

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I, II & III Date/Time Prepared: 5/30/2023 12:22 pm
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 3.01 <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.
Contractor use only	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. <input type="checkbox"/> If line 4, column 1 is "4": Enter number of times reopened 11. Contractor Vendor Code <u>4</u> 12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GATEWAY CARE CENTER (315177) 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.

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

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-58,676	2,115	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID	0			0	3.00
4.00 SNF - BASED HHA I	0	0	0	0	4.00
5.00 SNF - BASED RHC I	0		0	0	5.00
6.00 SNF - BASED FQHC I	0		0	0	6.00
7.00 SNF - BASED CMHC I	0		0	0	7.00
100.00 TOTAL	0	-58,676	2,115	0	100.00

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 12:22 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 139 GRANT AVENUE	PO Box:				1.00		
2.00	City: EATONTOWN	State: NJ	Zip Code: 07724			2.00		
3.00	County: MONMOUTH	CBSA Code: 35154	Urban/Rural: U			3.00		
3.01		CBSA Code:				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, 0, or N)			
		1.00	2.00	3.00	V	XVIII	XIX	
SNF and SNF-Based Component Identification:								
4.00	SNF	GATEWAY CARE CENTER	315177	01/01/1987	N	P	0	
5.00	Nursing Facility							
6.00	ICF/IID							
7.00	SNF-Based HHA							
8.00	SNF-Based RHC							
9.00	SNF-Based FQHC							
10.00	SNF-Based CMHC							
11.00	SNF-Based OLTC							
12.00	SNF-Based HOSPICE							
13.00	SNF-Based CORF							
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2022	12/31/2022		14.00	
15.00	Type of Control (See Instructions)				5		15.00	
					Y/N			
					1.00			
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					Y		16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y		18.00
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					103,535		20.00
21.00	Declining Balance					0		21.00
22.00	Sum of the Year's Digits					0		22.00
23.00	Sum of line 20 through 22					103,535		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00
				Part A	Part B	Other		
				1.00	2.00	3.00		
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					N	N	N
30.00	Skilled Nursing Facility							
31.00	Nursing Facility							
32.00	ICF/IID					N	N	N
33.00	SNF-Based HHA							
34.00	SNF-Based RHC							
35.00	SNF-Based FQHC						N	
36.00	SNF-Based CMHC							
36.00	SNF-Based OLTC							
				Y/N				
				1.00		2.00		
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					Y		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.					2		39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:		0	0	0			

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 12:22 pm
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	N	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.		44.00
	1.00	2.00	3.00
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.			
45.00	Name:	Contractor's Name:	Contractor's Number:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 12:22 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N		6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	03/17/2023	Y	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

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

Provider No. : 315177

Period:
 From 01/01/2022
 To 12/31/2022

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/30/2023 12:22 pm

		1.00	2.00	
Cost Report Preparer Contact Information				
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHARLES	REED	19.00
20.00	Enter the employer/company name of the cost report preparer.	EXECUCARE ASSOCIATES		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(609)738-3200	CRWASSC@NETSCAPE.NET	21.00

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

Provider No. : 315177

Period:
 From 01/01/2022
 To 12/31/2022

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/30/2023 12:22 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/17/2023	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00
		3.00	
Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE-PRESIDENT	19.00
20.00	Enter the employer/company name of the cost report preparer.		20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		21.00

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

Provider No. : 315177

Period:
 From 01/01/2022
 To 12/31/2022

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/30/2023 12:22 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	178	64,970	0	3,430	47,212	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	178	64,970	0	3,430	47,212	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	4,947	55,589	0	66	141	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/IID	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	4,947	55,589	0	66	141	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	73	280	0.00	51.97	334.84	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/IID	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	73	280	0.00	51.97	334.84	8.00
Component		Average Length of Stay	Admissions				
		Total	Title V	Title XVIII	Title XIX		Other
		16.00	17.00	18.00	19.00		20.00
1.00	SKILLED NURSING FACILITY	198.53	0	111	135	59	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/IID	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	198.53	0	111	135	59	8.00
Component		Admissions	Full Time Equivalent				
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	305	125.16	0.00	1.00		
2.00	NURSING FACILITY	0	0.00	0.00	2.00		
3.00	ICF/IID	0	0.00	0.00	3.00		
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	4.00		
5.00	Other Long Term Care	0	0.00	0.00	5.00		
6.00	SNF-Based CMHC	0	0.00	0.00	6.00		
7.00	HOSPICE	0	0.00	0.00	7.00		
8.00	Total (Sum of lines 1-7)	305	125.16	0.00	8.00		

