

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).

| | | | |
|---|---------------------------------|--|---|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | PROVIDER CCN: 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET S PARTS I II & III |
|---|---------------------------------|--|---|

PART I - COST REPORT STATUS

| | | | |
|-----------------------------|---|---|--------------------------|
| Provider use only | 1. <input checked="" type="checkbox"/> Electronically prepared cost report | Date: 05/12/2024 | Time: 11:37:22 AM |
| | 2. <input type="checkbox"/> Manually prepared cost report | | |
| | 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report. | | 0 |
| | 3.0.1 <input type="checkbox"/> No Medicare Utilization Enter "Y" for yes or leave blank for no | | 0 |
| Contractor use only: | 4. <input type="checkbox"/> Cost Report Status [1] As Submitted: [2] Settled without audit [3] Settled with audit [4] Reopened [5] Amended | 6. Contractor No. _____ | |
| | 5. Date Received _____ | 7. <input type="checkbox"/> First Cost Report for this Provider CCN | |
| | | 8. <input type="checkbox"/> Last Cost Report for this Provider CCN | |
| | | 9. <input type="checkbox"/> NPR Date: _____ | |
| | | 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened | |
| | | 11. Contractor Vendor Code _____ | |
| | | 12. Medicare Utilization Enter "F" for full, "L" for low, or "N" for no utilization _____ | |

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

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HUNTERDON CARE CENTER #31-5226 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:

05/12/2024 11:37:22 AM

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6OPHv058ULBDBMyd75r4ENsWL6:.fF

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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 | <i>Avi Maierovits</i> | 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. |
| 2 | Signatory Printed Name: Avi Maierovits | | |
| 3 | Signatory Title: Controller | | |
| 4 | Signature date: 05/12/2024 | | |

PART III - SETTLEMENT SUMMARY

| | TITLE V | TITLE XVIII | | TITLE XIX | |
|----------------------------|---------|-------------|---|-----------|-----|
| | | A | B | | |
| | 1 | 2 | 3 | 4 | |
| 1 SKILLED NURSING FACILITY | | 214 | 0 | | 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 | | 214 | 0 | 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.)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

| | | | |
|--|---------------------------------|--|-----------------------------|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET S-2 PART I |
|--|---------------------------------|--|-----------------------------|

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

| | | | | | | | | |
|---|---------|-----------------|------------|-------|----------------|-------|--|---|
| 1 | Street: | 1 LEISURE COURT | P.O. Box: | | | | | 1 |
| 2 | City: | FLEMINGTON | State: | NJ | Zip Code: | 08822 | | 2 |
| 3 | County: | HUNTERDON | CBSA Code: | 35084 | 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 | SNF | HUNTERDON CARE CENTER | 31-5226 | 03/20/1986 | N | P | N | 4 |
| 5 | Nursing Facility | | | | | ////////// | | 5 |
| 6 | ICF/IID | | | | ////////// | ////////// | | 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 | 70,223 | ////////// | 20 |
| 21 | Declining Balance | | ////////// | 21 |
| 22 | Sum of the Year's Digits | | ////////// | 22 |
| 23 | Sum of line 20 through 22 | 70,223 | ////////// | 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 |

In Lieu of CMS Form 2540-10

| | | | |
|--|----------------------|--|-----------------------|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX | PROVIDER CCN: | PERIOD | WORKSHEET S-2 |
| IDENTIFICATION DATA | 31-5226 | FROM: 01/01/2023 TO: 12/31/2023 | 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 "occurrence", enter 2. | | | 1 | 39 |

| | | Premiums | Paid Losses | Self insurance | |
|----|---|----------|-------------|----------------|----|
| 41 | List malpractice premiums and paid losses: | 434,109 | | | 41 |
| | Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? | | | Y / N | |
| 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 |

| | | | |
|---|--------------------------|---|--------------------------|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: 31-5226 | 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 |
| 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 |
| 7 | Were costs claimed for Allied Health Programs? (Y/N) see instructions. | | N | //// |
| 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 | //// |

| 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 | | | 1 Y/N | |
|----------------|---|--|----------|----|
| 12 | Have total beds available changed from prior cost reporting period? If "Y", see instructions. | | N | 12 |

| PS&R Data | | 1 Y/N | 2 Date | 3 Y/N | 4 Date | |
|-----------|--|----------|------------|----------|------------|----|
| | | Part A | Part A | Part B | 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:
31-5226

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

WORKSHEET S-3
PART I

| Component | | Number of Beds | Bed Days Available | Inpatient Days / Visits | | | | | Total |
|-----------|--------------------------|----------------|--------------------|-------------------------|-------------|-----------|--------|--------|--------|
| | | | | Title V | Title XVIII | Title XIX | Other | | |
| | | | | 3 | 4 | 5 | 6 | 7 | |
| 1 | Skilled Nursing Facility | 185 | 67,525 | //// | //// | 6,485 | 34,523 | 17,738 | 58,746 |
| 2 | Nursing Facility | | | //// | //// | | | | 0 |
| 3 | ICF/IID | | | //// | //// | | | | 0 |
| 4 | Home Health Agency | | | //// | //// | | | | 0 |
| 5 | Other Long Term Care | | | //// | //// | | | | 0 |
| 6 | SNF-Based CMHC | | | //// | //// | | | | 0 |
| 7 | Hospice | | | //// | //// | | | | 0 |
| 8 | TOTAL (Sum Lines 1-7) | 185 | 67,525 | //// | //// | 6,485 | 34,523 | 17,738 | 58,746 |

| Component | | Discharges | | | | | Average Length of Stay | | | |
|-----------|--------------------------|------------|-------------|-----------|-------|-------|------------------------|-------------|-----------|-------|
| | | Title V | Title XVIII | Title XIX | Other | Total | Title V | Title XVIII | Title XIX | Total |
| | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 1 | Skilled Nursing Facility | //// | 277 | 85 | 255 | 617 | //// | 23.41 | 406.15 | 95.21 |
| 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) | //// | 277 | 85 | 255 | 617 | //// | 23.41 | 406.15 | 95.21 |

| Component | | Admissions | | | | | Full Time Equivalent | | |
|-----------|--------------------------|------------|-------------|-----------|-------|-------|----------------------|----------------------|-----------------|
| | | Title V | Title XVIII | Title XIX | Other | Total | | Employees on Payroll | Nonpaid Workers |
| | | 17 | 18 | 19 | 20 | 21 | | 22 | 23 |
| 1 | Skilled Nursing Facility | //// | 315 | 54 | 249 | 618 | | 142.83 | |
| 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) | //// | 315 | 54 | 249 | 618 | | 142.83 | 0.00 |

SNF WAGE INDEX INFORMATION PROVIDER CCN: 31-5226 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) | 8,649,288 | 0 | 8,649,288 | 297,093.57 | 29.11 | 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) | 8,649,288 | 0 | 8,649,288 | 297,093.57 | 29.11 | 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) | 8,649,288 | 0 | 8,649,288 | 297,093.57 | 29.11 | 13 |
| OTHER WAGES AND RELATED COSTS | | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | |
| 14 | Contract Labor: Patient Related & Mgmt | 2,246,032 | | 2,246,032 | 46,088.76 | 48.73 | 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) | 2,060,283 | | 2,060,283 | //////////////////// | //////////////////// | 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) | 2,060,283 | 0 | 2,060,283 | //////////////////// | //////////////////// | 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 | 943,164 | 0 | 943,164 | 34,684.50 | 27.19 | 2 |
| 3 | Plant Operation, Maintenance & Repairs | 97,232 | 0 | 97,232 | 4,514.50 | 21.54 | 3 |
| 4 | Laundry & Linen Service | 0 | 0 | 0 | | 0.00 | 4 |
| 5 | Housekeeping | 0 | 0 | 0 | | 0.00 | 5 |
| 6 | Dietary | 943,162 | 0 | 943,162 | 48,759.25 | 19.34 | 6 |
| 7 | Nursing Administration | 266,373 | 0 | 266,373 | 3,391.75 | 78.54 | 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 | 191,202 | 0 | 191,202 | 6,427.75 | 29.75 | 11 |
| 12 | Nursing and Allied Health Education Activities | //////////////////// | //////////////////// | //////////////////// | //////////////////// | //////////////////// | 12 |
| 13 | Other General Service Cost | 245,953 | 0 | 245,953 | 15,161.32 | 16.22 | 13 |
| 14 | Total (sum lines 1 thru 13) | 2,687,086 | 0 | 2,687,086 | 112,939.07 | 23.79 | 14 |

MED-CALC SYSTEMS

In Lieu of CMS Form 2540-10

| | | | |
|-------------------------------|---------------------------------|--|--|
| SNF WAGE RELATED COSTS | PROVIDER CCN: 31-5226 | 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 | 27,075 | 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) | 975,326 | 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 | 311,172 | 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 | 648,737 | 17 |
| 18 | Medicare Taxes - Employers Portion Only | | 18 |
| 19 | Unemployment Insurance | | 19 |
| 20 | State or Federal Unemployment Taxes | 87,674 | 20 |
| OTHER | | | |
| 21 | Executive Deferred Compensation | | 21 |
| 22 | Day Care Cost and Allowances | | 22 |
| 23 | Tuition Reimbursement | 10,299 | 23 |
| 24 | Total Wage Related cost (Sum of lines 1 -23) | 2,060,283 | 24 |

