This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315205 Worksheet S Parts I, II & III Peri od: From 01/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 12:23 pm PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 5/30/2023 Time: 12:23 pm use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code 12.[ F ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received:

for no utilization.

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

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COOPER CENTER FOR REHAB AND HEALTH (315205) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Joe E	Blachorsky	l t	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	Joe Bl achorsky			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-117, 169	1, 676	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-117, 169	1, 676	0	100.00

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

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

Health Financial Systems COOPER CENTER FOR REHAB AND HEALTH In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315205 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 12:23 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 2 COOPER PLAZA PO Box: 1.00 2.00 City: CAMDEN State: NJ Zi p Code: 08103 2.00 3.00 County: CAMDEN CBSA Code: 15804 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF COOPER CENTER FOR REHAB 315205 05/01/2003 N Р 0 4.00 AND HEALTH 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 106, 696 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 106, 696 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses:

0

0

41.00

Heal th	Financial Systems	In Lie	u of Form CMS-2	2540-10		
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315		Worksheet S-2	
COMPLEX INDENTIFICATION DATA From 01/01/2022						
To 12/31/2022						pared: 23 pm
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrativ	ve and General cost	N	42. 00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing o	cost centers and		
	amounts.					
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1. Cha	pter 10?		N	43.00
	If line 43 is yes, enter the home office			ress of the home		44.00
	office on lines 45. 46 and 47.	oo onarii nambor ana ontor	the hame and add.	. 555 51 11.5 1165		00
	1.00	2.00		3.00		
	If this facility is part of a chain or		and address of		Lines	
	bel ow.	gam zatron, enter the nam	and address of	the nome office on the	111103	
45.00			lo.			45 00
45. 00	Name:	Contractor's Name:	Cor	ntractor's Number:		45. 00
46. 00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zi p	p Code:		47. 00

		PER CENTER FOR REH				u of Form CMS	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	IY HEALIH CARE	Provi der	No.: 315205	Peri od: From 01/01/2022 To 12/31/2022		epared:
					Y/N	Date	
	General Instruction: For all column 1 respons	and onton in column	n 1 "V" fo	vs Voc. as "N"	1.00	2.00	
	responses the format will be (mm/dd/yyyy)	ses enter in corum	ını, yıo	or res or in	TOT NO. FOR ALL	the date	
	Completed by All Skilled Nursing Facilites						
. 00	Provider Organization and Operation  Has the provider changed ownership immediatel	Ly prior to the be	ainning of	the cost	N		1.00
. 00	reporting period? If column 1 is "Y", enter instructions)	the date of the ch	nange in col	umn 2. (see			1.00
				Y/N 1.00	Date	V/I	
. 00	Has the provider terminated participation in	the Medicare Prod	ıram? lf	1.00 N	2. 00	3. 00	2, 00
. 00	column 1 is yes, enter in column 2 the date of						1 2.00
00	3, "V" for voluntary or "I" for involuntary.						2.00
. 00	Is the provider involved in business transactions tracts, with individuals or entities (e.g.			Y			3. 00
	or medical supply companies) that are related	d to the provider	or its				
	officers, medical staff, management personnel of directors through ownership, control, or to						
	relationships? (see instructions)	ranning and other s	ыштаг				
				Y/N	Туре	Date	
	Figure 1 Data and Danage			1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepare	ared by a Certifie	ed Public	Y	С		4.00
00	Accountant? (Y/N) Column 2: If yes, enter "A'	" for Audited, "C"	for				1.00
	Compiled, or "R" for Reviewed. Submit complete						
00	available in column 3. (see instructions) If Are the cost report total expenses and total			l N			5. 00
. 00	those on the filed financial statements? If of						3.00
	reconciliation.						
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities	-			1.00	2.00	
00	Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column	2: Is the	provider the	N	N	6. 00
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s2 (V/N) saa instr	ructi ons		N		7. 00
. 00	Were approvals and/or renewals obtained during			for Nursing	N N		8. 00
	School and/or Allied Health Program? (Y/N) se						
						Y/N 1.00	
	Bad Debts					1.00	
. 00	Is the provider seeking reimbursement for back					Y	9. 00
0. 00	If line 9 is "Y", did the provider's bad deb	t collection polic	cy change du	ıring this cos	st reporting	N	10. 00
1. 00	period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and	d/or coinsurance w	waived? If "	Y". see instr	ructions.	N	11.00
	Bed Complement			, , , , , , , , , , , , , , , , , , , ,			
2. 00	Have total beds available changed from prior	cost reporting pe	eriod? If "Y	1		N Downt D	12. 00
		Descripti	on	Y/N	art A Date	Part B Y/N	
		0		1.00	2. 00	3. 00	
2 00	PS&R Data Was the cost report prepared using the PS&R			N	02/17/2022	N	13.00
3. 00	only? If either col. 1 or 3 is "Y", enter			IN IN	03/17/2023	IN	13.00
	the paid through date of the PS&R used to						
	prepare this cost report in cols. 2 and 4. (see Instructions.)						
1. 00	Was the cost report prepared using the PS&R			N		N	14. 00
	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.						
5. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that			N		N	15. 00
	have been billed but are not included on the						
	PS&R used to file this cost report? If "Y",						
				1	1		1
. 00	see Instructions.			N.I		K.I	1/ 00
ı. 00	see Instructions. If line 13 or 14 is "Y", then were			N		N	16. 00
. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report			N		N	16. 00
5. 00 7. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N N		N N	16. 00

18.00

adjustments made to PS&R data for Other?
Describe the other adjustments:

18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions.

Heal th	Financial Systems COOPE	R CENTER FOR I	REHAB	AND HEALTH	In Lie	u of Form CMS-2	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY	' HEALTH CARE		Provi der No. : 315205	Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022	Date/Time Pre	nared.
					12,01,2022	5/30/2023 12:	23 pm
				1. 00	2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/	position	CHARLE	ES	REED		19. 00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost re	port	EXECU	CARE ASSOCIATES			20. 00
	preparer.						
21.00	Enter the telephone number and email address o	f the cost	(609)7	738-3200	CRWASSC@NETSCA	PE. NET	21. 00
	report preparer in columns 1 and 2, respective	۱y.					
	Treport preparer in corumns rand 2, respective	' y .			T.	!	ı

| Peri od: | Worksheet S-2 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: 
 Heal th Financial
 Systems
 COOPER CENTER FOR IT

 SKILLED NURSING
 FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 Provi der No.: 315205 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2022	Date/Time Prepare 5/30/2023 12:23	
	· ·	Part B			0,00,2020 12.20	<u> </u>
		Date				
		4. 00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	03/17/2023			13	3. 00
	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.)					
14. 00	Was the cost report prepared using the PS&R				1.4	4. 00
14.00	for total and the provider's records for				14	+. 00
	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.					
15. 00	If line 13 or 14 is "Y", were adjustments				15	5. 00
	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.					
16. 00	1				16	6. 00
10.00	adjustments made to PS&R data for				10	5. 00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17.00	If line 13 or 14 is "Y", then were				17	7. 00
	adjustments made to PS&R data for Other?					
	Describe the other adjustments:					
18. 00	Was the cost report prepared only using the				18	8. 00
	provider's records? If "Y" see Instructions.					
			3.00	_		
	Cost Report Preparer Contact Information		0.00	-		
	Enter the first name, last name and the title	e/position	VI CE-PRESI DENT		19	9. 00
	held by the cost report preparer in columns 1	i, 2, and 3,				
	respecti vel y.					
20. 00	Enter the employer/company name of the cost r	report			20	0. 00
04.00	preparer.	6 11				4 00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective				21	1. 00
	preport preparer in corumns rand 2, respectiv	very.	I			

Health Financial Systems COOPER CENTER FOR I COMPLEX STATISTICAL DATA

Provi der No.: 315205

				10	0 12/31/2022	5/30/2023 12:	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	120 0 0	43, 800 0 0	0	3, 683 0	32, 614 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00	SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7)	0 120	0 43, 800	0	0 3, 683	0 32, 614	6. 00 7. 00 8. 00
8.00	Total (Suil of Titles 1-7)	Inpatient D		O	Di scharges	32, 014	8.00
	C	0+1	T-+-1	T: +1 - 1/	T: +1 - VV/I I I	T: +1 - VIV	
	Component	0ther 6.00	<u>Total</u> 7. 00	Ti tl e V 8.00	Title XVIII 9.00	Title XIX 10.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	5, 384 0 0 0 0	41, 681 0 0 0 0	0	77	235 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	5, 384 Di scha	41, 681 arges	Aver	77 age Length of	235 Stay	8. 00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	11.00 202 0 0	12.00 514 0 0	13. 00 0. 00 0. 00	14. 00 47. 83	15. 00 138. 78 0. 00 0. 00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0 202	0 514	0. 00 0. 00	0. 00 47. 83	0. 00 138. 78	7. 00 8. 00
8.00	Total (Suil of Titles 1-7)	Average Length of Stay		Admi s	si ons		8.00
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1. 00 2. 00 3. 00 4. 00 5. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	81. 09 0. 00 0. 00	0	117	125 0 0	274 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00	SNF-Based CMHC HOSPI CE	0.00	0	0			6.00
8. 00	Total (Sum of lines 1-7)	0. 00 81. 09 Admi ssi ons	O Full Time	117	0 125	0 274	7. 00 8. 00
	Component	Total 21.00	Employees on Payroll 22.00	Nonpai d Workers 23.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	516 0 0 0 0 0 0 516	101. 77 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315205