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2023 12:22 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	6,541,501	0	6,541,501	260,334.00	25.13 1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00 2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00 3.00
4.00	Home office personnel	0	0	0	0.00	0.00 4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00 5.00
6.00	Revised wages (line 1 minus line 5)	6,541,501	0	6,541,501	260,334.00	25.13 6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00 7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00 8.00
9.00	CMHC	0	0	0	0.00	0.00 9.00
10.00	HOSPICE	0	0	0	0.00	0.00 10.00
11.00	Other excluded areas	0	0	0	0.00	0.00 11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00 12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	6,541,501	0	6,541,501	260,334.00	25.13 13.00
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1,483,015	0	1,483,015	36,342.00	40.81 14.00
15.00	Contract Labor: Physician services-Part A	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)	1,465,008	0	1,465,008		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	1,465,008	0	1,465,008		

SNF WAGE INDEX INFORMATION

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2023 12:22 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	819,046	0	819,046	21,876.00	2.00
3.00	Plant Operation, Maintenance & Repairs	106,144	0	106,144	4,304.00	3.00
4.00	Laundry & Linen Service	55,006	0	55,006	2,762.00	4.00
5.00	Housekeeping	221,513	0	221,513	13,981.00	5.00
6.00	Dietary	700,856	0	700,856	36,544.00	6.00
7.00	Nursing Administration	226,026	0	226,026	5,477.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	114,779	0	114,779	2,144.00	11.00
12.00	Nursing and Allied Health Ed. Act.					12.00
13.00	Other General Service	625,470	0	625,470	31,138.00	13.00
14.00	Total (sum lines 1 thru 13)	2,868,840	0	2,868,840	118,226.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2023 12: 22 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	33,524	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	626,441	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	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	211,026	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	499,501	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	89,346	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	5,170	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1,465,008	24.00
		Amount Reported	
		1.00	
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-3
Part V
Date/Time Prepared:
5/30/2023 12:22 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	644,104	144,994	789,098	14,529.00	54.31	1.00
2.00	Licensed Practical Nurses (LPNs)	1,062,614	239,204	1,301,818	30,639.00	42.49	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,633,953	367,818	2,001,771	89,261.00	22.43	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,340,671	752,016	4,092,687	134,429.00	30.44	4.00
5.00	Physical Therapists	156,099	35,139	191,238	2,017.00	94.81	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	161,813	36,426	198,239	3,933.00	50.40	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	14,078	3,169	17,247	1,729.00	9.98	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)	373,879		373,879	4,460.00	83.83	14.00
15.00	Licensed Practical Nurses (LPNs)	361,265		361,265	6,178.00	58.48	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	670,938		670,938	24,456.00	27.43	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,406,082		1,406,082	35,094.00	40.07	17.00
18.00	Physical Therapists	32,493		32,493	573.00	56.71	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	44,440		44,440	675.00	65.84	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-7
Date/Time Prepared:
5/30/2023 12:22 pm

		Group	Days	
		1.00	2.00	
1.00		RUX		1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5.00		RHX		5.00
6.00		RHL		6.00
7.00		RMX		7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00		RUC		10.00
11.00		RUB		11.00
12.00		RUA		12.00
13.00		RVC		13.00
14.00		RVB		14.00
15.00		RVA		15.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00		RMA		21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25.00		ES2		25.00
26.00		ES1		26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30.00		HD1		30.00
31.00		HC2		31.00
32.00		HC1		32.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36.00		LE1		36.00
37.00		LD2		37.00
38.00		LD1		38.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00		CE2		43.00
44.00		CE1		44.00
45.00		CD2		45.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00		CC1		48.00
49.00		CB2		49.00
50.00		CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53.00		SE3		53.00
54.00		SE2		54.00
55.00		SE1		55.00
56.00		SSC		56.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00		IB2		59.00
60.00		IB1		60.00
61.00		IA2		61.00
62.00		IA1		62.00
63.00		BB2		63.00
64.00		BB1		64.00
65.00		BA2		65.00
66.00		BA1		66.00
67.00		PE2		67.00
68.00		PE1		68.00
69.00		PD2		69.00
70.00		PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1		74.00
75.00		PA2		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet S-7

