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

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

OMB NO. 0938-0463

Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S PARTS I II & III

PART I - COST REPORT STATUS

Provider use only

1.	[X]	Electronically prepared cost report	**Date:** 05/10/2024 **Time:** 12:32:22 PM
2.	[ ]	Manually prepared cost report	
3.	[ ]	If this is an amended report enter the number of times the provider resubmitted this cost report.	0
3.0.1	[ ]	No Medicare Utilization Enter "Y" for yes or leave blank for no	0

Contractor use only:

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

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

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IMPERIAL CARE CENTER #31-5199 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:
05/10/2024 12:32:22 PM
Xpy3br07FSZYubigHkYdm8ukIV5RN0
Cj18R0lGHADNa08BIJn6YCDJ6M7RLL
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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	Yudi Steinfeld		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Yudi Steinfeld			2
3	Signatory Title	Controller			3
4	Signature date	05/10/2024			4

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX	
		1	2	3	4	
1	SKILLED NURSING FACILITY		(44,903)	(3,740)		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		(44,903)	(3,740)	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.

MED-CALC SYSTEMS	In Lieu of CMS Form 2540-10		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD: FROM: 01/01/2023	WORKSHEET S-2 PART I
IDENTIFICATION DATA	31-5199	TO: 12/31/2023	

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	919 GROVE ROAD	P.O. Box:					1
2	City:	NEPTUNE	State:	NJ	Zip Code:	07753		2
3	County:	MONMOUTH	CBSA Code:	35614	Urban / Rural:	U		3

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider CCN:	Date Certified		Payment System (P, O, or N) V	XVIII	XIX	
	0	1	2	3		4	5	6	
4	S N F	IMPERIAL CARE CENTER	31-5199	03/01/1984		N	P	N	4
5	Nursing Facility						//////////		5
6	I C F / I I D					//////////	//////////		6
7	SNF-Based HHA								7
8	SNF-Based RHC								8
9	SNF-Based FQHC								9
10	SNF-Based CMHC								10
11	SNF-Based OLTC		//////////	//////////		//////////	//////////	//////////	11
12	SNF-Based HOSPICE					//////////	//////////	//////////	12
13	OTHER (specify)					//////////	//////////	//////////	13
14	Cost Reporting Period (mm/dd/yyyy)			FROM: 01/01/2023		TO: 12/31/2023			14
15	Type of Control	5							15

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

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

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

20	Straight Line	305,364	//////////	20
21	Declining Balance		//////////	21
22	Sum of the Year's Digits		//////////	22
23	Sum of line 20 through 22	305,364	//////////	23
24	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)		Y	25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		N	26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies		N	27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports		N	28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: 31-5199	PERIOD FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S-2 PART I (Cont.)

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

		Part A	Part B	Other	
29	Skilled Nursing Facility	N	N	////////////////////	29
30	Nursing Facility	////////////////////	////////////////////////		30
31	I C F / I I D	////////////////////	////////////////////////		31
32	SNF-Based HHA			////////////////////	32
33	SNF-Based RHC	////////////////////		////////////////////	33
34	SNF-Based FQHC	////////////////////		////////////////////	34
35	SNF-Based CMHC	////////////////////	N	////////////////////	35
36	SNF-Based OLTC	////////////////////	////////////////////////	////////////////////	36
				Y / N	
37	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients.			N	37
38	Are you legally-required to carry malpractice insurance?			Y	38
39	Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-made" enter 1. If policy is "occurence", enter 2.			1	39

	//////////////////////////////// //	Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:	110,794			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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S-2 Part II

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

Completed by All Skilled Nursing Facilities

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

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

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

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

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

Bed Complement

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

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

COST REPORT PREPARER CONTACT INFORMATION

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

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

PROVIDER CCN: 31-5199

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

WORKSHEET S-3 PART I

	Component		Number of Beds	Bed Days Available		Inpatient Days / Visits: Title V	Title XVIII	Title XIX	Other	Total
			1	2		3	4	5	6	7
1	Skilled Nursing Facility		121	44,165			3,177	24,609	4,061	31,847
2	Nursing Facility									0
3	ICF/IID									0
4	Home Health Agency									0
5	Other Long Term Care									0
6	SNF-Based CMHC									
7	Hospice									0
8	TOTAL (Sum Lines 1-7)		121	44,165			3,177	24,609	4,061	31,847

	Component		Discharges: Title V	Title XVIII	Title XIX	Other	Total	Average Length of Stay: Title V	Title XVIII	Title XIX	Total
			8	9	10	11	12	13	14	15	16
1	Skilled Nursing Facility			68	71	51	190		46.72	346.61	167.62
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)			68	71	51	190		46.72	346.61	167.62

	Component		Admissions: Title V	Title XVIII	Title XIX	Other	Total		Full Time Equivalent: Employees on Payroll	Nonpaid Workers
			17	18	19	20	21		22	23
1	Skilled Nursing Facility			95	37	59	191		82.38	
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)			95	37	59	191		82.38	0.00