Amount Reported   Salaries (col. Salary in col. 3 at aries (col. 4) and aries (col. 4)   Related to Salary in col. 3 at aries (col. 4)   Related to Salary in col. 3 at aries (col. 4) and aries (col. 4)   Related to Salary in col. 3 at aries (col. 4) and aries (col. 4) a
Norksheet A-6
PART II - DIRECT SALARIES
PART II - DIRECT SALARIES   SAL
SALARIES   1.00   Total salaries (See Instructions)   5,086,100   0   5,086,100   211,689.00   24.03   1.00   2.00   Physician salaries-Part A   0   0   0   0.00   0.00   2.00   3.00   Physician salaries-Part B   0   0   0   0.00   0.00   3.00   4.00   Home office personnel   0   0   0   0.00   0.00   3.00   4.00   5.00   Sum of lines 2 through 4   0   0   0   0   0.00   0.00   5.00   6.00   Revised wages (line 1 minus line 5)   5,086,100   0   5,086,100   211,689.00   24.03   6.00   7.00   0   0   0   0   0   0   0   0   0
Total salaries (See Instructions)   5,086,100   0   5,086,100   211,689.00   24.03   1.00
2.00   Physician salaries-Part A
3.00   Physician salaries-Part B
4. 00       Home office personnel       0       0       0       0.00       0.00       0.00       4. 00         5. 00       Sum of lines 2 through 4       0       0       0       0.00       0.00       5. 00         6. 00       Revised wages (line 1 minus line 5)       5, 086, 100       0       5, 086, 100       211, 689.00       24. 03       6. 00         7. 00       Other Long Term Care       0       0       0       0.00       0.00       0.00       0.00       7. 00         8. 00       HOME HEALTH AGENCY COST       0       0       0       0.00       0.00       0.00       0.00       0.00       0.00       9.0
5.00 Sum of lines 2 through 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
6.00 Revised wages (line 1 minus line 5) 5,086,100 0 5,086,100 211,689.00 24.03 6.00 7.00 Other Long Term Care 0 0 0 0 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0 0.00 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 5,086,100 0 5,086,100 211,689.00 24.03 13.00 12.00 Contract Labor: Patient Related & Mgmt 900,891 0 900,891 21,361.00 42.17 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0 0.00 0.00 15.00
7. 00 Other Long Term Care 0 0 0 0 0.00 0.00 7. 00 8. 00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8. 00 9. 00 CMHC 0 0 0 0 0.00 0.00 0.00 9. 00 10. 00 0.00 0.
8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0 0.00 0.00 11.00 11.00 Other excluded areas 0 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 12.00 12.00 Total Adjusted Salaries (Line 6 minus Line 5,086,100 0 5,086,100 211,689.00 24.03 13.00 12.00 12.00 Contract Labor: Patient Related & Mgmt 900,891 0 900,891 21,361.00 42.17 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0 0.00 0.00 15.00
9.00 CMHC 0 0 0 0 0.00 0.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.
10.00 HOSPICE 0 0 0 0 0.00 0.00 10.00 11.00 11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12.00 12.00 Other excluded Salaries (line 6 minus line 1.00 0.00 0.00 0.00 12.00 12.00 Other excluded salary (Sum of lines 7 0 0 0 0 0 0.00 0.00 12.00 12.00 Other excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12.00 12.00 Other excluded salary (Sum of lines 7 0 0 0 0.00 0.00 12.00 12.00 12.00 Other excluded areas 0 0 0 0 0.00 0.00 12.00
11. 00 Other excluded areas 0 0 0 0 0.00 0.00 11. 00 12. 00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0 0.00 0.00 12. 00 13. 00 13. 00 14. 00 15. 00 0 0 0 0 0. 00 14. 00 15. 00 15. 00 0 0. 00 0 0. 00 15. 00 15. 00 0 0. 00 15. 00 0 0. 00 15. 00 0 0. 00 0. 00 15. 00 0 0. 00 0. 00 15. 00 0 0. 00 0. 00 15. 00 0 0. 00 0. 00 15. 00 0 0. 00 0. 00 15. 00 0 0. 00 0. 00 15. 00 0 0. 00 0
12. 00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0 0.00 0.00 12. 00 through 11)  13. 00 Total Adjusted Salaries (Line 6 minus Line 5, 086, 100 0 5, 086, 100 211, 689. 00 24. 03 13. 00 12)  OTHER WAGES & RELATED COSTS  14. 00 Contract Labor: Patient Related & Mgmt 900, 891 0 900, 891 21, 361. 00 42. 17 14. 00 15. 00 Contract Labor: Physician services-Part A 0 0 0 0 0. 00 15. 00
through 11) 13.00   Total Adjusted Salaries (line 6 minus line   5,086,100   0   5,086,100   211,689.00   24.03   13.00
13. 00 Total Adjusted Salaries (line 6 minus line 5, 086, 100 0 5, 086, 100 211, 689. 00 24. 03 13. 00 12) OTHER WAGES & RELATED COSTS  14. 00 Contract Labor: Patient Related & Mgmt 900, 891 0 900, 891 21, 361. 00 42. 17 14. 00 15. 00 Contract Labor: Physician services-Part A 0 0 0 0 0. 00 15. 00
12)
OTHER WAGES & RELATED COSTS           14.00         Contract Labor: Patient Related & Mgmt         900,891         0         900,891         21,361.00         42.17         14.00           15.00         Contract Labor: Physician services-Part A         0         0         0         0.00         0.00         15.00
14. 00     Contract Labor: Patient Related & Mgmt     900, 891     0     900, 891     21, 361. 00     42. 17     14. 00       15. 00     Contract Labor: Physician services-Part A     0     0     0     0     0.00     0.00     15. 00
15.00 Contract Labor: Physician services-Part A 0 0 0 0 0.00 0.00 15.00
16.00 Home office salaries & wage related costs         0         0         0         0.00         0.00         16.00
WAGE-RELATED COSTS
17.00   Wage-related costs core (See Part IV)   909,334   0   909,334   17.00
18.00   Wage-related costs other (See Part IV)   0   0   0   18.00
19.00   Wage related costs (excluded units)   0   0   19.00
20.00   Physician Part A - WRC   0   0   20.00
21.00   Physician Part B - WRC   0   0   21.00
22.00 Total Adjusted Wage Related cost (see 909, 334 0 909, 334 22.00
instructions)

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 1 Provi der No.: 315205

							5/30/2023 12:	23 pm
		Amount		ss. of			Average Hourly	
		Reported	Sal ari	es from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksh	eet A-6	1 ± col. 2)	Salary in col.	col. 4)	
						3		
		1. 00	2	00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES							
1.00	Employee Benefits	0		0	C	0.00	0.00	1.00
2.00	Administrative & General	594, 638		0	594, 638	17, 818. 00	33. 37	2.00
3.00	Plant Operation, Maintenance & Repairs	109, 797		0	109, 797	4, 822. 00	22. 77	3. 00
4.00	Laundry & Li nen Servi ce	34, 948		0	34, 948	2, 726. 00	12. 82	4.00
5.00	Housekeepi ng	233, 640		0	233, 640	15, 031. 00	15. 54	5. 00
6.00	Di etary	404, 605		0	404, 605	23, 482. 00	17. 23	6.00
7.00	Nursing Administration	223, 408		0	223, 408	4, 136. 00	54.02	7. 00
8.00	Central Services and Supply	0		0	C	0.00	0.00	8. 00
9.00	Pharmacy	0		0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0		0	C	0.00	0.00	10.00
11. 00	Soci al Servi ce	291, 691		0	291, 691	8, 220. 00	35. 49	11. 00
12.00	Nursing and Allied Health Ed. Act.							12. 00
13.00	Other General Service	114, 094		0	114, 094	7, 932. 00	14. 38	13. 00
14.00	Total (sum lines 1 thru 13)	2, 006, 821		0	2, 006, 821	84, 167. 00	23. 84	14. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared:

	To 12/31/20	22   Date/Time Pre   5/30/2023 12:	
		Amount	LO PIII
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3. 00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4. 00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Heal th Insurance (Purchased or Self Funded)	266, 532	8. 00
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14. 00		0	14. 00
	Workers' Compensation Insurance	114, 551	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	386, 917	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
	State or Federal Unemployment Taxes	141, 334	20. 00
	OTHER		
21. 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of Lines 1 - 23)	909, 334	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25. 00

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES

Provi der No.: 315205

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part V | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2022

				1	0 12/31/2022	5/30/2023 12:	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	
		Reported	Benefits	Salaries (col.	Related to	Wage (col. 3 ÷	
				1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3. 00	4. 00	5. 00	
	Di rect Sal ari es						
4 00	Nursing Occupations	000 007	10.447	004 404	F 4// 00	(0.44	4 00
1.00	Registered Nurses (RNs)	283, 037	48, 447				1.00
2.00	Licensed Practical Nurses (LPNs)	799, 180	136, 794				2.00
3. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	1, 503, 423	257, 337	1, 760, 760	85, 698. 00	20. 55	3. 00
4.00	Total Nursing (sum of lines 1 through 3)	2, 585, 640	442, 578	3, 028, 218	115, 881. 00	26. 13	4.00
5.00	Physical Therapists	292, 489	50, 065	342, 554	6, 489. 00	52. 79	5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	179, 644	30, 749	210, 393	4, 727. 00	44. 51	8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11. 00	Speech Therapists	21, 506	3, 681	25, 187	426.00	59. 12	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	,					
14. 00	Registered Nurses (RNs)	0		0	0.00		
	Licensed Practical Nurses (LPNs)	541, 277		541, 277			
16. 00	Certified Nursing Assistant/Nursing	359, 614		359, 614	11, 451. 00	31. 40	16. 00
47.00	Assi stants/Ai des	000 001		000 004	04 0/4 00	40.47	47.00
	Total Nursing (sum of lines 14 through 16)	900, 891		900, 891	21, 361. 00		
18.00	Physical Therapists	0		0	0.00		
19. 00	Physical Therapy Assistants	0		0	0.00		
20.00	Physical Therapy Aides	0		0	0.00		
21. 00	Occupational Therapists	0		0	0.00		
22. 00	Occupational Therapy Assistants	0		0	0.00		
23. 00	Occupational Therapy Aides			0	0.00		
	Speech Therapists Respiratory Therapists	0		0			
25. 00 26. 00	Other Medical Staff	0		0 0			
20.00	Tottier Medical Staff	ı Y		1	0.00	U. 00	∠0.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315205 Peri od: Worksheet S-7 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 12:23 pm Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE<sub>2</sub> 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC<sub>2</sub> 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB2 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52 00 CA1 SE3 53.00 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75. 00 PA<sub>2</sub>

Health Financial Systems	COOPER CENTER FOR REHA	B AND HEAL	TH	In Lie	u of Form CM	//S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315205	Peri od: From 01/01/2022	Worksheet :	S-7
				To 12/31/2022	Date/Ti me 5/30/2023	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Regis payments beginning 10/01/2003. Congress expenses. For lines 101 through 106: En column 2 the percentage of total expens line 1, column 3. Indicate in column 3 with direct patient care and related ex (See instructions)	expected this increase ter in column 1 the amou es for each category to "Y" for yes or "N" for r	to be used nt of the total SNF o if the s	for direct pexpense for e revenue from pending refle	atient care and ach category. Er Worksheet G-2, F cts increases as	related nter in Part I, ssociated	
101. 00 Staffi ng						101.00
102.00 Recruitment						102.00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104.00
105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part	L line 1 column 2)					105. 00 106. 00
100.00 Total Sivi revenue (Worksheet G-2, Part	i, iiile i, cordilli 3)		I	I	I	1100.00

Heal th	Financial Systems COOL	PER CENTER FOR RE			In Lie	u of Form CMS-2	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
					rom 01/01/2022		
				T	o 12/31/2022	Date/Time Pre	pared:
						5/30/2023 12:	23 pm
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col . 4)	
					,	COI . +)	
		1.00	0.00	0.00	A-6)	F 00	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES		1, 613, 187	1, 613, 187	26, 459	1, 639, 646	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		106, 750	106, 750	-26, 459	80, 291	2.00
3.00	00300 EMPLOYEE BENEFITS	0	870, 575			870, 575	3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	594, 638	2, 328, 228	•		2, 922, 866	4. 00
		1					
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	109, 797	826, 143			935, 940	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	34, 948	-1, 548			33, 400	6. 00
7. 00	00700 HOUSEKEEPI NG	233, 640	47, 647	281, 287	0	281, 287	7. 00
8.00	00800 DI ETARY	404, 605	352, 833	757, 438	0	757, 438	8. 00
9.00	00900 NURSING ADMINISTRATION	223, 408	54, 747			278, 155	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	314, 216			314, 216	•
		-			0		
11. 00	01100 PHARMACY	0	61, 007	61, 007	0	61, 007	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	) 0	0	0	12. 00
13.00	01300 SOCI AL SERVI CE	291, 691	0	291, 691	0	291, 691	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	l ol	0		0	0	14.00
15. 00	01500 ACTIVITIES	114, 094	12, 634	126, 728	0	126, 728	15. 00
13.00		114, 094	12, 034	120,720	L U	120, 720	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00	03000 SKILLED NURSING FACILITY	2, 585, 640	900, 891	3, 486, 531	0	3, 486, 531	30. 00
31.00	03100 NURSING FACILITY	0	0	) 0	0	0	31.00
32.00	03200   CF/IID	l ol	0	ol o	ol	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
33. 00	ANCILLARY SERVICE COST CENTERS	<u> </u>		,	<u> </u>	0	33.00
40.00			475	1 4/5		475	40.00
40. 00	04000 RADI OLOGY	l ol	465	•		465	40. 00
41. 00	04100 LABORATORY	0	26, 515	26, 515	0	26, 515	41. 00
42.00	04200 I NTRAVENOUS THERAPY	O	0	) 0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY		0	ol o	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	292, 489	48, 000	340, 489	0	340, 489	44. 00
		1	40,000			-	1
45. 00	04500 OCCUPATI ONAL THERAPY	179, 644	0	179, 644		179, 644	45. 00
46. 00	04600 SPEECH PATHOLOGY	21, 506	0	21, 506	0	21, 506	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	0	ol o	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	128, 212	128, 212	0	128, 212	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	o o	120, 212	) 120, 212	0	0	50.00
			0	1	0		
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						[
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	0	0	0	0	61.00
62.00	06200 FQHC						62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00				1		0	70.00
70. 00	07000 HOME HEALTH AGENCY COST	0	Ü	0	-	0	70. 00
71. 00	07100 AMBULANCE	0	6, 555	6, 555	0	6, 555	71. 00
73.00	07300 CMHC	O	0	) 0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						Ī
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0	0	80.00
81. 00			0		0	0	•
	08100   NTEREST EXPENSE		0		U		81.00
82. 00	08200 UTILIZATION REVIEW - SNF	이	0	ol o	0	0	82. 00
83. 00	08300 H0SPI CE	0	0	)  0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	5, 086, 100	7, 697, 057	12, 783, 157	0	12, 783, 157	89. 00
	NONREI MBURSABLE COST CENTERS			•			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	) 0	Λ	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		0		-	0	91.00
			0	1	ا ا		1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	ט	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0 (	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	) 0	0	0	94. 00
100.00		5, 086, 100	7, 697, 057	12, 783, 157	o	12, 783, 157	100.00
					1		

Heal th FinancialSystemsCOOPER CENTERRECLASSIFICATIONAND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES COOPER CENTER FOR REHAB AND HEALTH In Lieu of Form CMS-2540-10 Provi der No.: 315205 