Date/Time Prepared:
5/30/2023 12:22 pm

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		Provider No. : 315177		Period: From 01/01/2022 To 12/31/2022		Worksheet A		
Date/Time Prepared: 5/30/2023 12:22 pm								
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100		1,779,180	1,779,180	99,892	1,879,072	1.00	
2.00	00200		103,535	103,535	-99,892	3,643	2.00	
3.00	00300	0	1,472,553	1,472,553	0	1,472,553	3.00	
4.00	00400	819,046	2,454,912	3,273,958	0	3,273,958	4.00	
5.00	00500	106,144	866,522	972,666	0	972,666	5.00	
6.00	00600	55,006	10,992	65,998	0	65,998	6.00	
7.00	00700	221,513	315,779	537,292	0	537,292	7.00	
8.00	00800	700,856	813,200	1,514,056	0	1,514,056	8.00	
9.00	00900	226,026	73,748	299,774	0	299,774	9.00	
10.00	01000	0	227,853	227,853	0	227,853	10.00	
11.00	01100	0	51,232	51,232	0	51,232	11.00	
12.00	01200	0	0	0	0	0	12.00	
13.00	01300	114,779	848	115,627	0	115,627	13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	625,470	236,973	862,443	0	862,443	15.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	3,340,671	1,406,082	4,746,753	0	4,746,753	30.00	
31.00	03100	0	0	0	0	0	31.00	
32.00	03200	0	0	0	0	0	32.00	
33.00	03300	0	0	0	0	0	33.00	
ANCILLARY SERVICE COST CENTERS								
40.00	04000	0	0	0	0	0	40.00	
41.00	04100	0	23,645	23,645	0	23,645	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	0	0	0	0	0	43.00	
44.00	04400	156,099	80,493	236,592	0	236,592	44.00	
45.00	04500	161,813	0	161,813	0	161,813	45.00	
46.00	04600	14,078	44,440	58,518	0	58,518	46.00	
47.00	04700	0	0	0	0	0	47.00	
48.00	04800	0	0	0	0	0	48.00	
49.00	04900	0	106,632	106,632	0	106,632	49.00	
50.00	05000	0	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
73.00	07300	0	0	0	0	0	73.00	
SPECIAL PURPOSE COST CENTERS								
80.00	08000	0	0	0	0	0	80.00	
81.00	08100	0	0	0	0	0	81.00	
82.00	08200	0	0	0	0	0	82.00	
83.00	08300	0	0	0	0	0	83.00	
89.00	SUBTOTALS (sum of lines 1-84)		6,541,501	10,068,619	16,610,120	0	16,610,120	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	09300	0	0	0	0	0	93.00	
94.00	09400	0	0	0	0	0	94.00	
100.00	TOTAL		6,541,501	10,068,619	16,610,120	0	16,610,120	100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet A
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 + - col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	-920,767	958,305	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	3,643	2.00
3.00	00300	EMPLOYEE BENEFITS	0	1,472,553	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-862,788	2,411,170	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	-164,502	808,164	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	65,998	6.00
7.00	00700	HOUSEKEEPING	0	537,292	7.00
8.00	00800	DIETARY	0	1,514,056	8.00
9.00	00900	NURSING ADMINISTRATION	0	299,774	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	227,853	10.00
11.00	01100	PHARMACY	0	51,232	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	115,627	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	ACTIVITIES	0	862,443	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	-23,043	4,723,710	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF/IID	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	40.00
41.00	04100	LABORATORY	0	23,645	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	236,592	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	161,813	45.00
46.00	04600	SPEECH PATHOLOGY	0	58,518	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	106,632	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
73.00	07300	CMHC	0	0	73.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	-1,971,100	14,639,020	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
100.00		TOTAL	-1,971,100	14,639,020	100.00

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-6
Date/Time Prepared:
5/30/2023 12:22 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
1.00	(1) B - RECLASS LHI DEPRE					
		CAP REL COSTS - BLDGS & FIXTURES	1.00	0	99,892	1.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		0	99,892	100.00

