

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet S Parts I, II & III Date/Time Prepared: 11/26/2024 3:29 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report Date: 11/26/2024 Time: 3:29 pm 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLLINGSWOOD MANOR (315404) for the cost reporting period beginning 07/01/2023 and ending 06/30/2024 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part I Date/Time Prepared: 11/26/2024 3:29 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 460 HADDON AVENUE	PO Box:				1.00		
2.00	City: COLLINGSWOOD	State: NJ	Zip Code: 08108			2.00		
3.00	County: CAMDEN	CBSA Code: 15804	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
SNF and SNF-Based Component Identification:								
4.00	SNF	COLLINGSWOOD MANOR	315404	12/01/1997	N	P	0	
5.00	Nursing Facility							
6.00	ICF/IID							
7.00	SNF-Based HHA							
8.00	SNF-Based RHC							
9.00	SNF-Based FQHC							
10.00	SNF-Based CMHC							
11.00	SNF-Based OLTC							
12.00	SNF-Based HOSPICE							
13.00	SNF-Based CORF							
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yyyy)			07/01/2023	06/30/2024		14.00	
15.00	Type of Control (See Instructions)			1			15.00	
					Y/N			
					1.00			
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	16.00	
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N	17.00	
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y	18.00	
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.00	
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N	19.01	
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					1,068,575	20.00	
21.00	Declining Balance					0	21.00	
22.00	Sum of the Year's Digits					0	22.00	
23.00	Sum of line 20 through 22					1,068,575	23.00	
24.00	If depreciation is funded, enter the balance as of the end of the period.					0	24.00	
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					Y	25.00	
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N	26.00	
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N	27.00	
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N	28.00	
				Part A	Part B	Other		
				1.00	2.00	3.00		
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					N	N	N
30.00	Skilled Nursing Facility							
31.00	Nursing Facility							
32.00	ICF/IID					N	N	N
33.00	SNF-Based HHA							
34.00	SNF-Based RHC							
35.00	SNF-Based FQHC						N	
36.00	SNF-Based CMHC							
36.00	SNF-Based OLTC							
				Y/N				
				1.00	2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.					1		39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:		164,342	0	0		41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part I Date/Time Prepared: 11/26/2024 3:29 pm
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	Y	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.	H53010	44.00
		1.00	2.00
		3.00	
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name: UNITED METHODIST HOMES OF NJ	Contractor's Name: UNITED METHODIST HOMES OF NJ	Contractor's Number: 12001
46.00	Street: 3311 HIGHWAY 33	PO Box:	
47.00	City: NEPTUNE	State: NJ	Zip Code: 07753

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet S-2 Part II Date/Time Prepared: 11/26/2024 3:29 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	10/24/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	Y			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			N	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	10/07/2024	N	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

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

Provider No. : 315404

Period:
 From 07/01/2023
 To 06/30/2024

Worksheet S-2
 Part II
 Date/Time Prepared:
 11/26/2024 3:29 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DEANDRA	FALLON	19.00
20.00	Enter the employer/company name of the cost report preparer	BAKER TILLY ADVISORY GROUP, LP		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	570-820-0301	DEANDRA.FALLON@BAKERTILLY.COM	21.00

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

Provider No. : 315404

Period:
 From 07/01/2023
 To 06/30/2024

Worksheet S-2
 Part II
 Date/Time Prepared:
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		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

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

Provider No. : 315404

Period:
 From 07/01/2023
 To 06/30/2024

Worksheet S-3
 Part I
 Date/Time Prepared:
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Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	60	21,960	0	3,575	6,057	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	128	46,848				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	188	68,808	0	3,575	6,057	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	9,027	18,659	0	142	18	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	34,684	34,684				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	43,711	53,343	0	142	18	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	191	351	0.00	25.18	336.50	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	42	42				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	233	393	0.00	25.18	336.50	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	53.16	0	163	9	175	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	825.81				40	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	135.73	0	163	9	215	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	347	36.61	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST				4.00		
5.00	Other Long Term Care	40	41.49	0.00	5.00		
6.00	SNF-Based CMHC				6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	387	78.10	0.00	8.00		

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet S-3
Part II
Date/Time Prepared:
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	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	9,287,082	0	9,287,082	316,569.00	29.34 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	9,287,082	0	9,287,082	316,569.00	29.34 6.00
7.00	Other Long Term Care	2,524,240	0	2,524,240	86,289.00	29.25 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	57,340	0	57,340	3,214.00	17.84 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	2,581,580	0	2,581,580	89,503.00	28.84 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	6,705,502	0	6,705,502	227,066.00	29.53 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1,198,220	0	1,198,220	35,667.00	33.59 14.00
15.00	Contract Labor: Physician services-Part A	20,012	0	20,012	104.00	192.42 15.00
16.00	Home office salaries & wage related costs	847,106	0	847,106	12,952.00	65.40 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	2,112,170	0	2,112,170		
18.00	Wage-related costs other (See Part IV)	3,768	0	3,768		
19.00	Wage related costs (excluded units)	587,131	0	587,131		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,528,807	0	1,528,807		