SNF WAGE INDEX INFORMATION | **PROVIDER CCN:** 31-5199 | 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)	4,937,281	0	4,937,281	171,344.97	28.81	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)	4,937,281	0	4,937,281	171,344.97	28.81	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)	4,937,281	0	4,937,281	171,344.97	28.81	13
	OTHER WAGES AND RELATED COSTS	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	
14	Contract Labor: Patient Related & Mgmt	1,172,630		1,172,630	29,472.11	39.79	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)	810,258		810,258	////////////////////////////	////////////////////////////	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)	810,258	0	810,258	////////////////////////////	////////////////////////////	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	814,013	0	814,013	18,089.15	45.00	2
3	Plant Operation, Maintenance & Repairs	163,154	0	163,154	6,728.69	24.25	3
4	Laundry & Linen Service	0	0	0		0.00	4
5	Housekeeping	0	0	0		0.00	5
6	Dietary	584,249	0	584,249	32,690.35	17.87	6
7	Nursing Administration	154,946	0	154,946	2,090.76	74.11	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	74,324	0	74,324	2,136.50	34.79	11
12	Nursing and Allied Health Education Activities	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	12
13	Other General Service Cost	299,925	0	299,925	15,946.39	18.81	13
14	Total (sum lines 1 thru 13)	2,090,611	0	2,090,611	77,681.84	**26.91**	14

SNF WAGE RELATED COSTS	PROVIDER CCN: 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET S-3 PART IV

PART IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost	8,700	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)	297,984	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	98,047	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	361,752	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	40,095	20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement	3,680	23
24	Total Wage Related cost (Sum of lines 1 -23)	810,258	24

Part B Other than Core Related Cost		Amount Reported	
25			25

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN: 31-5199	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)	772,513	126,777	899,290	18,025.43	49.89	1
2	Licensed Practical Nurses (LPNs)	673,188	110,477	783,665	18,159.00	43.16	2
3	Certified Nursing Assistants/Nursing Assistants/Aides	1,086,986	178,385	1,265,371	50,661.77	24.98	3
4	Total Nursing (sum of lines 1 through 3)	2,532,687	415,639	2,948,326	86,846.20	33.95	4
5	Physical Therapists	89,251	14,647	103,898	1,878.35	55.31	5
6	Physical Therapy Assistants			-		0.00	6
7	Physical Therapy Aides	74,092	12,159	86,251	2,080.18	41.46	7
8	Occupational Therapists	105,898	17,379	123,277	1,998.00	61.70	8
9	Occupational Therapy Assistants			-		0.00	9
10	Occupational Therapy Aides			-		0.00	10
11	Speech Therapists	44,741	7,343	52,084	860.40	60.53	11
12	Respiratory Therapists			-		0.00	12
13	Other Medical Staff			-		0.00	13
	Contract Labor	////////////	////////////	////////////	////////////	////////////	/
	Nursing Occupations	////////////	////////////	////////////	////////////	////////////	/
14	Registered Nurses (RNs)	122,078	////////////	122,078	1,950.08	62.60	14
15	Licensed Practical Nurses (LPNs)	226,261	////////////	226,261	4,089.53	55.33	15
16	Certified Nursing Assistants/Nursing Assistants/Aides	756,961	////////////	756,961	23,403.15	32.34	16
17	Total Nursing (sum of lines 14 through 16)	1,105,300	////////////	1,105,300	29,442.76	37.54	17
18	Physical Therapists		////////////	-		0.00	18
19	Physical Therapy Assistants		////////////	-		0.00	19
20	Physical Therapy Aides		////////////	-		0.00	20
21	Occupational Therapists	777	////////////	777	11.60	66.98	21
22	Occupational Therapy Assistants		////////////	-		0.00	22
23	Occupational Therapy Aides		////////////	-		0.00	23
24	Speech Therapists	2,553	////////////	2,553	17.75	143.83	24
25	Respiratory Therapists		////////////	-		0.00	25
26	Other Medical Staff		////////////	-		0.00	26

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: 31-5199 | 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		915,030	**915,030**	0	**915,030**	(209,739)	**705,291**
2	0200	Capital-Related Costs - Movable Equipment		0	**0**	0	**0**	0	**0**
3	0300	Employee Benefits	0	810,258	**810,258**	0	**810,258**	0	**810,258**
4	0400	Administrative and General	814,013	1,611,024	**2,425,037**	0	**2,425,037**	(801,936)	**1,623,101**
5	0500	Plant Operation, Maintenance and Repairs	163,154	308,016	**471,170**	0	**471,170**	0	**471,170**
6	0600	Laundry and Linen Service	0	292,625	**292,625**	0	**292,625**	0	**292,625**
7	0700	Housekeeping	0	334,970	**334,970**	0	**334,970**	0	**334,970**
8	0800	Dietary	584,249	654,662	**1,238,911**	0	**1,238,911**	0	**1,238,911**
9	0900	Nursing Administration	154,946	24,000	**178,946**	0	**178,946**	0	**178,946**
10	1000	Central Services and Supply	0	175,146	**175,146**	0	**175,146**	0	**175,146**
11	1100	Pharmacy	0	0	**0**	0	**0**	0	**0**
12	1200	Medical Records and Library	0	0	**0**	0	**0**	0	**0**
13	1300	Social Service	74,324	0	**74,324**	0	**74,324**	0	**74,324**
14	1400	Nursing and Allied Health Education Activities	0	0	**0**	0	**0**	0	**0**
15	1500	Other General Service Cost	299,925	62,710	**362,635**	0	**362,635**	0	**362,635**
INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	Skilled Nursing Facility	2,532,688	1,118,749	**3,651,437**	0	**3,651,437**	0	**3,651,437**
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	6,260	**6,260**	0	**6,260**	0	**6,260**
41	4100	Laboratory	0	12,530	**12,530**	0	**12,530**	0	**12,530**
42	4200	Intravenous Therapy	0	0	**0**	0	**0**	0	**0**
43	4300	Oxygen (Inhalation) Therapy	0	23,698	**23,698**	0	**23,698**	0	**23,698**
44	4400	Physical Therapy	163,343	64,000	**227,343**	0	**227,343**	0	**227,343**
45	4500	Occupational Therapy	105,898	777	**106,675**	0	**106,675**	0	**106,675**
46	4600	Speech Pathology	44,741	2,553	**47,294**	0	**47,294**	0	**47,294**
47	4700	Electrocardiology	0	0	**0**	0	**0**	0	**0**
48	4800	Medical Supplies Charged to Patients	0	0	**0**	200	**200**	0	**200**
49	4900	Drugs Charged to Patients	0	112,949	**112,949**	(200)	**112,749**	0	**112,749**
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: 31-5199