				To 12/31/2022 Date/Time Pro 5/30/2023 12:	
	Cost Center Description	Adjustments to	Net Expenses	070072020 12.	20 0111
	·	Expenses (Fr	For Allocation		
		Wkst A-8)	(col. 5 +-		
			col. 6)		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	83, 325	1, 722, 971		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	03, 329		•	2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	870, 575		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-956, 017			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	935, 940		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	33, 400		6. 00
7.00	00700 HOUSEKEEPI NG	0	281, 287		7. 00
8.00	00800 DI ETARY	0	757, 438		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	278, 155		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	314, 216		10.00
11.00	01100 PHARMACY	0	61, 007	l e e e e e e e e e e e e e e e e e e e	11.00
12. 00 13. 00	01200   MEDI CAL RECORDS & LI BRARY   01300   SOCI AL SERVI CE	0	0 291, 691		12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	291, 091		14. 00
15. 00	01500 ACTIVITIES	0	126, 728	l control of the cont	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		120,720	1	10.00
30.00	03000 SKILLED NURSING FACILITY	38, 069	3, 524, 600		30.00
31.00	03100 NURSING FACILITY	0	0		31. 00
32.00	03200   CF/IID	0	_	l e e e e e e e e e e e e e e e e e e e	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		33. 00
	ANCILLARY SERVICE COST CENTERS		1		
40.00	04000 RADI OLOGY	0		l control of the cont	40.00
41.00	04100 LABORATORY	0	26, 515		41. 00
42. 00 43. 00	04200   INTRAVENOUS THERAPY   04300   OXYGEN (INHALATION) THERAPY	0	0	l e e e e e e e e e e e e e e e e e e e	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	340, 489		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	179, 644	•	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	21, 506	l e e e e e e e e e e e e e e e e e e e	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0		47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	128, 212		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51. 00	05100 SUPPORT SURFACES	0	0	)	51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS	Ι ο		N.	40.00
60. 00 61. 00	06000   CLI NI C   06100   RURAL HEALTH CLI NI C	0	0	•	60. 00 61. 00
62. 00	06200 FQHC			,	62. 00
02.00	OTHER REIMBURSABLE COST CENTERS				02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		70. 00
71.00	07100 AMBULANCE	0	6, 555		71. 00
73. 00	07300 CMHC	0	0		73. 00
	SPECIAL PURPOSE COST CENTERS		1		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	,	l e e e e e e e e e e e e e e e e e e e	80.00
	08100 I NTEREST EXPENSE	0	0	l e e e e e e e e e e e e e e e e e e e	81.00
82.00	08200   UTI LI ZATI ON REVI EW - SNF   08300   HOSPI CE	0	_		82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-834, 623	_		89. 00
07.00	NONREI MBURSABLE COST CENTERS	-034, 023	11, 740, 334	·	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
	09100 BARBER AND BEAUTY SHOP	0	Ö	l e e e e e e e e e e e e e e e e e e e	91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
	09300 NONPAI D WORKERS	0	0		93. 00
	09400 PATIENTS LAUNDRY	0	0		94. 00
100.00	TOTAL	-834, 623	11, 948, 534	·	100. 00

Health Financial Systems	COOPER CENTER FOR REHAB AND H	IEALTH	In Li€	eu of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi		Peri od: From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 23 pm
		Increases			
	Cost Center	Li ne #	Sal ary Non Sal ary		
	2.00	3.00	4. 00	5. 00	
(1) B - RECLASS LHI DEPRE					
1.00	CAP REL COSTS - BLDGS & FIXTURES	1.0	00 0	26, 459	1. 00
TOTALS					
100. 00	Total Reclassifications ( of columns 4 and 5 must		C	26, 459	100. 00
	equal sum of columns 8 an	u			

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

Health Financial Systems	COOPER CENTER FOR REHAB AND HEA	LTH	In Lieu of Form CMS-254		
RECLASSI FI CATI ONS	Provi de		Peri od:	Worksheet A-6	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 12:	
		Decreases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	6. 00	7. 00	8. 00	9. 00	
(1) B - RECLASS LHI DEPRE					
1.00	CAP REL COSTS - MOVABLE EQUI PMENT	2.00	0	26, 459	1. 00
TOTALS					
100. 00			0	26, 459	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der No.: 315205

				10	) 12/31/2022	5/30/2023 12:2	
				Acqui si ti ons		0,00,2020 12.1	
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	'	Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	427, 645	0	0	0	30, 764	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1, 844, 395	112, 117	0	112, 117	0	6.00
7.00	Subtotal (sum of lines 1-6)	2, 272, 040	112, 117	0	112, 117	30, 764	7.00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	2, 272, 040	112, 117	0	112, 117	30, 764	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	396, 881	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	1, 956, 512	0				6.00
7.00	Subtotal (sum of lines 1-6)	2, 353, 393	0				7.00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	2, 353, 393	0				9. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

Provi der No.: 315205

Peri od: Worksheet A-8 From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

Description (1)					10 12/31/2022	5/30/2023 12:	
Description (1)					Expense Classification on		
Adjustment   1.00					To/From Which the Amount is	to be Adjusted	
Adjustment   1.00							
Adjustment   1.00							
Adjustment   1.00							
Adjustment   1.00		D (4)	(a) B : E			T 12 N	
1.00		Description (1)		Amount	Cost Center	Line No.	
Investment income on restricted funds (Chapter 2)   7   7   7   7   7   7   7   7   7				2 00	2 00	4 00	
Chapter 2)	1 00	Investment income on restricted funds					1 00
2.00	1.00		ь	-3, 551	ADMINISTRATIVE & GENERAL	4.00	1.00
80	2 00			(		0.00	2 00
3.00   Refunds and rebates of expenses (chapter 8)   0   0.00   3.00   0.00   4.00   0.00   4.00   0.00   4.00   0.00   4.00   0.00   4.00   0.00   4.00   0.00   4.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   6.00   0.00   0.00   6.00   0.00	2.00					0.00	2.00
A.00   Rental of provider space by suppliers	3.00			C		0.00	3. 00
Chapter 8				C		0.00	4. 00
(chapter 21) 7.00 7.00 8.00 8.00 8.00 8.00 8.00 8.00							
Television and radio service (chapter 21)   0   0   0   0   0   0   0   0   0	5.00	Telephone services (pay stations excluded)		C		0.00	5. 00
Parking lot (chapter 21)							
Remuneration applicable to provider-based polypsic lan adjustment   Section				C			
physician adjustment				_		0.00	
9.00   Home office cost (chapter 21)   0   0.00   9.00   9.00   10.0	8. 00		A-8-2	C			8. 00
10.00   Sale of scrap, waste, etc. (chapter 23)   0   0.00   10.00   10.00   11.00   Capital expenditures (chapter 24)   12.00   Adjustment result in grom transactions with related organizations (chapter 27)   12.00   Laundry and linen service   0   0.00   13.00   13.00   14.00   15.		1' '					
11.00				_			
Capital expenditures (chapter 24)   Adjustment resulting from transactions with related organizations (chapter 10)   12.00   12.00   13.00   14.00   14.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   16.00				_			
12.00   Adjustment resulting from transactions with related organizations (chapter 10)   12.3, 189   12.3, 189   12.00   13.00   14.	11.00			C	,	0.00	11.00
related organizations (chapter 10)	12 00		Λ_Q_1	123 190			12 00
13.00   Laundry and I inen service   0   0.00   13.00   13.00   15.00   Cost of meals - Guests   0   0.00   15.00   16.00   15.00   16.00   15.00   16.00	12.00		A-0-1	123, 107			12.00
14. 00   Revenue - Employee meals   0   0.00   14. 00   15. 00   15. 00   15. 00   15. 00   16. 00   15. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   17. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   19. 00	13. 00			c		0.00	13. 00
15. 00   Cost of meals - Guests   0   Sale of medical supplies to other than patients   17. 00   Sale of medical supplies to other than patients   17. 00   Sale of furgs to other than patients   0   0.00   17. 00   18. 00   18. 00   19				Ċ			
16.00   Sale of medical supplies to other than patients   0   0.00   16.00     17.00   Sale of drugs to other than patients   0   0.00   17.00     18.00   Sale of drugs to other than patients   0   0.00   18.00     19.00   Vending machines   0   0.00   18.00     19.00   Uncome from imposition of interest, finance or penal ty charges (chapter 21)   0   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00   0.00     19.00   0.00   0.00     19.00   0.00   0.00     19.00   0.00   0.00     19.00   0.00   0.00     19.00   0.00   0.00     19.00   0.0	15. 00	, ,		C			
17.00   Sale of drugs to other than patients   0   0.00   17.00   18.00   18.00   21.00   19.00   20.00   19.00   20.00   10.00   19.00   20.00   10.00   20	16.00	Sale of medical supplies to other than		C		0.00	16. 00
18.00   Sale of medical records and abstracts   0   0.00   18.00   19.00   1		patients					
19.00   Vending machines   0   0.00   19.00   20.00   10.00   10.00   20.00				_			
20.00   Income from imposition of interest, finance or penal ty charges (chapter 21)   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments   0   0.00   21.00				_			
21.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments   0		g .		_	1	•	
21.00   Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments   Utilization reviewphysicians' compensation (chapter 21)   Outilizationbuildings and fixtures   OCAP REL COSTS - BLDGS & 1.00 23.00	20. 00			C	)	0.00	20. 00
and borrowings to repay Medicare overpayments  22. 00 Utilization reviewphysicians' compensation (chapter 21)  23. 00 Depreciationbuildings and fixtures  0 CAP REL COSTS - BLDGS & 1. 00 23. 00  FIXTURES  24. 00 Depreciationmovable equipment  0 CAP REL COSTS - MOVABLE EQUIPMENT  25. 00 MANAGEMENT FEE  A -635, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 00 25. 01 ADVERTISING A -4, 950 ADMINISTRATIVE & GENERAL 4. 00 25. 01 25. 02 AVERTISING PROMOTIONAL A -8, 970 ADMINISTRATIVE & GENERAL 4. 00 25. 02 25. 04 PENALTIES A -126 ADMINISTRATIVE & GENERAL 4. 00 25. 02 25. 05 PENALTIES - COVID A -2, 303 ADMINISTRATIVE & GENERAL 4. 00 25. 04 25. 05 PENALTIES - COVID A -1, 300 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 06 BAD DEBT - MC A -65, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 07 Total (sum of lines 1 through 99) (Transfer)  0 CAP REL COSTS - BLDGS & 1. 00 24. 00 25. 00 4 FIXTURES  0 CAP REL COSTS - MOVABLE 2. 00 24. 00 24. 00 25. 00 4 FIXTURES 2. 00 24. 00 25. 00 4 -63, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 00 25. 01 25. 02 ADVERTISING PROMOTIONAL 4 -1, 300 ADMINISTRATIVE & GENERAL 4. 00 25. 04 25. 05 PENALTIES - COVID 4 -1, 300 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 06 BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 07 DART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 07 26. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 07 25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 07 25. 08 MISC INCOME 100. 00 25. 06	21 00					0.00	21 00
Outlitzation reviewphysicians' compensation (chapter 21)   Outlitzation reviewphysicians' compensation (chapter 21)   Outlitzationbuildings and fixtures   Ocap Rel Costs - Bldgs & 1.00 23.00	21.00			C	,	0.00	21.00
22.00   Utilization reviewphysicians' compensation (chapter 21)   Depreciationbuildings and fixtures   OCAP REL COSTS - BLDGS & FIXTURES   DCAP REL COSTS - BLDGS & FIXTURES   DCAP REL COSTS - MOVABLE   EQUIPMENT   EQ							
Chapter 21)   Depreciationbuildings and fixtures   OCAP REL COSTS - BLDGS &   1.00   23.00	22 00			٦	UTILIZATION REVIEW - SNE	82 00	22 00
23. 00 Depreciationbuildings and fixtures  24. 00 Depreciationmovable equipment  25. 00 MANAGEMENT FEE  A -635, 000 ADMINISTRATIVE & GENERAL  25. 01 ADVERTISING  A -4, 950 ADMINISTRATIVE & GENERAL  4. 00 25. 01  25. 02 ADVERTISING PROMOTIONAL  A -8, 970 ADMINISTRATIVE & GENERAL  4. 00 25. 02  25. 03 MISC EXPS  A -126 ADMINISTRATIVE & GENERAL  4. 00 25. 03  25. 04 PENALTIES  A -2, 303 ADMINISTRATIVE & GENERAL  4. 00 25. 03  25. 05 PENALTIES - COVID  A -1, 300 ADMINISTRATIVE & GENERAL  4. 00 25. 04  25. 05 PENALTIES - COVID  A -1, 300 ADMINISTRATIVE & GENERAL  4. 00 25. 05  25. 06 BAD DEBT - MC  25. 07 PART A BAD DEBTS  A -228, 112 ADMINISTRATIVE & GENERAL  4. 00 25. 06  100. 00 Total (sum of lines 1 through 99) (Transfer)	22.00				Sitt Et Zitt on Review Sitt	02.00	22.00
24. 00 Depreciationmovable equipment	23.00	( )		C	CAP REL COSTS - BLDGS &	1.00	23. 00
EQUI PMENT   25. 00					FI XTURES		
25. 00 MANAGEMENT FEE A -635, 000 ADMI NI STRATI VE & GENERAL 4. 00 25. 00   25. 01 ADVERTI SI NG A -4, 950 ADMI NI STRATI VE & GENERAL 4. 00 25. 01   25. 02 ADVERTI SI NG PROMOTI ONAL A -8, 970 ADMI NI STRATI VE & GENERAL 4. 00 25. 02   25. 03 MI SC EXPS A -126 ADMI NI STRATI VE & GENERAL 4. 00 25. 03   25. 04 PENALTI ES A -2, 303 ADMI NI STRATI VE & GENERAL 4. 00 25. 04   25. 05 PENALTI ES - COVI D A -1, 300 ADMI NI STRATI VE & GENERAL 4. 00 25. 05   25. 06 BAD DEBT - MC A -65, 000 ADMI NI STRATI VE & GENERAL 4. 00 25. 05   25. 07 PART A BAD DEBTS A -228, 112 ADMI NI STRATI VE & GENERAL 4. 00 25. 07   25. 08 MI SC I NCOME B -8, 500 ADMI NI STRATI VE & GENERAL 4. 00 25. 08   100. 00 Total (sum of lines 1 through 99) (Transfer B34, 623	24.00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE	2.00	24. 00
25. 01 ADVERTISING A -4, 950 ADMINISTRATIVE & GENERAL 4. 00 25. 01 25. 02 ADVERTISING PROMOTIONAL A -8, 970 ADMINISTRATIVE & GENERAL 4. 00 25. 02 25. 03 MI SC EXPS A -126 ADMINISTRATIVE & GENERAL 4. 00 25. 03 25. 04 PENALTIES A -2, 303 ADMINISTRATIVE & GENERAL 4. 00 25. 04 25. 05 PENALTIES - COVID A -1, 300 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 06 BAD DEBT - MC A -65, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 08 MISC INCOME B -8, 500 ADMINISTRATIVE & GENERAL 4. 00 25. 08 100. 00 Total (sum of lines 1 through 99) (Transfer -834, 623 100. 00							
25. 02 ADVERTISING PROMOTIONAL A -8, 970 ADMINISTRATIVE & GENERAL 4. 00 25. 02 25. 03 MISC EXPS A -126 ADMINISTRATIVE & GENERAL 4. 00 25. 03 25. 04 PENALTIES A -2, 303 ADMINISTRATIVE & GENERAL 4. 00 25. 04 25. 05 PENALTIES - COVID A -1, 300 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 06 BAD DEBT - MC 25. 07 PART A BAD DEBTS A -65, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 06 25. 06 A -65, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 06 A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 06 A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 06 A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 06 A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 06 A -284, 623 A -2834, 623			A			l l	
25. 03 MI SC EXPS A -126 ADMI NI STRATI VE & GENERAL 4. 00 25. 03 25. 04 PENALTI ES - COVI D A -1, 300 ADMI NI STRATI VE & GENERAL 4. 00 25. 05 25. 06 BAD DEBT - MC A -65, 000 ADMI NI STRATI VE & GENERAL 4. 00 25. 06 25. 07 PART A BAD DEBTS A -228, 112 ADMI NI STRATI VE & GENERAL 4. 00 25. 06 25. 08 MI SC INCOME B -8, 500 ADMI NI STRATI VE & GENERAL 4. 00 25. 06 100. 00 Total (sum of lines 1 through 99) (Transfer B -834, 623						l l	
25. 04 PENALTIES				· ·			
25. 05 PENALTIES - COVID A -1, 300 ADMINISTRATIVE & GENERAL 4. 00 25. 05 25. 06 BAD DEBT - MC A -65, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 06 25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 08 MISC INCOME B -8, 500 ADMINISTRATIVE & GENERAL 4. 00 25. 08 100. 00 Total (sum of lines 1 through 99) (Transfer -834, 623 -834, 623						1	
25. 06 BAD DEBT - MC A -65, 000 ADMINISTRATIVE & GENERAL 4. 00 25. 06 25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 08 MISC INCOME B -8, 500 ADMINISTRATIVE & GENERAL 4. 00 25. 08 100. 00 Total (sum of lines 1 through 99) (Transfer -834, 623 -834, 623 -800 ADMINISTRATIVE & GENERAL 100. 00						1	
25. 07 PART A BAD DEBTS A -228, 112 ADMINISTRATIVE & GENERAL 4. 00 25. 07 25. 08 MISC INCOME B -8, 500 ADMINISTRATIVE & GENERAL 4. 00 25. 08 100. 00 Total (sum of lines 1 through 99) (Transfer -834, 623 100. 00						•	
25.08 MISC INCOME B -8,500 ADMINISTRATIVE & GENERAL 4.00 25.08 100.00 Total (sum of lines 1 through 99) (Transfer -834,623 100.00			•				
100.00 Total (sum of lines 1 through 99) (Transfer -834,623 100.00			1	· ·		•	
			Ď			4.00	
10 Not Karloot 11, 661. 6, 1116 100)	100.00			-034, 023	<u>'</u>		100.00
(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.	(1) Da	•	ı Lumn nertain to	i CMS Pub 15-1	1 1	1	1

