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

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

OMB NO. 0938-0463

Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S PARTS I II & III

PART I - COST REPORT STATUS

Provider use only

1.	[X]	Electronically prepared cost report	**Date:** 05/02/2024 **Time:** 02:40:43 PM
2.	[ ]	Manually prepared cost report	
3.	[ ]	If this is an amended report enter the number of times the provider resubmitted this cost report.	0
3.0.1	[ ]	No Medicare Utilization Enter "Y" for yes or leave blank for no	0

Contractor use only:

4.	[ ]	Cost Report Status	6. Contractor No. _____
	[1]	As Submitted:	7. [ ] First Cost Report for this Provider CCN
	[2]	Settled without audit	8. [ ] Last Cost Report for this Provider CCN
	[3]	Settled with audit	9. [ ] NPR Date: _____
	[4]	Reopened	10. [ ] If line 4, column 1 is "4": Enter number of times reopened
	[5]	Amended	11. Contractor Vendor Code _____
5.		Date Received	12. Medicare Utilization Enter "F" for full, "L" for low, or "N" for no utilization _____

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

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMILTON GROVE HEALTHCARE #31-5423 for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR ENCRYPTION:
05/02/2024 02:40:43 PM
XpHKKA0pIfXPTWgcK9ARlH.kaT5hC0
3IfmF08eI.opyJ4APrpUEruHlzjdUC
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PRINT FILE ENCRYPTION:

DO NOT SIGN UNTIL ENCRYPTION APPEARS HERE

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Avi Maierovits		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	Avi Maierovits			2
3	Signatory Title	Controller			3
4	Signature date	05/02/2024			4

PART III - SETTLEMENT SUMMARY

			TITLE XVIII			
		TITLE V	A	B	TITLE XIX	
		1	2	3	4	
1	SKILLED NURSING FACILITY	//////////// ////////////	205,226	(26)		1
2	NURSING FACILITY	//////////// ////////////	//////////// ////////////	////////////	0	2
3	I C F / IID	//////////// ////////////	//////////// ////////////	////////////		3
4	SNF - BASED HHA	//////////// ////////////	0	0		4
5	SNF - BASED RHC	//////////// ////////////	//////////// ////////////	0		5
6	SNF - BASED FQHC	//////////// ////////////	//////////// ////////////			6
7	SNF - BASED CMHC	//////////// ////////////	//////////// ////////////	0		7
100	TOTAL		205,226	(26)	0	100

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

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD: FROM: 01/01/2023	WORKSHEET S-2 PART I
IDENTIFICATION DATA	31-5423	TO: 12/31/2023	

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	2300 HAMILTON AVENUE	P.O. Box:					1
2	City:	TRENTON	State:	NJ	Zip Code:	08619		2
3	County:	MERCER	CBSA Code:	45940	Urban / Rural:	U		3

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider CCN:	Date Certified		Payment System (P, O, or N) V	XVIII	XIX	
	0	1	2	3		4	5	6	
4	S N F	HAMILTON GROVE HEALTHCARI	31-5423	12/01/1997		N	P	N	4
5	Nursing Facility						////////////////////////		5
6	I C F / I I D					////////////////////	////////////////////////		6
7	SNF-Based HHA								7
8	SNF-Based RHC								8
9	SNF-Based FQHC								9
10	SNF-Based CMHC								10
11	SNF-Based OLTC		////////////////////////	////////////////////		////////////////////	////////////////////////	//////////////////	11
12	SNF-Based HOSPICE					////////////////////	////////////////////////	//////////////////	12
13	OTHER (specify)					////////////////////	////////////////////////	//////////////////	13
14	Cost Reporting Period (mm/dd/yyyy)			FROM: 01/01/2023		TO: 12/31/2023			14
15	Type of Control	5							15

	Type of Freestanding Skilled Nursing Facility	Y / N	
16	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	Y	16
17	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?	N	17
18	Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10? If yes, complete Worksheet A-8-1.	Y	18

	Miscellaneous Cost Reporting information		
19	Is this a low Medicare utilization cost report, enter "Y" for yes, or "N" for no.	N	19
19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)		19.01

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

20	Straight Line	343,995	////////////////////	20
21	Declining Balance		////////////////////	21
22	Sum of the Year's Digits		////////////////////	22
23	Sum of line 20 through 22	343,995	////////////////////	23
24	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)		Y	25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		N	26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies		N	27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports		N	28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: 31-5423	PERIOD FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S-2 PART I (Cont.)

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

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

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

	//////////////////////////////// //	Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:	28,884			41

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

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

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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S-2 Part II

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

Completed by All Skilled Nursing Facilities

	Provider Organization and Operation	1 Y/N	2 Date		
1	Has the Provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1

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

	Financial Data and Reports	1 Y/N	2 Type	3 Date	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5

	Approved Educational Activities	1 Y/N	2 Legal Oper.	
6	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N	6
7	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N		7
8	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N		8

	Bad Debts	1 Y/N	
9	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.	Y	9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.	N	10
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	N	11

Bed Complement

12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.	N	12

	PS&R Data	1 Y/N Part A	2 Date Part A	3 Y/N Part B	4 Date Part B	
13	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4 .(see Instructions.)	Y	05/01/2024	Y	05/01/2024	13
14	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N		14
15	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N		15
16	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions.	N		N		16
17	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:_____	N		N		17
18	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N		18

COST REPORT PREPARER CONTACT INFORMATION

19	First name	Abi	Last name	Goldenberg	Title	Owner	19
20	Employer	Taz Reporting LLC					20
21	Phone number	7183386900		Email address	agoldenberg@mfandco.com		21

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

PROVIDER CCN: 31-5423

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

WORKSHEET S-3 PART I

	Component		Number of Beds	Bed Days Available		Inpatient Days / Visits: Title V	Title XVIII	Title XIX	Other	Total
			1	2		3	4	5	6	7
1	Skilled Nursing Facility		218	79,570			8,206	50,785	11,734	70,725
2	Nursing Facility									0
3	ICF/IID									0
4	Home Health Agency									0
5	Other Long Term Care									0
6	SNF-Based CMHC									
7	Hospice									0
8	TOTAL (Sum Lines 1-7)		218	79,570			8,206	50,785	11,734	70,725

	Component		Discharges: Title V	Title XVIII	Title XIX	Other	Total	Average Length of Stay: Title V	Title XVIII	Title XIX	Total
			8	9	10	11	12	13	14	15	16
1	Skilled Nursing Facility			170	141	181	492		48.27	360.18	143.75
2	Nursing Facility						0			0.00	0.00
3	ICF/IID						0			0.00	0.00
4	Home Health Agency										
5	Other Long Term Care						0				0.00
6	SNF-Based CMHC										
7	Hospice						0		0.00	0.00	0.00
8	TOTAL (Sum Lines 1-7)			170	141	181	492		48.27	360.18	143.75

	Component		Admissions: Title V	Title XVIII	Title XIX	Other	Total	Full Time Equivalent	Employees on Payroll	Nonpaid Workers
			17	18	19	20	21		22	23
1	Skilled Nursing Facility			173	119	215	507		151.36	
2	Nursing Facility						0			
3	ICF/IID						0			
4	Home Health Agency									
5	Other Long Term Care						0			
6	SNF-Based CMHC									
7	Hospice						0			
8	TOTAL (Sum Lines 1-7)			173	119	215	507		151.36	0.00

SNF WAGE INDEX INFORMATION | **PROVIDER CCN:** 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET S-3 PARTS II & III**