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)	4,937,281	6,529,957	**11,467,238**	0	**11,467,238**	(1,011,675)	**10,455,563**
NON REIMBURSABLE COST CENTERS			////////////////	////////////////	////////////////	////////////////	////////////////	////////////////	////////////////
90	9000	Gift, Flower, Coffee Shop & Canteen	0	14,262	**14,262**	0	**14,262**	0	**14,262**
91	9100	Barber and Beauty Shop	0	0	**0**	0	**0**	0	**0**
92	9200	Physicians' Private Offices	0	0	**0**	0	**0**	0	**0**
93	9300	Nonpaid Workers	0	0	**0**	0	**0**	0	**0**
94	9400	Patients Laundry	0	0	**0**	0	**0**	0	**0**
95	9500	Other Nonreimbursable Cost	0	0	**0**	0	**0**	0	**0**
100		TOTAL	**4,937,281**	**6,544,219**	**11,481,500**	**0**	**11,481,500**	**(1,011,675)**	**10,469,825**

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

RECLASSIFICATIONS	PROVIDER CCN: 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET A-6

			INCREASE				DECREASE			
	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	COST CENTER	LINE NO.	SALARY	NON-SALARY	COST CENTER	LINE NO.	SALARY	NON-SALARY
		1	2	3	4	5	6	7	8	9
1	RECLASS MED SUPP	A	Medical Supplies Charged to P	48		200	Drugs Charged to Patie	49		200
2										
3										
4										
5										
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68										
69										
70										
71										
72										
100	**TOTAL RECLASSIFICATIONS**	//////////	//	//////////	0	200	//////////////////////////////////	//////////	0	200

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

	PROVIDER CCN:	PERIOD:	
	31-5199	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	4	5	6	7
1	Land				**0**		**0**	
2	Land Improvements				**0**		**0**	
3	Buildings and Fixtures				**0**		**0**	
4	Building Improvements	1,157,248	61,532		**61,532**	13,803	**1,204,977**	
5	Fixed Equipment				**0**		**0**	
6	Movable Equipment	87,808			**0**	16,753	**71,055**	
7	Subtotal (sum of lines 1-6)	**1,245,056**	**61,532**	**0**	**61,532**	**30,556**	**1,276,032**	0
8	Reconciling Items				**0**		**0**	
9	Total (line 7 minus line 8)	1,245,056	61,532	0	61,532	30,556	1,276,032	0

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET A-8

	(1) DESCRIPTION	(2) BASIS* FOR ADJ	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED AMOUNT	COST CENTER	LINE #
1	Investment income on restricted funds (Chapter 2)	B	(49,145)	Administrative and General	4
2	Trade, quantity and time discounts on purchases (Chapter 8)				
3	Refunds and rebates of expenses (Chapter 8)				
4	Rental of provider space by suppliers (Chapter 8)				
5	Telephone services (pay stations excluded) (Chapter 21)				
6	Television and radio service (Chapter 21)				
7	Parking lot (Chapter 21)				
8	Remuneration applicable to provider-	////////////////	////////////////////////	//	////////////////////
	based physician adjustment	A-8-2	0	//	////////////////////
9	Home office costs (Chapter 21)				
10	Sale of scrap, waste, etc. (Chapter23)				
11	Nonallowable costs related to certain	////////////////	////////////////////////	//	////////////////////
	Capital expenditures (Chapter 24)				
12	Adjustment resulting from transactions	////////////////	////////////////////////	//	////////////////////
	with related organizations (Chapter 10)	A-8-1	(209,739)	//	////////////////////
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	(537)	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	(752,254)	Administrative and General	4
25.01					
25.02					
25.03					
25.04					
	A-8 ADDITIONAL ADJUSTMENTS (FROM BELOW)	////////////////	0	//	////////////////////
100	TOTAL	////////////////	(1,011,675)	//	////////////////////

ADJUSTMENTS TO EXPENSES	PROVIDER CCN 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023

WORKSHEET A-8

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

SUBTOTAL OF ADDITIONAL ADJUSTMENTS 0

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: 31-5199	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		1	Capital-Related Costs - Building &	Rent		579,492	(579,492)
2		1	Capital-Related Costs - Building &	Insurance	18,639		18,639
3		1	Capital-Related Costs - Building &	Mortgage Interest	111,536		111,536
4		1	Capital-Related Costs - Building &	Property Taxes	100,877		100,877
5		1	Capital-Related Costs - Building &	Depreciation	135,523		135,523
6		1	Capital-Related Costs - Building &	Amortization	3,178		3,178
7							0
8							0
9							0
9.01							0
9.02							0
9.03							0
9.04							0
9.05							0
9.06							0
9.07							0
9.08							0
9.09							0
9.10							0
10 TOTAL					369,753	579,492	(209,739)

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	Related Organization(s) Percentage of Ownership	Related Organization(s) Type of Business
		1	2	3	4	5	6
1		A	Imperial Care Center	100.00	Grove Realty	100.00	Realty
2							
3							
4							
5							
6							
7							
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: 31-5199 | 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: 31-5199

