// | 0 | //////////////////// |
| 55 | Donor created - EFB unrestricted | //////////////////// | //////////////////// | 0 | //////////////////// |
| 56 | Governing body created - EFB | //////////////////// | //////////////////// | 0 | //////////////////// |
| 57 | PFB - invested in plant | //////////////////// | //////////////////// | //////////////////// | 0 |
| 58 | PFB - reserve for plant improvement | //////////////////// | //////////////////// | //////////////////// | 0 |
| 59 | TOTAL FUND BALANCES | (2,906,054) | 0 | 0 | 0 |
| | (Sum of lines 52 thru 58) | | | | |
| 60 | TOTAL LIABILITIES & FUND BALANCES | 29,843,741 | 0 | 0 | 0 |
| | (Sum of lines 51 and 59) | | | | |

| STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET G-1 |
|---|---|---|---|

| | | General Fund | | Specific Purpose Fund | | Endowment Fund | | Plant Fund | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 1 | Fund balances at beginning of period | //////////// | 44,693 | //////////// | | //////////// | | //////////// | |
| 2 | Net income (loss) (From Wkst. G-3, line 31) | //////////// | (2,950,747) | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 3 | Total (Sum of line 1 and line 2) | //////////// | (2,906,054) | //////////// | 0 | //////////// | 0 | //////////// | 0 |
| 4 | Additions (Credit adjustments) | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 5 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 6 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 7 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 8 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 9 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 10 | Total additions (Sum of lines 5 - 9) | //////////// | 0 | //////////// | 0 | //////////// | 0 | //////////// | 0 |
| 11 | Subtotal (Line 3 plus line 10) | //////////// | (2,906,054) | //////////// | 0 | //////////// | 0 | //////////// | 0 |
| 12 | Deductions (Debit adjustments) | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// | //////////// |
| 13 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 14 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 15 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 16 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 17 | | | //////////// | | //////////// | | //////////// | | //////////// |
| 18 | Total deductions (Sum of lines 13 - 17) | //////////// | 0 | | 0 | //////////// | 0 | //////////// | 0 |
| 19 | Fund balance at end of period per | //////////// | | //////////// | | //////////// | | //////////// | |
| | balance sheet (Line 11 - line 18) | //////////// | (2,906,054) | //////////// | 0 | //////////// | 0 | //////////// | 0 |

| STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET G-2 PARTS I/II |
|---|---|---|---|

PART I - PATIENT REVENUES

| | REVENUE CENTER | | INPATIENT | OUTPATIENT | TOTAL |
|---|---|---|---|---|---|
| | | | 1 | 2 | 3 |
| GENERAL INPATIENT ROUTINE CARE SERVICES | | | //////////////////////// | //////////////////////// | //////////////////////// |
| 1 | Skilled Nursing Facility | | 23,660,768 | //////////////////////// | 23,660,768 |
| 2 | Nursing facility | | 0 | //////////////////////// | 0 |
| 3 | ICF-IID | | 0 | //////////////////////// | 0 |
| 4 | Other long term care | | 0 | //////////////////////// | 0 |
| 5 | Total general inpatient care services | | 23,660,768 | //////////////////////// | 23,660,768 |
| | (Sum of lines 1 - 4) | | | | |
| ALL OTHER CARE SERVICES | | | | | |
| 6 | Ancillary services | | 2,241,532 | 0 | 2,241,532 |
| 7 | Clinic | | //////////////////////// | 0 | 0 |
| 8 | Home Health Agency | | //////////////////////// | 0 | 0 |
| 9 | Ambulance | | //////////////////////// | 0 | 0 |
| 10 | RHC/FQHC | | //////////////////////// | 0 | 0 |
| 11 | CMHC | | //////////////////////// | 0 | 0 |
| 12 | Hospice | | 0 | 0 | 0 |
| 13 | Other Svc Revenues | | 0 | 0 | 0 |
| 14 | Total Patient Revenues (Sum of lines 5 - 13) | | 25,902,300 | 0 | 25,902,300 |
| | (Transfer column 3 to Worksheet G-3, Line 1) | | | | |

PART II - OPERATING EXPENSES

| | | | |
|---|---|---|---|
| 1 | Operating Expenses ( Per Worksheet A, Col. 3, Line 100 ) | //////////////////////// | 26,895,272 |
| 2 | | | //////////////////////// |
| 3 | | | //////////////////////// |
| 4 | | | //////////////////////// |
| 5 | | | //////////////////////// |
| 6 | | | //////////////////////// |
| 7 | | | //////////////////////// |
| 8 | Total Additions ( Sum of lines 2 - 7 ) | //////////////////////// | 0 |
| 9 | | | //////////////////////// |
| 10 | | | //////////////////////// |
| 11 | | | //////////////////////// |
| 12 | | | //////////////////////// |
| 13 | | | //////////////////////// |
| 14 | Total Deductions ( Sum of lines 9 - 13 ) | //////////////////////// | 0 |
| 15 | Total Operating Expenses ( Sum of lines 1 and 8, minus line 14 ) | //////////////////////// | 26,895,272 |

| STATEMENT OF REVENUES & EXPENSES | PROVIDER CCN: 31-5174 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET G-3 |
|---|---|---|---|

| | | |
|---|---|---|
| 1 | Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14) | 25,902,300 |
| 2 | Less: contractual allowances and discounts on patients accounts | ( 2,295,030 ) |
| 3 | Net patient revenues (Line 1 minus line 2) | 23,607,270 |
| 4 | Less: total operating expenses (From Worksheet G-2, Part II, line 15) | 26,895,272 |
| 5 | Net income from service to patients (Line 3 minus 4) | (3,288,002) |
| ////////// | OTHER INCOME: | //////////////////////////// |
| 6 | Contributions, donations, bequests, etc | 0 |
| 7 | Income from investments | 287,805 |
| 8 | Revenues from communications (Telephone and Internet service) | 0 |
| 9 | Revenue from television and radio service | 0 |
| 10 | Purchase discounts | 0 |
| 11 | Rebates and refunds of expenses | 0 |
| 12 | Parking lot receipts | 0 |
| 13 | Revenue from laundry and linen service | 0 |
| 14 | Revenue from meals sold to employees and guests | 0 |
| 15 | Revenue from rental of living quarters | 0 |
| 16 | Revenue from sale of medical and surgical supplies to other than patients | 0 |
| 17 | Revenue from sale of drugs to other than patients | 0 |
| 18 | Revenue from sale of medical records and abstracts | 0 |
| 19 | Tuition (fees, sale of textbooks, uniforms, etc.) | 0 |
| 20 | Revenue from gifts, flower, coffee shops, canteen | 444 |
| 21 | Rental of vending machines | 0 |
| 22 | Rental of skilled nursing space | 0 |
| 23 | Governmental appropriations | 0 |
| 24 | Prior Year Income | 49,006 |
| 24.50 | COVID-19 PHE Funding | 0 |
| 25 | Total other income (Sum of lines 6 - 24) | 337,255 |
| 26 | Total (Line 5 plus line 25) | (2,950,747) |
| 27 | | 0 |
| 28 | | 0 |
| 29 | | 0 |
| 30 | Total other expenses (Sum of lines 27 - 29) | 0 |
| 31 | Net income (or loss) for the period (Line 26 minus line 30) | (2,950,747) |