Part B Other than Core Related Cost

| | | Amount Reported | |
|----|--|-----------------|----|
| 25 | | | 25 |

| SNF REPORTING OF DIRECT CARE EXPENDITURES | | PROVIDER CCN: 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | | WORKSHEET S-3 PART V | |
|---|---|--------------------------|---|-------------------------------------|--|---------------------------------------|
| Occupational Category | | Amount Reported | Fringe Benefits | Adjusted Salaries (col. 1 + col. 2) | Paid Hours Related to Salary in col. 3 | Average Hourly Wage (col. 3 ÷ col. 4) |
| | | 1 | 2 | 3 | 4 | 5 |
| Direct Salaries | | //// | //// | //// | //// | //// |
| Nursing Occupations | | //// | //// | //// | //// | //// |
| 1 | Registered Nurses (RNs) | 1,753,189 | 417,614 | 2,170,803 | 37,084.75 | 58.54 |
| 2 | Licensed Practical Nurses (LPNs) | 1,647,040 | 392,329 | 2,039,369 | 44,234.50 | 46.10 |
| 3 | Certified Nursing Assistants/Nursing Assistants/Aides | 2,561,973 | 610,268 | 3,172,241 | 102,835.25 | 30.85 |
| 4 | Total Nursing (sum of lines 1 through 3) | 5,962,202 | 1,420,211 | 7,382,413 | 184,154.50 | 40.09 |
| 5 | Physical Therapists | | | - | | 0.00 |
| 6 | Physical Therapy Assistants | | | - | | 0.00 |
| 7 | Physical Therapy Aides | | | - | | 0.00 |
| 8 | Occupational Therapists | | | - | | 0.00 |
| 9 | Occupational Therapy Assistants | | | - | | 0.00 |
| 10 | Occupational Therapy Aides | | | - | | 0.00 |
| 11 | Speech Therapists | | | - | | 0.00 |
| 12 | Respiratory Therapists | | | - | | 0.00 |
| 13 | Other Medical Staff | | | - | | 0.00 |
| Contract Labor | | //// | //// | //// | //// | //// |
| Nursing Occupations | | //// | //// | //// | //// | //// |
| 14 | Registered Nurses (RNs) | 582,006 | //// | 582,006 | 3,220.01 | 180.75 |
| 15 | Licensed Practical Nurses (LPNs) | 585,286 | //// | 585,286 | 9,333.39 | 62.71 |
| 16 | Certified Nursing Assistants/Nursing Assistants/Aides | 242,944 | //// | 242,944 | 18,813.53 | 12.91 |
| 17 | Total Nursing (sum of lines 14 through 16) | 1,410,236 | //// | 1,410,236 | 31,366.93 | 44.96 |
| 18 | Physical Therapists | 366,210 | //// | 366,210 | 7,765.72 | 47.16 |
| 19 | Physical Therapy Assistants | | //// | - | | 0.00 |
| 20 | Physical Therapy Aides | | //// | - | | 0.00 |
| 21 | Occupational Therapists | 320,217 | //// | 320,217 | 5,073.18 | 63.12 |
| 22 | Occupational Therapy Assistants | | //// | - | | 0.00 |
| 23 | Occupational Therapy Aides | | //// | - | | 0.00 |
| 24 | Speech Therapists | 149,369 | //// | 149,369 | 1,882.93 | 79.33 |
| 25 | Respiratory Therapists | | //// | - | | 0.00 |
| 26 | Other Medical Staff | | //// | - | | 0.00 |

| RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | | | PROVIDER CCN: 31-5226 | | | 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 | | 2,448,893 | 2,448,893 | 0 | 2,448,893 | (1,029,278) | 1,419,615 |
| 2 | 0200 | Capital-Related Costs - Movable Equipment | | 0 | 0 | 0 | 0 | 0 | 0 |
| 3 | 0300 | Employee Benefits | 0 | 2,060,282 | 2,060,282 | 0 | 2,060,282 | 0 | 2,060,282 |
| 4 | 0400 | Administrative and General | 943,164 | 2,878,963 | 3,822,127 | 0 | 3,822,127 | (377,794) | 3,444,333 |
| 5 | 0500 | Plant Operation, Maintenance and Repairs | 97,232 | 444,359 | 541,591 | 0 | 541,591 | 0 | 541,591 |
| 6 | 0600 | Laundry and Linen Service | 0 | 80,289 | 80,289 | 0 | 80,289 | 0 | 80,289 |
| 7 | 0700 | Housekeeping | 0 | 720,222 | 720,222 | 0 | 720,222 | 0 | 720,222 |
| 8 | 0800 | Dietary | 943,162 | 583,350 | 1,526,512 | 0 | 1,526,512 | 0 | 1,526,512 |
| 9 | 0900 | Nursing Administration | 266,373 | 701 | 267,074 | 0 | 267,074 | 0 | 267,074 |
| 10 | 1000 | Central Services and Supply | 0 | 300,232 | 300,232 | 0 | 300,232 | 0 | 300,232 |
| 11 | 1100 | Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 12 | 1200 | Medical Records and Library | 0 | 200 | 200 | 0 | 200 | 0 | 200 |
| 13 | 1300 | Social Service | 191,202 | 230 | 191,432 | 0 | 191,432 | 0 | 191,432 |
| 14 | 1400 | Nursing and Allied Health Education Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 15 | 1500 | Other General Service Cost | 245,953 | 29,767 | 275,720 | 0 | 275,720 | 0 | 275,720 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | 3000 | Skilled Nursing Facility | 5,962,202 | 1,417,308 | 7,379,510 | 0 | 7,379,510 | (21,967) | 7,357,543 |
| 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 | 6,609 | 6,609 | 0 | 6,609 | 0 | 6,609 |
| 41 | 4100 | Laboratory | 0 | 21,717 | 21,717 | 0 | 21,717 | 0 | 21,717 |
| 42 | 4200 | Intravenous Therapy | 0 | 1,435 | 1,435 | 0 | 1,435 | 0 | 1,435 |
| 43 | 4300 | Oxygen (Inhalation) Therapy | 0 | 9,014 | 9,014 | 0 | 9,014 | 0 | 9,014 |
| 44 | 4400 | Physical Therapy | 0 | 835,796 | 835,796 | (469,586) | 366,210 | 0 | 366,210 |
| 45 | 4500 | Occupational Therapy | 0 | 0 | 0 | 320,217 | 320,217 | 0 | 320,217 |
| 46 | 4600 | Speech Pathology | 0 | 0 | 0 | 149,369 | 149,369 | 0 | 149,369 |
| 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 | 204,184 | 204,184 | 0 | 204,184 | 0 | 204,184 |
| 50 | 5000 | Dental Care - Title XIX only | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 51 | 5100 | Support Surfaces | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 52 | 5200 | Other Ancillary Service Cost Center | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | | | PROVIDER CCN: 31-5226 | | | 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) | 8,649,288 | 12,043,551 | 20,692,839 | 0 | 20,692,839 | (1,429,039) | 19,263,800 |
| 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 | 12,000 | 12,000 | 0 | 12,000 | 0 | 12,000 |
| 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 | 8,649,288 | 12,055,551 | 20,704,839 | 0 | 20,704,839 | (1,429,039) | 19,275,800 |

RECLASSIFICATIONS

PROVIDER CCN:
31-5226

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

WORKSHEET A-6

| | EXPLANATION OF RECLASSIFICATION ENTRY | CODE (1) 1 | INCREASE | | | DECREASE | | | | | |
|-----|---------------------------------------|---------------|----------------------|---------------|-------------|-----------------|------------------|---------------|-------------|-----------------|---------|
| | | | COST CENTER 2 | LINE NO. 3 | SALARY 4 | NON-SALARY 5 | COST CENTER 6 | LINE NO. 7 | SALARY 8 | NON-SALARY 9 | |
| 1 | RECLASS OT | A | Occupational Therapy | 45 | | 320,217 | Physical Therapy | 44 | | 320,217 | |
| 2 | RECLASS ST | B | Speech Pathology | 46 | | 149,369 | Physical Therapy | 44 | | 149,369 | |
| 3 | | | | | | | | | | | |
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| 70 | | | | | | | | | | | |
| 71 | | | | | | | | | | | |
| 72 | | | | | | | | | | | |
| 100 | TOTAL RECLASSIFICATIONS | | | | | 0 | 469,586 | | | 0 | 469,586 |

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

| | | | |
|--|--------------------------|---|---------------|
| | PROVIDER CCN: 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET A-7 |
|--|--------------------------|---|---------------|