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	705,291	705,291						
2	Capital-Related Costs - Movable Equipment	0	////////////////////////////	0					
3	Employee Benefits	810,258	14,244	0	824,502				
4	Administrative and General	1,623,101	144,108	0	135,936	1,903,145	1,903,145		
5	Plant Operation, Maintenance and Repairs	471,170	26,221	0	27,246	524,637	116,552	641,189	
6	Laundry and Linen Service	292,625	33,344	0	0	325,969	72,416	41,058	439,443
7	Housekeeping	334,970	10,312	0	0	345,282	76,707	12,698	0
8	Dietary	1,238,911	71,843	0	97,567	1,408,321	312,868	88,465	0
9	Nursing Administration	178,946	12,178	0	25,875	216,999	48,208	14,995	0
10	Central Services and Supply	175,146	1,765	0	0	176,911	39,302	2,174	0
11	Pharmacy	0	2,127	0	0	2,127	473	2,619	0
12	Medical Records and Library	0	0	0	0	0	0	0	0
13	Social Service	74,324	4,895	0	12,412	91,631	20,356	6,028	0
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	362,635	11,596	0	50,086	424,317	94,265	14,279	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	3,651,437	333,637	0	422,947	4,408,021	979,269	410,824	439,443
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	6,260	0	0	0	6,260	1,391	0	0
41	Laboratory	12,530	0	0	0	12,530	2,784	0	0
42	Intravenous Therapy	0	0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy	23,698	0	0	0	23,698	5,265	0	0
44	Physical Therapy	227,343	17,635	0	27,277	272,255	60,483	21,715	0
45	Occupational Therapy	106,675	10,854	0	17,684	135,213	30,039	13,365	0
46	Speech Pathology	47,294	5,938	0	7,472	60,704	13,486	7,312	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	200	0	0	0	200	44	0	0
49	Drugs Charged to Patients	112,749	0	0	0	112,749	25,048	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: 31-5199

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

WORKSHEET B
PART I

	COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAP.REL. BLDGS & FIXTURES	CAP.REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	OTHER ADMIN & GENERAL	PLANT OP. MAINT & REPAIRS	LAUNDRY & LINEN SERVICE
		0	1	2	3	3a	4.00	5	6
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0
52.02	Other Ancillary Service Cost Center III	0	0	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS									
60	Clinic	0	0	0	0	0	0	0	0
61	Rural Health Clinic	0	0	0	0	0	0	0	0
62	FQHC	0	0	0	0	0	0	0	0
63	Other Outpatient Service Cost	0	0	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost	0	0	0	0	0	0	0	0
71	Ambulance	0	0	0	0	0	0	0	0
72	Outpatient Rehabilitation	0	0	0	0	0	0	0	0
73	CMHC	0	0	0	0	0	0	0	0
74	Other Reimbursable Cost	0	0	0	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS									
83	Hospice	0	0	0	0	0	0	0	0
84	Other Special Purpose Cost I	0	0	0	0	0	0	0	0
84.01	Other Special Purpose Cost II	0	0	0	0	0	0	0	0
89	SUBTOTALS (sum of lines 1 through 84)	10,455,563	700,697	0	824,502	10,450,969	1,898,956	635,532	439,443
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	14,262	0	0	0	14,262	3,168	0	0
91	Barber and Beauty Shop	0	4,594	0	0	4,594	1,021	5,657	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
100	TOTAL	10,469,825	705,291	0	824,502	10,469,825	1,903,145	641,189	439,443

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN:
31-5199

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	434,687							
8	Dietary	65,462	1,875,116						
9	Nursing Administration	11,096	0	291,298					
10	Central Services and Supply	1,609	0	0	219,996				
11	Pharmacy	1,938	0	0	0	7,157			
12	Medical Records and Library	0	0	0	0	0	0		
13	Social Service	4,460	0	0	0	0	0	122,475	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	10,566	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	304,001	1,875,116	291,298	219,996	7,157	0	122,475	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	16,068	0	0	0	0	0	0	0
45	Occupational Therapy	9,890	0	0	0	0	0	0	0
46	Speech Pathology	5,411	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:
31-5199

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)	430,501	1,875,116	291,298	219,996	7,157	0	122,475	0
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	4,186	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	434,687	1,875,116	291,298	219,996	7,157	0	122,475	0

ALLOCATION OF CAPITAL-RELATED COSTS

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

PROVIDER CCN: 31-5199

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		14,244	0	14,244	14,244			
4	Administrative and General		144,108	0	144,108	2,348	146,456		
5	Plant Operation, Maintenance and Repairs		26,221	0	26,221	471	8,969	35,661	
6	Laundry and Linen Service		33,344	0	33,344	0	5,573	2,284	41,201
7	Housekeeping		10,312	0	10,312	0	5,903	706	0
8	Dietary		71,843	0	71,843	1,686	24,077	4,920	0
9	Nursing Administration		12,178	0	12,178	447	3,710	834	0
10	Central Services and Supply		1,765	0	1,765	0	3,024	121	0
11	Pharmacy		2,127	0	2,127	0	36	146	0
12	Medical Records and Library		0	0	0	0	0	0	0
13	Social Service		4,895	0	4,895	214	1,567	335	0
14	Nursing and Allied Health Education Activities		0	0	0	0	0	0	0
15	Other General Service Cost		11,596	0	11,596	865	7,254	794	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility		333,637	0	333,637	7,307	75,359	22,848	41,201
31	Nursing Facility		0	0	0	0	0	0	0
32	ICF/IID		0	0	0	0	0	0	0
33	Other Long Term Care		0	0	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS									
40	Radiology		0	0	0	0	107	0	0
41	Laboratory		0	0	0	0	214	0	0
42	Intravenous Therapy		0	0	0	0	0	0	0
43	Oxygen (Inhalation) Therapy		0	0	0	0	405	0	0
44	Physical Therapy		17,635	0	17,635	471	4,654	1,208	0
45	Occupational Therapy		10,854	0	10,854	306	2,312	743	0
46	Speech Pathology		5,938	0	5,938	129	1,038	407	0
47	Electrocardiology		0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients		0	0	0	0	3	0	0
49	Drugs Charged to Patients		0	0	0	0	1,928	0	0
50	Dental Care - Title XIX only		0	0	0	0	0	0	0
51	Support Surfaces		0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center		0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II		0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS

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

PROVIDER CCN: 31-5199

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	700,697	0	700,697	14,244	146,133	35,346	41,201
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen		0	0	0	0	244	0	0
91	Barber and Beauty Shop		4,594	0	4,594	0	79	315	0
92	Physicians' Private Offices		0	0	0	0	0	0	0
93	Nonpaid Workers		0	0	0	0	0	0	0
94	Patients Laundry		0	0	0	0	0	0	0
95	Other Nonreimbursable Cost		0	0	0	0	0	0	0
98	Cross Foot Adjustments		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
99	Negative Cost Center		0	0	0	0	0	0	0
100	TOTAL	0	705,291	0	705,291	14,244	146,456	35,661	41,201

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5199

	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	16,921							
8	Dietary	2,548	105,074						
9	Nursing Administration	432	0	17,601					
10	Central Services and Supply	63	0	0	4,973				
11	Pharmacy	75	0	0	0	2,384			
12	Medical Records and Library	0	0	0	0	0	0		
13	Social Service	174	0	0	0	0	0	7,185	
14	Nursing and Allied Health Education Activities	0	0	0	0	0	0	0	0
15	Other General Service Cost	411	0	0	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	11,834	105,074	17,601	4,973	2,384	0	7,185	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	625	0	0	0	0	0	0	0
45	Occupational Therapy	385	0	0	0	0	0	0	0
46	Speech Pathology	211	0	0	0	0	0	0	0
47	Electrocardiology	0	0	0	0	0	0	0	0
48	Medical Supplies Charged to Patients	0	0	0	0	0	0	0	0
49	Drugs Charged to Patients	0	0	0	0	0	0	0	0
50	Dental Care - Title XIX only	0	0	0	0	0	0	0	0
51	Support Surfaces	0	0	0	0	0	0	0	0
52	Other Ancillary Service Cost Center	0	0	0	0	0	0	0	0
52.01	Other Ancillary Service Cost Center II	0	0	0	0	0	0	0	0

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: 31-5199

	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)	16,758	105,074	17,601	4,973	2,384	0	7,185	0
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shop & Canteen	0	0	0	0	0	0	0	0
91	Barber and Beauty Shop	163	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	16,921	105,074	17,601	4,973	2,384	0	7,185	0

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5199 | 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	35,155							
2	Capital-Related Costs - Movable Equipment		0						
3	Employee Benefits	710	0	4,937,281					
4	Administrative and General	7,183	0	814,013	(1,903,145)	8,566,680			
5	Plant Operation, Maintenance and Repairs	1,307	0	163,154		524,637	25,955		
6	Laundry and Linen Service	1,662	0	0		325,969	1,662	31,847	
7	Housekeeping	514	0	0		345,282	514		23,779
8	Dietary	3,581	0	584,249		1,408,321	3,581		3,581
9	Nursing Administration	607	0	154,946		216,999	607		607
10	Central Services and Supply	88	0	0		176,911	88		88
11	Pharmacy	106	0	0		2,127	106		106
12	Medical Records and Library		0	0		0	0		0
13	Social Service	244	0	74,324		91,631	244		244
14	Nursing and Allied Health Education Activities		0	0		0	0		0
15	Other General Service Cost	578	0	299,925		424,317	578		578
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	16,630	0	2,532,688		4,408,021	16,630	31,847	16,630
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		6,260	0		0
41	Laboratory		0	0		12,530	0		0
42	Intravenous Therapy		0	0		0	0		0
43	Oxygen (Inhalation) Therapy		0	0		23,698	0		0
44	Physical Therapy	879	0	163,343		272,255	879		879
45	Occupational Therapy	541	0	105,898		135,213	541		541
46	Speech Pathology	296	0	44,741		60,704	296		296
47	Electrocardiology		0	0		0	0		0
48	Medical Supplies Charged to Patients		0	0		200	0		0
49	Drugs Charged to Patients		0	0		112,749	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: 31-5199 | 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)	////////////	34,926	0	4,937,281	(1,903,145)	8,547,824	25,726	31,847	23,550
NON REIMBURSABLE COST CENTERS		////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
90	Gift, Flower, Coffee Shop & Canteen	////////////		0	0		14,262	0		0
91	Barber and Beauty Shop	////////////	229	0	0		4,594	229		229
92	Physicians' Private Offices	////////////		0	0		0	0		0
93	Nonpaid Workers	////////////		0	0		0	0		0
94	Patients Laundry	////////////		0	0		0	0		0
95	Other Nonreimbursable Cost	////////////		0	0		0	0		0
98	Cross Foot Adjustment	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
99	Negative Cost Center	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////	////////////
102	Cost to Be Allocated (Per Worksheet B, Part I)	////////////	705,291	0	824,502	////////////	1,903,145	641,189	439,443	434,687
103	Unit Cost Multiplier (Worksheet B, Part I)	////////////	20.062324	0.000000	0.166995	////////////	0.222157	24.703872	13.798568	18.280289
104	Cost to Be Allocated (Per Worksheet B, Part II)	////////////	////////////	////////////	14,244	////////////	146,456	35,661	41,201	16,921
105	Unit Cost Multiplier (Worksheet B, Part II)	////////////	////////////	////////////	0.002885	////////////	0.017096	1.373955	1.293717	0.711594