Provider No. : 315404

Period:
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To 06/30/2024

Worksheet S-3
Part III
Date/Time Prepared:
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	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	1,284,890	0	1,284,890	26,449.00	2.00
3.00	Plant Operation, Maintenance & Repairs	400,881	0	400,881	19,650.00	3.00
4.00	Laundry & Linen Service	117,663	0	117,663	5,344.00	4.00
5.00	Housekeeping	377,444	0	377,444	18,991.00	5.00
6.00	Dietary	909,917	0	909,917	49,438.00	6.00
7.00	Nursing Administration	0	0	0.00	0.00	7.00
8.00	Central Services and Supply	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0.00	0.00	10.00
11.00	Social Service	47,436	0	47,436	1,654.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	297,361	0	297,361	13,515.00	13.00
14.00	Total (sum lines 1 thru 13)	3,435,592	0	3,435,592	135,041.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2024 3:29 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	153,017	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	893,023	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	11,273	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3,142	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	247,299	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	557,760	17.00
18.00	Medicare Taxes - Employers Portion Only	130,833	18.00
19.00	Unemployment Insurance	114,768	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,055	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	2,112,170	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	3,768	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet S-3
Part V
Date/Time Prepared:
11/26/2024 3:29 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	1,169,479	265,940	1,435,419	22,557.00	63.64	1.00
2.00	Licensed Practical Nurses (LPNs)	332,071	75,513	407,584	8,661.00	47.06	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	982,048	223,318	1,205,366	39,789.00	30.29	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,483,598	564,771	3,048,369	71,007.00	42.93	4.00
5.00	Physical Therapists	220,953	50,245	271,198	6,254.00	43.36	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	74,907	17,034	91,941	2,016.00	45.61	7.00
8.00	Occupational Therapists	93,197	21,193	114,390	1,974.00	57.95	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	70,367	16,001	86,368	1,898.00	45.50	10.00
11.00	Speech Therapists	110,497	25,127	135,624	2,137.00	63.46	11.00
12.00	Respiratory Therapists	66,726	15,173	81,899	1,602.00	51.12	12.00
13.00	Other Medical Staff	149,665	34,034	183,699	5,140.00	35.74	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	190,594		190,594	3,074.00	62.00	14.00
15.00	Licensed Practical Nurses (LPNs)	132,088		132,088	2,402.00	54.99	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	875,538		875,538	30,191.00	29.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,198,220		1,198,220	35,667.00	33.59	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet S-7
Date/Time Prepared:
11/26/2024 3:29 pm

		Group	Days	
		1. 00	2. 00	
1. 00		RUX		1. 00
2. 00		RUL		2. 00
3. 00		RVX		3. 00
4. 00		RVL		4. 00
5. 00		RHX		5. 00
6. 00		RHL		6. 00
7. 00		RMX		7. 00
8. 00		RML		8. 00
9. 00		RLX		9. 00
10. 00		RUC		10. 00
11. 00		RUB		11. 00
12. 00		RUA		12. 00
13. 00		RVC		13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31. 00
32. 00		HC1		32. 00
33. 00		HB2		33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37. 00
38. 00		LD1		38. 00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41. 00		LB2		41. 00
42. 00		LB1		42. 00
43. 00		CE2		43. 00
44. 00		CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00		CB1		50. 00
51. 00		CA2		51. 00
52. 00		CA1		52. 00
53. 00		SE3		53. 00
54. 00		SE2		54. 00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		IB2		59. 00
60. 00		IB1		60. 00
61. 00		IA2		61. 00
62. 00		IA1		62. 00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66. 00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69. 00		PD2		69. 00
70. 00		PD1		70. 00
71. 00		PC2		71. 00
72. 00		PC1		72. 00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00		PA2		75. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet S-7