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 | | | |
| 1 Land | | | | 0 | | 0 | |
| 2 Land Improvements | | | | 0 | | 0 | |
| 3 Buildings and Fixtures | | | | 0 | | 0 | |
| 4 Building Improvements | 989,522 | 98,697 | | 98,697 | 41,060 | 1,047,159 | |
| 5 Fixed Equipment | | | | 0 | | 0 | |
| 6 Movable Equipment | 27,865 | 42,105 | | 42,105 | | 69,970 | |
| 7 Subtotal (sum of lines 1-6) | 1,017,387 | 140,802 | 0 | 140,802 | 41,060 | 1,117,129 | 0 |
| 8 Reconciling Items | | | | 0 | | 0 | |
| 9 Total (line 7 minus line 8) | 1,017,387 | 140,802 | 0 | 140,802 | 41,060 | 1,117,129 | 0 |

| | | |
|-------------------------|-------------------------|---|
| ADJUSTMENTS TO EXPENSES | PROVIDER CCN 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 |
|-------------------------|-------------------------|---|

| (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 | (14,973) | 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. (Chapter 23) | | | | |
| 11 Nonallowable costs related to certain Capital expenditures (Chapter 24) | ////////// | ////////// | ////////// | ////////// |
| 12 Adjustment resulting from transactions with related organizations (Chapter 10) | ////////// A-8-1 | ////////// (1,231,061) | ////////// | ////////// |
| 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 | (177) | 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 | (182,828) | Administrative and General | 4 |
| 25.01 | | | | |
| 25.02 | | | | |
| 25.03 | | | | |
| 25.04 | | | | |
| A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW) | | ////////// | 0 | ////////// |
| 100 | TOTAL | ////////// | (1,429,039) | ////////// |

| | | |
|-------------------------|-------------------------|---|
| ADJUSTMENTS TO EXPENSES | PROVIDER CCN 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 |
|-------------------------|-------------------------|---|

| (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 | | | | |
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| 25.18 | | | | |
| 25.19 | | | | |
| 25.20 | | | | |
| 25.21 | | | | |
| 25.22 | | | | |
| 25.23 | | | | |
| 25.24 | | | | |
| 25.25 | | | | |

SUBTOTAL OF ADDITIONAL ADJUSTMENTS

0

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

| | | | |
|---|--------------------------|---|------------------------|
| STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | PROVIDER CCN: 31-5226 | 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 | 816,082 | 816,082 | 0 |
| 2 | 10 | Central Services and Supply | Med Supplies | 243,054 | 243,054 | 0 |
| 3 | 43 | Oxygen (Inhalation) Therapy | Oxygen | 4,183 | 4,183 | 0 |
| 4 | 10 | Central Services and Supply | OTC Drugs | 7,000 | 7,000 | 0 |
| 5 | 8 | Dietary | Dietary | 581,686 | 581,686 | 0 |
| 6 | 5 | Plant Operation, Maintenance and R | Maintenance | 40,346 | 40,346 | 0 |
| 7 | 6 | Laundry and Linen Service | Diapers | 80,289 | 80,289 | 0 |
| 8 | 4 | Administrative and General | Office Supplies | 23,909 | 23,909 | 0 |
| 9 | 4 | Administrative and General | Office Support | 909,979 | 1,089,795 | (179,816) |
| 9.01 | 1 | Capital-Related Costs - Building & | Rent | | 2,300,430 | (2,300,430) |
| 9.02 | 30 | Skilled Nursing Facility | Nursing | 281,865 | 303,832 | (21,967) |
| 9.03 | 1 | Capital-Related Costs - Building & | Mortgage Interest | 337,083 | | 337,083 |
| 9.04 | 1 | Capital-Related Costs - Building & | Depreciation | 584,620 | | 584,620 |
| 9.05 | 1 | Capital-Related Costs - Building & | Property Tax | 305,088 | | 305,088 |
| 9.06 | 1 | Capital-Related Costs - Building & | Property Insurance | 44,361 | | 44,361 |
| 9.07 | | | | | | 0 |
| 9.08 | | | | | | 0 |
| 9.09 | | | | | | 0 |
| 9.10 | | | | | | 0 |
| 10 TOTAL | | | | 4,259,545 | 5,490,606 | (1,231,061) |

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.

| | Description | (1) Symbol | Name | Percentage of Ownership | Related Organization(s) | | |
|-------|-------------|---------------|--------------|-------------------------|-------------------------|-------------------------|------------------|
| | | | | | Name | Percentage of Ownership | Type of Business |
| | | | | | 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 | Hunterdon | 100.00 | Foremost Realty | 100.00 | Realty |
| 7 | | A | Hunterdon | 100.00 | Care Street | 100.00 | Nursing |
| 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: 31-5226 | | 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: 31-5226 | 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 | 1,419,615 | 1,419,615 | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | 0 | //////////////////// | 0 | | | | | |
| 3 | Employee Benefits | 2,060,282 | 0 | 0 | 2,060,282 | | | | |
| 4 | Administrative and General | 3,444,333 | 96,875 | 0 | 224,664 | 3,765,872 | 3,765,872 | | |
| 5 | Plant Operation, Maintenance and Repairs | 541,591 | 58,098 | 0 | 23,161 | 622,850 | 151,230 | 774,080 | |
| 6 | Laundry and Linen Service | 80,289 | 21,918 | 0 | 0 | 102,207 | 24,816 | 13,416 | |
| 7 | Housekeeping | 720,222 | 13,250 | 0 | 0 | 733,472 | 178,090 | 8,110 | |
| 8 | Dietary | 1,526,512 | 139,546 | 0 | 224,663 | 1,890,721 | 459,075 | 85,415 | |
| 9 | Nursing Administration | 267,074 | 1,566 | 0 | 63,451 | 332,091 | 80,633 | 958 | |
| 10 | Central Services and Supply | 300,232 | 2,100 | 0 | 0 | 302,332 | 73,407 | 1,285 | |
| 11 | Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 12 | Medical Records and Library | 200 | 0 | 0 | 0 | 200 | 49 | 0 | |
| 13 | Social Service | 191,432 | 3,666 | 0 | 45,545 | 240,643 | 58,429 | 2,244 | |
| 14 | Nursing and Allied Health Education Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 15 | Other General Service Cost | 275,720 | 27,092 | 0 | 58,586 | 361,398 | 87,749 | 16,583 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Skilled Nursing Facility | 7,357,543 | 1,014,894 | 0 | 1,420,212 | 9,792,649 | 2,377,694 | 621,211 | |
| 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 | 6,609 | 0 | 0 | 0 | 6,609 | 1,605 | 0 | |
| 41 | Laboratory | 21,717 | 0 | 0 | 0 | 21,717 | 5,273 | 0 | |
| 42 | Intravenous Therapy | 1,435 | 0 | 0 | 0 | 1,435 | 348 | 0 | |
| 43 | Oxygen (Inhalation) Therapy | 9,014 | 0 | 0 | 0 | 9,014 | 2,189 | 0 | |
| 44 | Physical Therapy | 366,210 | 21,326 | 0 | 0 | 387,536 | 94,095 | 13,054 | |
| 45 | Occupational Therapy | 320,217 | 14,205 | 0 | 0 | 334,422 | 81,199 | 8,695 | |
| 46 | Speech Pathology | 149,369 | 0 | 0 | 0 | 149,369 | 36,267 | 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 | 204,184 | 0 | 0 | 0 | 204,184 | 49,577 | 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 | |

| COST ALLOCATION GENERAL SERVICE COSTS | | PROVIDER CCN: 31-5226 | 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 | |
| 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) | 19,263,800 | 1,414,536 | 0 | 2,060,282 | 19,258,721 | 3,761,725 | 770,971 | 140,439 |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 91 | Barber and Beauty Shop | 0 | 5,079 | 0 | 0 | 5,079 | 1,233 | 3,109 | 0 |
| 92 | Physicians' Private Offices | 12,000 | 0 | 0 | 0 | 12,000 | 2,914 | 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 | |
| 100 | TOTAL | 19,275,800 | 1,419,615 | 0 | 2,060,282 | 19,275,800 | 3,765,872 | 774,080 | 140,439 |

| | | | | | | | | | |
|--|--|--|--|--------------------------|---|----------------------------------|--|--|--|
| COST ALLOCATION GENERAL SERVICE COSTS | | | | PROVIDER CCN: 31-5226 | 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 | 919,672 | | | | | | | |
| 8 | Dietary | 104,384 | 2,539,595 | | | | | | |
| 9 | Nursing Administration | 1,171 | 0 | 414,853 | | | | | |
| 10 | Central Services and Supply | 1,571 | 0 | 0 | 378,595 | | | | |
| 11 | Pharmacy | 0 | 0 | 0 | 0 | 0 | | | |
| 12 | Medical Records and Library | 0 | 0 | 0 | 0 | 0 | 249 | | |
| 13 | Social Service | 2,742 | 0 | 0 | 0 | 0 | 0 | 304,058 | |
| 14 | Nursing and Allied Health Education Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 15 | Other General Service Cost | 20,265 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Skilled Nursing Facility | 759,163 | 2,539,595 | 414,853 | 378,595 | 0 | 249 | 304,058 | 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 | 15,952 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 45 | Occupational Therapy | 10,625 | 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: 31-5226 | | 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) | 915,873 | 2,539,595 | 414,853 | 378,595 | 0 | 249 | 304,058 | 0 |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 91 | Barber and Beauty Shop | 3,799 | 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 | 919,672 | 2,539,595 | 414,853 | 378,595 | 0 | 249 | 304,058 | 0 |