	PART II DIRECT SALARIES	Amount Reported	Reclass.of Salaries from Wkst A-6	Adjusted Salaries	Paid Hrs Related to col.3	Average Hrly Wage	
		1	2	3	4	5	
1	Total salary (See Instructions)	8,444,243	0	8,444,243	314,825.25	26.82	1
2	Physician salaries-Part A			0		0.00	2
3	Physician salaries-Part B			0		0.00	3
4	Home office personnel			0		0.00	4
5	Sum of lines 2 thru 4	0	0	0	0.00	0.00	5
6	Revised wages (line 1 minus line 5)	8,444,243	0	8,444,243	314,825.25	26.82	6
7	Other Long Term Care	0	0	0		0.00	7
8	HHA	0	0	0		0.00	8
9	CMHC	0	0	0		0.00	9
10	Hospice	0	0	0		0.00	10
11	Other excluded areas	0	0	0		0.00	11
12	Subtotal Excluded salary (Sum of lines 7-11)	0	0	0	0.00	0.00	12
13	Total Adjusted Salaries (line 6 minus line 12)	8,444,243	0	8,444,243	314,825.25	26.82	13
	OTHER WAGES AND RELATED COSTS	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	
14	Contract Labor: Patient Related & Mgmt	1,713,394		1,713,394	26,394.80	64.91	14
15	Contract Labor: Physician services-Part A			0		0.00	15
16	Home office salaries & wage related costs			0		0.00	16
	WAGE RELATED COSTS	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	
17	Wage related costs core. (See Part IV)	1,739,610		1,739,610	////////////////////////////	////////////////////////////	17
18	Wage related costs other (See Part IV)	0		0	////////////////////////////	////////////////////////////	18
19	Wage related costs (excluded units)			0	////////////////////////////	////////////////////////////	19
20	Physicians Part A - WRC			0	////////////////////////////	////////////////////////////	20
21	Physicians Part B - WRC			0	////////////////////////////	////////////////////////////	21
22	Total Adj. Wage Related costs (see instructions)	1,739,610	0	1,739,610	////////////////////////////	////////////////////////////	22

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
1	Employee Benefits	0	0	0		0.00	1
2	Administrative & General	743,615	0	743,615	19,751.75	37.65	2
3	Plant Operation, Maintenance & Repairs	96,946	0	96,946	4,420.75	21.93	3
4	Laundry & Linen Service	0	0	0		0.00	4
5	Housekeeping	196,356	0	196,356	10,651.00	18.44	5
6	Dietary	831,961	0	831,961	46,782.90	17.78	6
7	Nursing Administration	456,211	0	456,211	7,117.50	64.10	7
8	Central Services and Supply	0	0	0		0.00	8
9	Pharmacy	0	0	0		0.00	9
10	Medical Records & Medical Records Library	0	0	0		0.00	10
11	Social Service	204,980	0	204,980	5,865.25	34.95	11
12	Nursing and Allied Health Education Activities	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	12
13	Other General Service Cost	267,442	0	267,442	14,098.00	18.97	13
14	Total (sum lines 1 thru 13)	2,797,511	0	2,797,511	108,687.15	**25.74**	14

SNF WAGE RELATED COSTS	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S-3 PART IV

PART IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	18,636	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	802,164	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accidental Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	181,688	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	627,372	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	109,750	20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)	1,739,610	24

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

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN: 31-5423		PERIOD: FROM: 01/01/2023 TO: 12/31/2023		WORKSHEET S-3 PART V	
	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)	
Occupational Category	1	2	3	4	5	
Direct Salaries	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	//////
Nursing Occupations	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	//////
1 Registered Nurses (RNs)	880,174	181,326	1,061,500	21,103.60	50.30	1
2 Licensed Practical Nurses (LPNs)	1,895,813	390,559	2,286,372	55,136.50	41.47	2
3 Certified Nursing Assistants/Nursing Assistants/Aides	2,870,745	591,406	3,462,151	129,898.00	26.65	3
4 Total Nursing (sum of lines 1 through 3)	5,646,732	1,163,291	6,810,023	206,138.10	33.04	4
5 Physical Therapists			-		0.00	5
6 Physical Therapy Assistants			-		0.00	6
7 Physical Therapy Aides			-		0.00	7
8 Occupational Therapists			-		0.00	8
9 Occupational Therapy Assistants			-		0.00	9
10 Occupational Therapy Aides			-		0.00	10
11 Speech Therapists			-		0.00	11
12 Respiratory Therapists			-		0.00	12
13 Other Medical Staff			-		0.00	13
Contract Labor	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	/
Nursing Occupations	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	/
14 Registered Nurses (RNs)		////////////////////////////	-		0.00	14
15 Licensed Practical Nurses (LPNs)	610,966	////////////////////////////	610,966	10,916.70	55.97	15
16 Certified Nursing Assistants/Nursing Assistants/Aides	87,150	////////////////////////////	87,150	2,148.01	40.57	16
17 Total Nursing (sum of lines 14 through 16)	698,116	////////////////////////////	698,116	13,064.71	53.44	17
18 Physical Therapists	432,996	////////////////////////////	432,996	6,103.52	70.94	18
19 Physical Therapy Assistants		////////////////////////////	-		0.00	19
20 Physical Therapy Aides		////////////////////////////	-		0.00	20
21 Occupational Therapists	470,205	////////////////////////////	470,205	5,898.20	79.72	21
22 Occupational Therapy Assistants		////////////////////////////	-		0.00	22
23 Occupational Therapy Aides		////////////////////////////	-		0.00	23
24 Speech Therapists	112,077	////////////////////////////	112,077	1,328.37	84.37	24
25 Respiratory Therapists		////////////////////////////	-		0.00	25
26 Other Medical Staff		////////////////////////////	-		0.00	26

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET A

		COST CENTER (Omit Cents)	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSI-FICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)
A	B	C	1	2	3	4	5	6	7
GENERAL SERVICE COST CENTERS									
1	0100	Capital-Related Costs - Building & Fixture		5,588,780	**5,588,780**	0	**5,588,780**	(3,894,152)	**1,694,628**
2	0200	Capital-Related Costs - Movable Equipment		0	**0**	0	**0**	0	**0**
3	0300	Employee Benefits	0	1,739,610	**1,739,610**	0	**1,739,610**	0	**1,739,610**
4	0400	Administrative and General	743,615	3,008,535	**3,752,150**	0	**3,752,150**	111,138	**3,863,288**
5	0500	Plant Operation, Maintenance and Repairs	96,946	585,185	**682,131**	0	**682,131**	0	**682,131**
6	0600	Laundry and Linen Service	0	65,023	**65,023**	0	**65,023**	0	**65,023**
7	0700	Housekeeping	196,356	665,090	**861,446**	0	**861,446**	0	**861,446**
8	0800	Dietary	831,961	707,546	**1,539,507**	0	**1,539,507**	0	**1,539,507**
9	0900	Nursing Administration	456,211	716	**456,927**	0	**456,927**	0	**456,927**
10	1000	Central Services and Supply	0	469,315	**469,315**	0	**469,315**	0	**469,315**
11	1100	Pharmacy	0	0	**0**	0	**0**	0	**0**
12	1200	Medical Records and Library	0	0	**0**	0	**0**	0	**0**
13	1300	Social Service	204,980	0	**204,980**	0	**204,980**	0	**204,980**
14	1400	Nursing and Allied Health Education Activities	0	0	**0**	0	**0**	0	**0**
15	1500	Other General Service Cost	267,442	19,356	**286,798**	0	**286,798**	0	**286,798**
INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	Skilled Nursing Facility	5,646,732	731,811	**6,378,543**	0	**6,378,543**	(8,146)	**6,370,397**
31	3100	Nursing Facility	0	0	**0**	0	**0**	0	**0**
32	3200	ICF/IID	0	0	**0**	0	**0**	0	**0**
33	3300	Other Long Term Care	0	0	**0**	0	**0**	0	**0**
ANCILLARY SERVICE COST CENTERS									
40	4000	Radiology	0	10,418	**10,418**	0	**10,418**	0	**10,418**
41	4100	Laboratory	0	23,170	**23,170**	0	**23,170**	0	**23,170**
42	4200	Intravenous Therapy	0	11,580	**11,580**	0	**11,580**	0	**11,580**
43	4300	Oxygen (Inhalation) Therapy	0	30,516	**30,516**	0	**30,516**	0	**30,516**
44	4400	Physical Therapy	0	1,015,278	**1,015,278**	(582,282)	**432,996**	0	**432,996**
45	4500	Occupational Therapy	0	0	**0**	470,205	**470,205**	0	**470,205**
46	4600	Speech Pathology	0	0	**0**	112,077	**112,077**	0	**112,077**
47	4700	Electrocardiology	0	0	**0**	0	**0**	0	**0**
48	4800	Medical Supplies Charged to Patients	0	0	**0**	0	**0**	0	**0**
49	4900	Drugs Charged to Patients	0	230,457	**230,457**	0	**230,457**	0	**230,457**
50	5000	Dental Care - Title XIX only	0	0	**0**	0	**0**	0	**0**
51	5100	Support Surfaces	0	0	**0**	0	**0**	0	**0**
52	5200	Other Ancillary Service Cost Center	0	0	**0**	0	**0**	0	**0**