Date/Time Prepared:
11/26/2024 3:29 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,268,125	1,268,125	0	1,268,125	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300	0	2,115,938	2,115,938	0	2,115,938	3.00
4.00	00400	1,284,890	2,759,042	4,043,932	0	4,043,932	4.00
5.00	00500	400,881	929,020	1,329,901	0	1,329,901	5.00
6.00	00600	117,663	45,747	163,410	0	163,410	6.00
7.00	00700	377,444	114,164	491,608	0	491,608	7.00
8.00	00800	909,917	1,346,986	2,256,903	0	2,256,903	8.00
9.00	00900	0	0	0	0	0	9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	47,436	0	47,436	0	47,436	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	228,217	34,285	262,502	0	262,502	15.00
15.01	01501	69,144	1,178	70,322	0	70,322	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,633,263	1,619,269	4,252,532	0	4,252,532	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	2,524,240	144,985	2,669,225	0	2,669,225	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	12,275	12,275	0	12,275	40.00
41.00	04100	0	22,849	22,849	0	22,849	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	66,726	11,149	77,875	0	77,875	43.00
44.00	04400	295,860	133,356	429,216	-118,179	311,037	44.00
45.00	04500	163,564	0	163,564	83,998	247,562	45.00
46.00	04600	110,497	0	110,497	34,181	144,678	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	23,254	23,254	0	23,254	48.00
49.00	04900	0	154,818	154,818	0	154,818	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000	0	0	0	0	0	80.00
81.00	08100	0	0	0	0	0	81.00
82.00	08200	0	0	0	0	0	82.00
83.00	08300	0	0	0	0	0	83.00
89.00		9,229,742	10,736,440	19,966,182	0	19,966,182	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	57,340	28,184	85,524	0	85,524	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
100.00		9,287,082	10,764,624	20,051,706	0	20,051,706	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-548	1,267,577	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	-48,040	2,067,898	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-839,889	3,204,043	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	-338	1,329,563	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	163,410	6.00
7.00	00700	HOUSEKEEPING	0	491,608	7.00
8.00	00800	DIETARY	-62,835	2,194,068	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	47,436	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	262,502	15.00
15.01	01501	CHAPLAIN	0	70,322	15.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	4,252,532	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	2,669,225	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	12,275	40.00
41.00	04100	LABORATORY	0	22,849	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	77,875	43.00
44.00	04400	PHYSICAL THERAPY	0	311,037	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	247,562	45.00
46.00	04600	SPEECH PATHOLOGY	0	144,678	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,254	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	154,818	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-951,650	19,014,532	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	85,524	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
100.00		TOTAL	-951,650	19,100,056	100.00

RECLASSIFICATIONS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-6

Date/Time Prepared:
11/26/2024 3:29 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
	(1) A - TO RECLASS OT AND ST					
1.00		OCCUPATIONAL THERAPY	45.00	29,629	54,369	1.00
2.00		SPEECH PATHOLOGY	46.00	12,057	22,124	2.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		41,686	76,493	100.00

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

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-6

Date/Time Prepared:
11/26/2024 3:29 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
	(1) A - TO RECLASS OT AND ST					
1.00		PHYSICAL THERAPY	44.00	41,686	76,493	1.00
2.00			0.00	0	0	2.00
	TOTALS			41,686	76,493	100.00
100.00						

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-7

Date/Time Prepared:
11/26/2024 3:29 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	257,870	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	25,953,266	398,719	0	398,719	655,657	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	2,765,809	145,171	0	145,171	268,833	5.00
6.00 Movable Equipment	205,130	0	0	0	123,680	6.00
7.00 Subtotal (sum of lines 1-6)	29,182,075	543,890	0	543,890	1,048,170	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	29,182,075	543,890	0	543,890	1,048,170	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	257,870	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	25,696,328	0				
4.00 Building Improvements	0	0				
5.00 Fixed Equipment	2,642,147	0				
6.00 Movable Equipment	81,450	0				
7.00 Subtotal (sum of lines 1-6)	28,677,795	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	28,677,795	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8

Date/Time Prepared:
11/26/2024 3:29 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line No.	
			1.00	2.00	3.00	4.00
1.00 Investment income on restricted funds (chapter 2)	B	-548	CAP REL COSTS - BLDGS & FIXTURES		1.00	1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	2.00
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00	3.00
4.00 Rental of provider space by suppliers (chapter 8)		0			0.00	4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	5.00
6.00 Television and radio service (chapter 21)	B	-220	PLANT OPERATION, MAINT. & REPAIRS		5.00	6.00
7.00 Parking lot (chapter 21)		0			0.00	7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0				8.00
9.00 Home office cost (chapter 21)		0			0.00	9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-179,852				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals	B	-59,390	DIETARY		8.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF		82.00	22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT		2.00	24.00
25.00 MISCELLANEOUS INCOME	B	-995	ADMINISTRATIVE & GENERAL		4.00	25.00
25.01 MARKETING SAL/OTHER	A	-432,230	ADMINISTRATIVE & GENERAL		4.00	25.01
25.02 NON-ALLOWABLE EXPENSE	A	-14,784	ADMINISTRATIVE & GENERAL		4.00	25.02
25.03 BED TAX	A	-212,028	ADMINISTRATIVE & GENERAL		4.00	25.03
25.04 MARKETING BENEFITS	A	-48,040	EMPLOYEE BENEFITS		3.00	25.04
25.05 ELECTRIC REVENUE	B	-118	PLANT OPERATION, MAINT. & REPAIRS		5.00	25.05
25.06		0			0.00	25.06
25.07 FOOD	A	-3,445	DIETARY		8.00	25.07
29.00		0			0.00	29.00
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-951,650				100.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

- A. Costs - if cost, including applicable overhead, can be determined.
- B. Amount Received - if cost cannot be determined.