| ALLOCATION OF CAPITAL-RELATED COSTS | | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | PROVIDER CCN: 31-5226 | 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 | | 96,875 | 0 | 96,875 | 0 | 96,875 | | |
| 5 | Plant Operation, Maintenance and Repairs | | 58,098 | 0 | 58,098 | 0 | 3,890 | 61,988 | |
| 6 | Laundry and Linen Service | | 21,918 | 0 | 21,918 | 0 | 638 | 1,074 | |
| 7 | Housekeeping | | 13,250 | 0 | 13,250 | 0 | 4,581 | 649 | |
| 8 | Dietary | | 139,546 | 0 | 139,546 | 0 | 11,809 | 6,840 | |
| 9 | Nursing Administration | | 1,566 | 0 | 1,566 | 0 | 2,074 | 77 | |
| 10 | Central Services and Supply | | 2,100 | 0 | 2,100 | 0 | 1,888 | 103 | |
| 11 | Pharmacy | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 12 | Medical Records and Library | | 0 | 0 | 0 | 0 | 1 | 0 | |
| 13 | Social Service | | 3,666 | 0 | 3,666 | 0 | 1,503 | 180 | |
| 14 | Nursing and Allied Health Education Activities | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 15 | Other General Service Cost | | 27,092 | 0 | 27,092 | 0 | 2,257 | 1,328 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Skilled Nursing Facility | | 1,014,894 | 0 | 1,014,894 | 0 | 61,167 | 49,747 | |
| 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 | 0 | 0 | 41 | 0 | |
| 41 | Laboratory | | 0 | 0 | 0 | 0 | 136 | 0 | |
| 42 | Intravenous Therapy | | 0 | 0 | 0 | 0 | 9 | 0 | |
| 43 | Oxygen (Inhalation) Therapy | | 0 | 0 | 0 | 0 | 56 | 0 | |
| 44 | Physical Therapy | | 21,326 | 0 | 21,326 | 0 | 2,421 | 1,045 | |
| 45 | Occupational Therapy | | 14,205 | 0 | 14,205 | 0 | 2,089 | 696 | |
| 46 | Speech Pathology | | 0 | 0 | 0 | 0 | 933 | 0 | |
| 47 | Electrocardiology | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 48 | Medical Supplies Charged to Patients | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 49 | Drugs Charged to Patients | | 0 | 0 | 0 | 0 | 1,275 | 0 | |
| 50 | Dental Care - Title XIX only | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 51 | Support Surfaces | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52 | Other Ancillary Service Cost Center | | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52.01 | Other Ancillary Service Cost Center II | | 0 | 0 | 0 | 0 | 0 | 0 | |

| ALLOCATION OF CAPITAL-RELATED COSTS | | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | | PROVIDER CCN: 31-5226 | 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 | 1,414,536 | 0 | 1,414,536 | 0 | 96,768 | 61,739 | 23,630 |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 91 | Barber and Beauty Shop | 5,079 | 0 | 5,079 | 0 | 32 | 249 | 0 | |
| 92 | Physicians' Private Offices | 0 | 0 | 0 | 0 | 75 | 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 | 1,419,615 | 0 | 1,419,615 | 0 | 96,875 | 61,988 | 23,630 |

| ALLOCATION OF CAPITAL-RELATED COSTS | | | | | | PROVIDER CCN: 31-5226 | | | |
|---|--|---------|----------------|---------------------------|----------|---------------------------|----------------|-------------------------|--|
| 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 | 18,480 | | | | | | | | |
| 8 | 2,097 | 160,292 | | | | | | | |
| 9 | 24 | 0 | 3,741 | | | | | | |
| 10 | 32 | 0 | 0 | 4,123 | | | | | |
| 11 | 0 | 0 | 0 | 0 | 0 | | | | |
| 12 | 0 | 0 | 0 | 0 | 0 | 1 | | | |
| 13 | 55 | 0 | 0 | 0 | 0 | 0 | 5,404 | | |
| 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 15 | 407 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | 15,254 | 160,292 | 3,741 | 4,123 | 0 | 1 | 5,404 | 0 | |
| 31 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 32 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 33 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 40 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 41 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 42 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 43 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 44 | 321 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 45 | 214 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 46 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 47 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 48 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 49 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 50 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 51 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 52.01 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

| ALLOCATION OF CAPITAL-RELATED COSTS | | | | | | PROVIDER CCN: 31-5226 | | | | |
|--|---|----------------------|----------------------|----------------------|---------------------------|--------------------------|---------------------------|----------------------|-------------------------|--|
| 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) | 18,404 | 160,292 | 3,741 | 4,123 | 0 | 1 | 5,404 | 0 | |
| NON REIMBURSABLE COST CENTERS | | | | | | | | | | |
| 90 | Gift, Flower, Coffee Shop & Canteen | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 91 | Barber and Beauty Shop | 76 | 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 | 18,480 | 160,292 | 3,741 | 4,123 | 0 | 1 | 5,404 | 0 | |

| COST ALLOCATION STATISTICAL BASIS | | PROVIDER CCN: 31-5226 | 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 | 74,355 | | | | | | | | |
| 2 | Capital-Related Costs - Movable Equipment | | 0 | | | | | | | |
| 3 | Employee Benefits | | 0 | 8,649,288 | | | | | | |
| 4 | Administrative and General | 5,074 | 0 | 943,164 | (3,765,872) | 15,509,928 | | | | |
| 5 | Plant Operation, Maintenance and Repairs | 3,043 | 0 | 97,232 | | 622,850 | 66,238 | | | |
| 6 | Laundry and Linen Service | 1,148 | 0 | 0 | | 102,207 | 1,148 | 58,746 | | |
| 7 | Housekeeping | 694 | 0 | 0 | | 733,472 | 694 | | 64,396 | |
| 8 | Dietary | 7,309 | 0 | 943,162 | | 1,890,721 | 7,309 | | | 7,309 |
| 9 | Nursing Administration | 82 | 0 | 266,373 | | 332,091 | 82 | | | 82 |
| 10 | Central Services and Supply | 110 | 0 | 0 | | 302,332 | 110 | | | 110 |
| 11 | Pharmacy | | 0 | 0 | | 0 | 0 | | | 0 |
| 12 | Medical Records and Library | | 0 | 0 | | 200 | 0 | | | 0 |
| 13 | Social Service | 192 | 0 | 191,202 | | 240,643 | 192 | | | 192 |
| 14 | Nursing and Allied Health Education Activities | | 0 | 0 | | 0 | 0 | | | 0 |
| 15 | Other General Service Cost | 1,419 | 0 | 245,953 | | 361,398 | 1,419 | | | 1,419 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | |
| 30 | Skilled Nursing Facility | 53,157 | 0 | 5,962,202 | | 9,792,649 | 53,157 | 58,746 | | 53,157 |
| 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 | | 6,609 | 0 | | | 0 |
| 41 | Laboratory | | 0 | 0 | | 21,717 | 0 | | | 0 |
| 42 | Intravenous Therapy | | 0 | 0 | | 1,435 | 0 | | | 0 |
| 43 | Oxygen (Inhalation) Therapy | | 0 | 0 | | 9,014 | 0 | | | 0 |
| 44 | Physical Therapy | 1,117 | 0 | 0 | | 387,536 | 1,117 | | | 1,117 |
| 45 | Occupational Therapy | 744 | 0 | 0 | | 334,422 | 744 | | | 744 |
| 46 | Speech Pathology | | 0 | 0 | | 149,369 | 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 | | 204,184 | 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: 31-5226 | 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) | //// | 74,089 | 0 | 8,649,288 | (3,765,872) | 15,492,849 | 65,972 | 58,746 | 64,130 |
| NON REIMBURSABLE COST CENTERS | | //// | //// | //// | //// | //// | //// | //// | //// | //// |
| 90 | Gift, Flower, Coffee Shop & Canteen | //// | | 0 | 0 | | 0 | 0 | | 0 |
| 91 | Barber and Beauty Shop | //// | 266 | 0 | 0 | | 5,079 | 266 | | 266 |
| 92 | Physicians' Private Offices | //// | | 0 | 0 | | 12,000 | 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) | //// | 1,419,615 | 0 | 2,060,282 | //// | 3,765,872 | 774,080 | 140,439 | 919,672 |
| 103 | Unit Cost Multiplier (Worksheet B, Part I) | //// | 19.092395 | 0.000000 | 0.238202 | //// | 0.242804 | 11.686343 | 2.390614 | 14.281508 |
| 104 | Cost to Be Allocated (Per Worksheet B, Part II) | //// | //// | //// | 0 | //// | 96,875 | 61,988 | 23,630 | 18,480 |
| 105 | Unit Cost Multiplier (Worksheet B, Part II) | //// | //// | //// | 0.000000 | //// | 0.006246 | 0.935837 | 0.402240 | 0.286974 |