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

RECLASSIFICATIONS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-6

Date/Time Prepared:
5/30/2023 12:22 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
		6.00	7.00	8.00	9.00	
1.00	(1) B - RECLASS LHI DEPRE					
		CAP REL COSTS - MOVABLE EQUIPMENT	2.00	0	99,892	1.00
	TOTALS					
100.00				0	99,892	100.00

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-7

Date/Time Prepared:
5/30/2023 12:22 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	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	1,975,458	0	0	0	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	1,524,057	0	0	0	0	6.00
7.00 Subtotal (sum of lines 1-6)	3,499,515	0	0	0	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	3,499,515	0	0	0	0	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	0	0				
2.00 Land Improvements	0	0				
3.00 Buildings and Fixtures	0	0				
4.00 Building Improvements	1,975,458	0				
5.00 Fixed Equipment	0	0				
6.00 Movable Equipment	1,524,057	0				
7.00 Subtotal (sum of lines 1-6)	3,499,515	0				
8.00 Reconciling Items	0	0				
9.00 Total (line 7 minus line 8)	3,499,515	0				

ADJUSTMENTS TO EXPENSES

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8

Date/Time Prepared:
5/30/2023 12:22 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line No.
			1.00	2.00	3.00
1.00 Investment income on restricted funds (chapter 2)	B	-1,920	ADMINISTRATIVE & GENERAL	4.00	1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	2.00
3.00 Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4.00 Rental of provider space by suppliers (chapter 8)		0		0.00	4.00
5.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	5.00
6.00 Television and radio service (chapter 21)		0		0.00	6.00
7.00 Parking lot (chapter 21)		0		0.00	7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00 Home office cost (chapter 21)		0		0.00	9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00	11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-943,104			12.00
13.00 Laundry and linen service		0		0.00	13.00
14.00 Revenue - Employee meals		0		0.00	14.00
15.00 Cost of meals - Guests		0		0.00	15.00
16.00 Sale of medical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients		0		0.00	17.00
18.00 Sale of medical records and abstracts		0		0.00	18.00
19.00 Vending machines		0		0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	82.00	22.00
23.00 Depreciation--buildings and fixtures			OCAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00 Depreciation--movable equipment			OCAP REL COSTS - MOVABLE EQUIPMENT	2.00	24.00
25.00 SALARIES ASST. ADM.	A	-4,006	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01 BAD DEBT EXP 30% NON MCD	A	-66,862	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02 MANAGEMENT FEE	A	-775,000	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03 PROMOTIONAL ADVERTISING	A	-15,878	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04 NJ CORPORATE TAX	A	8,672	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05 OTHER REV - MISC.	B	-8,500	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06 SALE OF ELECTRICITY	B	-164,502	PLANT OPERATION, MAINT. & REPAIRS	5.00	25.06
25.07		0		0.00	25.07
25.08		0		0.00	25.08
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,971,100			100.00

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

(2) Basis for adjustment (see instructions).

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

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

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet A-8-1
Parts I-11
Date/Time Prepared:
5/30/2023 12:22 pm

	Line No.	Cost Center	Expense Items		
	1.00	2.00	3.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RE TAXES	1.00	
2.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	2.00	
3.00	4.00	ADMINISTRATIVE & GENERAL	REALTY ADMIN	3.00	
4.00	30.00	SKILLED NURSING FACILITY	AIDES	4.00	
5.00	30.00	SKILLED NURSING FACILITY	LPNS AND RNS	5.00	
6.00	0.00			6.00	
7.00	0.00			7.00	
8.00	0.00			8.00	
9.00	0.00			9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.			10.00	
	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)		
	4.00	5.00	6.00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	198,411	198,411	0	1.00	
2.00	639,233	1,560,000	-920,767	2.00	
3.00	706	0	706	3.00	
4.00	109,051	112,104	-3,053	4.00	
5.00	714,121	734,111	-19,990	5.00	
6.00	0	0	0	6.00	
7.00	0	0	0	7.00	
8.00	0	0	0	8.00	
9.00	0	0	0	9.00	
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1,661,522	2,604,626	-943,104	10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Parts I-III Date/Time Prepared: 5/30/2023 12:22 pm
	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

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

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

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

1.00		A	JONATHAN ROSENBERG	50.00	1.00
2.00		A	MURRAY MANDEL	20.00	2.00
3.00		A	GEORGE GROSSBERG	20.00	3.00
4.00		A	IRVING BUAER	10.00	4.00
5.00		G	ISREAL MINZER	0.00	5.00
6.00		D	MI NDY ROSENBERG	0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	100.00