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET A

COST CENTER (Omit Cents)			SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSI-FICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)
A	B	C	1	2	3	4	5	6	7
52.01	5201	Other Ancillary Service Cost Center II	0	0	**0**	0	**0**	0	**0**
52.02	5202	Other Ancillary Service Cost Center III	0	0	**0**	0	**0**	0	**0**
OUTPATIENT SERVICE COST CENTERS			////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////
60	6000	Clinic	0	0	**0**	0	**0**	0	**0**
61	6100	Rural Health Clinic	0	0	**0**	0	**0**	0	**0**
62	6200	FQHC	0	0	**0**	0	**0**	0	**0**
63	6300	Other Outpatient Service Cost	0	0	**0**	0	**0**	0	**0**
OTHER REIMBURSABLE COST CENTERS			////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////
70	7000	Home Health Agency Cost	0	0	**0**	0	**0**	0	**0**
71	7100	Ambulance	0	0	**0**	0	**0**	0	**0**
72	7200	Outpatient Rehabilitation	0	0	**0**	0	**0**	0	**0**
73	7300	CMHC	0	0	**0**	0	**0**	0	**0**
74	7400	Other Reimbursable Cost	0	0	**0**	0	**0**	0	**0**
SPECIAL PURPOSE COST CENTERS			////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////
80	8000	Malpractice Premiums & Paid Losses	////////////////	0	**0**	0	**0**	0	**-0-**
81	8100	Interest Expense	////////////////	0	**0**	0	**0**	0	**-0-**
82	8200	Utilization Review -- SNF	0	0	**0**	0	**0**	0	**-0-**
83	8300	Hospice	0	0	**0**	0	**0**	0	**0**
84	8400	Other Special Purpose Cost I	0	0	**0**	0	**0**	0	**0**
84.01	8401	Other Special Purpose Cost II	0	0	**0**	0	**0**	0	**0**
89		SUBTOTALS (sum of lines 1 through 84)	8,444,243	14,902,386	**23,346,629**	0	**23,346,629**	(3,791,160)	**19,555,469**
NON REIMBURSABLE COST CENTERS			////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////
90	9000	Gift, Flower, Coffee Shop & Canteen	0	0	**0**	0	**0**	0	**0**
91	9100	Barber and Beauty Shop	0	0	**0**	0	**0**	0	**0**
92	9200	Physicians' Private Offices	0	9,600	**9,600**	0	**9,600**	0	**9,600**
93	9300	Nonpaid Workers	0	0	**0**	0	**0**	0	**0**
94	9400	Patients Laundry	0	0	**0**	0	**0**	0	**0**
95	9500	Other Nonreimbursable Cost	0	0	**0**	0	**0**	0	**0**
100		TOTAL	**8,444,243**	**14,911,986**	**23,356,229**	**0**	**23,356,229**	**(3,791,160)**	**19,565,069**

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

RECLASSIFICATIONS	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET A-6

			INCREASE				DECREASE			
	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	COST CENTER	LINE NO.	SALARY	NON-SALARY	COST CENTER	LINE NO.	SALARY	NON-SALARY
		1	2	3	4	5	6	7	8	9
1	RECLASS OT	A	Occupational Therapy	45		470,205	Physical Therapy	44		470,205
2	RECLASS ST	B	Speech Pathology	46		112,077	Physical Therapy	44		112,077
3										
4										
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68										
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71										
72										
100	**TOTAL RECLASSIFICATIONS**	//////////	//	//////////	0	582,282	//////////////////////////////////	//////////	0	582,282

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

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets
			Purchases	Donation	Total			
		1	2	3	4	5	6	7
1	Land				**0**		**0**	
2	Land Improvements				**0**		**0**	
3	Buildings and Fixtures				**0**		**0**	
4	Building Improvements	4,984,256	41,126		**41,126**	663,714	**4,361,668**	
5	Fixed Equipment				**0**		**0**	
6	Movable Equipment	189,511	28,114		**28,114**	102,600	**115,025**	
7	Subtotal (sum of lines 1-6)	**5,173,767**	**69,240**	**0**	**69,240**	**766,314**	**4,476,693**	0
8	Reconciling Items				**0**		**0**	
9	Total (line 7 minus line 8)	5,173,767	69,240	0	69,240	766,314	4,476,693	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET A-8

	(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED AMOUNT	COST CENTER	LINE #
1	Investment income on restricted funds (Chapter 2)	B	(33,480)	Administrative and General	4
2	Trade, quantity and time discounts on purchases (Chapter 8)				
3	Refunds and rebates of expenses (Chapter 8)				
4	Rental of provider space by suppliers (Chapter 8)				
5	Telephone services (pay stations excluded) (Chapter 21)				
6	Television and radio service (Chapter 21)				
7	Parking lot (Chapter 21)				
8	Remuneration applicable to provider-	////////////////	////////////////////////	//	////////////////////
	based physician adjustment	A-8-2	0	//	////////////////////
9	Home office costs (Chapter 21)				
10	Sale of scrap, waste, etc. (Chapter23)				
11	Nonallowable costs related to certain	////////////////	////////////////////////	//	////////////////////
	Capital expenditures (Chapter 24)				
12	Adjustment resulting from transactions	////////////////	////////////////////////	//	////////////////////
	with related organizations (Chapter 10)	A-8-1	(3,571,898)	//	////////////////////
13	Laundry and Linen service				
14	Revenue - Employee meals				
15	Cost of meals - Guests				
16	Sale of medical supplies to other than patients				
17	Sale of drugs to other than patients				
18	Sale of medical records and abstracts	B	(25)	Administrative and General	4
19	Vending machines				
20	Income from imposition of interest,	////////////////	////////////////////////	//	////////////////////
	finance or penalty charges (Chapter 21)				
21	Interest expense on Medicare overpayments	////////////////	////////////////////////	//	////////////////////
	and borrowings to repay Medicare overpayments				
22	Utilization review--physicians' compensation (chapter 21)			Utilization Review -- SNF	82
23	Depreciation--buildings and fixtures			Capital-Related Costs - Building & Fixture	1
24	Depreciation--movable equipment			Capital-Related Costs - Moveable Equipment	2
25	Don,Misc,ProAds,Pens	A	(185,757)	Administrative and General	4
25.01					
25.02					
25.03					
25.04					
	A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)	////////////////	0	//	////////////////////
100	TOTAL	////////////////	(3,791,160)	//	////////////////////

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET A-8

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

SUBTOTAL OF ADDITIONAL ADJUSTMENTS 0

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

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

MED-CALC SYSTEMS

In Lieu of CMS Form 2540-10

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	**WORKSHEET A-8-1**

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

		Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A. , col. 5	Adjustments (Col 4 minus Col 5)
		1	2	3	4	5	6
1		3	Employee Benefits	Self Insurance	866,141	866,141	0
2		10	Central Services and Supply	Med Supplies	270,536	270,536	0
3		43	Oxygen (Inhalation) Therapy	Oxygen	8,015	8,015	0
4		10	Central Services and Supply	OTC Drugs	23,161	23,161	0
5		8	Dietary	Dietary	728,493	728,493	0
6		5	Plant Operation, Maintenance and F	Maintenance	77,142	77,142	0
7		6	Laundry and Linen Service	Diapers	65,023	65,023	0
8		4	Administrative and General	Office Supplies	17,383	17,383	0
9		4	Administrative and General	Office Support	1,058,726	1,267,935	(209,209)
9.01		1	Capital-Related Costs - Building &	Rent		5,150,000	(5,150,000)
9.02		30	Skilled Nursing Facility	Nursing	104,523	112,669	(8,146)
9.03		1	Capital-Related Costs - Building &	Mortgage Interest	720,178		720,178
9.04		1	Capital-Related Costs - Building &	Depreciation	133,183		133,183
9.05		1	Capital-Related Costs - Building &	Property Tax	402,487		402,487
9.06		4	Administrative and General	Insurance	539,609		539,609
9.07							0
9.08							0
9.09							0
9.10							0
10 TOTAL					5,014,600	8,586,498	(3,571,898)