<sup>(1)</sup> 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.

COOPER CENTER FOR REHAB AND HEALTH

Health Financial Systems COOPER CENTER FOR RISTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315205 OFFICE COSTS

UITICL	CUSTS					e/Time Prepared: 0/2023 12:23 pm
		Li ne No.	Cost	Center	Expense Ite	ems
		1. 00	2.	00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1. 00			CAP REL COSTS FIXTURES	- BLDGS &	RENT	1. 00
2. 00		1. 00	CAP REL COSTS FIXTURES	- BLDGS &	PROPERTY TAXES	2. 00
3.00		1. 00	CAP REL COSTS FIXTURES	- BLDGS &	PROPERTY INSURANCE	3. 00
4.00		4. 00	ADMI NI STRATI VE	& GENERAL	REALTY ADMIN	4.00
5.00		30. 00	SKILLED NURSIN	G FACILITY	AI DES	5.00
6.00		30. 00	SKILLED NURSIN	G FACILITY	LPNS AND RNS	6.00
7.00		0. 00				7.00
8.00		0. 00				8.00
9.00		0. 00				9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.					10.00
	12.	Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
			5			
		4. 00	5. 00	6. 00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00		1, 404, 751	1, 613, 187	-208, 436	b	1. 00
2.00		255, 738		255, 738		2. 00
3.00		36, 023	l e	36, 023		3. 00
4.00		1, 795	l e	1, 795		4. 00
5.00		78, 481	68, 898			5. 00
6.00		233, 285	204, 799	1		6. 00
7.00		0	0			7. 00
8.00		0	0			8.00
9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	2, 010, 073	1, 886, 884	123, 189		9. 00 10. 00

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

Provi der No.: 315205

Worksheet A-8-1

From 01/01/2022 Parts I-II Date/Time Prepared: 12/31/2022

5/30/2023 12:23 pm Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1. 00	A	CHARLES GROS	50.00	1.00
2. 00	A	JONATHAN ROSENBERG	12. 50	2.00
3. 00	A	ESTHER ROSENBERG	12. 50	3.00
4. 00	A	MOSHE ROSENBERG	25. 00	4. 00
5. 00	D	MINDY ROSENBERG	0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8. 00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

Name Percentage of Type of Business Ownership 4.00 5.00 6.00	Rel ated Organi	Related Organization(s) and/or Home Office						
Ownershi p								
	Name		Type of Business					
4, 00 5, 00 6, 00		Ownershi p		1				
	4. 00	5. 00	6. 00					

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

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

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

1.00	COOPER REALTY	50. 00 REALTY	1.00
2. 00	COOPER REALTY	12. 50 REALTY	2.00
3. 00	COOPER REALTY	12. 50 REALTY	3.00
4. 00	COOPER REALTY	25. 00 REALTY	4. 00
5. 00	PEACE OF MIND STAFFING	100.00 NURSING AGENCY	5. 00
6. 00		0.00	6. 00
7. 00		0.00	7.00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems COOPER CENTER FOR REHAB AND HEALTH In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315205 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 12:23 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 ЗА GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1, 722, 971 1, 722, 971 1 00 1 00 2.00 80, 291 80, 291 2 00 3.00 00300 EMPLOYEE BENEFITS 870, 575 147, 939 6,894 1, 025, 408 3.00 00400 ADMINISTRATIVE & GENERAL 8. 684 2, 281, 776 4 00 1 966 849 186, 358 119, 885 4 00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 935, 940 87,054 4,057 22, 136 1,049,187 5.00 1, 104 6.00 00600 LAUNDRY & LINEN SERVICE 33, 400 23, 687 7,046 65, 237 6.00 7.00 00700 HOUSEKEEPI NG 281, 287 125, 351 5,841 47, 104 459, 583 7.00 00800 DI ETARY 4 908 949, 246 8 00 757 438 105.328 81.572 8 00 9.00 00900 NURSING ADMINISTRATION 278, 155 28, 204 1, 314 45,041 352, 714 9.00 01000 CENTRAL SERVICES & SUPPLY 314, 216 5, 128 239 319, 583 10.00 10.00 0 01100 PHARMACY 61,007 61, 007 11.00 0 11.00 C 01200 MEDICAL RECORDS & LIBRARY 9, 768 10, 223 12.00 455 0 12 00 13.00 01300 SOCIAL SERVICE 291, 691 89, 211 4, 157 58, 808 443, 867 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 C 0 14.00 01500 ACTI VI TI ES 149, 730 0 23, 002 15.00 15.00 126, 728 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 3, 524, 600 520, 575 4, 590, 726 30.00 24, 260 521, 291 31.00 03100 NURSING FACILITY 0 0 31.00 0 03200 | CF/IID 32.00 0 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY C 40.00 465 465 04100 LABORATORY 41.00 0 0 0 26, 515 41.00 26, 515 04200 I NTRAVENOUS THERAPY 42.00 Ω 0 0 Ω 42.00 0 04300 OXYGEN (INHALATION) THERAPY 43.00 43.00 44.00 04400 PHYSI CAL THERAPY 340, 489 173,009 8,062 58, 969 580, 529 44.00 04500 OCCUPATIONAL THERAPY 45.00 179, 644 200, 847 9, 360 36, 218 426, 069 45.00 21, 506 47, 310 04600 SPEECH PATHOLOGY 20, 512 956 4, 336 46.00 46,00 04700 ELECTROCARDI OLOGY 47.00 C 0 0 Ω 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 Ω C 0 0 Λ 48 00 04900 DRUGS CHARGED TO PATIENTS 49.00 128, 212 C 0 0 128, 212 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 0 0 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 62 00 06200 FQHC 62 00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 n 0 0 0 70.00 07100 AMBULANCE 0 71.00 6,555 0 0 6,555 71.00 07300 CMHC 73.00 O 73.00 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82 00 83.00 08300 H0SPI CE Ω 83.00 SUBTOTALS (sum of lines 1-84) 11, 948, 534 1, 722, 971 80, 291 1, 025, 408 11, 948, 534 89.00 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91.00 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 0 0 92.00 09300 NONPALD WORKERS 0 93 00