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

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

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

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

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

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

1.00		GATEWAY EATONTOWN ASSOC	30.00	REALTY	1.00
2.00		GATEWAY EATONTOWN ASSOC	20.00	REALTY	2.00
3.00		GATEWAY EATONTOWN ASSOC	20.00	REALTY	3.00
4.00		GATEWAY EATONTOWN ASSOC	10.00	REALTY	4.00
5.00		GATEWAY EATONTOWN ASSOC	20.00	REALTY	5.00
6.00		PEACE OF MIND STAFFING	100.00	NURSING AGENCY	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/30/2023 12: 22 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	958,305	958,305			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	3,643		3,643		2.00
3.00 00300	EMPLOYEE BENEFITS	1,472,553	4,504	17	1,477,074	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,411,170	58,648	223	184,941	2,654,982
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	808,164	10,976	42	23,967	843,149
6.00 00600	LAUNDRY & LINEN SERVICE	65,998	25,888	98	12,420	104,404
7.00 00700	HOUSEKEEPING	537,292	25,004	95	50,018	612,409
8.00 00800	DIETARY	1,514,056	96,563	367	158,253	1,769,239
9.00 00900	NURSING ADMINISTRATION	299,774	13,144	50	51,037	364,005
10.00 01000	CENTRAL SERVICES & SUPPLY	227,853	13,928	53	0	241,834
11.00 01100	PHARMACY	51,232	0	0	0	51,232
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
13.00 01300	SOCIAL SERVICE	115,627	4,320	16	25,917	145,880
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00 01500	ACTIVITIES	862,443	26,872	102	141,231	1,030,648
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	4,723,710	598,692	2,276	754,327	6,079,005
31.00 03100	NURSING FACILITY	0	0	0	0	0
32.00 03200	ICF/IID	0	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	0
41.00 04100	LABORATORY	23,645	0	0	0	23,645
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00 04400	PHYSICAL THERAPY	236,592	26,205	100	35,247	298,144
45.00 04500	OCCUPATIONAL THERAPY	161,813	19,082	73	36,537	217,505
46.00 04600	SPEECH PATHOLOGY	58,518	17,331	66	3,179	79,094
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,127	46	0	12,173
49.00 04900	DRUGS CHARGED TO PATIENTS	106,632	3,019	11	0	109,662
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00 06200	FQHC	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00 07100	AMBULANCE	0	0	0	0	0
73.00 07300	CMHC	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	14,639,020	956,303	3,635	1,477,074	14,637,010
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00 09100	BARBER AND BEAUTY SHOP	0	2,002	8	0	2,010
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0
98.00	Cross Foot Adjustments	0	0	0	0	0
99.00	Negative Cost Centers	0	0	0	0	0
100.00	TOTAL	14,639,020	958,305	3,643	1,477,074	14,639,020

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/30/2023 12: 22 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	2,654,982				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	186,794	1,029,943			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	23,130	30,156	157,690		6.00	
7.00	00700	HOUSEKEEPING	135,675	29,126	0	777,210	7.00	
8.00	00800	DIETARY	391,963	112,482	0	90,065	2,363,749	8.00
9.00	00900	NURSING ADMINISTRATION	80,643	15,311	0	12,260	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	53,577	16,224	0	12,991	0	10.00
11.00	01100	PHARMACY	11,350	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	32,319	5,032	0	4,029	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	228,333	31,302	0	25,064	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,346,761	697,394	157,690	558,403	2,363,749	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	5,238	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	66,052	30,525	0	24,441	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	48,187	22,228	0	17,798	0	45.00
46.00	04600	SPEECH PATHOLOGY	17,523	20,188	0	16,165	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,697	14,126	0	11,311	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	24,295	3,517	0	2,816	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	2,654,537	1,027,611	157,690	775,343	2,363,749	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	445	2,332	0	1,867	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	2,654,982	1,029,943	157,690	777,210	2,363,749	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	472,219					9.00
10.00	01000	0	324,626				10.00
11.00	01100	0	0	62,582			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	187,260	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	472,219	324,626	62,582	0	187,260	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		472,219	324,626	62,582	0	187,260	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		472,219	324,626	62,582	0	187,260	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part I
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Stepdown Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	1,315,347			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	1,315,347	13,565,036	0	13,565,036
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	28,883	0	28,883
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	0	419,162	0	419,162
45.00 04500	OCCUPATIONAL THERAPY	0	0	305,718	0	305,718
46.00 04600	SPEECH PATHOLOGY	0	0	132,970	0	132,970
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	40,307	0	40,307
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	140,290	0	140,290
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,315,347	14,632,366	0	14,632,366
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	6,654	0	6,654
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	0	1,315,347	14,639,020	0	14,639,020