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

COST ALLOCATION STATISTICAL BASIS | PROVIDER CCN: 31-5199 | 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 (PATIENT DAYS)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)
		8	9	10	11	12	13	14	15
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture								
2	Capital-Related Costs - Movable Equipment								
3	Employee Benefits								
4	Administrative and General								
5	Plant Operation, Maintenance and Repairs								
6	Laundry and Linen Service								
7	Housekeeping								
8	Dietary	95,541							
9	Nursing Administration		31,847						
10	Central Services and Supply			31,847					
11	Pharmacy				31,847				
12	Medical Records and Library					0			
13	Social Service						31,847		
14	Nursing and Allied Health Education Activities							0	
15	Other General Service Cost								31,847
INPATIENT ROUTINE SERVICE COST CENTERS									
30	Skilled Nursing Facility	95,541	31,847	31,847	31,847	0	31,847		31,847
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: 31-5199 | 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 (PATIENT DAYS)	MEDICAL REC & LIB (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NURSING & ALLIED HEALTH (ASSIGNED TIME)	OTHER GEN. SERVICE (PATIENT DAYS)
		8	9	10	11	12	13	14	15
60	Clinic	////////////////////////////							
61	Rural Health Clinic								
62	FQHC								
63	Other Outpatient Service Cost								
OTHER REIMBURSABLE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
70	Home Health Agency Cost	0	0	0	0	0	0		0
71	Ambulance								
72	Outpatient Rehabilitation								
73	CMHC								
74	Other Reimbursable Cost								
SPECIAL PURPOSE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
83	Hospice								
84	Other Special Purpose Cost I								
84.01	Other Special Purpose Cost II								
89	SUBTOTALS (sum of lines 1 through 84)	95,541	31,847	31,847	31,847	0	31,847	0	31,847
NON REIMBURSABLE COST CENTERS		////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
90	Gift, Flower, Coffee Shop & Canteen								
91	Barber and Beauty Shop								
92	Physicians' Private Offices								
93	Nonpaid Workers								
94	Patients Laundry								
95	Other Nonreimbursable Cost								
98	Cross Foot Adjustment	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
99	Negative Cost Center	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
102	Cost to Be Allocated (Per Worksheet B, Part I)	1,875,116	291,298	219,996	7,157	0	122,475	0	543,427
103	Unit Cost Multiplier (Worksheet B, Part I)	19.626297	9.146796	6.907903	0.224731	0.000000	3.845731	0.000000	17.063679
104	Cost to Be Allocated (Per Worksheet B, Part II)	105,074	17,601	4,973	2,384	0	7,185	0	20,920
105	Unit Cost Multiplier (Worksheet B, Part II)	1.099779	0.552674	0.156153	0.074858	0.000000	0.225610	0.000000	0.656891

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN: 31-5199	PERIOD: **FROM: 01/01/2023 TO: 12/31/2023**	**WORKSHEET B-2**

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

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN: 31-5199	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET C

	Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)
		1	2	3
ANCILLARY SERVICE COST CENTERS:				
40	Radiology	7,651	6,260	1.222204
41	Laboratory	15,314	12,530	1.222187
42	Intravenous Therapy	0	0	0.000000
43	Oxygen (Inhalation) Therapy	28,963	23,698	1.222171
44	Physical Therapy	370,521	423,117	0.875694
45	Occupational Therapy	188,507	171,623	1.098378
46	Speech Pathology	86,913	121,048	0.718004
47	Electrocardiology	0	0	0.000000
48	Medical Supplies Charged	244	213	1.145540
49	Drugs Charged to Patients	137,797	152,449	0.903889
50	Dental Care - Title XIX only	0	0	0.000000
51	Support Surfaces	0	0	0.000000
52	Other Ancillary Service Cost Center	0	0	0.000000
52.01	Other Ancillary Service Cost Center II	0	0	0.000000
52.02	Other Ancillary Service Cost Center III	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS				
60	Clinic	0	0	0.000000
61	Rural Health Clinic	0000000000000000000	00000000000000000	0000000000000000000
62	FQHC	0000000000000000000	00000000000000000	0000000000000000000
63	Other Outpatient Service Cost	0	0	0.000000
71	Ambulance	0	0	0.000000
100	TOTAL	835,910	910,938	////////////////////////////////////

MED-CALC SYSTEMS			In Lieu of CMS Form 2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST			PROVIDER CCN : 31-5199	PERIOD : FROM: 01/01/2023 TO: 12/31/2023		WORKSHEET D

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

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

	PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST	RATIO OF COST TO CHARGES (WS C, col 3)	HEALTH CARE PROGRAM CHARGES PART A	HEALTH CARE PROGRAM CHARGES PART B	HEALTH CARE PROGRAM COST PART A	HEALTH CARE PROGRAM COST PART B
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS:						
40	Radiology	1.222204	2,701		3,301	0
41	Laboratory	1.222187	7,030		8,592	0
42	Intravenous Therapy	0.000000	0		0	0
43	Oxygen (Inhalation) Therapy	1.222171	0		0	0
44	Physical Therapy	0.875694	220,729		193,291	0
45	Occupational Therapy	1.098378	144,135		158,315	0
46	Speech Pathology	0.718004	59,587		42,784	0
47	Electrocardiology	0.000000	0		0	0
48	Medical Supplies Charged	1.145540	0		0	0
49	Drugs Charged to Patients	0.903889	53,249		48,131	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)		487,431	0	454,414	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 : 31-5199	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D