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09400 PATIENTS LAUNDRY

TOTAL

Cross Foot Adjustments

Negative Cost Centers

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315205 Per

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

5/30/2023 12:23 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 2, 281, 776 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 247, 654 1, 296, 841 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 15.399 23,600 104, 236 6.00 00700 HOUSEKEEPI NG 7.00 108, 482 124, 891 C 692, 956 7.00 8.00 00800 DI ETARY 224, 064 104, 941 0 0 1, 278, 251 8.00 9.00 00900 NURSING ADMINISTRATION 83, 256 28, 101 0 0 9.00 75, 436 01000 CENTRAL SERVICES & SUPPLY 5, 109 0 0 10.00 10.00 Ω 11.00 01100 PHARMACY 14, 400 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 2, 413 9, 732 0 0 0 12.00 01300 SOCIAL SERVICE 104, 772 o 0 13.00 13.00 88.884 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 0 14.00 15.00 01500 ACTI VI TI ES 35, 343 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 518, 662 30.00 03000 SKILLED NURSING FACILITY 104, 236 692, 956 1, 278, 251 30.00 1,083,609 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 110 0 0 0 0 40.00 41.00 04100 LABORATORY 6, 259 0 0 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 C 0 43.00 44.00 04400 PHYSI CAL THERAPY 137,030 172, 374 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 100, 571 200, 110 0 0 0 45.00 04600 SPEECH PATHOLOGY 46 00 20.437 0 46 00 11, 167 0 04700 ELECTROCARDI OLOGY 0 47.00 C 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 48.00 0 0 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 30, 264 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 Ω 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 0 06100 RURAL HEALTH CLINIC 61.00 0 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 07100 AMBULANCE 0 71.00 1.547 r 0 Λ 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 692, 956 1, 278, 251 2, 281, 776 1, 296, 841 104, 236 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 0 0 98.00 Cross Foot Adjustments 0 C 0 0 Λ 98 00 99.00 Negative Cost Centers 0 0 0 0 99.00 100.00 TOTAL 2, 281, 776 1, 296, 841 104, 236 692, 956 1, 278, 251 100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315205

| Period: | Worksheet B | From 01/01/2022 | Part | | Date/Time | Prepared: | 5/30/2023 | 12: 23 pm |

						5/30/2023 12:	23 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11.00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	464, 071					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	400, 128				10.00
11. 00	01100 PHARMACY		0.007.120	75, 407			11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		0	70, 107	22, 368	•	12. 00
13. 00	01300 SOCIAL SERVICE		0	o o	22, 000	637, 523	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0		0	037, 323	14. 00
15. 00	01500 ACTIVITIES		0	0	0	0	15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U		U	0	0	15.00
20.00	03000 SKILLED NURSING FACILITY	144 071	400 130	75 407	22 240	427 522	30. 00
30. 00 31. 00	03100 NURSING FACILITY	464, 071	400, 128	75, 407	22, 368	637, 523 0	31. 00
	03200   CF/IID	0	0	0	0		
32. 00		0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1		1			
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51.00	05100 SUPPORT SURFACES	o	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC		0	0	0	0	61.00
62. 00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS			I			
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	o	0	o	0	0	71. 00
73. 00	07300 CMHC	0	0	Ö	0	Ö	73. 00
70.00	SPECIAL PURPOSE COST CENTERS	٩		<u> </u>			70.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	464, 071	400, 128	75, 407	22, 368		
07.00	NONREI MBURSABLE COST CENTERS	404, 071	400, 120	75, 407	22, 300	037, 323	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN					0	90. 00
	09100 BARBER AND BEAUTY SHOP		0		0	0	91.00
91.00			0	0	0	0	
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	1	0	_	0		92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98.00	Cross Foot Adjustments	0	0		=	_	98. 00
99. 00	Negative Cost Centers	0		0	0	0	99. 00
100.00	D TOTAL	464, 071	400, 128	75, 407	22, 368	637, 523	100.00

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Health Financial Systems COOPER CENTER FOR REHAB AND HEALTH In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315205 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 12:23 pm OTHER GENERAL SERVI CE Cost Center Description NURSING AND ACTI VI TI ES Subtotal Post Stepdown Total ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TI ES 15.00 0 185, 073 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 185, 073 10, 053, 010 0 10, 053, 010 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 0 32.00 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 33.00 Ω O O 33 00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 575 40.00 575 0 41.00 04100 LABORATORY 0000000000 0 32.774 32, 774 41.00 04200 I NTRAVENOUS THERAPY 42 00 42 00 Ω C 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 889, 933 889, 933 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 726, 750 45.00 0 726, 750 45.00 04600 SPEECH PATHOLOGY 78, 914 78, 914 46.00 Ω 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 C 0 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 158, 476 49.00 158, 476 05000 DENTAL CARE - TITLE XIX ONLY 50.00 C 0 0 0 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω  $\cap$ 0 Ω 71.00 07100 AMBULANCE 0 0 8, 102 0 8, 102 71.00 73.00 07300 CMHC 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CF 83.00 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 185, 073 11, 948, 534 11, 948, 534 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0

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99.00

100.00

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

TOTAL

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315205

					10	) 12/31/2022	5/30/2023 12:	
				CAPI TAL REI	ATED COSTS		7 07 007 2020 121	
		Cost Center Description	Di rectly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
			Assigned New	FI XTURES	EQUI PMENT		BENEFITS	
			Capi tal					
			Related Costs 0	1. 00	2. 00	2A	3. 00	
	GENER	AL SERVICE COST CENTERS	0 1	1.00	2.00	ZA	3.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00		EMPLOYEE BENEFITS	O	147, 939	6, 894	154, 833	154, 833	3. 00
4.00	00400	ADMINISTRATIVE & GENERAL	0	186, 358	8, 684	195, 042	18, 102	4.00
5.00		PLANT OPERATION, MAINT. & REPAIRS	0	87, 054	4, 057	91, 111	3, 342	5. 00
6.00		LAUNDRY & LINEN SERVICE	0	23, 687		24, 791	1, 064	6. 00
7.00		HOUSEKEEPI NG	0	125, 351		131, 192	7, 112	7. 00
8. 00		DIETARY	0	105, 328		110, 236	12, 317	8. 00
9.00		NURSI NG ADMI NI STRATI ON	0	28, 204		29, 518	6, 801	9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	5, 128		5, 367	0	10.00
11. 00 12. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	0 749		10 222	0	11. 00 12. 00
13. 00		SOCIAL SERVICE	0	9, 768 89, 211	4, 157	10, 223 93, 368	8, 880	
14. 00		NURSING AND ALLIED HEALTH EDUCATION		09, 211		93, 300	0, 880	14. 00
15. 00	1	ACTIVITIES		0		0	3, 473	15. 00
10.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>		0	<u> </u>	0, 170	10.00
30.00		SKILLED NURSING FACILITY	0	520, 575	24, 260	544, 835	78, 714	30. 00
31.00	03100	NURSING FACILITY	O	0	0	o	0	31. 00
32.00		ICF/IID	0	0	0	0	0	32.00
33. 00		OTHER LONG TERM CARE	0	0	0	0	0	33. 00
		LARY SERVICE COST CENTERS						
40. 00	1	RADI OLOGY	0	0		0	0	40. 00
41. 00		LABORATORY	0	0		0	0	41.00
42. 00		I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00 44. 00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0	173, 009	8, 062	181, 071	0 8, 904	43. 00 44. 00
45. 00	1	OCCUPATIONAL THERAPY	0	200, 847		210, 207	5, 469	44. 00 45. 00
46. 00		SPEECH PATHOLOGY		20, 512		21, 468	655	46. 00
47. 00		ELECTROCARDI OLOGY	0	20, 312	1	21, 400	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ö	ō	0	48. 00
49.00		DRUGS CHARGED TO PATIENTS	0	0	0	o	0	49. 00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	o	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		TIENT SERVICE COST CENTERS						
60.00		CLI NI C	0	0		0	0	60. 00
61. 00		RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200							62. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0	0	0	o	0	70. 00
71.00	1	AMBULANCE	0	0	-	0	0	70.00
73. 00	07300		0	0		ol	0	73. 00
		AL PURPOSE COST CENTERS	-1	-	-1	-1		
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100	INTEREST EXPENSE						81. 00
82.00		UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPI CE	0	0	0	0	0	83. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	0	1, 722, 971	80, 291	1, 803, 262	154, 833	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	^		ol	^	90. 00
90.00		BARBER AND BEAUTY SHOP	0	0		0	0	90.00
92.00		PHYSICIANS PRIVATE OFFICES		0	0	0	0	92.00
93. 00		NONPALD WORKERS		0		ol Ol	0	93. 00
94. 00		PATIENTS LAUNDRY		0	0	ő	0	94. 00
98. 00		Cross Foot Adjustments	1	3		ol	· ·	98. 00
99. 00		Negative Cost Centers		0	0	o	0	99. 00
100.00	)	TOTAL	0	1, 722, 971	80, 291	1, 803, 262	154, 833	100. 00

Health Financial Systems COOPER CENTER FOR REHAB AND HEALTH In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315205 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/30/2023 12:23 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 4.00 7.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFITS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 213, 144 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 23, 134 117, 587 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 1.438 2, 140 29, 433 6.00 00700 HOUSEKEEPI NG 7.00 10, 133 11, 324 C 159, 761 7.00 8.00 00800 DI ETARY 20, 930 9, 515 0 152, 998 8.00 9.00 00900 NURSING ADMINISTRATION 7,777 2, 548 0 9.00 0 Ω 7, 046 01000 CENTRAL SERVICES & SUPPLY 10.00 463 0 0 10.00 Ω 11.00 01100 PHARMACY 1, 345 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 225 882 0 0 0 12.00 01300 SOCIAL SERVICE o 13.00 9, 787 0 13.00 8.059 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 0 14.00 15.00 01500 ACTI VI TI ES 3, 301 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 159, 761 30.00 03000 SKILLED NURSING FACILITY 152, 998 30.00 101, 224 47,030 29, 433 31.00 03100 NURSING FACILITY 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 10 0 0 0 0 40.00 04100 LABORATORY 41.00 585 0 0 0 0 0 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 0 Ω 0 42 00 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 C 0 43.00 44.00 04400 PHYSI CAL THERAPY 12,800 15, 629 0 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 9, 394 18, 144 0 45.00 04600 SPEECH PATHOLOGY 0 46 00 1,043 1, 853 0 46 00 04700 ELECTROCARDI OLOGY 0 47.00 C 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48.00 0 0 0 0 04900 DRUGS CHARGED TO PATIENTS 49.00 2.827 0 0 0 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY Ω 0 50.00 0 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 0 06100 RURAL HEALTH CLINIC 61.00 0 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 07100 AMBULANCE 0 0 71.00 145 r 0 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00

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SUBTOTALS (sum of lines 1-84)

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

NONREIMBURSABLE COST CENTERS

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315205

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 | 12: 23 pm

						5/30/2023 12:	23 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11.00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	46, 644					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	12, 876				10.00
11. 00	01100 PHARMACY			1, 345			11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		0	1, 515	11, 330	•	12. 00
13. 00	01300 SOCIAL SERVICE		0	l o	11,000	120, 094	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0		0	0	14. 00
15. 00	01500 ACTIVITIES		0		0	0	15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U		U		0	15.00
20.00	03000 SKILLED NURSING FACILITY	14 411	12 074	1 2/5	11 220	120.004	30. 00
30. 00 31. 00	03100 NURSING FACILITY	46, 644	12, 876	1, 345	11, 330	120, 094 0	31. 00
	03200   CF/IID	0	0	١	0		
32. 00		0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1					
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51.00	05100 SUPPORT SURFACES	o	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	0	0	0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	o	0	o	0	0	71. 00
73. 00	07300 CMHC	0	0	o o	0	Ö	73. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>			70.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	46, 644	12, 876	_	11, 330		
07.00	NONREI MBURSABLE COST CENTERS	40, 044	12, 670	1, 343	11, 330	120, 094	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN					0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP		0		0	0	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES		0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS		0	0	0	0	
93.00	09400 PATIENTS LAUNDRY		0	0	0	0	93. 00 94. 00
		1	0		0		
98.00	Cross Foot Adjustments	0	0	0	^	_	98. 00
99. 00	Negative Cost Centers	0	12.07/	1 245	11 222	120,004	99. 00
100.00	D TOTAL	46, 644	12, 876	1, 345	11, 330	120, 094	100.00

In Lieu of Form CMS-2540-10

| Period: | Worksheet B | From 01/01/2022 | Part II |
| To | 12/31/2022 | Date/Time Prepared: | 5/30/2023 | 12:23 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315205