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

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

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

					Related Organization(s)		
	Description	(1) Symbol	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business
		1	2	3	4	5	6
1		A	M Feigenbaum	34.00	Dynamic Health	50.00	Office Support
2		A	C Feigenbaum	4.00	Dynamic Health	50.00	Office Support
3		A	M Feigenbaum	34.00	Ocean Dietary	50.00	Purchasing
4		A	C Feigenbaum	4.00	Ocean Dietary	50.00	Purchasing
5		A	M Feigenbaum	34.00	Ocean Healthcr	100.00	Self Insurance
6		A	Hamilton Grove	100.00	Care Street	100.00	Nursing
7		A	Hamilton Grove	100.00	Hamilton Ave Realty	100.00	Realty
8							
9							
10							
10.01							
10.02							
10.03							
10.04							
10.05							

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | **WORKSHEET A-8-2**

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

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

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5423

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

WORKSHEET B
PART I

	COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	3	3a	4.00	5	6
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture	1,694,628	1,694,628						
2	Capital-Related Costs - Movable Equipment	0	////////////////////////////	0					
3	Employee Benefits	1,739,610	0	0	1,739,610				
4	Administrative and General	3,863,288	0	0	153,193	4,016,481	4,016,481		
5	Plant Operation, Maintenance and Repairs	682,131	0	0	19,972	702,103	181,366	883,469	
6	Laundry and Linen Service	65,023	0	0	0	65,023	16,797	0	81,820
7	Housekeeping	861,446	0	0	40,451	901,897	232,976	0	0
8	Dietary	1,539,507	0	0	171,393	1,710,900	441,956	0	0
9	Nursing Administration	456,927	0	0	93,984	550,911	142,310	0	0
10	Central Services and Supply	469,315	0	0	0	469,315	121,233	0	0
11	Pharmacy	0	0	0	0	0	0	0	0
12	Medical Records and Library	0	0	0	0	0	0	0	0
13	Social Service	204,980	0	0	42,228	247,208	63,858	0	0
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	286,798	0	0	55,096	341,894	88,317	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	6,370,397	1,672,884	0	1,163,293	9,206,574	2,378,225	872,133	81,820
31	Nursing Facility	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology	10,418	0	0	0	10,418	2,691	0	0
41	Laboratory	23,170	0	0	0	23,170	5,985	0	0
42	Intravenous Therapy	11,580	0	0	0	11,580	2,991	0	0
43	Oxygen (Inhalation) Therapy	30,516	0	0	0	30,516	7,883	0	0
44	Physical Therapy	432,996	21,744	0	0	454,740	117,468	11,336	0
45	Occupational Therapy	470,205	0	0	0	470,205	121,462	0	0
46	Speech Pathology	112,077	0	0	0	112,077	28,952	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	230,457	0	0	0	230,457	59,531	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: 31-5423

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

WORKSHEET B
PART I

	COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	3	3a	4.00	5	6
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	Clinic	0	0	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost	0	0	0	0	0	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
83	Hospice	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	19,555,469	1,694,628	0	1,739,610	19,555,469	4,014,001	883,469	81,820
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	9,600	0	0	0	9,600	2,480	0	0
93	Nonpaid Workers	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
99	Negative Cost Center		0	0	0	0	0	0	0
100	TOTAL	19,565,069	1,694,628	0	1,739,610	19,565,069	4,016,481	883,469	81,820

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN:
31-5423

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

WORKSHEET B
PART I
(cont.)

	COST CENTER	HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH
		7	8	9	10	11	12	13	14
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture								
2	Capital-Related Costs - Movable Equipment								
3	Employee Benefits								
4	Administrative and General								
5	Plant Operation, Maintenance and Repairs								
6	Laundry and Linen Service								
7	Housekeeping	1,134,873							
8	Dietary	0	2,152,856						
9	Nursing Administration	0	0	693,221					
10	Central Services and Supply	0	0	0	590,548				
11	Pharmacy	0	0	0	0	0			
12	Medical Records and Library	0	0	0	0	0	0		
13	Social Service	0	0	0	0	0	0	311,066	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	0	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	1,120,311	2,152,856	693,221	590,548	0	0	311,066	0
31	Nursing Facility	0	0	0	0	0	0	0	0
32	ICF/IID	0	0	0	0	0	0	0	0
33	Other Long Term Care	0	0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology	0	0	0	0	0	0	0	0
41	Laboratory	0	0	0	0	0	0	0	0
42	Intravenous Therapy	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy	0	0	0	0	0	0	0	0
44	Physical Therapy	14,562	0	0	0	0	0	0	0
45	Occupational Therapy	0	0	0	0	0	0	0	0
46	Speech Pathology	0	0	0	0	0	0	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	0	0	0	0	0	0	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN:
31-5423

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

WORKSHEET B
PART I
(cont.)

	COST CENTER	HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH
		7	8	9	10	11	12	13	14
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	Clinic	0	**0**	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost	0	0	0	0	0	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
83	Hospice	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	1,134,873	2,152,856	693,221	590,548	0	0	311,066	0
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	0	0
93	Nonpaid Workers	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
99	Negative Cost Center	0	0	0	0	0	0	0	0
100	TOTAL	1,134,873	2,152,856	693,221	590,548	0	0	311,066	0

ALLOCATION OF CAPITAL-RELATED COSTS

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

PROVIDER CCN: 31-5423

WORKSHEET B
PART II

	COST CENTER	DIRECTLY ASSIGNED	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	2a	3	4	5	6
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture	////////////////////////	////////////////////////	////////////////////////	////////////////////////				
2	Capital-Related Costs - Movable Equipment	////////////////////////	////////////////////////	////////////////////////	////////////////////////				
3	Employee Benefits		0	0	0	0			
4	Administrative and General		0	0	0	0	0		
5	Plant Operation, Maintenance and Repairs		0	0	0	0	0	0	
6	Laundry and Linen Service		0	0	0	0	0	0	0
7	Housekeeping		0	0	0	0	0	0	0
8	Dietary		0	0	0	0	0	0	0
9	Nursing Administration		0	0	0	0	0	0	0
10	Central Services and Supply		0	0	0	0	0	0	0
11	Pharmacy		0	0	0	0	0	0	0
12	Medical Records and Library		0	0	0	0	0	0	0
13	Social Service		0	0	0	0	0	0	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0
15	Other General Service Cost		0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility		1,672,884	0	1,672,884	0	0	0	0
31	Nursing Facility		0	0	0	0	0	0	0
32	ICF/IID		0	0	0	0	0	0	0
33	Other Long Term Care		0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology		0	0	0	0	0	0	0
41	Laboratory		0	0	0	0	0	0	0
42	Intravenous Therapy		0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	0	0	0
44	Physical Therapy		21,744	0	21,744	0	0	0	0
45	Occupational Therapy		0	0	0	0	0	0	0
46	Speech Pathology		0	0	0	0	0	0	0
47	Electrocardiology		0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients		0	0	0	0	0	0	0
49	Drugs Charged to Patients		0	0	0	0	0	0	0
50	Dental Care - Title XIX only		0	0	0	0	0	0	0
51	Support Surfaces		0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center		0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II		0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	PROVIDER CCN: 31-5423	**WORKSHEET B PART II**

	COST CENTER	DIRECTLY ASSIGNED	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	2a	3	4	5	6
52.02	Other Ancillary Service Cost Center III		0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	Clinic		0	0	0	0	0	0	0
61	Rural Health Clinic		0	0	0	0	0	0	0
62	FQHC		0	0	0	0	0	0	0
63	Other Outpatient Service Cost		0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost		0	0	0	0	0	0	0
71	Ambulance		0	0	0	0	0	0	0
72	Outpatient Rehabilitation		0	0	0	0	0	0	0
73	CMHC		0	0	0	0	0	0	0
74	Other Reimbursable Cost		0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
83	Hospice		0	0	0	0	0	0	0
84	Other Special Purpose Cost I		0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II		0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	0	1,694,628	0	1,694,628	0	0	0	0
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen		0	0	0	0	0	0	0
91	Barber and Beauty Shop		0	0	0	0	0	0	0
92	Physicians' Private Offices		0	0	0	0	0	0	0
93	Nonpaid Workers		0	0	0	0	0	0	0
94	Patients Laundry		0	0	0	0	0	0	0
95	Other Nonreimbursable Cost		0	0	0	0	0	0	0
98	Cross Foot Adjustments		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
99	Negative Cost Center		0	0	0	0	0	0	0
100	TOTAL	0	1,694,628	0	1,694,628	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5423