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

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
11/26/2024 3:29 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1.00
2.00		0.00			2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00		0.00			5.00
6.00		0.00			6.00
7.00		0.00			7.00
8.00		0.00			8.00
9.00		0.00			9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.				10.00
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
		4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1,074,924	1,254,776	-179,852	1.00
2.00		0	0	0	2.00
3.00		0	0	0	3.00
4.00		0	0	0	4.00
5.00		0	0	0	5.00
6.00		0	0	0	6.00
7.00		0	0	0	7.00
8.00		0	0	0	8.00
9.00		0	0	0	9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1,074,924	1,254,776	-179,852	10.00

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

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
11/26/2024 3:29 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

1.00	G	UNITED METHODIST HOMES OF NJ	100.00	1.00
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:		0.00	100.00

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

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

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

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

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

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

1.00		UNITED METHODIST HOMES OF NJ	100.00	SUPPORT SERVICES	1.00
2.00			0.00		2.00
3.00			0.00		3.00
4.00			0.00		4.00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part I
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,267,577	1,267,577			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	2,067,898	0	0	2,067,898	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,204,043	55,005	0	244,624	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,329,563	16,784	0	91,340	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	163,410	20,506	0	26,809	6.00
7.00 00700	HOUSEKEEPING	491,608	9,323	0	85,999	7.00
8.00 00800	DIETARY	2,194,068	39,151	0	207,322	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	47,436	4,661	0	10,808	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	262,502	22,376	0	51,999	15.00
15.01 01501	CHAPLAIN	70,322	0	0	15,754	15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	4,252,532	235,925	0	599,979	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	2,669,225	849,061	0	575,141	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	12,275	0	0	0	40.00
41.00 04100	LABORATORY	22,849	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	77,875	0	0	15,203	43.00
44.00 04400	PHYSICAL THERAPY	311,037	14,785	0	57,913	44.00
45.00 04500	OCCUPATIONAL THERAPY	247,562	0	0	44,018	45.00
46.00 04600	SPEECH PATHOLOGY	144,678	0	0	27,924	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,254	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	154,818	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	19,014,532	1,267,577	0	2,054,833	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	85,524	0	0	13,065	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	19,100,056	1,267,577	0	2,067,898	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part I
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	3,503,672				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	322,971	1,760,658			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	47,339	30,193	288,257		6.00	
7.00	00700	HOUSEKEEPING	131,851	13,726	0	732,507	7.00	
8.00	00800	DIETARY	548,258	57,646	0	24,597	3,071,042	8.00
9.00	00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	14,131	6,863	0	2,928	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	75,678	32,946	0	14,058	0	15.00
15.01	01501	CHAPLAIN	19,337	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,143,102	347,372	230,606	148,218	790,981	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	919,572	1,250,143	57,651	533,417	2,280,061	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	2,758	0	0	0	0	40.00
41.00	04100	LABORATORY	5,133	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	20,910	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	86,205	21,769	0	9,289	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	65,502	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	38,774	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,224	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	34,779	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	3,481,524	1,760,658	288,257	732,507	3,071,042	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	22,148	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	3,503,672	1,760,658	288,257	732,507	3,071,042	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	86,827	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	86,827	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	0	86,827	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	86,827	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part I
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE		Subtotal	Post Stepdown Adjustments	
		ACTIVITIES	CHAPLAIN			
		14.00	15.01			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	459,559			15.00
15.01 01501	CHAPLAIN	0	0	105,413		15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	459,559	36,873	8,331,974	0 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	68,540	9,202,811	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	15,033	0 40.00
41.00 04100	LABORATORY	0	0	0	27,982	0 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	113,988	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	500,998	0 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	357,082	0 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	211,376	0 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	28,478	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	189,597	0 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FQHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	459,559	105,413	18,979,319	0 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	120,737	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	459,559	105,413	19,100,056	0 100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part I
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300 EMPLOYEE BENEFITS		3.00
4.00	00400 ADMINISTRATIVE & GENERAL		4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600 LAUNDRY & LINEN SERVICE		6.00
7.00	00700 HOUSEKEEPING		7.00
8.00	00800 DIETARY		8.00
9.00	00900 NURSING ADMINISTRATION		9.00
10.00	01000 CENTRAL SERVICES & SUPPLY		10.00
11.00	01100 PHARMACY		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY		12.00
13.00	01300 SOCIAL SERVICE		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500 ACTIVITIES		15.00
15.01	01501 CHAPLAIN		15.01
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	8,331,974	30.00
31.00	03100 NURSING FACILITY	0	31.00
32.00	03200 ICF/IID	0	32.00
33.00	03300 OTHER LONG TERM CARE	9,202,811	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	04000 RADIOLOGY	15,033	40.00
41.00	04100 LABORATORY	27,982	41.00
42.00	04200 INTRAVENOUS THERAPY	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	113,988	43.00
44.00	04400 PHYSICAL THERAPY	500,998	44.00
45.00	04500 OCCUPATIONAL THERAPY	357,082	45.00
46.00	04600 SPEECH PATHOLOGY	211,376	46.00