				10 12/31/2022	5/30/2023 12:	
		OTHER GENERAL				
		SERVI CE				
Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
	ALLI ED HEALTH			Adjustments		
	EDUCATI ON					
OFNEDAL CEDIU OF COOT OFNITEDO	14. 00	15. 00	16. 00	17. 00	18. 00	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES		I	T			1 00
1.00   00100   CAP REL COSTS - BLDGS & FLXTURES 2.00   00200   CAP REL COSTS - MOVABLE EQUI PMENT						1. 00 2. 00
3. 00 00300 EMPLOYEE BENEFITS						3.00
4. 00   00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 00700 HOUSEKEEPI NG						7. 00
8. 00   00800 DI ETARY						8. 00
9.00 00900 NURSING ADMINISTRATION						9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 01100 PHARMACY						11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00   01300   SOCIAL SERVICE						13. 00
14.00   01400   NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00 01500 ACTI VI TI ES	0	6, 774	1			15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	0		1, 313, 058	0	1, 313, 058	30. 00
31.00 03100 NURSING FACILITY	0			1 1	0	31. 00
32. 00   03200   I CF/I I D	0		1	0	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0	)  (	0	0	33. 00
ANCI LLARY SERVI CE COST CENTERS			1 4		40	40.00
40. 00   04000  RADI OLOGY 41. 00   04100  LABORATORY	0	-	1		10	40.00
	0	-	58!	1	585	41. 00 42. 00
42.00   04200   INTRAVENOUS THERAPY 43.00   04300   0XYGEN (INHALATION) THERAPY	0				0	42.00
44. 00   04400   PHYSI CAL THERAPY	0		218, 40	1	218, 404	44.00
45. 00   04500   OCCUPATI ONAL THERAPY			243, 214		243, 214	45. 00
46. 00 04600 SPEECH PATHOLOGY			25, 019		25, 019	46. 00
47. 00   04700   ELECTROCARDI OLOGY	0		20,01		0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	l o	2, 82	7 0	2, 827	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C			0	50.00
51. 00 05100 SUPPORT SURFACES	0	l c		ol	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	C	)	0	0	60.00
61.00  06100 RURAL HEALTH CLINIC	0	0	) (	0	0	61. 00
62. 00 06200 FQHC						62.00
OTHER REIMBURSABLE COST CENTERS						
70. 00 07000 HOME HEALTH AGENCY COST	0		1	0	0	70. 00
71. 00   07100   AMBULANCE	0				145	71.00
73. 00 07300 CMHC	0	0	)  (	0	0	73. 00
SPECIAL PURPOSE COST CENTERS	ı					00.00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00   08100   INTEREST EXPENSE 82. 00   08200   UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00   08300   HOSPI CE	0				0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)			1, 803, 262		1, 803, 262	89. 00
NONREI MBURSABLE COST CENTERS		0,774	1,000,202	<u>-</u>	1,000,202	07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		ol o	0	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	1		ol ol	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	1		ol ol	0	92.00
93. 00 09300 NONPALD WORKERS	0	l c		ol ol	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0		ol ol	0	94. 00
98.00 Cross Foot Adjustments	0	0		o  o	0	98. 00
99.00 Negative Cost Centers	0	-	) (	이	0	99. 00
100. 00 TOTAL	0	6, 774	1, 803, 262	2 0	1, 803, 262	100. 00

Provi der No.: 315205

Peri od:

Health Financial Systems

COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2540-10
Worksheet B-1

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 12:23 pm CAPITAL RELATED COSTS Cost Center Description BLDGS & MOVABLE **EMPLOYEE** Reconciliation ADMINISTRATIVE **FLXTURES FOUL PMENT** BENEFITS & GENERAL (SQUARE FEET) (SQUARE FEET) (ACCUM COST) (GROSS SALARI ES) 1.00 2.00 4A 4.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 42.335 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 42, 335 2.00 3.00 00300 EMPLOYEE BENEFITS 3,635 3, 635 5, 086, 100 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4,579 4, 579 594, 638 -2, 281, 776 9, 666, 758 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 2, 139 109, 797 1, 049, 187 5 00 5 00 2, 139 00600 LAUNDRY & LINEN SERVICE 6.00 582 582 34, 948 0 65, 237 6.00 7.00 00700 HOUSEKEEPI NG 3,080 3, 080 233, 640 459, 583 7.00 00800 DI ETARY 2.588 404, 605 0 949, 246 8.00 8 00 2 588 00900 NURSING ADMINISTRATION 9.00 693 693 223, 408 352, 714 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 126 126 319, 583 10.00 11.00 01100 PHARMACY 0 0 61,007 11.00 0 01200 MEDICAL RECORDS & LIBRARY 240 240 10 223 12 00 12 00 0 13.00 01300 SOCIAL SERVICE 2, 192 2, 192 291, 691 443, 867 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 0 14.00 149, 730 01500 ACTIVITIES 15.00 114,094 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 12, 791 12, 791 2, 585, 640 0 4, 590, 726 30.00 03100 NURSING FACILITY 0 31.00 31.00 03200 | CF/IID 0 0 32.00 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 465 40.00 0 41.00 04100 LABORATORY 0 0 26, 515 41.00 0 04200 I NTRAVENOUS THERAPY O 42.00 0 C 0 42 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 0 0 43.00 04400 PHYSI CAL THERAPY 44.00 4, 251 4, 251 292, 489 0 580, 529 44.00 04500 OCCUPATIONAL THERAPY 4.935 45.00 4.935 179,644 426, 069 45.00 46.00 04600 SPEECH PATHOLOGY 504 504 21, 506 47, 310 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 Ω 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 128, 212 49 00 49 00 C 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 C 0 0 50.00 05100 SUPPORT SURFACES 51.00 0 0 0 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 Ω O 0 Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 6, 555 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82 00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE Λ 83.00 SUBTOTALS (sum of lines 1-84) 42, 335 42, 335 5, 086, 100 -2, 281, 776 9, 666, 758 89.00 89.00 NONREI MBURSABLE COST CENTERS 90 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90 00 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 0 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 94 00 0 0 0 94 00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 1, 025, 408 102.00 Cost to be allocated (per Wkst. B, 1, 722, 971 80, 291 2, 281, 776 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 40.698500 1.896563 0.201610 0. 236044 103. 00 104.00 Cost to be allocated (per Wkst. B, 154, 833 213, 144 104. 00 Part II) 0. 022049 105. 00 105 00 Unit cost multiplier (Wkst. B, Part 0.030442  $\Pi$ 

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315205

In Lieu of Form CMS-2540-10

					0 12/31/2022	5/30/2023 12:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, , , ,
		OPERATI ON,		(PATIENT DAYS)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(PATIENT DAYS)			, <u>-</u>	
		REPAI RS				(NURSI NG	
		(SQUARE FEET)	4.00	7.00	0.00	SALARI ES)	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	31, 982	,				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	582	l .				6.00
7. 00	00700 HOUSEKEEPI NG	3, 080	1	41, 681			7. 00
8.00	00800 DI ETARY	2, 588	1	l c	125, 043		8. 00
9.00	00900 NURSING ADMINISTRATION	693	0	o c	0	2, 585, 640	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	126	0	o c	0	0	10.00
11. 00	01100 PHARMACY	0	0	C	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	240	0	C	0	0	12. 00
13. 00	01300 SOCI AL SERVI CE	2, 192	! 0	) C	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. 00
15. 00	01500 ACTI VI TI ES	0	0	C	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00	03000 SKILLED NURSING FACILITY	12, 791		41, 681	125, 043	2, 585, 640	30. 00
31. 00	03100 NURSING FACILITY	0		O C	ı .	0	31.00
32. 00	03200   CF/    D	0		0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS			l o		0	40.00
40.00	04000 RADI OLOGY	0		0	0	0	40.00
41. 00 42. 00	04100 LABORATORY				0	0 0	41.00
43. 00	04200   NTRAVENOUS THERAPY 04300   OXYGEN (INHALATION) THERAPY				0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	4, 251	0		0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	4, 935	1		0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	504	1		0	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		l o	0	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		o o		0	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		o	d	0	Ō	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	o	d	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	o c	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	C		0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	61. 00
62. 00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS				1		
70. 00	07000 HOME HEALTH AGENCY COST	0	l	1	-	0	70. 00
71. 00	07100 AMBULANCE	0	1		_	_	71. 00
73. 00	07300 CMHC	0	0	<u> </u>	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS			1			00.00
80.00							80.00
	08100 I NTEREST EXPENSE		1				81.00
82. 00 83. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE				0	0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	31, 982	41, 681	41, 681	125, 043		89. 00
07.00	NONREI MBURSABLE COST CENTERS	31, 702	. 41,001	41,001	123, 043	2, 303, 040	0 7. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP			1	_		91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		1	_	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	d	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	o	d	0	0	94.00
98.00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00	Cost to be allocated (per Wkst. B,	1, 296, 841	104, 236	692, 956	1, 278, 251	464, 071	102. 00
	Part I)						
103.00		40. 549090	ł .	1		0. 179480	
104.00		117, 587	29, 433	159, 761	152, 998	46, 644	104. 00
40= :	Part II)						405 55
105.00	1 1	3. 676662	0. 706149	3. 832945	1. 223563	0. 018040	105.00
	1 )	1	I	I	I	I	I

In Lieu of Form CMS-2540-10 Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315205 Peri od: Worksheet B-1

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 12:23 pm Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & ALLI ED HEALTH SERVICES & (PATIENT DAYS) **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (ASSI GNED (PATIENT DAYS) (PATLENT DAYS) TIME) 12.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 41,681 10.00 01100 PHARMACY 41, 681 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 41, 681 12.00 01300 SOCIAL SERVICE 0 13 00 41, 681 13 00 C C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 41,681 41, 681 41, 681 41, 681 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 0 41.00 04100 LABORATORY 0000000000 0 0 0 0 0 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 r 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 61.00 0 Ω 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 Λ 83 00 SUBTOTALS (sum of lines 1-84) 89.00 41,681 41,681 41, 681 41,681 0 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP C 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 0 93.00 09300 NONPALD WORKERS 0 0 93.00 94 00 09400 PATIENTS LAUNDRY 0 O ol 94 00 r 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, 400, 128 75, 407 22, 368 637, 523 0 102.00 Part I) 0.536647 0.000000 103.00 103 00 Unit cost multiplier (Wkst. B, Part I) 9 599770 1 809146 15. 295290 11, 330 104.00 Cost to be allocated (per Wkst. B, 120, 094 0 104.00 12,876 1, 345 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0. 308918 0.032269 0.271826 2.881265 11)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

			10 12/31/2022	5/30/2023 12: 23 pm
		OTHER GENERAL	-	
		SERVI CE		
	Cost Center Description	ACTI VI TI ES		
	<b>'</b>	(PATIENT DAYS)		
		15.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS	1		3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE			6.00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8.00
9.00	00900 NURSI NG ADMI NI STRATI ON			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	ļ		10. 00
11. 00	01100 PHARMACY			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY			12.00
13.00	01300 SOCI AL SERVI CE			13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15.00	01500 ACTI VI TI ES	41, 681		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	41, 681		30.00
31.00	03100 NURSING FACILITY	o		31.00
32.00	03200   CF/IID	l ol		32. 00
33. 00	03300 OTHER LONG TERM CARE	0		33.00
	ANCILLARY SERVICE COST CENTERS	-1		33:33
40. 00	04000 RADI OLOGY	0		40. 00
41. 00	04100 LABORATORY	o		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	o		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00	04400 PHYSI CAL THERAPY	0		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0		45. 00
		0		
46.00	04600 SPEECH PATHOLOGY	0		46.00
47. 00	04700 ELECTROCARDI OLOGY			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	05100 SUPPORT SURFACES	0		51.00
	OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLI NI C	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FQHC			62. 00
	OTHER REIMBURSABLE COST CENTERS			
70. 00	07000 HOME HEALTH AGENCY COST	0		70. 00
71. 00	07100 AMBULANCE	0		71.00
73. 00	07300 CMHC	0		73. 00
	SPECIAL PURPOSE COST CENTERS			
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
	08100 I NTEREST EXPENSE			81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF			82. 00
83.00	08300 H0SPI CE	O		83. 00
89.00	SUBTOTALS (sum of lines 1-84)	41, 681		89. 00
	NONREI MBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	l ol		91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	o		92. 00
93. 00	09300 NONPALD WORKERS	o		93. 00
94. 00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00	Cross Foot Adjustments			98. 00
99. 00	Negative Cost Centers			99. 00
102.00	1 1 9	185, 073		102.00
102.00	Part I)	185, 073		102.00
103. 00		4. 440225		103. 00
103.00		6, 774		104. 00
104.00	Part II)	0,774		104.00
105.00		0. 162520		105. 00
100.00	II)	0. 102320		100.00
	1 1117	ı l		ı