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

| COST ALLOCATION STATISTICAL BASIS | | PROVIDER CCN: 31-5226 | | | 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 (PATIENT DAYS) | 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 | 176,238 | //// | //// | //// | //// | //// | //// | //// |
| 9 | Nursing Administration | //// | 58,746 | //// | //// | //// | //// | //// | //// |
| 10 | Central Services and Supply | //// | //// | 58,746 | //// | //// | //// | //// | //// |
| 11 | Pharmacy | //// | //// | //// | 0 | //// | //// | //// | //// |
| 12 | Medical Records and Library | //// | //// | //// | //// | 58,746 | //// | //// | //// |
| 13 | Social Service | //// | //// | //// | //// | //// | 58,746 | //// | //// |
| 14 | Nursing and Allied Health Education Activities | //// | //// | //// | //// | //// | //// | 0 | //// |
| 15 | Other General Service Cost | //// | //// | //// | //// | //// | //// | //// | 58,746 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Skilled Nursing Facility | 176,238 | 58,746 | 58,746 | 0 | 58,746 | 58,746 | //// | 58,746 |
| 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: 31-5226 | | | 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 (PATIENT DAYS) | 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) | 176,238 | 58,746 | 58,746 | 0 | 58,746 | 58,746 | 0 | 58,746 |
| 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) | 2,539,595 | 414,853 | 378,595 | 0 | 249 | 304,058 | 0 | 485,995 |
| 103 | Unit Cost Multiplier (Worksheet B, Part I) | 14.410031 | 7.061808 | 6.444609 | 0.000000 | 0.004239 | 5.175808 | 0.000000 | 8.272819 |
| 104 | Cost to Be Allocated (Per Worksheet B, Part II) | 160,292 | 3,741 | 4,123 | 0 | 1 | 5,404 | 0 | 31,084 |
| 105 | Unit Cost Multiplier (Worksheet B, Part II) | 0.909520 | 0.063681 | 0.070184 | 0.000000 | 0.000017 | 0.091989 | 0.000000 | 0.529125 |

| | | | |
|----------------------------|--------------------------|---|--------------------------------|
| POST STEP DOWN ADJUSTMENTS | PROVIDER CCN: 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET B-2 |
|----------------------------|--------------------------|---|--------------------------------|

| DESCRIPTION -1- | WORKSHEET B PART NO. LINE NO. (1 or 2) -2- -3- | | AMOUNT -4- |
|--------------------|--|--|---------------|
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| RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | PROVIDER CCN: | PERIOD : | WORKSHEET C |
| | 31-5226 | FROM: 01/01/2023 TO: 12/31/2023 | |

| 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 | 8,214 | 6,609 | 1.242851 |
| 41 | Laboratory | 26,990 | 21,717 | 1.242805 |
| 42 | Intravenous Therapy | 1,783 | 31,568 | 0.056481 |
| 43 | Oxygen (Inhalation) Therapy | 11,203 | 9,014 | 1.242844 |
| 44 | Physical Therapy | 510,637 | 819,873 | 0.622825 |
| 45 | Occupational Therapy | 434,941 | 716,904 | 0.606694 |
| 46 | Speech Pathology | 185,636 | 334,408 | 0.555118 |
| 47 | Electrocardiology | 0 | 0 | 0.000000 |
| 48 | Medical Supplies Charged | 0 | 0 | 0.000000 |
| 49 | Drugs Charged to Patients | 253,761 | 459,138 | 0.552690 |
| 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 | 000000000000000000 | 000000000000000000 | 000000000000000000 |
| 62 | FQHC | 000000000000000000 | 000000000000000000 | 000000000000000000 |
| 63 | Other Outpatient Service Cost | 0 | 0 | 0.000000 |
| 71 | Ambulance | 0 | 0 | 0.000000 |
| 100 | TOTAL | 1,433,165 | 2,399,231 | //////////////////////////////////// |

| MED-CALC SYSTEMS | | In Lieu of CMS Form 2540-10 | | | | |
|--|---|--|--|--------------------------------------|--------------------------|--------------------------------------|
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST | | PROVIDER CCN : 31-5226 | PERIOD : FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET D | | |
| Check <input type="checkbox"/> Title V (1) Check One: <input checked="" type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Other One: <input checked="" type="checkbox"/> Title XVIII <input type="checkbox"/> PPS - Must also complete Part II <input type="checkbox"/> Title XIX (1) | | | | | | |
| PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST | | RATIO OF COST TO CHARGES (WS C, col 3) 1 | HEALTH CARE PROGRAM CHARGES | | HEALTH CARE PROGRAM COST | |
| | | | PART A | PART B | PART A | PART B |
| | | | 2 | 3 | 4 | 5 |
| ANCILLARY SERVICE COST CENTERS: | | | | | | |
| 40 | Radiology | 1.242851 | 3,036 | | 3,773 | 0 |
| 41 | Laboratory | 1.242805 | 7,825 | | 9,725 | 0 |
| 42 | Intravenous Therapy | 0.056481 | 28,383 | | 1,603 | 0 |
| 43 | Oxygen (Inhalation) Therapy | 1.242844 | 0 | | 0 | 0 |
| 44 | Physical Therapy | 0.622825 | 376,531 | | 234,513 | 0 |
| 45 | Occupational Therapy | 0.606694 | 362,802 | | 220,110 | 0 |
| 46 | Speech Pathology | 0.555118 | 190,515 | | 105,758 | 0 |
| 47 | Electrocardiology | 0.000000 | 0 | | 0 | 0 |
| 48 | Medical Supplies Charged | 0.000000 | 0 | | 0 | 0 |
| 49 | Drugs Charged to Patients | 0.552690 | 428,208 | | 236,666 | 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) | | 1,397,300 | 0 | 812,148 | 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 : 31-5226 | PERIOD : FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET D |

Check Title V (1) Check One: SNF NF ICF/IID Other
 One: Title XVIII PPS - Must also complete Part II
 Title XIX (1)

| PART II - APPORTIONMENT OF VACCINE COST | | |
|---|--|----------|
| 1 | Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) | 0.552690 |
| 2 | Program vaccine charges (From your records, or the P S & R.) ---> | 0 |
| 3 | Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18) | 0 |

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 Nursing & Allie health Costs fr Pass Through (Col. 3 X Col. 4) | |
|---------------------------------------|--|--|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40 | Radiology | 8,214 | 0 | 0.000000 | 3,773 | 0 |
| 41 | Laboratory | 26,990 | 0 | 0.000000 | 9,725 | 0 |
| 42 | Intravenous Therapy | 1,783 | 0 | 0.000000 | 1,603 | 0 |
| 43 | Oxygen (Inhalation) Therapy | 11,203 | 0 | 0.000000 | 0 | 0 |
| 44 | Physical Therapy | 510,637 | 0 | 0.000000 | 234,513 | 0 |
| 45 | Occupational Therapy | 434,941 | 0 | 0.000000 | 220,110 | 0 |
| 46 | Speech Pathology | 185,636 | 0 | 0.000000 | 105,758 | 0 |
| 47 | Electro cardiology | 0 | 0 | 0.000000 | 0 | 0 |
| 48 | Medical Supplies | 0 | 0 | 0.000000 | 0 | 0 |
| 49 | Drugs Charged to Patients | 253,761 | 0 | 0.000000 | 236,666 | 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) | 1,433,165 | 0 | //////////////////////////////////// | 812,148 | 0 |

| | | | | | |
|---|---|--|------------------|------------------------------------|--------------------------------------|
| MED-CALC SYSTEMS | | In Lieu of CMS Form 2540-10 | | | |
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST | | PROVIDER CCN : | PERIOD : | WORKSHEET D | |
| | | 31-5226 | FROM: 01/01/2023 | | |
| | | | TO: 12/31/2023 | | |
| PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST | | | | | |
| Check <input type="checkbox"/> Title V (1) | | Check One: <input type="checkbox"/> SNF <input checked="" type="checkbox"/> NF <input type="checkbox"/> ICF/IID <input type="checkbox"/> Other | | | |
| One: <input type="checkbox"/> Title XVIII | | <input type="checkbox"/> PPS - Must also complete Part II | | | |
| <input checked="" type="checkbox"/> Title XIX (1) | | | | | |
| PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST | | HEALTH CARE PROGRAM INPATIENT CHARGES | | HEALTH CARE PROGRAM INPATIENT COST | |
| | | RATIO OF COST TO CHARGES | | | |
| | | PART A PART B | | PART A PART B | |
| | | 1 2 3 | | 4 5 | |
| ANCILLARY SERVICE COST CENTERS: | | //////////////////////////////////// | | | |
| 40 | Radiology | 1.242851 | | 0 | //////////////////////////////////// |
| 41 | Laboratory | 1.242805 | | 0 | //////////////////////////////////// |
| 42 | Intravenous Therapy | 0.056481 | | 0 | //////////////////////////////////// |
| 43 | Oxygen (Inhalation) Therapy | 1.242844 | | 0 | //////////////////////////////////// |
| 44 | Physical Therapy | 0.622825 | | 0 | //////////////////////////////////// |
| 45 | Occupational Therapy | 0.606694 | | 0 | //////////////////////////////////// |
| 46 | Speech Pathology | 0.555118 | | 0 | //////////////////////////////////// |
| 47 | Electro cardiology | 0.000000 | | 0 | //////////////////////////////////// |
| 48 | Medical Supplies Charged | 0.000000 | | 0 | //////////////////////////////////// |
| 49 | Drugs Charged to Patients | 0.552690 | | 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 : 31-5226 | PERIOD : FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET D-1 PARTS I & II |
| Check One: | <input type="checkbox"/> Title V | <input checked="" type="checkbox"/> Title XVIII | <input type="checkbox"/> Title XIX |
| Check One: | <input checked="" type="checkbox"/> SNF | <input type="checkbox"/> NF | <input type="checkbox"/> ICF/IID |