47.00	04700 ELECTROCARDIOLOGY	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	28,478	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	189,597	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100 SUPPORT SURFACES	0	51.00
OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLINIC	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	61.00
62.00	06200 FOHC	0	62.00
OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST	0	70.00
71.00	07100 AMBULANCE	0	71.00
73.00	07300 CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100 INTEREST EXPENSE		81.00
82.00	08200 UTILIZATION REVIEW - SNF		82.00
83.00	08300 HOSPICE	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	18,979,319	89.00
NONREIMBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	120,737	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300 NONPAID WORKERS	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	94.00
98.00	Cross Foot Adjustments	0	98.00
99.00	Negative Cost Centers	0	99.00
100.00	TOTAL	19,100,056	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part II
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	55,005	0	55,005	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	16,784	0	16,784	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	20,506	0	20,506	6.00
7.00 00700	HOUSEKEEPING	0	9,323	0	9,323	7.00
8.00 00800	DIETARY	0	39,151	0	39,151	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	4,661	0	4,661	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	ACTIVITIES	0	22,376	0	22,376	15.00
15.01 01501	CHAPLAIN	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	235,925	0	235,925	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	849,061	0	849,061	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	14,785	0	14,785	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	0	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,267,577	0	1,267,577	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	1,267,577	0	1,267,577	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
3.00	00300						3.00	
4.00	00400	55,005					4.00	
5.00	00500	5,071	21,855				5.00	
6.00	00600	743	375	21,624			6.00	
7.00	00700	2,070	170	0	11,563		7.00	
8.00	00800	8,608	716	0	388	48,863	8.00	
9.00	00900	0	0	0	0	0	9.00	
10.00	01000	0	0	0	0	0	10.00	
11.00	01100	0	0	0	0	0	11.00	
12.00	01200	0	0	0	0	0	12.00	
13.00	01300	222	85	0	46	0	13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	1,188	409	0	222	0	15.00	
15.01	01501	304	0	0	0	0	15.01	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	17,943	4,312	17,299	2,340	12,585	30.00	
31.00	03100	0	0	0	0	0	31.00	
32.00	03200	0	0	0	0	0	32.00	
33.00	03300	14,438	15,518	4,325	8,420	36,278	33.00	
ANCILLARY SERVICE COST CENTERS								
40.00	04000	43	0	0	0	0	40.00	
41.00	04100	81	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	328	0	0	0	0	43.00	
44.00	04400	1,353	270	0	147	0	44.00	
45.00	04500	1,028	0	0	0	0	45.00	
46.00	04600	609	0	0	0	0	46.00	
47.00	04700	0	0	0	0	0	47.00	
48.00	04800	82	0	0	0	0	48.00	
49.00	04900	546	0	0	0	0	49.00	
50.00	05000	0	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
73.00	07300	0	0	0	0	0	73.00	
SPECIAL PURPOSE COST CENTERS								
80.00	08000						80.00	
81.00	08100						81.00	
82.00	08200						82.00	
83.00	08300	0	0	0	0	0	83.00	
89.00	SUBTOTALS (sum of lines 1-84)		54,657	21,855	21,624	11,563	48,863	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	348	0	0	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	09300	0	0	0	0	0	93.00	
94.00	09400	0	0	0	0	0	94.00	
98.00	Cross Foot Adjustments				0	0	0	98.00
99.00	Negative Cost Centers		0	0	0	0	0	99.00
100.00	TOTAL		55,005	21,855	21,624	11,563	48,863	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part II
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	0					9.00
10.00	01000	0	0				10.00
11.00	01100	0	0	0			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	5,014	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	5,014	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	0	5,014	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		0	0	0	0	5,014	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part II
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE		Subtotal	Post Step-Down Adjustments	
		ACTIVITIES	CHAPLAIN			
		14.00	15.01			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	24,195			15.00
15.01 01501	CHAPLAIN	0	0	304		15.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	24,195	106	319,719	0 30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0 31.00
32.00 03200	ICF/IID	0	0	0	0	0 32.00
33.00 03300	OTHER LONG TERM CARE	0	0	198	928,238	0 33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	43	0 40.00
41.00 04100	LABORATORY	0	0	0	81	0 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	328	0 43.00
44.00 04400	PHYSICAL THERAPY	0	0	0	16,555	0 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	0	1,028	0 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	0	609	0 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	82	0 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	546	0 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FQHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
73.00 07300	CMHC	0	0	0	0	0 73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	24,195	304	1,267,229	0 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	348	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	24,195	304	1,267,577	0 100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B
Part II
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	2.00
3.00	00300	EMPLOYEE BENEFITS	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	6.00
7.00	00700	HOUSEKEEPING	7.00
8.00	00800	DIETARY	8.00
9.00	00900	NURSING ADMINISTRATION	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	10.00
11.00	01100	PHARMACY	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	12.00
13.00	01300	SOCIAL SERVICE	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	14.00
15.00	01500	ACTIVITIES	15.00
15.01	01501	CHAPLAIN	15.01
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	319,719
31.00	03100	NURSING FACILITY	0
32.00	03200	ICF/IID	0
33.00	03300	OTHER LONG TERM CARE	928,238
ANCILLARY SERVICE COST CENTERS			
40.00	04000	RADIOLOGY	43
41.00	04100	LABORATORY	81
42.00	04200	INTRAVENOUS THERAPY	0
43.00	04300	OXYGEN (INHALATION) THERAPY	328
44.00	04400	PHYSICAL THERAPY	16,555
45.00	04500	OCCUPATIONAL THERAPY	1,028
46.00	04600	SPEECH PATHOLOGY	609
47.00	04700	ELECTROCARDIOLOGY	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	82
49.00	04900	DRUGS CHARGED TO PATIENTS	546
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0
51.00	05100	SUPPORT SURFACES	0
OUTPATIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	0
61.00	06100	RURAL HEALTH CLINIC	0
62.00	06200	FOHC	0
OTHER REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0
71.00	07100	AMBULANCE	0
73.00	07300	CMHC	0
SPECIAL PURPOSE COST CENTERS			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0
81.00	08100	INTEREST EXPENSE	0
82.00	08200	UTILIZATION REVIEW - SNF	0
83.00	08300	HOSPICE	0
89.00		SUBTOTALS (sum of lines 1-84)	1,267,229
NONREIMBURSABLE COST CENTERS			
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	348
91.00	09100	BARBER AND BEAUTY SHOP	0
92.00	09200	PHYSICIANS PRIVATE OFFICES	0
93.00	09300	NONPAID WORKERS	0
94.00	09400	PATIENTS LAUNDRY	0
98.00		Cross Foot Adjustments	0
99.00		Negative Cost Centers	0
100.00		TOTAL	1,267,577