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part II
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300	EMPLOYEE BENEFITS	0	4,504	17	4,521
4.00	00400	ADMINISTRATIVE & GENERAL	0	58,648	223	58,871
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	0	10,976	42	11,018
6.00	00600	LAUNDRY & LINEN SERVICE	0	25,888	98	25,986
7.00	00700	HOUSEKEEPING	0	25,004	95	25,099
8.00	00800	DIETARY	0	96,563	367	96,930
9.00	00900	NURSING ADMINISTRATION	0	13,144	50	13,194
10.00	01000	CENTRAL SERVICES & SUPPLY	0	13,928	53	13,981
11.00	01100	PHARMACY	0	0	0	0
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0
13.00	01300	SOCIAL SERVICE	0	4,320	16	4,336
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0
15.00	01500	ACTIVITIES	0	26,872	102	26,974
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	598,692	2,276	600,968
31.00	03100	NURSING FACILITY	0	0	0	0
32.00	03200	ICF/IID	0	0	0	0
33.00	03300	OTHER LONG TERM CARE	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	0	0
41.00	04100	LABORATORY	0	0	0	0
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0
44.00	04400	PHYSICAL THERAPY	0	26,205	100	26,305
45.00	04500	OCCUPATIONAL THERAPY	0	19,082	73	19,155
46.00	04600	SPEECH PATHOLOGY	0	17,331	66	17,397
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,127	46	12,173
49.00	04900	DRUGS CHARGED TO PATIENTS	0	3,019	11	3,030
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0
51.00	05100	SUPPORT SURFACES	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	0
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0
62.00	06200	FOHC	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0
71.00	07100	AMBULANCE	0	0	0	0
73.00	07300	CMHC	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00	08100	INTEREST EXPENSE				81.00
82.00	08200	UTILIZATION REVIEW - SNF				82.00
83.00	08300	HOSPICE	0	0	0	0
89.00		SUBTOTALS (sum of lines 1-84)	0	956,303	3,635	959,938
NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0
91.00	09100	BARBER AND BEAUTY SHOP	0	2,002	8	2,010
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0
93.00	09300	NONPAID WORKERS	0	0	0	0
94.00	09400	PATIENTS LAUNDRY	0	0	0	0
98.00		Cross Foot Adjustments				98.00
99.00		Negative Cost Centers				99.00
100.00		TOTAL	0	958,305	3,643	961,948

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 315177		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/30/2023 12: 22 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	59,437				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	4,182	15,273			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	518	447	26,989		6.00	
7.00	00700	HOUSEKEEPING	3,038	432	0	28,722	7.00	
8.00	00800	DIETARY	8,775	1,668	0	3,328	111,185	8.00
9.00	00900	NURSING ADMINISTRATION	1,805	227	0	453	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	1,199	241	0	480	0	10.00
11.00	01100	PHARMACY	254	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	724	75	0	149	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	ACTIVITIES	5,112	464	0	926	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	30,149	10,341	26,989	20,637	111,185	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	117	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	1,479	453	0	903	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1,079	330	0	658	0	45.00
46.00	04600	SPEECH PATHOLOGY	392	299	0	597	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	60	209	0	418	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	544	52	0	104	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC						62.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
73.00	07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	59,427	15,238	26,989	28,653	111,185	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	10	35	0	69	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00		Cross Foot Adjustments			0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	59,437	15,273	26,989	28,722	111,185	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part II
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	15,835					9.00
10.00	01000	0	15,901				10.00
11.00	01100	0	0	254			11.00
12.00	01200	0	0	0	0		12.00
13.00	01300	0	0	0	0	5,363	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,835	15,901	254	0	5,363	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		15,835	15,901	254	0	5,363	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00		0	0	0	0	0	98.00
99.00		0	0	0	0	0	99.00
100.00		15,835	15,901	254	0	5,363	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B
Part II
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	Subtotal	Post Step-Down Adjustments	Total	
		ACTIVITIES				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	ACTIVITIES	0	33,908			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	33,908	873,840	0	873,840
31.00 03100	NURSING FACILITY	0	0	0	0	0
32.00 03200	ICF/IID	0	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	0
41.00 04100	LABORATORY	0	0	117	0	117
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0
44.00 04400	PHYSICAL THERAPY	0	0	29,248	0	29,248
45.00 04500	OCCUPATIONAL THERAPY	0	0	21,334	0	21,334
46.00 04600	SPEECH PATHOLOGY	0	0	18,695	0	18,695
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,860	0	12,860
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	3,730	0	3,730
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00 06200	FOHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00 07100	AMBULANCE	0	0	0	0	0
73.00 07300	CMHC	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW - SNF					82.00
83.00 08300	HOSPICE	0	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	0	33,908	959,824	0	959,824
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00 09100	BARBER AND BEAUTY SHOP	0	0	2,124	0	2,124
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0
98.00	Cross Foot Adjustments	0	0	0	0	0
99.00	Negative Cost Centers	0	0	0	0	0
100.00	TOTAL	0	33,908	961,948	0	961,948