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

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

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	0.903889
2	Program vaccine charges (From your records, or the P S & R.) --->	39,700
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	35,884

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

		Total Cost (From Worksheet B, Part I, Col 18)	Nursing & Allied Health (From Wkst. B, Part I, Column 14)	Ratio of Nursing & Allied Health Costs To Total Costs - Part A (Col. 2 / Col.. 1)	Program Part A Cost (From Wkst. D. Part I, Col. 4)	Part A ursing & Allie ealth Costs fo Pass Through (Col. 3 X Col. 4
		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS		////////////////////////////////	////////////////////////////////	////////////////////////////////	////////////////////////////////	////////////////////
40	Radiology	7,651	0	0.000000	3,301	0
41	Laboratory	15,314	0	0.000000	8,592	0
42	Intravenous Therapy	0	0	0.000000	0	0
43	Oxygen (Inhalation) Therapy	28,963	0	0.000000	0	0
44	Physical Therapy	370,521	0	0.000000	193,291	0
45	Occupational Therapy	188,507	0	0.000000	158,315	0
46	Speech Pathology	86,913	0	0.000000	42,784	0
47	Electro cardiology	0	0	0.000000	0	0
48	Medical Supplies	244	0	0.000000	0	0
49	Drugs Charged to Patients	137,797	0	0.000000	48,131	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)	835,910	0	////////////////////////////////	454,414	0

MED-CALC SYSTEMS		In Lieu of CMS Form 2540-10		
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST		PROVIDER CCN : 31-5199	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

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

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

	PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST	RATIO OF COST TO CHARGES	HEALTH CARE PROGRAM INPATIENT CHARGES		HEALTH CARE PROGRAM INPATIENT COST	
			PART A	PART B	PART A	PART B
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS:	////////////////////////	////////////////////////	////////////////////////	////////////////////////	////////////////////////
40	Radiology	1.222204		////////////////////////	0	////////////////////////
41	Laboratory	1.222187		////////////////////////	0	////////////////////////
42	Intravenous Therapy	0.000000		////////////////////////	0	////////////////////////
43	Oxygen (Inhalation) Therapy	1.222171		////////////////////////	0	////////////////////////
44	Physical Therapy	0.875694		////////////////////////	0	////////////////////////
45	Occupational Therapy	1.098378		////////////////////////	0	////////////////////////
46	Speech Pathology	0.718004		////////////////////////	0	////////////////////////
47	Electro cardiology	0.000000		////////////////////////	0	////////////////////////
48	Medical Supplies Charged	1.145540		////////////////////////	0	////////////////////////
49	Drugs Charged to Patients	0.903889		////////////////////////	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 : 31-5199	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title V	[X] Title XVIII	[ ] Title XIX
Check One:	[X] SNF	[ ] NF	[ ] ICF/IID

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days	31,847
2	Private room days	
3	Inpatient days including private room days applicable to the Program	3,177
4	Medically necessary private room days applicable to the Program	
5	Total general inpatient routine service cost	9,601,027

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges	10,454,797
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.918337
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)	9,601,027

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	301.47
17	Program routine service cost (Line 3 times line 16)	957,770
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)	957,770
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)	650,323
21	Per diem capital related costs (Line 20 divided by line 1)	20.42
22	Program capital related cost (Line 3 times line 21)	64,874
23	Inpatient routine service cost (Line 19 minus line 22)	892,896
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)	892,896
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	31,847
2	Program inpatient days. (see instructions)	3,177
3	'Total Nursing & Allied Health costs. (see instructions)	0
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)	0.099758
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)	0

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

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN : 31-5199	PERIOD : FROM: 01/01/2023 TO: 12/31/2023	WORKSHEET D-1 PARTS I & II
Check One:	[ ] Title XVIII	**[X] Title XIX**	
Check One:	**[X] NF**	[ ] ICF/IID	

PART I CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

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

PROGRAM INPATIENT ROUTINE SERVICE COSTS

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	PROVIDER CCN : 31-5199	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)	2,205,887
2	Nursing and Allied Health Education Activities (pass through payments)	0
3	Subtotal (Sum of lines 1 and 2)	2,205,887
4	Primary payor amounts	(0)
5	Coinsurance	(330,800)
6	Allowable bad debts (from your records)	103,460
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	66,201
8	Adjusted reimbursable bad debts. (See instructions)	67,249
9	Recovery of bad debts - for statistical records only	
10	Utilization review	0
11	Subtotal (See instructions)	1,942,336
12	Interim payments (See instructions)	1,948,392
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)	1,345
14.99	Sequestration amount (see instructions)	37,502
15	Balance due provider/program (Line 11 minus line 12, 13 and 14.99, plus or minus line 14)	**(44,903)**
	(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)	35,884
19	Total reasonable costs (Sum of lines 17 and 18)	35,884
20	Medicare Part B ancillary charges (See instructions)	39,700
21	Cost of covered services (Lesser of line 19 or line 20)	35,884
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)	35,884
26	Interim payments (See instructions)	38,906
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)	718
29	Balance due provider/program (Line 25 minus line 26, 27 and 28.99 plus or minus line 28)	**(3,740)**
	(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: 31-5199	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			////////////////////////	1,837,585	////////////////////////	38,906
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.			////////////////////////	127,613	////////////////////////	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1)		.01				
			.02				
		Program to Provider	.03				
			.04				
			.05				
			.50	07/21/23	16,806		
		Provider to Program	.51				
			.52				
		*	.53				
			.54				
	SUBTOTAL (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99	////////////////////////	(16,806)	////////////////////////	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.)			////////////////////////	1,948,392	////////////////////////	38,906
				////////////////////////		////////////////////////	