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

| | | |
|---|--|------------|
| 1 | Inpatient days including private room days | 58,746 |
| 2 | Private room days | |
| 3 | Inpatient days including private room days applicable to the Program | 6,485 |
| 4 | Medically necessary private room days applicable to the Program | |
| 5 | Total general inpatient routine service cost | 17,814,501 |

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

| | | |
|----|--|------------|
| 6 | General inpatient routine service charges | 21,368,995 |
| 7 | General inpatient routine service cost/charge ratio (Line 5 divided by line 6) | 0.833661 |
| 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) | 17,814,501 |

PROGRAM INPATIENT ROUTINE SERVICE COSTS

| | | |
|----|---|-----------|
| 16 | Adjusted general inpatient service cost per diem (Line 15 divided by line 1) | 303.25 |
| 17 | Program routine service cost (Line 3 times line 16) | 1,966,576 |
| 18 | Medically necessary private room cost applicable to program (line 4 times line 13) | 0 |
| 19 | Total program general inpatient routine service cost (Line 17 plus line 18) | 1,966,576 |
| 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) | 1,369,337 |
| 21 | Per diem capital related costs (Line 20 divided by line 1) | 23.31 |
| 22 | Program capital related cost (Line 3 times line 21) | 151,165 |
| 23 | Inpatient routine service cost (Line 19 minus line 22) | 1,815,411 |
| 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) | 1,815,411 |
| 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 | 58,746 |
| 2 | Program inpatient days. (see instructions) | 6,485 |
| 3 | Total Nursing & Allied Health costs. (see instructions) | 0 |
| 4 | Nursing & Allied Health ratio. (Line 2 divided by line 1) | 0.110390 |
| 5 | Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4) | 0 |

| | | | |
|---|--------------------------------------|---|-------------------------------|
| COMPUTATION OF INPATIENT ROUTINE COSTS Check One: | PROVIDER CCN : | PERIOD : | WORKSHEET D-1 PARTS I & II |
| | 31-5226 | FROM: 01/01/2023 TO: 12/31/2023 | |
| | <input type="checkbox"/> Title XVIII | <input checked="" type="checkbox"/> Title XIX | |
| Check One: <input checked="" type="checkbox"/> NF | <input type="checkbox"/> 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 room days, line 2) | 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 : 31-5226 | 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) | 4,853,652 |
| 2 | Nursing and Allied Health Education Activities (pass through payments) | 0 |
| 3 | Subtotal (Sum of lines 1 and 2) | 4,853,652 |
| 4 | Primary payor amounts | (0) |
| 5 | Coinsurance | (511,000) |
| 6 | Allowable bad debts (from your records) | 118,789 |
| 7 | Allowable Bad debts for dual eligible beneficiaries (see instructions) | 30,589 |
| 8 | Adjusted reimbursable bad debts. (See instructions) | 77,213 |
| 9 | Recovery of bad debts - for statistical records only | |
| 10 | Utilization review | 0 |
| 11 | Subtotal (See instructions) | 4,419,865 |
| 12 | Interim payments (See instructions) | 4,331,254 |
| 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) | 1,544 |
| 14.99 | Sequestration amount (see instructions) | 86,853 |
| 15 | Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14) | 214 |
| | (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) | 0 |
| 19 | Total reasonable costs (Sum of lines 17 and 18) | 0 |
| 20 | Medicare Part B ancillary charges (See instructions) | 0 |
| 21 | Cost of covered services (Lesser of line 19 or line 20) | 0 |
| 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) | 0 |
| 26 | Interim payments (See instructions) | 0 |
| 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) | 0 |
| 29 | Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28) | 0 |
| | (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: 31-5226 | 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 | //////////////////////////////////// | 4,255,799 | //////////////////////////////////// | 0 | | |
| 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. | //////////////////////////////////// | 86,728 | //////////////////////////////////// | | | |
| 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) | Program to Provider | .01 | | | | |
| | | .02 | | | | |
| | | .03 | | | | |
| | | .04 | | | | |
| | | .05 | | | | |
| | Provider to Program * | .50 | 05/25/23 | 11,273 | | |
| | | .51 | | | | |
| | | .52 | | | | |
| | | .53 | | | | |
| | | .54 | | | | |
| SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) | | .99 | //////////////////////////////////// | (11,273) | //////////////////////////////////// | 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.) | | //////////////////////////////////// | 4,331,254 | //////////////////////////////////// | 0 | |

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) | Program to Provider | .01 | | | | |
| | | .02 | | | | |
| | | .03 | | | | |
| | Provider to Program | .50 | | | | |
| | | .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.

| | | | |
|--|--------------------------|---|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY | PROVIDER CCN: 31-5226 | PERIOD: FROM: 01/01/2023 TO: 12/31/2023 | WORKSHEET E PART II TITLE XIX |
|--|--------------------------|---|--|

| | | | |
|------------|----------------------------------|---|----------------------------------|
| Check one: | <input type="checkbox"/> Title V | <input checked="" type="checkbox"/> Title XIX | |
| Check one: | <input type="checkbox"/> SNF | <input checked="" type="checkbox"/> NF | <input type="checkbox"/> 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 services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) | |
| 18 | Ratio of line 16 to line 17 (not to exceed 1.000000) | 1.000000 |
| 19 | Total customary charges (see instructions) | 0 |

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

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

| | | | |
|---------------|--------------------------|---|--------------------|
| BALANCE SHEET | PROVIDER CCN: 31-5226 | 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 | 1,429,059 | | |
| 2 | Temporary investments | 0 | | |
| 3 | Notes receivable | 0 | | |
| 4 | Accounts receivable | 2,507,581 | | |
| 5 | Other receivables | 0 | | |
| 6 | Less: allowances for uncollectible notes and A/R | 0 | | |
| 7 | Inventory | 0 | | |
| 8 | Prepaid expenses | 423,234 | | |
| 9 | Other current assets | 0 | | |
| 10 | Due from other funds | 0 | | |
| 11 | TOTAL CURRENT ASSETS | 4,359,874 | 0 | 0 |
| | (Sum of lines 1 - 10) | | | |

| FIXED ASSETS | | | | |
|--------------|--------------------------------|----------------|----------|----------|
| 12 | Land | 0 | | |
| 13 | Land improvements | 0 | | |
| 14 | Less: Accumulated depreciation | 0 | | |
| 15 | Buildings | 0 | | |
| 16 | Less Accumulated depreciation | 0 | | |
| 17 | Leasehold improvements | 1,047,159 | | |
| 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 | 69,970 | | |
| 24 | Less: Accumulated depreciation | (410,597) | | |
| 25 | Minor equipment - Depreciable | 0 | | |
| 26 | Minor equipment nondepreciable | 0 | | |
| 27 | Other fixed assets | 0 | | |
| 28 | TOTAL FIXED ASSETS | 706,532 | 0 | 0 |
| | (Sum of lines 12 - 27) | | | |

| OTHER ASSETS | | | | |
|--------------|------------------------------|------------------|----------|----------|
| 29 | Investments | 0 | | |
| 30 | Deposits on leases | 0 | | |
| 31 | Due from owners/officers | 0 | | |
| 32 | Other assets | 11,840 | | |
| 33 | TOTAL OTHER ASSETS | 11,840 | 0 | 0 |
| | (Sum of lines 29 - 32) | | | |
| 34 | TOTAL ASSETS | 5,078,246 | 0 | 0 |
| | (Sum of lines 11, 28 and 33) | | | |

| | | | |
|---------------|--------------------------|---|-------------------------|
| BALANCE SHEET | PROVIDER CCN: 31-5226 | 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 | 1,251,949 | | | |
| 36 | Salaries, wages & fees payable | 432,157 | | | |
| 37 | Payroll taxes payable | 334,913 | | | |
| 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 | 2,019,019 | 0 | 0 | 0 |
| | (Sum of lines 35 - 42) | | | | |