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

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5423

	COST CENTER	HOUSE-KEEPING	DIETARY	NURSING ADMIN.	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH
		7	8	9	10	11	12	13	14
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	Clinic	0	**0**	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost	0	0	0	0	0	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
83	Hospice	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	0	0	0	0	0	0	0	0
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	0	0	0	0	0	0	0	0
92	Physicians' Private Offices	0	0	0	0	0	0	0	0
93	Nonpaid Workers	0	0	0	0	0	0	0	0
94	Patients Laundry	0	0	0	0	0	0	0	0
95	Other Nonreimbursable Cost	0	0	0	0	0	0	0	0
98	Cross Foot Adjustments	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
99	Negative Cost Center	0	0	0	0	0	0	0	0
100	TOTAL	0	0	0	0	0	0	0	0

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-1

	COST CENTER		CAP.REL. BLDG/FIX (SQUARE FEET)	CAP.REL. MOV.EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS GROSS SALARIES	RECONCI-LIATION *	ADMIN & GENERAL (ACCUM COST)	PLANT OP. MAINT/REP. (SQUARE FEET)	LNDRY/LIN SERVICE (PATIENT DAYS)	HOUSE-KEEPING (SQUARE FEET)
		0	1	2	3	4.00a	4.00	5	6	7
GENERAL SERVICE COST CENTERS										
1	Capital-Related Costs - Building & Fixture		121,580							
2	Capital-Related Costs - Movable Equipment			0						
3	Employee Benefits			0	8,444,243					
4	Administrative and General			0	743,615	(4,016,481)	15,548,588			
5	Plant Operation, Maintenance and Repairs			0	96,946		702,103	121,580		
6	Laundry and Linen Service			0	0		65,023	0	70,725	
7	Housekeeping			0	196,356		901,897	0		121,580
8	Dietary			0	831,961		1,710,900	0		0
9	Nursing Administration			0	456,211		550,911	0		0
10	Central Services and Supply			0	0		469,315	0		0
11	Pharmacy			0	0		0	0		0
12	Medical Records and Library			0	0		0	0		0
13	Social Service			0	204,980		247,208	0		0
14	Nursing and Allied Health Education Activities			0	0		0	0		0
15	Other General Service Cost			0	267,442		341,894	0		0
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Skilled Nursing Facility		120,020	0	5,646,732		9,206,574	120,020	70,725	120,020
31	Nursing Facility			0	0		0	0	0	0
32	ICF/IID			0	0		0	0	0	0
33	Other Long Term Care			0	0		0	0	0	0
ANCILLARY SERVICE COST CENTERS										
40	Radiology			0	0		10,418	0		0
41	Laboratory			0	0		23,170	0		0
42	Intravenous Therapy			0	0		11,580	0		0
43	Oxygen (Inhalation) Therapy			0	0		30,516	0		0
44	Physical Therapy		1,560	0	0		454,740	1,560		1,560
45	Occupational Therapy			0	0		470,205	0		0
46	Speech Pathology			0	0		112,077	0		0
47	Electrocardiology			0	0		0	0		0
48	Medical Supplies Charged to Patients			0	0		0	0		0
49	Drugs Charged to Patients			0	0		230,457	0		0
50	Dental Care - Title XIX only			0	0		0	0		0
51	Support Surfaces			0	0		0	0		0
52	Other Ancillary Service Cost Center			0	0		0	0		0
52.01	Other Ancillary Service Cost Center II			0	0		0	0		0
52.02	Other Ancillary Service Cost Center III			0	0		0	0		0
OUTPATIENT SERVICE COST CENTERS										

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-1

	COST CENTER		CAP.REL. BLDG/FIX (SQUARE FEET)	CAP.REL. MOV.EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS GROSS SALARIES	RECONCI-LIATION *	ADMIN & GENERAL (ACCUM COST)	PLANT OP. MAINT/REP. (SQUARE FEET)	LNDRY/LIN SERVICE (PATIENT DAYS)	HOUSE-KEEPING (SQUARE FEET)
		0	1	2	3	4.00a	4.00	5	6	7
60	Clinic	////////////		0	0		0	0		0
61	Rural Health Clinic	////////////					0			
62	FQHC	////////////					0			
63	Other Outpatient Service Cost	////////////		0	0		0	0		0
OTHER REIMBURSABLE COST CENTERS		////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
70	Home Health Agency Cost	////////////		0	0		0	0	0	0
71	Ambulance	////////////		0	0		0	0		0
72	Outpatient Rehabilitation	////////////		0	0		0	0		0
73	CMHC	////////////		0	0		0	0		0
74	Other Reimbursable Cost	////////////		0	0		0	0		0
SPECIAL PURPOSE COST CENTERS		////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
83	Hospice	////////////		0	0		0	0		0
84	Other Special Purpose Cost I	////////////		0	0		0	0		0
84.01	Other Special Purpose Cost II	////////////		0	0		0	0		0
89	SUBTOTALS (sum of lines 1 through 84)	////////////	121,580	0	8,444,243	(4,016,481)	15,538,988	121,580	70,725	121,580
NON REIMBURSABLE COST CENTERS		////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
90	Gift, Flower, Coffee Shop & Canteen	////////////		0	0		0	0		0
91	Barber and Beauty Shop	////////////		0	0		0	0		0
92	Physicians' Private Offices	////////////		0	0		9,600	0		0
93	Nonpaid Workers	////////////		0	0		0	0		0
94	Patients Laundry	////////////		0	0		0	0		0
95	Other Nonreimbursable Cost	////////////		0	0		0	0		0
98	Cross Foot Adjustment	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
99	Negative Cost Center	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
102	Cost to Be Allocated (Per Worksheet B, Part I)	////////////	1,694,628	0	1,739,610	////////////	4,016,481	883,469	81,820	1,134,873
103	Unit Cost Multiplier (Worksheet B, Part I)	////////////	13.938378	0.000000	0.206011	////////////	0.258318	7.266565	1.156875	9.334372
104	Cost to Be Allocated (Per Worksheet B, Part II)	////////////	////////////	////////////	0	////////////	0	0	0	0
105	Unit Cost Multiplier (Worksheet B, Part II)	////////////	////////////	////////////	0.000000	////////////	0.000000	0.000000	0.000000	0.000000

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

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-1 (cont.)

	COST CENTER	DIETARY (MEALS SERVED)	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)
		8	9	10	11	12	13	14	15
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture								
2	Capital-Related Costs - Movable Equipment								
3	Employee Benefits								
4	Administrative and General								
5	Plant Operation, Maintenance and Repairs								
6	Laundry and Linen Service								
7	Housekeeping								
8	Dietary	212,175							
9	Nursing Administration		70,725						
10	Central Services and Supply			70,725					
11	Pharmacy				0				
12	Medical Records and Library					0			
13	Social Service						70,725		
14	Nursing and Allied Health Education Activities							0	
15	Other General Service Cost								70,725
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	212,175	70,725	70,725	0	0	70,725		70,725
31	Nursing Facility	0	0	0	0	0	0		0
32	ICF/IID	0	0	0	0	0	0		0
33	Other Long Term Care	0	0	0	0	0	0		0
ANCILLARY SERVICE COST CENTERS									
40	Radiology								
41	Laboratory								
42	Intravenous Therapy								
43	Oxygen (Inhalation) Therapy								
44	Physical Therapy								
45	Occupational Therapy								
46	Speech Pathology								
47	Electrocardiology								
48	Medical Supplies Charged to Patients								
49	Drugs Charged to Patients								
50	Dental Care - Title XIX only								
51	Support Surfaces								
52	Other Ancillary Service Cost Center								
52.01	Other Ancillary Service Cost Center II								
52.02	Other Ancillary Service Cost Center III								
OUTPATIENT SERVICE COST CENTERS									

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5423 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-1 (cont.)