TO BE COMPLETED BY CONTRACTOR

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN: 31-5199	PERIOD: FROM: 01/01/2023 TO: 12/31/2023	**WORKSHEET E PART II TITLE XIX**

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

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

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

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

REASONABLE CHARGES

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

CUSTOMARY CHARGES:

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT:

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

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

BALANCE SHEET	PROVIDER CCN: 31-5199	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	1,042,103			
2	Temporary investments	0			
3	Notes receivable	0			
4	Accounts receivable	1,334,065			
5	Other receivables	0			
6	Less: allowances for uncollectible notes and A/R	0			
7	Inventory	0			
8	Prepaid expenses	55,641			
9	Other current assets	480,459			
10	Due from other funds	0			
11	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2,912,268	0	0	0
	FIXED ASSETS				
12	Land	0			
13	Land improvements	0			
14	Less: Accumulated depreciation	0			
15	Buildings	0			
16	Less Accumulated depreciation	0			
17	Leasehold improvements	1,204,977			
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	71,055			
24	Less: Accumulated depreciation	(627,054)			
25	Minor equipment - Depreciable	0			
26	Minor equipment nondepreciable	0			
27	Other fixed assets	0			
28	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	648,978	0	0	0
	OTHER ASSETS				
29	Investments	0			
30	Deposits on leases	0			
31	Due from owners/officers	0			
32	Other assets	0			
33	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0	0	0	0
34	TOTAL ASSETS (Sum of lines 11, 28 and 33)	3,561,246	0	0	0

BALANCE SHEET	PROVIDER CCN: 31-5199	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	831,389			
36	Salaries, wages & fees payable	340,434			
37	Payroll taxes payable	134,263			
38	Notes & loans payable (Short term)	0			
39	Deferred income	44,627			
40	Accelerated payments	0	////////////////////////////	//	//
41	Due to other funds	0			
42	Other current liabilities	0			
43	TOTAL CURRENT LIABILITIES	1,350,713	0	0	0
	(Sum of lines 35 - 42)				
	LONG TERM LIABILITIES				
44	Mortgage payable	0			
45	Notes payable	0			
46	Unsecured loans	1,117,342			
47	Loans from owners:	0			
48	Other long term liabilities	0			
49	Other (Specify)	0			
50	TOTAL LONG TERM LIABILITIES	1,117,342	0	0	0
	(Sum of lines 44 - 49)				
51	TOTAL LIABILITIES	2,468,055	0	0	0
	(Sum of lines 43 and 50)				
	CAPITAL ACCOUNTS				
52	General fund balance	1,093,191	////////////////////////////	//	//
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	1,093,191	0	0	0
	(Sum of lines 52 thru 58)				
60	TOTAL LIABILITIES & FUND BALANCES	3,561,246	0	0	0
	(Sum of lines 51 and 59)				

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

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: 31-5199	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	////////////////////////////	2,122,431	////////////////////////////		////////////////////////////		////////////////////////////	
2	Net income (loss) (From Wkst. G-3, line 31)	////////////////////////////	(229,240)	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
3	Total (Sum of line 1 and line 2)	////////////////////////////	1,893,191	////////////////////////////	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)	////////////////////////////	1,893,191	////////////////////////////	0	////////////////////////////	0	////////////////////////////	0
12	Deductions (Debit adjustments)	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////	////////////////////////////
13	Members Drawings	800,000	////////////////////////////		////////////////////////////		////////////////////////////		////////////////////////////
14			////////////////////////////		////////////////////////////		////////////////////////////		////////////////////////////
15			////////////////////////////		////////////////////////////		////////////////////////////		////////////////////////////
16			////////////////////////////		////////////////////////////		////////////////////////////		////////////////////////////
17			////////////////////////////		////////////////////////////		////////////////////////////		////////////////////////////
18	Total deductions (Sum of lines 13 - 17)	////////////////////////////	800,000		0	////////////////////////////	0	////////////////////////////	0
19	Fund balance at end of period per	////////////////////////////		////////////////////////////		////////////////////////////		////////////////////////////	
	balance sheet (Line 11 - line 18)	////////////////////////////	1,093,191	////////////////////////////	0	////////////////////////////	0	////////////////////////////	0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: 31-5199	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		10,454,797	////////////////////////////////	10,454,797
2	Nursing facility		0	////////////////////////////////	0
3	ICF-IID		0	////////////////////////////////	0
4	Other long term care		0	////////////////////////////////	0
5	Total general inpatient care services		10,454,797	////////////////////////////////	10,454,797
	(Sum of lines 1 - 4)				
ALL OTHER CARE SERVICES					
6	Ancillary services		880,263	0	880,263
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)		11,335,060	0	11,335,060
	(Transfer column 3 to Worksheet G-3, Line 1)				

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)	////////////////////////////////	11,481,500
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)	////////////////////////////////	11,481,500

STATEMENT OF REVENUES & EXPENSES	PROVIDER CCN: 31-5199	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)	11,335,060
2	Less: contractual allowances and discounts on patients accounts	(744,839)
3	Net patient revenues (Line 1 minus line 2)	10,590,221
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	11,481,500
5	Net income from service to patients (Line 3 minus 4)	(891,279)
//////////	OTHER INCOME:	////////////////////////////
6	Contributions, donations, bequests, etc	0
7	Income from investments	49,145
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	537
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	Employee Retention Credit	612,357
24.50	COVID-19 PHE Funding	0
25	Total other income (Sum of lines 6 - 24)	662,039
26	Total (Line 5 plus line 25)	(229,240)
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)	(229,240)