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	147,118					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	9,075,823			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	6,384	0	1,073,631	-3,503,672	15,596,384	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	1,948	0	400,881	0	1,437,687	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	2,380	0	117,663	0	210,725	6.00
7.00 00700	HOUSEKEEPING	1,082	0	377,444	0	586,930	7.00
8.00 00800	DIETARY	4,544	0	909,917	0	2,440,541	8.00
9.00 00900	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	541	0	47,436	0	62,905	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	2,597	0	228,217	0	336,877	15.00
15.01 01501	CHAPLAIN	0	0	69,144	0	86,076	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	27,382	0	2,633,263	0	5,088,436	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	98,544	0	2,524,240	0	4,093,427	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	12,275	40.00
41.00 04100	LABORATORY	0	0	0	0	22,849	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	66,726	0	93,078	43.00
44.00 04400	PHYSICAL THERAPY	1,716	0	254,174	0	383,735	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	193,193	0	291,580	45.00
46.00 04600	SPEECH PATHOLOGY	0	0	122,554	0	172,602	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	23,254	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	154,818	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	147,118	0	9,018,483	-3,503,672	15,497,795	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	57,340	0	98,589	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1,267,577	0	2,067,898		3,503,672	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	8.616056	0.000000	0.227847		0.224646	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		55,005	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.003527	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	138,786					6.00
7.00	00700	2,380	322,510				7.00
8.00	00800	1,082	0	135,324			8.00
9.00	00900	4,544	0	4,544	196,101		9.00
10.00	01000	0	0	0	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	541	0	541	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	2,597	0	2,597	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,382	258,008	27,382	50,508	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	98,544	64,502	98,544	145,593	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,716	0	1,716	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		138,786	322,510	135,324	196,101	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		1,760,658	288,257	732,507	3,071,042	0	102.00
103.00		12.686135	0.893792	5.412987	15.660512	0.000000	103.00
104.00		21,855	21,624	11,563	48,863	0	104.00
105.00		0.157473	0.067049	0.085447	0.249173	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1

Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	0					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	18,659		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.01	01501	0	0	0	0	0	15.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	18,659	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0		0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200						62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		0	0	0	18,659	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		0	0	0	86,827	0	102.00
103.00		0.000000	0.000000	0.000000	4.653358	0.000000	103.00
104.00		0	0	0	5,014	0	104.00
105.00		0.000000	0.000000	0.000000	0.268718	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet B-1
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		OTHER GENERAL SERVICE			
		ACTIVITIES (PATIENT DAYS)	CHAPLAIN (PATIENT DAYS)		
		15.00	15.01		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00	00300	EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600	LAUNDRY & LINEN SERVICE			6.00
7.00	00700	HOUSEKEEPING			7.00
8.00	00800	DIETARY			8.00
9.00	00900	NURSING ADMINISTRATION			9.00
10.00	01000	CENTRAL SERVICES & SUPPLY			10.00
11.00	01100	PHARMACY			11.00
12.00	01200	MEDICAL RECORDS & LIBRARY			12.00
13.00	01300	SOCIAL SERVICE			13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION			14.00
15.00	01500	ACTIVITIES	18,659		15.00
15.01	01501	CHAPLAIN	0	53,343	15.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	18,659	18,659	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	34,684	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	40.00
41.00	04100	LABORATORY	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81.00	08100	INTEREST EXPENSE			81.00
82.00	08200	UTILIZATION REVIEW - SNF			82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	18,659	53,343	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
98.00		Cross Foot Adjustments			98.00
99.00		Negative Cost Centers			99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	459,559	105,413	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	24.629348	1.976136	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	24,195	304	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	1.296693	0.005699	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet C

Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
			Wkst. B, Pt 1, col. 18)		divided by col. 2	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	15,033	12,275	1.224684	40.00
41.00	04100	LABORATORY	27,982	25,814	1.083985	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	113,988	77,875	1.463730	43.00
44.00	04400	PHYSICAL THERAPY	500,998	458,349	1.093049	44.00
45.00	04500	OCCUPATIONAL THERAPY	357,082	438,273	0.814748	45.00
46.00	04600	SPEECH PATHOLOGY	211,376	178,443	1.184558	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,478	23,254	1.224650	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	189,597	154,894	1.224044	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0.000000	60.00
61.00	06100	RURAL HEALTH CLINIC				61.00
62.00	06200	FQHC				62.00
71.00	07100	AMBULANCE	0	0	0.000000	71.00
100.00		Total	1,444,534	1,369,177		100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet D Part I Date/Time Prepared: 11/26/2024 3:29 pm			
		Title XVIII (1)	Skilled Nursing Facility	PPS			
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost			
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)		
		1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADIOLOGY	1.224684	6,060	0	7,422	0	40.00
41.00	04100 LABORATORY	1.083985	22,619	0	24,519	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1.463730	0	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	1.093049	276,121	0	301,814	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.814748	275,200	0	224,219	0	45.00
46.00	04600 SPEECH PATHOLOGY	1.184558	121,309	0	143,698	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.224650	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.224044	132,273	0	161,908	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0.000000	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC						61.00
62.00	06200 FQHC						62.00
71.00	07100 AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		833,582	0	863,580	0	100.00

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

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

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet D Parts II-III Date/Time Prepared: 11/26/2024 3:29 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description						1.00	
PART II - APPORTIONMENT OF VACCINE COST							
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)				1.224044	1.00
2.00		Program vaccine charges (From your records, or the PS&R)				0	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)				0	3.00
Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH							
ANCILLARY SERVICE COST CENTERS							
40.00	04000	RADIOLOGY	15,033	0	0.000000	7,422	0 40.00
41.00	04100	LABORATORY	27,982	0	0.000000	24,519	0 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	113,988	0	0.000000	0	0 43.00
44.00	04400	PHYSICAL THERAPY	500,998	0	0.000000	301,814	0 44.00
45.00	04500	OCCUPATIONAL THERAPY	357,082	0	0.000000	224,219	0 45.00
46.00	04600	SPEECH PATHOLOGY	211,376	0	0.000000	143,698	0 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,478	0	0.000000	0	0 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	189,597	0	0.000000	161,908	0 49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0 50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0 51.00
100.00		Total (Sum of lines 40 - 52)	1,444,534	0		863,580	0 100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Parts I-III Date/Time Prepared: 11/26/2024 3:29 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		18,659	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		3,575	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		8,331,974	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		11,050,773	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.753972	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		11,050,773	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		592.25	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		8,331,974	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		446.54	16.00
17.00	Program routine service cost (Line 3 times line 16)		1,596,381	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		1,596,381	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		319,719	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		17.13	21.00
22.00	Program capital related cost (Line 3 times line 21)		61,240	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		1,535,141	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		1,535,141	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		18,659	1.00
2.00	Program inpatient days (see instructions)		3,575	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)		0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)		0.191597	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet D-1 Parts I-III Date/Time Prepared: 11/26/2024 3:29 pm
	Title XIX	Skilled Nursing Facility	Cost