	COST CENTER	DIETARY (MEALS SERVED)	NURSING ADMIN. (PATIENT DAYS)	CENTRAL SVC & SUPP (PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)
		8	9	10	11	12	13	14	15
60	Clinic	////////////////////////////							
61	Rural Health Clinic								
62	FQHC								
63	Other Outpatient Service Cost								
OTHER REIMBURSABLE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
70	Home Health Agency Cost	0	0	0	0	0	0		0
71	Ambulance								
72	Outpatient Rehabilitation								
73	CMHC								
74	Other Reimbursable Cost								
SPECIAL PURPOSE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
83	Hospice								
84	Other Special Purpose Cost I								
84.01	Other Special Purpose Cost II								
89	SUBTOTALS (sum of lines 1 through 84)	212,175	70,725	70,725	0	0	70,725	0	70,725
NON REIMBURSABLE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
90	Gift, Flower, Coffee Shop & Canteen								
91	Barber and Beauty Shop								
92	Physicians' Private Offices								
93	Nonpaid Workers								
94	Patients Laundry								
95	Other Nonreimbursable Cost								
98	Cross Foot Adjustment	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
99	Negative Cost Center	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
102	Cost to Be Allocated (Per Worksheet B, Part I)	2,152,856	693,221	590,548	0	0	311,066	0	430,211
103	Unit Cost Multiplier (Worksheet B, Part I)	10.146605	9.801640	8.349919	0.000000	0.000000	4.398247	0.000000	6.082870
104	Cost to Be Allocated (Per Worksheet B, Part II)	0	0	0	0	0	0	0	0
105	Unit Cost Multiplier (Worksheet B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5423	PERIOD: **FROM: 01/01/2023 TO: 12/31/2023**	**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET B PART NO. (1 or 2)	LINE NO.	AMOUNT
	-1-	-2-	-3-	-4-
1				
2				
3				
4				
5				
6				
7				
8				
9				
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44				
45				
46				
47				
48				
49				
50				
				0

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5423	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET C

	Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)
		1	2	3
ANCILLARY SERVICE COST CENTERS:				
40	Radiology	13,109	10,418	1.258303
41	Laboratory	29,155	23,170	1.258308
42	Intravenous Therapy	14,571	14,387	1.012789
43	Oxygen (Inhalation) Therapy	38,399	30,516	1.258324
44	Physical Therapy	598,106	880,262	0.679464
45	Occupational Therapy	591,667	955,907	0.618959
46	Speech Pathology	141,029	227,849	0.618958
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	0	0	0.000000
49	Drugs Charged to Patients	289,988	425,381	0.681714
50	Dental Care - Title XIX only	0	0	0.000000
51	Support Surfaces	0	0	0.000000
52	Other Ancillary Service Cost Center	0	0	0.000000
52.01	Other Ancillary Service Cost Center II	0	0	0.000000
52.02	Other Ancillary Service Cost Center III	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS				
60	Clinic	0	0	0.000000
61	Rural Health Clinic	0000000000000000000	00000000000000000	0000000000000000000
62	FQHC	0000000000000000000	00000000000000000	0000000000000000000
63	Other Outpatient Service Cost	0	0	0.000000
71	Ambulance	0	0	0.000000
100	TOTAL	1,716,024	2,567,890	////////////////////////////////////

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2023 TO: 12/31/2023		WORKSHEET D
Check One: [ ] Title V (1) [X] Title XVIII [ ] Title XIX (1)		Check One:	[X] SNF [ ] NF [ ] ICF/IID [ ] Other [ ] PPS - Must also complete Part II			

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST		RATIO OF COST TO CHARGES	HEALTH CARE PROGRAM CHARGES		HEALTH CARE PROGRAM COST	
		(WS C, col 3)	PART A	PART B	PART A	PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:						
40	Radiology	1.258303	5,455		6,864	0
41	Laboratory	1.258308	17,605		22,153	0
42	Intravenous Therapy	1.012789	14,387		14,571	0
43	Oxygen (Inhalation) Therapy	1.258324	0		0	0
44	Physical Therapy	0.679464	391,040		265,698	0
45	Occupational Therapy	0.618959	438,785		271,590	0
46	Speech Pathology	0.618958	147,372		91,217	0
47	Electrocardiology	0.000000	0		0	0
48	Medical Supplies Charged	0.000000	0		0	0
49	Drugs Charged to Patients	0.681714	420,043		286,349	0
50	Dental Care - Title XIX only	0.000000	////////////////////////////////	////////////////////////////////	0	////////////////////
51	Support Surfaces	0.000000	0		0	0
52	Other Ancillary Service Cost Center	0.000000	0		0	0
52.01	Other Ancillary Service Cost Center II	0.000000	0		0	0
52.02	Other Ancillary Service Cost Center III	0.000000	0		0	0
OUTPATIENT SERVICE COST CENTERS						
60	Clinic	0.000000	0		0	0
61	Rural Health Clinic	0.000000			0	0
62	FQHC	0.000000			0	0
63	Other Outpatient Service Cost	0.000000	0		0	0
71	Ambulance	0.000000	////////////////////////////////	////////////////////////////////		
	(2)					
100	Total (Sum of lines 40 - 71)		1,434,687	0	958,442	0

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

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

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D

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

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

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	0.681714
2	Program vaccine charges (From your records, or the P S & R.) --->	400
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	273

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

		Total Cost (From Worksheet B, Part I, Col 18)	Nursing & Allied Health (From Wkst. B, Part I, Column 14)	Ratio of Nursing & Allied Health Costs To Total Costs - Part A (Col. 2 / Col.. 1)	Program Part A Cost (From Wkst. D. Part I, Col. 4)	Part A ursing & Allie ealth Costs fo Pass Through (Col. 3 X Col. 4
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS	////////////	////////////	////////////	////////////	////////////
40	Radiology	13,109	0	0.000000	6,864	0
41	Laboratory	29,155	0	0.000000	22,153	0
42	Intravenous Therapy	14,571	0	0.000000	14,571	0
43	Oxygen (Inhalation) Therapy	38,399	0	0.000000	0	0
44	Physical Therapy	598,106	0	0.000000	265,698	0
45	Occupational Therapy	591,667	0	0.000000	271,590	0
46	Speech Pathology	141,029	0	0.000000	91,217	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	0	0	0.000000	0	0
49	Drugs Charged to Patients	289,988	0	0.000000	286,349	0
50	Dental Care - Title XIX only	0	0	0.000000	0	0
51	Support Surfaces	0	0	0.000000	0	0
52	Other Ancillary Service Cost Center	0	0	0.000000	0	0
52.01	Other Ancillary Service Cost Center II	0	0	0.000000	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0.000000	0	0
100	Total (Sum of lines 40 - 52)	1,716,024	0	////////////	958,442	0

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10		
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

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

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

	PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST	RATIO OF COST TO CHARGES	HEALTH CARE PROGRAM INPATIENT CHARGES		HEALTH CARE PROGRAM INPATIENT COST	
			PART A	PART B	PART A	PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:		////////////////////////	////////////////////////	////////////////////////		////////////////////////
40	Radiology	1.258303		////////////////////////	0	////////////////////////
41	Laboratory	1.258308		////////////////////////	0	////////////////////////
42	Intravenous Therapy	1.012789		////////////////////////	0	////////////////////////
43	Oxygen (Inhalation) Therapy	1.258324		////////////////////////	0	////////////////////////
44	Physical Therapy	0.679464		////////////////////////	0	////////////////////////
45	Occupational Therapy	0.618959		////////////////////////	0	////////////////////////
46	Speech Pathology	0.618958		////////////////////////	0	////////////////////////
47	Electro cardiology	0.000000		////////////////////////	0	////////////////////////
48	Medical Supplies Charged	0.000000		////////////////////////	0	////////////////////////
49	Drugs Charged to Patients	0.681714		////////////////////////	0	////////////////////////
50	Dental Care - Title XIX only	0.000000		////////////////////////	0	////////////////////////
51	Support Surfaces	0.000000		////////////////////////	0	////////////////////////
52	Other Ancillary Service Cost Center	0.000000		////////////////////////	0	////////////////////////
52.01	Other Ancillary Service Cost Center II	0.000000		////////////////////////	0	////////////////////////
52.02	Other Ancillary Service Cost Center III	0.000000		////////////////////////	0	////////////////////////
OUTPATIENT SERVICE COST CENTERS		////////////////////////	////////////////////////	////////////////////////		////////////////////////
60	Clinic	0.000000		////////////////////////	0	////////////////////////
61	Rural Health Clinic	0.000000		////////////////////////	0	////////////////////////
62	FQHC	0.000000		////////////////////////	0	////////////////////////
63	Other Outpatient Service Cost	0.000000		////////////////////////	0	////////////////////////
71	Ambulance	0.000000		////////////////////////	0	////////////////////////
				////////////////////////		////////////////////////
100	Total (Sum of lines 40 - 71)		**0**	////////////////////////	**0**	////////////////////////

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

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title V	[X] Title XVIII	[ ] Title XIX
Check One:	[X] SNF	[ ] NF	[ ] ICF/IID