Peri od: Worksheet C From 01/01/2022 Pate/Time Pr Provi der No.: 315205

		Т	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
Cost Center Description	Total	(from	Total Charges		
	Wkst. B,	Pt I,	o o	di vi ded by	
	col.	18)		col. 2	
	1. (	00	2. 00	3. 00	
ANCI LLARY SERVI CE COST CENTERS					
40. 00   04000   RADI OLOGY		575	465		1
41. 00   04100   LABORATORY		32, 774	26, 515	1. 236055	41. 00
42.00 O4200 INTRAVENOUS THERAPY		0	0	0. 000000	42. 00
43.00 O4300 OXYGEN (INHALATION) THERAPY		0	0	0. 000000	43.00
44. 00 O4400 PHYSI CAL THERAPY	3	89, 933	552, 085	1. 611949	44.00
45. 00   04500   OCCUPATI ONAL THERAPY	-	26, 750	466, 434	1. 558098	45. 00
46. 00 O4600 SPEECH PATHOLOGY		78, 914	116, 414	0. 677874	46. 00
47. 00   04700   ELECTROCARDI OLOGY		0	0	0. 000000	47. 00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0. 000000	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS	,	58, 476	128, 212	1. 236047	49. 00
50.00   05000   DENTAL CARE - TITLE XIX ONLY		0	0	0. 000000	50. 00
51. 00 05100 SUPPORT SURFACES		0	0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS					
60. 00  06000  CLI NI C		0	0	0. 000000	60.00
61.00  06100   RURAL HEALTH CLINIC					61. 00
62. 00   06200   FQHC					62. 00
71. 00   07100   AMBULANCE		8, 102	6, 555	1. 236003	71. 00
100. 00   Total	1, 8	95, 524	1, 296, 680		100. 00

Health Financial Systems	COOPER CENTER FOR	REHAB AND HEAL	ТН	In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COS	TS	Provi der		Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII (1)	Skilled Nursing Facility		
		Heal th Care Pr	rogram Charges	Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND C	OUTPATIENT COST					
ANCILLARY SERVICE COST CENTERS				_		_
40. 00  04000 RADI OLOGY	1. 236559			0 0	0	1 .0.00
41. 00  04100   LABORATORY	1. 236055			0 0	0	1
42. 00  04200   I NTRAVENOUS THERAPY	0. 000000			0 0	0	1 .2. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	1 .0.00
44. 00  04400 PHYSI CAL THERAPY	1. 611949			0 255, 881	1	1 1.00
45. 00 04500 OCCUPATI ONAL THERAPY	1. 558098		(	0 225, 371	1	10.00
46. 00 04600 SPEECH PATHOLOGY	0. 677874		(	0 24, 416	1	1 .0.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000		(	0 0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIE			(	0 0	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 236047	<b>1</b>	(	0 0	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	1			)	50. 00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51. 00
OUTPATIENT SERVICE COST CENTERS				ما م		
60. 00   06000   CLI NI C	0. 000000	0	(	0 0	0	00.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC	1 22/002					62.00
71. 00 07100 AMBULANCE (2)	1. 236003	ł .		0 505 //6	0	
100.00   Total (Sum of lines 40 - 71)		339, 404	1	0 505, 668	sj 0	100. 00
(1) For title V and XIX use columns 1, 2, and	4 only.					

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

Heal th	Financial Systems COOP	PER CENTER FOR	REHAB AND HEAL	.TH	In Lie	eu of Form CMS-2	2540-10
	FIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315205	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III	pared:
	Title XVIII Skilled Nursing Facility						
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1. 00 2. 00 3. 00	Drugs charged to patients - ratio of cost Program vaccine charges (From your recomprogram costs (Line 1 x line 2) (Title ) E, Part I, line 18)	rds, or the PS	&R)			1. 236047 6, 683 8, 261	1. 00 2. 00 3. 00
	Cost Center Description		Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Allied Healt Costs to Tota Costs - Part (Col. 2 / Col 1)	I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS ANCILLARY SERVICE COST CENTERS	FOR NURSING &	ALLIED HEALIH				
40 00	04000 RADI OLOGY	575		0.00000	0	0	40. 00
42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	32, 774 0 0 889, 933 726, 750 78, 914 0 0 158, 476		0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000	00 00 00 00 00 00 00 00 00 00 00 00 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42. 00
100.00	Total (Sum of lines 40 - 52)	1, 887, 422	c	•	505, 668	0	100. 00

COMPU	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315205	Peri od:	Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Parts I-II Date/Time Prep 5/30/2023 12:2	
		Title XVIII	Skilled Nursing Facility	PPS	20 piii
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
1. 00	Inpatient days including private room days			41, 681	1.00
2.00	Private room days			0	
3.00	Inpatient days including private room days applicable to the Pro	ogram		3, 683	
4.00	Medically necessary private room days applicable to the Program			0	
5. 00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			10, 053, 010	5.00
6. 00	General inpatient routine service charges			12, 453, 669	6.00
7. 00	General inpatient routine service cost/charge ratio (Line 5 div	vided by line 6)		0. 807233	
8. 00	Enter private room charges from your records			0	1
9. 00	Average private room per diem charge (Private room charges line 2)	8 divided by private	room days, line	0. 00	9. 00
10.00	Enter semi-private room charges from your records			0	
11. 00	Average semi-private room per diem charge (Semi-private room cl semi-private room days)		ed by		11. 00
12. 00	Average per diem private room charge differential (Line 9 minus	,			12.00
13.00	Average per diem private room cost differential (Line 7 times li	,		0.00	
14.00	Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost		minus lins 14)	0 10, 053, 010	
13.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	IIII IIus TTTIe 14)	10, 053, 010	15.00
16. 00	Adjusted general inpatient service cost per diem (Line 15 divid	ded by line 1)		241. 19	
17. 00	Program routine service cost (Line 3 times line 16)			888, 303	
18.00	Medically necessary private room cost applicable to program (1)	,		0	
19. 00 20. 00	Total program general inpatient routine service cost (Line 17   Capital related cost allocated to inpatient routine service cos		rt II column 10	888, 303 1, 313, 058	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	IS (FIUII WKSL. B, Pai	t II COLUMII 16,	1, 313, 036	
	Per diem capital related costs (Line 20 divided by line 1)			31. 50	
22. 00	Program capital related cost (Line 3 times line 21)			116, 015	
23.00	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provi	dor rocords)		772, 288 0	
25. 00	1 33 3 1	,	nus Line 24)	772, 288	
26. 00		Trimitation (Line 23 iiii	ilus IIIIe 24)	172, 200	26. 00
	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27. 00
	Reimbursable inpatient routine service costs (Line 22 plus the				28.00
	(Transfer to Worksheet E, Part II, line 4) (See instructions)			1	
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	title XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS F	FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days			41, 681	
2.00	Program inpatient days (see instructions)		VII VA	3, 683	
			or VIVI	01	1 2 00
3. 00 4. 00	Total nursing & allied health costs. (see instructions)(Do not of Nursing & allied health ratio. (line 2 divided by line 1)	complete for titles v	OF ALA)	0. 088362	

OOM O	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315205	Peri od:	Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Parts I-II Date/Time Prep 5/30/2023 12:2	
		Title XIX	Skilled Nursing Facility	Cost	20 piii
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
. 00	Inpatient days including private room days			41, 681	
2. 00	Private room days			0	
3.00	Inpatient days including private room days applicable to the Pro	ogram		32, 614	
1.00	Medically necessary private room days applicable to the Program			10.053.010	
5. 00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			10, 053, 010	5.00
5. 00	General inpatient routine service charges			12, 453, 669	6.00
7. 00	General inpatient routine service cost/charge ratio (Line 5 div	vided by line 6)		0. 807233	
3. 00	Enter private room charges from your records	,		0	l .
0.00	Average private room per diem charge (Private room charges line 2)	8 divided by private	room days, line	0. 00	9. 00
0.00	Enter semi-private room charges from your records			0	
1. 00	Average semi-private room per diem charge (Semi-private room charge) semi-private room days)	narges line 10, divide	d by	0. 00	11. 0
2. 00	Average per diem private room charge differential (Line 9 minus				12. 0
3. 00	Average per diem private room cost differential (Line 7 times li			0.00	
4.00 Private room cost differential adjustment (Line 2 times line 13) 5.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)			0		
15.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus iine 14)	10, 053, 010	] 15.00
16.00	Adjusted general inpatient service cost per diem (Line 15 divid	ded by line 1)		241. 19	16.00
7. 00	Program routine service cost (Line 3 times line 16)			7, 866, 171	
18. 00	Medically necessary private room cost applicable to program (li			0	
19.00	Total program general inpatient routine service cost (Line 17 p			7, 866, 171	
20.00	Capital related cost allocated to inpatient routine service cost line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ts (From Wkst. B, Par	t II column 18,	1, 313, 058	
	Per diem capital related costs (Line 20 divided by line 1)			31.50	1
2.00	Program capital related cost (Line 3 times line 21)			1, 027, 341	
	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provi	dor rocards)		6, 838, 830 0	
25. 00	99 9		nus Line 24)	6, 838, 830	
26. 00	1 - 5	Tim tation (Line 25 iiii	ilus i i ile 24)	0, 030, 030	
	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)	0.00	
	Reimbursable inpatient routine service costs (Line 22 plus the			7, 866, 171	
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		, i	, ,	
1) Li	nes 26 and 27 are not applicable for title XVIII, but may be used	d for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS F	OR PPS PASS-THROUGH			
1.00	Total SNF inpatient days			41, 681	
2. 00	Program inpatient days (see instructions)			32, 614	
	Total nursing & allied health costs. (see instructions)(Do not of	complete for titles V	or XLX)	0	3.00
3. 00 4. 00	Nursing & allied health ratio. (line 2 divided by line 1)	comprete for trives v	01 (11/1)	0. 782467	4.00

Health Financial Systems	COOPER CENTER FOR REHAB	AND HEALTH	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SE	TTLEMENT FOR TITLE XVIII		From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 12:23 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		1.00	
1.00	Inpatient PPS amount (See Instructions)			2, 416, 964	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	<b>3</b>		2, 416, 964	
4.00	Primary payor amounts			2, 499	•
5.00	Coinsurance			482, 749	5. 00
6.00	Allowable bad debts (From your records)			495, 106	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		49, 069	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			321, 819	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			2, 253, 535	11.00
12.00	Interim payments (See instructions)			2, 342, 920	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	14.55 Demonstration payment adjustment amount after sequestration				14. 55
14. 75	4.75 Sequestration for non-claims based amounts (see instructions)			4, 055	14. 75
14. 99	1.99   Sequestration amount (see instructions)			23, 729	14. 99
15. 00				-117, 169	15. 00
16. 00	16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - 1	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			8, 261	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			8, 261	
20. 00	Medicare Part B ancillary charges (See instructions)			6, 683	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			6, 683	
22. 00	Pri mary payor amounts			0	
23. 00	Coi nsurance and deducti bl es			0	
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
24. 02	Adjusted reimbursable bad debts (see instructions)			0	
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			6, 683	
26.00	,			4, 923	
27. 00				0	
28. 00				0	28. 00
28. 50				0	28. 50
28. 55 28. 99	Demonstration payment adjustment amount after sequestration Sequestration amount (see instructions)			0 84	28. 55 28. 99
28. 99	Balance due provider/program (see instructions)				28. 99 29. 00
	Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 115 2	1, 676	
30.00	Triotested amounts (Nonarrowanie cost report itells) ili accordanc	e with two rub. 15-2,	36011011 113. 2	U	30.00

Health Financial Systems	COOPER CENTER FOR REHAE	3 AND HEALTH	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V	and TITLE XIX ONLY	Provi der No.: 315205	From 01/01/2022	Worksheet E Part II Date/Time Prepared: 5/30/2023 12:23 pm
		Title XIX	Skilled Nursing Facility	Cost

		little XIX	Facility	COST	
			1 4011111		
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	1. 00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	3. 00
4.00	Inpatient routine services (see instructions)			7, 866, 171	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			7, 866, 171	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)			7, 866, 171	
9.00	Primary payor amounts			0	9. 00
10.00	Total Reasonable Cost (Line 8 minus line 9)			7, 866, 171	10.00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges			-	11. 00
12.00	Outpatient service charges			0	12.00
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services o	on a charge basis	0	17. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)				40.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	
19. 00	Total customary charges (see instructions)			0	19. 00
00.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	00.00
20.00	Cost of covered services (see Instructions)			0	
21. 00	Deducti bl es			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			- 1	
26. 00	Subtotal (sum of lines 24 and 25)	v calleated based on a	nonmontion of	0	
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl cost limit	y corrected based on t	correction of	0	27.00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	nrogram	0	28. 00
20.00	lutilization	tron or a decrease in	pi ogi alli	O	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	reciable assets (	0	
00.00	if minus, enter amount in parentheses)	o a. opoo o o. aop.	00. 00. 0 000010 (	J.	00.00
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments	,		0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	theses) (see	0	
	Instructions)	, , , , , , , , , , , , , , , , , , , ,	-, (	-	
			•	'	-

Health Financial Systems COOPER C ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provi der No.: 315205