LONG TERM LIABILITIES

| | | | | | |
|----|-----------------------------|-----------|---|---|---|
| 44 | Mortgage payable | 0 | | | |
| 45 | Notes payable | 0 | | | |
| 46 | Unsecured loans | 1,997,680 | | | |
| 47 | Loans from owners: | 0 | | | |
| 48 | Other long term liabilities | 0 | | | |
| 49 | Other (Specify) | 0 | | | |
| 50 | TOTAL LONG TERM LIABILITIES | 1,997,680 | 0 | 0 | 0 |
| | (Sum of lines 44 - 49) | | | | |
| 51 | TOTAL LIABILITIES | 4,016,699 | 0 | 0 | 0 |
| | (Sum of lines 43 and 50) | | | | |

CAPITAL ACCOUNTS

| | | | | | |
|----|-------------------------------------|-----------|--------------------------------------|--------------------------------------|--------------------------------------|
| 52 | General fund balance | 1,061,547 | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 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 | 1,061,547 | 0 | 0 | 0 |
| | (Sum of lines 52 thru 58) | | | | |
| 60 | TOTAL LIABILITIES & FUND BALANCES | 5,078,246 | 0 | 0 | 0 |
| | (Sum of lines 51 and 59) | | | | |

| | | | |
|--|--------------------------|---|---------------|
| STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER CCN: 31-5226 | 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 | //////////////////////////////////// | 270,919 | //////////////////////////////////// | | //////////////////////////////////// | | //////////////////////////////////// | |
| 2 | Net income (loss) (From Wkst. G-3, line 31) | //////////////////////////////////// | 790,628 | //////////////////////////////////// | | //////////////////////////////////// | | //////////////////////////////////// | |
| 3 | Total (Sum of line 1 and line 2) | //////////////////////////////////// | 1,061,547 | //////////////////////////////////// | 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) | //////////////////////////////////// | 1,061,547 | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 |
| 12 | Deductions (Debit adjustments) | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 13 | | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 14 | | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 15 | | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 16 | | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 17 | | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| 18 | Total deductions (Sum of lines 13 - 17) | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 |
| 19 | Fund balance at end of period per | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// | //////////////////////////////////// |
| | balance sheet (Line 11 - line 18) | //////////////////////////////////// | 1,061,547 | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 | //////////////////////////////////// | 0 |

| | | | |
|---|--------------------------|---|--------------------------------|
| STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER CCN: 31-5226 | 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 | 21,368,995 | //////////////////////////////////// | 21,368,995 |
| 2 | Nursing facility | 0 | //////////////////////////////////// | 0 |
| 3 | ICF-IID | 0 | //////////////////////////////////// | 0 |
| 4 | Other long term care | 0 | //////////////////////////////////// | 0 |
| 5 | Total general inpatient care services | 21,368,995 | //////////////////////////////////// | 21,368,995 |
| (Sum of lines 1 - 4) | | | | |

| | | | | |
|--|--|--------------------------------------|---|------------|
| ALL OTHER CARE SERVICES | | | | |
| 6 | Ancillary services | 2,402,771 | 0 | 2,402,771 |
| 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) | 23,771,766 | 0 | 23,771,766 |
| (Transfer column 3 to Worksheet G-3, Line 1) | | | | |

PART II - OPERATING EXPENSES

| | | | |
|----|--|--------------------------------------|--------------------------------------|
| 1 | Operating Expenses (Per Worksheet A, Col. 3, Line 100) | //////////////////////////////////// | 20,704,839 |
| 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) | //////////////////////////////////// | 20,704,839 |

| | | | |
|-------------------------------------|--------------------------|---|------------------|
| STATEMENT OF REVENUES & EXPENSES | PROVIDER CCN: 31-5226 | 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) | 23,771,766 |
| 2 | Less: contractual allowances and discounts on patients accounts | (2,296,213) |
| 3 | Net patient revenues (Line 1 minus line 2) | 21,475,553 |
| 4 | Less: total operating expenses (From Worksheet G-2, Part II, line 15) | 20,704,839 |
| 5 | Net income from service to patients (Line 3 minus 4) | 770,714 |
| //////// | OTHER INCOME: | //////// |
| 6 | Contributions, donations, bequests, etc | 0 |
| 7 | Income from investments | 14,973 |
| 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 | 177 |
| 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 | 4,764 |
| 24.50 | COVID-19 PHE Funding | 0 |
| 25 | Total other income (Sum of lines 6 - 24) | 19,914 |
| 26 | Total (Line 5 plus line 25) | 790,628 |
| 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) | 790,628 |



MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

**PRIME CARE HEALTH, LLC
D/B/A HUNTERDON CARE CENTER**

Financial Statements

Year Ended December 31, 2023

Prime Care Health, LLC D/B/A Hunterdon Care Center

Year Ended December 31, 2023

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MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Members,
Prime Care Health, LLC D/B/A Hunterdon Care Center:

Opinion

We have audited the accompanying financial statements of Prime Care Health, LLC D/B/A Hunterdon Care Center, 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 Prime Care Health, LLC D/B/A Hunterdon Care Center 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 Prime Care Health, LLC D/B/A Hunterdon Care Center 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 Prime Care Health, LLC D/B/A Hunterdon Care Center'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.



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 Prime Care Health, LLC D/B/A Hunterdon Care Center'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 Prime Care Health, LLC D/B/A Hunterdon Care Center'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

April 1, 2024

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Balance Sheet
December 31, 2023

Assets

| | | | |
|--|----|------------|----------------------|
| Cash | \$ | 1,429,062 | |
| Accounts Receivable (Net) | | 2,427,581 | |
| Prepaid Expenses | | 423,234 | |
| Total Current Assets | | 4,279,877 | \$ 4,279,877 |
| | | | |
| Leasehold Improvements | | 1,047,159 | |
| Furniture & Equipment | | 69,970 | |
| | | 1,117,129 | |
| Less: Accum. Depreciation & Amortization | | 410,597 | |
| Total Fixed Assets | | 706,532 | 706,532 |
| | | | |
| Right-of-Use Asset | | 16,182,943 | |
| Security Deposits | | 11,840 | |
| Total Other Assets | | 16,194,783 | 16,194,783 |
| | | | |
| Total Assets | | | \$ 21,181,192 |

Liabilities and Equity

| | | | |
|--|--|------------|----------------------|
| Accounts Payable | | 1,251,949 | |
| Lease Liabilities | | 497,056 | |
| Withholding Taxes Payable | | 10,030 | |
| Accrued Payroll | | 432,157 | |
| Accrued Expenses & Taxes | | 324,884 | |
| Due to Managed Medicaid | | 1,997,680 | |
| Total Current Liabilities | | 4,513,756 | \$ 4,513,756 |
| | | | |
| Lease Liabilities | | 15,685,887 | |
| Total Long Term Liabilities | | 15,685,887 | 15,685,887 |
| | | | |
| Members' Equity | | | 981,549 |
| | | | |
| Total Liabilities & Members' Equity | | | \$ 21,181,192 |

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Statement of Operations
For the year ended December 31, 2023

| | | | |
|-----------------------------|----|-----------|-----------------------|
| Total Revenue From Patients | | \$ | 21,395,554 |
| Operating Expenses: | | | |
| Payroll | \$ | | 8,649,288 |
| Employee Benefits | | | 2,060,283 |
| Professional Care | | | 2,919,201 |
| Dietary & Housekeeping | | | 1,383,861 |
| Plant & Maintenance | | | 2,893,252 |
| General & Administrative | | | <u>2,798,953</u> |
| Total Operating Expenses | | | <u>20,704,838</u> |
| Income From Operations | | | 690,716 |
| Other Income | | | <u>19,914</u> |
| Net Income | | \$ | <u>710,630</u> |

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Statement of Members' Equity
For the year ended December 31, 2023

Members' Equity:

| | |
|--|--------------------------|
| Balance as of Beginning of Period | \$ 270,919 |
| Net Income for the Period | <u>710,630</u> |
| Total Members' Equity - End of Period | <u>\$ 981,549</u> |

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Statement of Cash Flows
For the year ended December 31, 2023

Cash Flows From Operating Activities:

| | | |
|--|------------------|----------------------------|
| Net Income | | \$ 710,630 |
| Adjustments to reconcile Net Income to Net Cash Provided by Operating Activities: | | |
| Depreciation & Amortization | | 70,223 |
| Bad Debt Provision | | 80,000 |
| (Increase) Decrease In: | | |
| Accounts Receivable | \$ 34,164 | |
| Prepaid Expenses | 86,404 | |
| Increase (Decrease) In: | | |
| Accounts Payable | (445,796) | |
| Accrued Payroll & Withholding Taxes | (103,151) | |
| Accrued Expenses & Taxes | (33,488) | |
| Exchanges | 355,840 | |
| Total Adjustments | <u>(106,027)</u> | <u>(106,027)</u> |
| Net Cash Provided By Operating Activities | | 754,826 |
| Cash Flows From Investing Activities: | | |
| Capital Expenditures | <u>(140,802)</u> | |
| Net Cash Used In Investing Activities | | <u>(140,802)</u> |
| Net Change In Cash | | 614,024 |
| Cash - Beginning of Period | | <u>815,038</u> |
| Cash - End of Period | | \$ <u>1,429,062</u> |
| Supplemental Disclosures: | | |
| Interest Paid | | \$ 5,026 |

**Prime Care Health, LLC
D/B/A Hunterdon Care Center
Notes To The Financial Statements**

1) **Organization:**

Prime Care Health, LLC D/B/A Hunterdon Care Center (Facility), a limited liability company, is licensed by the New Jersey State Department of Health to run and operate a 185 bed skilled nursing facility located in Flemington, New Jersey. The facility began operations in May 2009.