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	70,725
2	Private room days	
3	Inpatient days including private room days applicable to the Program	8,206
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	17,836,965

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	24,119,819
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.739515
8	Enter private room charges from your records	
9	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00
10	Enter semi-private room charges from your records	
11	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00
12	Average per diem private room charge differential (Line 9 minus line 11)	0.00
13	Average per diem private room cost differential (Line 7 times line 12)	0.00
14	Private room cost differential adjustment (Line 2 times line 13)	0
15	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	17,836,965

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	252.20
17	Program routine service cost (Line 3 times line 16)	2,069,553
18	Medically necessary private room cost applicable to program (line 4 times line 13)	0
19	Total program general inpatient routine service cost (Line 17 plus line 18)	2,069,553
20	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 30 for SNF; line 31 for NF,or line 32 for ICF/MR)	1,672,884
21	Per diem capital related costs (Line 20 divided by line 1)	23.65
22	Program capital related cost (Line 3 times line 21)	194,072
23	Inpatient routine service cost (Line 19 minus line 22)	1,875,481
24	Aggregate charges to beneficiaries for excess costs (From provider records)	
25	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	1,875,481
26	Enter the per diem limitation (1)	N/A
27	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	N/A
28	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)	
	(Transfer to Worksheet E, Part II, line 4) (See instructions)	
	(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	

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

1	Total inpatient days	70,725
2	Program inpatient days. (see instructions)	8,206
3	'Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.116027
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	0

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

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5423	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title XVIII	**[X] Title XIX**	
Check One:	**[X] NF**	[ ] ICF/IID	

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

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

PROGRAM INPATIENT ROUTINE SERVICE COSTS

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	PROVIDER CCN : 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	**WORKSHEET E PART I**

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

1	Inpatient PPS amount (See Instructions)	5,683,496
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	5,683,496
4	Primary payor amounts	(0)
5	Coinsurance	(1,205,430)
6	Allowable bad debts (from your records)	704,926
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	346,909
8	Adjusted reimbursable bad debts. (See instructions)	458,202
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	4,936,268
12	Interim payments (See instructions)	4,632,317
13	Tentative adjustment	
14	Other Adjustments (See Instructions)	
14.50	Demonstration payment adjustment amount before sequestration	0
14.55	Demonstration payment adjustment amount after sequestration	0
14.75	Sequestration for non-claims based amounts (see instructions)	9,164
14.99	Sequestration amount (see instructions)	89,561
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	**205,226**
	(Indicate overpayment in parentheses) (See Instructions)	
16	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	

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

17	Ancillary services Part B	0
18	Vaccine cost (From Wkst D, Part II, line 3)	273
19	Total reasonable costs (Sum of lines 17 and 18)	273
20	Medicare Part B ancillary charges (See instructions)	400
21	Cost of covered services (Lesser of line 19 or line 20)	273
22	Primary payor amounts	(0)
23	Coinsurance and deductibles	(0)
24	Allowable bad debts (from your records)	
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	
24.02	Reimbursable bad debts (see instructions)	0
25	Subtotal (Sum of lines 21 and 24.02, minus lines 22 and 23)	273
26	Interim payments (See instructions)	294
27	Tentative adjustment	
28	Other Adjustments (See Instructions)	
28.50	Demonstration payment adjustment amount before sequestration	0
28.55	Demonstration payment adjustment amount after sequestration	0
28.99	Sequestration amount (see instructions)	5
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	**(26)**
	(Indicate overpayments in parentheses) (See Instructions)	
30	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	**WORKSHEET E-1**

	Description			Inpatient Part A		Part B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
				1	2	3	4
1	Total interim payments paid to provider			//////////	4,388,505	//////////	294
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.			//////////	243,812	//////////	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1)		.01				
			.02				
		Program to Provider	.03				
			.04				
			.05				
			.50				
		Provider to Program	.51				
			.52				
		*	.53				
			.54				
	SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99	//////////	0	//////////	0
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) Transfer to Wkst E, Part I line 12 for Part A, and line 26 for Part B.)			//////////	4,632,317	//////////	294
				//////////		//////////	

TO BE COMPLETED BY CONTRACTOR

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	**WORKSHEET E PART II TITLE XIX**

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

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

COMPUTATION OF NET COST OF COVERED SER PART A - INPATIENT SERVICES

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

REASONABLE CHARGES

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

CUSTOMARY CHARGES:

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

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

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

BALANCE SHEET	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	**WORKSHEET G**

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	ASSETS				
	CURRENT ASSETS				
1	Cash on hand and in banks	873,074			
2	Temporary investments	0			
3	Notes receivable	0			
4	Accounts receivable	3,812,246			
5	Other receivables	0			
6	Less: allowances for uncollectible notes and A/R	0			
7	Inventory	0			
8	Prepaid expenses	132,595			
9	Other current assets	0			
10	Due from other funds	0			
11	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4,817,915	0	0	0
	FIXED ASSETS				
12	Land	0			
13	Land improvements	0			
14	Less: Accumulated depreciation	0			
15	Buildings	0			
16	Less Accumulated depreciation	0			
17	Leasehold improvements	4,361,668			
18	Less: Accumulated Amortization	0			
19	Fixed equipment	0			
20	Less: Accumulated depreciation	0			
21	Automobiles and trucks	0			
22	Less: Accumulated depreciation	0			
23	Major movable equipment	115,025			
24	Less: Accumulated depreciation	(2,825,916)			
25	Minor equipment - Depreciable	0			
26	Minor equipment nondepreciable	0			
27	Other fixed assets	0			
28	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1,650,777	0	0	0
	OTHER ASSETS				
29	Investments	0			
30	Deposits on leases	0			
31	Due from owners/officers	0			
32	Other assets	20,053			
33	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	20,053	0	0	0
34	TOTAL ASSETS (Sum of lines 11, 28 and 33)	6,488,745	0	0	0

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

BALANCE SHEET	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET G (cont'd)

	LIABILITIES & FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
35	Accounts payable	1,091,155			
36	Salaries, wages & fees payable	514,583			
37	Payroll taxes payable	290,079			
38	Notes & loans payable (Short term)	0			
39	Deferred income	0			
40	Accelerated payments	0	////////////////////////////	//	//
41	Due to other funds	0			
42	Other current liabilities	0			
43	TOTAL CURRENT LIABILITIES	1,895,817	0	0	0
	(Sum of lines 35 - 42)				
	LONG TERM LIABILITIES				
44	Mortgage payable	0			
45	Notes payable	0			
46	Unsecured loans	531,290			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	531,290	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	2,427,107	0	0	0
	(Sum of lines 43 and 50)				
	CAPITAL ACCOUNTS				
52	General fund balance	4,061,638	////////////////////////////	//	//
53	Specific purpose fund	//	0	//	//
54	Donor created - EFB restricted	//	////////////////////////////	0	//
55	Donor created - EFB unrestricted	//	////////////////////////////	0	//
56	Governing body created - EFB	//	////////////////////////////	0	//
57	PFB - invested in plant	//	////////////////////////////	//	0
58	PFB - reserve for plant improvement	//	////////////////////////////	//	0
59	TOTAL FUND BALANCES	4,061,638	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	6,488,745	0	0	0
	(Sum of lines 51 and 59)				

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET G-1

		General Fund		Specific Purpose Fund		Endowment Fund		Plant Fund	
		1	2	3	4	5	6	7	8
1	Fund balances at beginning of period	////////////////////////////////	4,115,900	////////////////////////////		////////////////////////		////////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////////////	505,738	////////////////////////////	////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
3	Total (Sum of line 1 and line 2)	////////////////////////////////	4,621,638	////////////////////////////	0	////////////////////////	0	////////////////////////	0
4	Additions (Credit adjustments)	////////////////////////////////	////////////////////////////////	////////////////////////////	////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
5			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
6			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
7			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
8			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
9			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
10	Total additions (Sum of lines 5 - 9)	////////////////////////////////	0	////////////////////////////	0	////////////////////////	0	////////////////////////	0
11	Subtotal (Line 3 plus line 10)	////////////////////////////////	4,621,638	////////////////////////////	0	////////////////////////	0	////////////////////////	0
12	Deductions (Debit adjustments)	////////////////////////////////	////////////////////////////////	////////////////////////////	////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
13	Members Drawings	560,000	////////////////////////////////		////////////////////		////////////////////////		////////////////////////
14			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
15			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
16			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
17			////////////////////////////////		////////////////////		////////////////////////		////////////////////////
18	Total deductions (Sum of lines 13 - 17)	////////////////////////////////	560,000		0	////////////////////////	0	////////////////////////	0
19	Fund balance at end of period per	////////////////////////////////		////////////////////////////		////////////////////////		////////////////////////	
	balance sheet (Line 11 - line 18)	////////////////////////////////	4,061,638	////////////////////////////	0	////////////////////////	0	////////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET G-2 PARTS I/II