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 12: 23 pm PPS

Title XVIII

		11 (1	e XVIII S	Facility	PPS	
		Inpatien	t Part A		t B	
		/- -  /	A	/ -  -  /	A	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	1, 907, 987	3.00	4, 923	1. 0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		340, 077		0	2. 0
	services rendered in the cost reporting period. If none, enter zero					
	List separately each retroactive lump sum adjustment					3.0
	amount based on subsequent revision of the interim rate					0.0
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
	ADJUSTMENTS TO PROVIDER	08/12/2022	94, 856		0	3.0
3. 02			0		0	3.0
3. 03			0		0	3.0
3. 04 3. 05			0		0	3. C
	Provider to Program				U	3. 0
	ADJUSTMENTS TO PROGRAM		0		0	3.5
3. 51	ADSOSTMENTS TO TROOMAIN		l ő		0	3. 5
. 52			l o		o	3. 5
. 53			0		0	3. 5
3. 54			0		0	3. 5
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		94, 856		0	3. 9
	- 3. 98)					
1.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 342, 920		4, 923	4. 0
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B) TO BE COMPLETED BY CONTRACTOR					
	List separately each tentative settlement payment after					5. (
	desk review. Also show date of each payment. If none,					3. (
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 0
5. 02			0		0	5. 0
6. 03			0		0	5.0
	Provider to Program			1		
	TENTATI VE TO PROGRAM		0		0	5. 5
5. 51			0		0	5. 5
5. 52 5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 5 5. 9
	- 5. 98)		0		٥	5. \
	Determined net settlement amount (balance due) based on					6. (
	the cost report. (1)					
	PROGRAM TO PROVIDER		0		1, 676	6. (
5. 02	PROVI DER TO PROGRAM		117, 169		0	6.0
7. 00	Total Medicare program liability (see instructions)		2, 225, 751		6, 599	7. C
			Contract	tor Name	Contractor	
				00	Number	
2 00	Name of Contractor		1.	00	2. 00	0.0
3.00	Name of Contractor		l	on which the p		8.0

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

Health Financial Systems COOPER CENTER FOR BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column onl y)

Provi der No.: 315205

| Period: | Worksheet G | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 12: 23 pm |

oni y)				12/01/2022	5/30/2023 12:	23 pm
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	Assets	1.00	2.00	0.00	1. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	169, 745	1	-	0	
2.00	Temporary investments	0		-	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	1, 659, 093	(		0	
5.00	Other receivables	1,039,093			0	
6. 00	Less: allowances for uncollectible notes and accounts	-409, 767	1	o o	Ö	
	recei vabl e					
7.00	Inventory	0		0	0	
8.00	Prepai d expenses	303, 271	(	0	0	
9.00	Other current assets	42, 258	i	0	0	
10.00	Due from other funds	1 7/4 /00		-	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10) FIXED ASSETS	1, 764, 600	1	0	0	11.00
12. 00	Land	1 0		0	0	12.00
13. 00	Land improvements	0		-	Ö	
14. 00	Less: Accumulated depreciation	0		o o	Ö	
15. 00	Bui I di ngs	0		0	0	1
16.00	Less Accumulated depreciation	0	(	0	0	
17.00	Leasehold improvements	396, 881	(	0	0	17.00
18.00	Less: Accumulated Amortization	-183, 052	(	0	0	18. 00
19. 00	Fixed equipment	0	(	0	0	1
20. 00	Less: Accumulated depreciation	0	(	0	0	
21. 00	Automobiles and trucks	0	(	0	0	
22. 00	Less: Accumul ated depreciation	0	(	0	0	
23. 00	Major movable equipment	1, 956, 512	1	0	0	
24. 00	Less: Accumulated depreciation	-1, 671, 220	(	0	0	1
25. 00	Mi nor equi pment - Depreci abl e	0		0	0	
26. 00 27. 00	Minor equipment nondepreciable Other fixed assets	0		-	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	499, 121		-		
20.00	OTHER ASSETS	477, 121		0	0	20.00
29. 00	Investments	0		0	0	29.00
30.00	Deposits on Leases	o o		-	Ö	
31. 00	Due from owners/officers	0		o o	Ö	
32. 00	Other assets	100, 000		0	0	
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	100, 000	(	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	2, 363, 721	(	0	0	34.00
	Liabilities and Fund Balances					1
	CURRENT LI ABI LI TI ES		1			4
35. 00	Accounts payable	149, 403	ı	-	0	
36. 00	Salaries, wages, and fees payable	0	(	0	_	1
37. 00	Payroll taxes payable	9, 873		0	0	
38. 00 39. 00	Notes & Loans payable (Short term) Deferred income	0		0	0	
40.00			(	0	U	40.00
41. 00	Accel erated payments Due to other funds		(	0	О	
42. 00	Other current liabilities	2, 555, 348	1			1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 714, 624	1	o o		
10. 00	LONG TERM LIABILITIES	2,711,021		<u>,                                      </u>		10.00
44. 00	Mortgage payable	0		0	0	44.00
45. 00	Notes payable	0		0	O	1
46. 00	Unsecured Loans	0		0	0	
47.00	Loans from owners:	0	(	0	0	47. 00
48.00	Other long term liabilities	0	(	0	0	48. 00
49.00	OTHER (SPECIFY)	0	(	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	(	0	0	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	2, 714, 624	(	0	0	<u>∫</u> 51. 00
	CAPI TAL ACCOUNTS		1	T		٠
52. 00	General fund balance	-350, 903	i			52.00
53.00	Specific purpose fund			^ ا		53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54.00
				0		1
	Governing body created - endowment fund balance Plant fund balance - invested in plant	1			О	56. 00 57. 00
56.00	•					
57. 00	Plant fund halance - reserve for plant improvement			1	ı	1 20.00
	Plant fund balance - reserve for plant improvement, replacement, and expansion					
57. 00	repl acement, and expansi on	-350, 903	(	0	0	59.00
57. 00 58. 00		-350, 903 2, 363, 721	1	0 0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315205

					0 12/31/2022	5/30/2023 12:	
		General	Fund	Special Po	urpose Fund	Endowment Fund	EG PIII
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		551, 384		C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-113, 820				2. 00
3.00	Total (sum of line 1 and line 2)		437, 564		C		3. 00
4. 00	Additions (credit adjustments)						4. 00
5. 00		0		(		0	5. 00
6. 00		0		(	)	0	6. 00
7.00		0		(		0	7. 00
8.00		0		(		0	8. 00
9.00	T-t-1 -dditi (6 li 5 0)	O		(	7	0	9.00
10.00	Total additions (sum of line 5 - 9)		427 574				10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments)		437, 564			ή	11. 00 12. 00
12.00	DIST	788, 467		(		0	12.00
14. 00	טו או	788, 467		(		0	14. 00
15. 00				(	1		15. 00
16. 00				(	1		16. 00
17. 00						0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		788, 467	`	1		18. 00
19. 00	Fund balance at end of period per balance		-350, 903			á	19. 00
	sheet (Line 11 - line 18)		000, 700			1	171.00
		Endowment Fund	PI ant	Fund			
	I <del></del>	6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(	)		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)			,			2.00
3.00	Total (sum of line 1 and line 2)	0		(	)		3. 00
4.00	Additions (credit adjustments)						4.00
5. 00 6. 00			0				5. 00 6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 5 - 9)	0	J	(			10.00
11. 00	Subtotal (line 3 plus line 10)			,			11. 00
12. 00	Deductions (debit adjustments)						12. 00
13. 00	DIST		o				13. 00
14. 00			o				14. 00
15.00			Ol				15.00
15. 00 16. 00			0				15. 00 16. 00
			0 0 0				
16.00	Total deductions (sum of lines 13 - 17)	0	0 0 0	(			16. 00
16. 00 17. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0	0 0 0				16. 00 17. 00
16. 00 17. 00 18. 00		1	0 0				16. 00 17. 00 18. 00

Health Financial Systems	COOPER CENTER FOR REHAE	3 AND HEA	ALTH		In Lie	u of	Form	CMS-2540-	10
OTATELIEUT OF BATLEUT BEVENUES AN	D ADEDATING EVERYORS			045005					_

Heal th	Financial Systems COOPER CENTER FOR REHA	AB AND HEAL	.TH	In Lie	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2022 Fo 12/31/2022		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services			_		
1.00	SKILLED NURSING FACILITY		12, 453, 669	-	12, 453, 669	1.00
2.00	NURSING FACILITY			)	0	2. 00
3. 00	ICF/IID			)	0	3. 00
4.00	OTHER LONG TERM CARE		(	)	0	4. 00
5. 00	Total general inpatient care services (Sum of lines 1 - 4)		12, 453, 669	7	12, 453, 669	5. 00
	All Other Care Services			_1	1	
6. 00	ANCI LLARY SERVI CES		1, 296, 680		1, 296, 680	6. 00
7. 00	CLINIC			0	_	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	
9.00	AMBULANCE			0	0	
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
12.00	HOSPI CE			0	0	12. 00
13. 00	OTHER (SPECIFY)	_	(	0		13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	3 to	13, 750, 349	9 0	13, 750, 349	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description			1.00	0.00	
	DART LL OPERATING EVERNOES			1. 00	2. 00	
1 00	PART II - OPERATING EXPENSES				10 700 157	1 1 00
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				12, 783, 157	1.00
2.00	Add (Specify)			0		2.00
3.00				0		3.00
4.00				0		4. 00
5.00				0		5. 00 6. 00
6. 00 7. 00				0		7.00
7. 00 8. 00	T-+-! A-			0		
9. 00	Total Additions (Sum of lines 2 - 7)			0	0	9.00
10.00	Deduct (Specify)			0		
11. 00				0		10. 00 11. 00
				0		
12.00				0		12.00
13.00	Total Daduations (Sum of Lines 0 12)			0	1	13.00
14. 00	Total Deductions (Sum of Lines 9 - 13)				12 702 157	
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			1	12, 783, 157	15.00

Health Financial Systems	COOPER CENTER FOR REHAE	3 AND HEALTH		In Li€	eu of Form CMS-2540-10
CTATEMENT OF DATIENT DEVENUES AND	D ODEDATING EVERNOES	D : 1 N	045005	D	W 1 1 1 0 0

Heal th	Financial Systems COOPER CENTER FOR REF	HAB AND HEALTH	In Lieu of Form CMS-2540-10				
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315205	Peri od:	Worksheet G-3			
			From 01/01/2022				
			To 12/31/2022				
				5/30/2023 12:	23 pili		
				1. 00			
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		13, 750, 349	1. 00		
2.00	Less: contractual allowances and discounts on patients account	,		1, 093, 063	2. 00		
3.00	Net patient revenues (Line 1 minus line 2)	13		12, 657, 286	3. 00		
4.00	Less: total operating expenses (From Worksheet G-2, Part II, I	line 15)		12, 783, 157	4. 00		
5.00	Net income from service to patients (Line 3 minus 4)	11116 13)		-125, 871	5. 00		
3.00	Other income:			-125, 071	3.00		
6. 00	Contributions, donations, bequests, etc			0	6. 00		
7. 00	Income from investments			3, 551	7. 00		
8. 00	Revenues from communications (Telephone and Internet service)	)		0,001	8. 00		
9. 00	Revenue from television and radio service	,		0	9. 00		
10. 00	Purchase di scounts			0	10.00		
11. 00	Rebates and refunds of expenses			0	11. 00		
	Parking lot receipts			0	12. 00		
	Revenue from Laundry and Linen service			0	13. 00		
	Revenue from meals sold to employees and guests			0	14. 00		
	Revenue from rental of living quarters			0	15. 00		
	Revenue from sale of medical and surgical supplies to other th	han patients		0	16. 00		
	Revenue from sale of drugs to other than patients			0	17. 00		
	Revenue from sale of medical records and abstracts			0	18. 00		
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00		
	Revenue from gifts, flower, coffee shops, canteen			0	20. 00		
	Rental of vending machines			0	21. 00		
	Rental of skilled nursing space			0	22. 00		
	Governmental appropriations			0	23. 00		
	MISC INCOME			8, 500			
24. 50	COVI D-19 PHE Funding			0	24. 50		
	Total other income (Sum of lines 6 - 24)			12, 051	25. 00		
	Total (Line 5 plus line 25)			-113, 820	26. 00		
27.00	Other expenses (specify)			0	27. 00		
28. 00				0	28. 00		
29. 00				0	29. 00		
30.00	Total other expenses (Sum of lines 27 - 29)			0	30. 00		
31.00	Net income (or loss) for the period (Line 26 minus line 30)			-113, 820	31. 00		