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		18,659	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		6,057	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		8,331,974	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		11,050,773	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.753972	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		11,050,773	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		592.25	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		8,331,974	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		446.54	16.00
17.00	Program routine service cost (Line 3 times line 16)		2,704,693	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		2,704,693	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		319,719	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		17.13	21.00
22.00	Program capital related cost (Line 3 times line 21)		103,756	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		2,600,937	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		2,600,937	25.00
26.00	Enter the per diem limitation (1)		0.00	26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		0	27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		2,704,693	28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		18,659	1.00
2.00	Program inpatient days (see instructions)		6,057	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)		0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)		0.324615	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIIII		Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part I Date/Time Prepared: 11/26/2024 3:29 pm
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		2,332,887	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		2,332,887	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		243,480	5.00
6.00	Allowable bad debts (From your records)		0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		0	8.00
9.00	Recovery of bad debts - for statistical records only		0	9.00
10.00	Utilization review		0	10.00
11.00	Subtotal (See instructions)		2,089,407	11.00
12.00	Interim payments (See instructions)		2,047,619	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		0	14.75
14.99	Sequestration amount (see instructions)		41,788	14.99
15.00	Balance due provider/program (see Instructions)		0	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		0	19.00
20.00	Medicare Part B ancillary charges (See instructions)		0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		0	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		0	25.00
26.00	Interim payments (See instructions)		0	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		0	28.99
29.00	Balance due provider/program (see instructions)		0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315404	Period: From 07/01/2023 To 06/30/2024	Worksheet E Part II Date/Time Prepared: 11/26/2024 3:29 pm
		Title XIX	Skilled Nursing Facility	Cost
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		2,704,693	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		2,704,693	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		2,704,693	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		2,704,693	10.00
REASONABLE CHARGES				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet E-1

Date/Time Prepared:
11/26/2024 3:29 pm
PPS

Title XVIII

Skilled Nursing
Facility

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		2,047,619		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		2,047,619		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		0		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,047,619		0	7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					8.00

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only) Provider No. : 315404 Period: From 07/01/2023 To 06/30/2024 Worksheet G Date/Time Prepared: 11/26/2024 3:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	61,490	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,615,304	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-1,232,100	0	0	0	6.00
7.00	Inventory	75,306	0	0	0	7.00
8.00	Prepaid expenses	140,052	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	33,054,642	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	36,714,694	0	0	0	11.00
FIXED ASSETS						
12.00	Land	257,870	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	25,696,328	0	0	0	15.00
16.00	Less Accumulated depreciation	-16,457,363	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	2,642,147	0	0	0	19.00
20.00	Less: Accumulated depreciation	-1,695,441	0	0	0	20.00
21.00	Automobiles and trucks	81,450	0	0	0	21.00
22.00	Less: Accumulated depreciation	-81,450	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	10,443,541	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	724,786	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	724,786	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	47,883,021	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	959,587	0	0	0	35.00
36.00	Salaries, wages, and fees payable	962,533	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	55,714	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	21,712	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1,999,546	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	3,493,010	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	10,844,236	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	14,337,246	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	16,336,792	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	31,546,229	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	31,546,229	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	47,883,021	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet G-1

Date/Time Prepared:
11/26/2024 3:29 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		33,562,888			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-2,016,657				2.00
3.00	Total (sum of line 1 and line 2)		31,546,231			0	3.00
4.00	Additions (credit adjustments)						4.00
5.00	INTERCOMPANY RECONCILIATION	0		0		0	5.00
6.00	ROUNDING	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 5 - 9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		31,546,231			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING	2		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		2			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		31,546,229			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)						4.00
5.00	INTERCOMPANY RECONCILIATION		0				5.00
6.00	ROUNDING		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 5 - 9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments)						12.00
13.00	ROUNDING		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet G-2
Parts I-III
Date/Time Prepared:
11/26/2024 3:29 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	11,050,773		11,050,773	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	9,645,132		9,645,132	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	20,695,905		20,695,905	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,297,420	0	1,297,420	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	21,993,325	0	21,993,325	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			20,051,706	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			20,051,706	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315404

Period:
From 07/01/2023
To 06/30/2024

Worksheet G-3

Date/Time Prepared:
11/26/2024 3:29 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	21,993,325	1.00
2.00	Less: contractual allowances and discounts on patients accounts	4,225,884	2.00
3.00	Net patient revenues (Line 1 minus line 2)	17,767,441	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	20,051,706	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2,284,265	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	170,167	6.00
7.00	Income from investments	34,916	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	220	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	59,390	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INSURANCE REVENUE	0	24.00
24.01	CATERING / COUNTRY STORE	57,686	24.01
24.02	TRANSPORTATION - RESIDENTIAL	10,836	24.02
24.03	MISCELLANEOUS INCOME	0	24.03
24.04	INVESTMENT SETTLEMENT	37	24.04
24.05	GRANT REVENUE	0	24.05
24.06	MAINTENANCE SERVICES	0	24.06
24.07	ELECTRIC INCOME	118	24.07
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	333,370	25.00
26.00	Total (Line 5 plus line 25)	-1,950,895	26.00
27.00	LOSS ON DISPOSAL	51,670	27.00
27.01	BARBER AND BEAUTY	0	27.01
28.00	MISC EXPENSE	14,092	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	65,762	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-2,016,657	31.00