PART I - PATIENT REVENUES

	REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL
			1	2	3
GENERAL INPATIENT ROUTINE CARE SERVICES			////////////////////////////////	////////////////////////////////	////////////////////////////////
1	Skilled Nursing Facility		24,119,819	////////////////////////////////	24,119,819
2	Nursing facility		0	////////////////////////////////	0
3	ICF-IID		0	////////////////////////////////	0
4	Other long term care		0	////////////////////////////////	0
5	Total general inpatient care services		24,119,819	////////////////////////////////	24,119,819
	(Sum of lines 1 - 4)				
ALL OTHER CARE SERVICES					
6	Ancillary services		2,599,559	0	2,599,559
7	Clinic		////////////////////////////////	0	0
8	Home Health Agency		////////////////////////////////	0	0
9	Ambulance		////////////////////////////////	0	0
10	RHC/FQHC		////////////////////////////////	0	0
11	CMHC		////////////////////////////////	0	0
12	Hospice		0	0	0
13	Other Svc Revenues		0	0	0
14	Total Patient Revenues (Sum of lines 5 - 13)		26,719,378	0	26,719,378
	(Transfer column 3 to Worksheet G-3, Line 1)				

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////////////	23,356,229
2			////////////////////////////////
3			////////////////////////////////
4			////////////////////////////////
5			////////////////////////////////
6			////////////////////////////////
7			////////////////////////////////
8	Total Additions (Sum of lines 2 - 7)	////////////////////////////////	0
9			////////////////////////////////
10			////////////////////////////////
11			////////////////////////////////
12			////////////////////////////////
13			////////////////////////////////
14	Total Deductions (Sum of lines 9 - 13)	////////////////////////////////	0
15	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)	////////////////////////////////	23,356,229

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN: 31-5423	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET G-3

1	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	26,719,378
2	Less: contractual allowances and discounts on patients accounts	(2,993,782)
3	Net patient revenues (Line 1 minus line 2)	23,725,596
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	23,356,229
5	Net income from service to patients (Line 3 minus 4)	369,367
//////////	OTHER INCOME:	////////////////////////////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	33,480
8	Revenues from communications (Telephone and Internet service)	0
9	Revenue from television and radio service	0
10	Purchase discounts	0
11	Rebates and refunds of expenses	0
12	Parking lot receipts	0
13	Revenue from laundry and linen service	0
14	Revenue from meals sold to employees and guests	0
15	Revenue from rental of living quarters	0
16	Revenue from sale of medical and surgical supplies to other than patients	0
17	Revenue from sale of drugs to other than patients	0
18	Revenue from sale of medical records and abstracts	25
19	Tuition (fees, sale of textbooks, uniforms, etc.)	0
20	Revenue from gifts, flower, coffee shops, canteen	0
21	Rental of vending machines	0
22	Rental of skilled nursing space	0
23	Governmental appropriations	0
24	Prior Year Income	102,866
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	136,371
26	Total (Line 5 plus line 25)	505,738
27		0
28		0
29		0
30	Total other expenses (Sum of lines 27 - 29)	0
31	Net income (or loss) for the period (Line 26 minus line 30)	505,738

MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Members,
Hamilton Grove Healthcare & Rehab LLC:

Opinion

We have audited the accompanying financial statements of Hamilton Grove Healthcare & Rehab LLC, which comprise the balance sheet as of December 31, 2023, and the related statement of income, members' equity, and cash flow for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Hamilton Grove Healthcare & Rehab LLC as of December 31, 2023, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Hamilton Grove Healthcare & Rehab LLC and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Hamilton Grove Healthcare & Rehab LLC's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

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MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

Independent Auditors' Report Continued

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Hamilton Grove Healthcare & Rehab LLC's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Hamilton Grove Healthcare & Rehab LLC's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Martin Friedman CPA, PC

MARTIN FRIEDMAN, C.P.A. P.C.
Certified Public Accountants

Brooklyn, NY

February 21, 2024

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Hamilton Grove Healthcare & Rehab LLC
Balance Sheet
December 31, 2023

Assets		
Cash	$ 873,082	
Accounts Receivable (Net)	3,812,246	
Prepaid Expenses	132,595	
Total Current Assets		$ 4,817,923
Leasehold Improvements	4,361,668	
Furniture & Equipment	115,025	
	4,476,693	
Less: Accum. Depreciation & Amortization	2,825,916	
Total Fixed Assets		1,650,777
Right-of-Use Asset	24,693,549	
Security Deposits	20,053	
Total Other Assets		24,713,602
Total Assets		**$ 31,182,302**
Liabilities and Equity		
Accounts Payable	1,091,155	
Lease Liabilities	690,348	
Accrued Payroll	514,583	
Accrued Expenses & Taxes	290,079	
Due to Managed Medicaid	531,290	
Total Current Liabilities		$ 3,117,455
Lease Liabilities	24,003,201	
Total Long Term Liabilities		24,003,201
Members' Equity		4,061,646
Total Liabilities & Members' Equity		**$ 31,182,302**

See accompanying notes to the financial statements.

Hamilton Grove Healthcare & Rehab LLC
Statement of Operations
For the year ended December 31, 2023

Total Revenue From Patients		$ 23,725,597
Operating Expenses:		
Payroll	$ 8,444,243	
Employee Benefits	1,739,609	
Professional Care	2,631,415	
Dietary & Housekeeping	1,437,658	
Plant & Maintenance	6,173,964	
General & Administrative	2,929,333	
Total Operating Expenses		23,356,222
Income From Operations		369,375
Other Income		136,371
Net Income		**$ 505,746**

See accompanying notes to the financial statements.

Hamilton Grove Healthcare & Rehab LLC
Statement of Members' Equity
For the year ended December 31, 2023

Members' Equity:	
Balance as of Beginning of Period	$ 4,115,900
Net Income for the Period	505,746
Members' Distributions	(560,000)
Total Members' Equity - End of Period	**$ 4,061,646**

See accompanying notes to the financial statements.

Hamilton Grove Healthcare & Rehab LLC
Statement of Cash Flows
For the year ended December 31, 2023

Cash Flows From Operating Activities:		
Net Income		$ 505,746
Adjustments to reconcile Net Income to Net Cash Provided by Operating Activities:		
Depreciation & Amortization		343,995
(Increase) Decrease In:		
Accounts Receivable	$ (711,249)	
Prepaid Expenses	(19,207)	
Increase (Decrease) In:		
Accounts Payable	(109,021)	
Accrued Payroll & Withholding Taxes	166,595	
Accrued Expenses & Taxes	34,605	
Exchanges	359	
Total Adjustments		(637,918)
Net Cash Provided By Operating Activities		211,823
Cash Flows From Investing Activities:		
Capital Expenditures	(69,240)	
Net Cash Used In Investing Activities		(69,240)
Cash Flows From Financing Activities		
Distributions	(560,000)	
Net Cash Used In Financing Activities		(560,000)
Net Change In Cash		(417,417)
Cash - Beginning of Period		1,290,499
Cash - End of Period		**$ 873,082**

See accompanying notes to the financial statements.

MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT
ON ADDITIONAL INFORMATION

To the Members,
Hamilton Grove Healthcare & Rehab LLC:

Our report on our audit of the basic financial statements of Hamilton Grove Healthcare & Rehab LLC for 2023 appears on page 1. That audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information on pages 13 through 15 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Martin Friedman CPA, PC

MARTIN FRIEDMAN C.P.A. P.C.
Certified Public Accountants

Brooklyn, NY

February 21, 2024

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Hamilton Grove Healthcare & Rehab LLC
Supplementary Schedules
For the year ended December 31, 2023

Revenue From Patients:		
Private	$ 5,687,958	
Medicaid	12,338,860	
Medicare	5,698,779	
Total Revenue From Patients		$ 23,725,597
Other Income:		
Interest	33,480	
Other	102,891	
Total Other Income		136,371
Total Revenue		**$ 23,861,968**