2) **Summary of Significant Accounting Policies:**

The accounting policies that affect the significant elements of the financial statements are summarized below.

Method of Accounting -

The Facility maintains its books and prepares its financial statements on the accrual basis of accounting.

Cash -

For purposes of the statement of cash flows, the Facility considers time deposits, certificates of deposits, and all highly liquid investments, with maturity of three months or less, to be cash. The facility maintains cash balances at financial institutions, which periodically exceed the Federal Deposit Insurance Corporation limit during the year.

Fixed Assets -

Property and equipment are stated at cost. Depreciation and amortization for assets are computed using the straight-line method over the estimated useful lives of the assets.

Patient Care Revenue -

Major portions of the Facility's revenue are derived from payments under the Medicaid and Medicare programs. Revenue received from these programs is based in part on cost reimbursement principles which are subject to judgmental interpretation and to audits which could result in an adjustment to revenue. Medicare final settlements are reflected as charges or credits to operating revenues in the year finalized.

Use of Estimates -

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

**Prime Care Health, LLC
D/B/A Hunterdon Care Center
Notes To The Financial Statements**

Accrued Payroll -

Most employees earn credits during the current year for vacations to be taken in the following year. The expense for this liability is accrued during the year vacations are earned rather than in the year vacations are taken.

Income Taxes -

Prime Care Health, LLC D/B/A Hunterdon Care Center is treated as a partnership for income tax purposes, and as such the members are taxed separately on their distributive share of the Facility's income whether or not that income is actually distributed.

Advertising -

Advertising costs are expensed as incurred and included in general and administrative expenses. Advertising expense for the year ended December 31, 2023 was \$63,799.

3) **Accounts Receivable:**

The Facility grants credit, without collateral, to its patients, the majority of whom are insured under third-party payor agreements. The amount of receivables from patients and third-party payors at December 31, 2023 was as follows:

| | |
|--|---------------------|
| Medicaid Patients | \$ 1,004,217 |
| Medicare Patients | 908,331 |
| Private Patients (Net of Security Deposit) | <u>610,033</u> |
| | 2,522,581 |
| Less Allowance for Doubtful Accounts | <u>(95,000)</u> |
| Total | \$ <u>2,427,581</u> |

Management periodically reviews accounts receivable, and all receivables deemed uncollectible are charged to income when that determination is made. Management considers accounts receivable as stated to be collectible.

4) **Nursing Home User Fee:**

In 2023, all New Jersey facilities were assessed a provider assessment tax of \$14.67 per patient day. Concurrently with the tax assessment, the State prospectively calculated a revenue add-on to the Medicaid rate.

5) **Uncertainty in Income Taxes:**

Management has determined that there are no material uncertain tax positions that require recognition or disclosure in the financial statements. Periods ended December 31, 2020 and subsequent remain subject to examination by applicable taxing authorities.

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Notes To The Financial Statements

6) Right-of-Use Asset and Lease Liability:

The Facility's operating lease right-of-use assets and lease liabilities were for a building lease.

The Facility occupies premises pursuant to a 40 year non-arms-length lease with Foremost Realty, LP (a related company through common ownership) that will expire in 2049. The lease, as amended in March 5, 2012, provides for minimum annual rentals of 105% of the debt service amount including all escrow requirements.

The Facility recognizes lease expense for operating leases on a straight-line basis over the lease term. The lease expense for 2023 was \$2,300,430.

The Facility determines the present value of the remaining lease payments using the US Treasury risk-free rate at the time of adoption of the Standard, which was 2.01%. The facility does not have any variable lease payments, residual value guarantees, or material lease incentives.

The Facility has not recognized any material impairments of its operating lease right-of-use asset as of December 31, 2023. As of December 31, 2023, the facility's operating lease liability and corresponding asset was \$16,182,943 of which \$497,056 of the liability was considered short term.

The Facility's future minimum lease payments for the next five years, as of December 31, 2023, were as follows:

| | |
|------|-----------|
| 2024 | \$817,771 |
| 2025 | \$817,771 |
| 2026 | \$817,771 |
| 2027 | \$817,771 |
| 2028 | \$817,771 |

The future minimum lease payments include only the remaining non-cancelable lease payments under the operating leases with a term of more than 12 months as of December 31, 2023.

In addition, the Facility leased office space from Dynamic Healthcare (a related company through common ownership). Total rent expense for the year ended December 31, 2023 was \$78,240.

7) Due to Managed Medicaid:

The Facility received overpayments from managed Medicaid HMO's which get recouped when audited by the managed Medicaid HMO.

8) Subsequent Events:

The Facility has evaluated subsequent events through April 1, 2024, the date which the financial statements were available to be issued. No significant subsequent events have been identified by management.



MARTIN FRIEDMAN CPA PC
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT
ON ADDITIONAL INFORMATION

To the Members,
Prime Care Health, LLC D/B/A Hunterdon Care Center:

Our report on our audit of the basic financial statements of Prime Care Health, LLC D/B/A Hunterdon Care Center 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 11 through 13 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

April 1, 2024

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Supplementary Schedules
For the year ended December 31, 2023

Revenue From Patients:

| | | |
|-----------------------------|-----------------|---------------|
| Private | \$ 6,647,035 | |
| Medicaid | 9,732,638 | |
| Medicare | 5,095,881 | |
| Provision for Bad Debts | <u>(80,000)</u> | |
| Total Revenue From Patients | | \$ 21,395,554 |

Other Income:

| | | |
|--------------------|--------------|---------------|
| Interest | 14,973 | |
| Other | <u>4,941</u> | |
| Total Other Income | | <u>19,914</u> |

Total Revenue **\$ 21,415,468**

**Prime Care Health, LLC
D/B/A Hunterdon Care Center
Supplementary Schedules
For the year ended December 31, 2023**

Payroll:

| | | |
|-------------------------|---------------|----------------------------|
| Administrative & Office | \$ 943,164 | |
| Nursing | 6,228,575 | |
| Social Services | 191,202 | |
| Recreation | 245,953 | |
| Dietary | 943,162 | |
| Maintenance | <u>97,232</u> | |
| Total Payroll | | \$ <u>8,649,288</u> |

Employee Benefits:

| | | |
|--------------------------------|---------------|----------------------------|
| Payroll Taxes | 736,411 | |
| Workmen's Compensation | 311,172 | |
| Union | 28,650 | |
| Non-Union Pension | 27,075 | |
| Employee Benefits | 946,676 | |
| Uniform & Transp. Allowance | <u>10,299</u> | |
| Total Employee Benefits | | \$ <u>2,060,283</u> |

Professional Care:

| | | |
|--------------------------------|----------------|----------------------------|
| Prescription Drugs | 183,075 | |
| Medical Supplies | 333,568 | |
| Contracted Nursing Service | 1,410,236 | |
| Fees & Expenses | <u>992,322</u> | |
| Total Professional Care | | \$ <u>2,919,201</u> |

Prime Care Health, LLC
D/B/A Hunterdon Care Center
Supplementary Schedules
For the year ended December 31, 2023

Dietary & Housekeeping:

| | |
|------------------------|----------------|
| Food | \$ 535,473 |
| Other Dietary Expenses | 47,877 |
| Laundry | 80,289 |
| Housekeeping | <u>720,222</u> |

Total Dietary & Housekeeping **\$ 1,383,861**

Plant & Maintenance:

| | |
|-----------------------------|---------------|
| Rent | 2,378,670 |
| Light, Heat & Power | 213,916 |
| Maintenance | 179,378 |
| Water & Sewer Charges | 51,065 |
| Depreciation & Amortization | <u>70,223</u> |

Total Plant & Maintenance **\$ 2,893,252**

General & Administrative:

| | |
|----------------------------|---------------|
| Office | 1,259,115 |
| Contracted Office Services | 130,000 |
| Telephone | 28,398 |
| Dues & Subscriptions | 17,539 |
| Auto & Travel | 11,759 |
| Professional Fees | 77,279 |
| Insurance | 436,071 |
| Interest | 5,026 |
| Nursing Home User Fee | 728,615 |
| Advertising | 63,799 |
| Miscellaneous | <u>41,352</u> |

Total General & Administrative **\$ 2,798,953**