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	57,451					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		57,451				2.00
3.00 00300	EMPLOYEE BENEFITS	270	270	6,541,501			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	3,516	3,516	819,046	-2,654,982	11,984,038	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	658	658	106,144	0	843,149	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	1,552	1,552	55,006	0	104,404	6.00
7.00 00700	HOUSEKEEPING	1,499	1,499	221,513	0	612,409	7.00
8.00 00800	DIETARY	5,789	5,789	700,856	0	1,769,239	8.00
9.00 00900	NURSING ADMINISTRATION	788	788	226,026	0	364,005	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	835	835	0	0	241,834	10.00
11.00 01100	PHARMACY	0	0	0	0	51,232	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	259	259	114,779	0	145,880	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	ACTIVITIES	1,611	1,611	625,470	0	1,030,648	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	35,892	35,892	3,340,671	0	6,079,005	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF/IID	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	23,645	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	1,571	1,571	156,099	0	298,144	44.00
45.00 04500	OCCUPATIONAL THERAPY	1,144	1,144	161,813	0	217,505	45.00
46.00 04600	SPEECH PATHOLOGY	1,039	1,039	14,078	0	79,094	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	727	727	0	0	12,173	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	181	181	0	0	109,662	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
73.00 07300	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW - SNF						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	57,331	57,331	6,541,501	-2,654,982	11,982,028	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	120	120	0	0	2,010	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	958,305	3,643	1,477,074		2,654,982	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	16.680389	0.063411	0.225800		0.221543	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			4,521		59,437	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000691		0.004960	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	53,007					6.00
7.00	00700	1,552	55,589				7.00
8.00	00800	1,499	0	49,956			8.00
9.00	00900	5,789	0	5,789	166,767		9.00
10.00	01000	788	0	788	0	55,589	10.00
11.00	01100	835	0	835	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	259	0	259	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
15.00	01500	1,611	0	1,611	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	35,892	55,589	35,892	166,767	55,589	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,571	0	1,571	0	0	44.00
45.00	04500	1,144	0	1,144	0	0	45.00
46.00	04600	1,039	0	1,039	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	727	0	727	0	0	48.00
49.00	04900	181	0	181	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		52,887	55,589	49,836	166,767	55,589	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	120	0	120	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		1,029,943	157,690	777,210	2,363,749	472,219	102.00
103.00		19.430321	2.836712	15.557891	14.173961	8.494828	103.00
104.00		15,273	26,989	28,722	111,185	15,835	104.00
105.00		0.288132	0.485510	0.574946	0.666709	0.284859	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1

Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	55,589					10.00
11.00	01100	0	55,589				11.00
12.00	01200	0	0	55,589			12.00
13.00	01300	0	0	0	55,589		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	55,589	55,589	55,589	55,589	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	0	0	0	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
89.00		55,589	55,589	55,589	55,589	0	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
98.00							98.00
99.00							99.00
102.00		324,626	62,582	0	187,260	0	102.00
103.00		5.839752	1.125798	0.000000	3.368652	0.000000	103.00
104.00		15,901	254	0	5,363	0	104.00
105.00		0.286046	0.004569	0.000000	0.096476	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet B-1
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		OTHER GENERAL SERVICE		
		ACTIVITIES (PATIENT DAYS)		
		15.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500	ACTIVITIES	55,589	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	55,589	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF/IID	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	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	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FOHC	0	62.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
73.00	07300	CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW - SNF		82.00
83.00	08300	HOSPICE	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	55,589	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
98.00		Cross Foot Adjustments		98.00
99.00		Negative Cost Centers		99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	1,315,347	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	23.662001	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	33,908	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.609977	105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet C Date/Time Prepared: 5/30/2023 12:22 pm	
Cost Center Description		Total (from Wkst. B, Pt 1, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	0	0.000000 40.00
41.00	04100	LABORATORY	28,883	23,645	1.221527 41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000 42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000 43.00
44.00	04400	PHYSICAL THERAPY	419,162	249,982	1.676769 44.00
45.00	04500	OCCUPATIONAL THERAPY	305,718	425,869	0.717869 45.00
46.00	04600	SPEECH PATHOLOGY	132,970	138,134	0.962616 46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000 47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,307	0	0.000000 48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	140,290	106,632	1.315646 49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000 50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000 51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	0.000000 60.00
61.00	06100	RURAL HEALTH CLINIC			61.00
62.00	06200	FQHC			62.00
71.00	07100	AMBULANCE	0	0	0.000000 71.00
100.00		Total	1,067,330	944,262	100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/30/2023 12:22 pm		
		Title XVIII (1)	Skilled Nursing Facility	PPS		
		Health Care Program Charges		Health Care Program Cost		
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
Ratio of Cost to Charges (Fr. Wkst. C Column 3)						
1.00		2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST						
ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADIOLOGY	0.000000	0	0	0	40.00
41.00	04100 LABORATORY	1.221527	0	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0.000000	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	43.00
44.00	04400 PHYSICAL THERAPY	1.676769	80,660	0	135,248	44.00
45.00	04500 OCCUPATIONAL THERAPY	0.717869	124,903	0	89,664	45.00
46.00	04600 SPEECH PATHOLOGY	0.962616	43,704	0	42,070	46.00
47.00	04700 ELECTROCARDIOLOGY	0.000000	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	1.315646	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0.000000	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0.000000	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC					61.00
62.00	06200 FQHC					62.00
71.00	07100 AMBULANCE (2)	0.000000		0		71.00
100.00	Total (Sum of lines 40 - 71)		249,267	0	266,982	100.00

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

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

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III Date/Time Prepared: 5/30/2023 12:22 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description			1.00	
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PART II - APPORTIONMENT OF VACCINE COST				
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.315646	1.00
2.00		Program vaccine charges (From your records, or the PS&R)	20,048	2.00
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	26,376	3.00

Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)
		1.00	2.00	3.00	4.00	5.00

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0.000000	0	0	40.00
41.00	04100	LABORATORY	28,883	0	0.000000	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	04400	PHYSICAL THERAPY	419,162	0	0.000000	135,248	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	305,718	0	0.000000	89,664	0	45.00
46.00	04600	SPEECH PATHOLOGY	132,970	0	0.000000	42,070	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,307	0	0.000000	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	140,290	0	0.000000	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00		Total (Sum of lines 40 - 52)	1,067,330	0		266,982	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Prepared: 5/30/2023 12: 22 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		55,589	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		3,430	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		13,565,036	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		15,855,523	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.855540	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		13,565,036	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		244.02	16.00
17.00	Program routine service cost (Line 3 times line 16)		836,989	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		836,989	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		873,840	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		15.72	21.00
22.00	Program capital related cost (Line 3 times line 21)		53,920	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		783,069	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		783,069	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

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

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		55,589	1.00
2.00	Program inpatient days (see instructions)		3,430	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)		0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)		0.061703	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

COMPUTATION OF INPATIENT ROUTINE COSTS		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-III Date/Time Prepared: 5/30/2023 12: 22 pm
		Title XIX	Skilled Nursing Facility	Cost

				1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS					
INPATIENT DAYS					
1.00	Inpatient days including private room days		55,589	1.00	
2.00	Private room days		0	2.00	
3.00	Inpatient days including private room days applicable to the Program		47,212	3.00	
4.00	Medically necessary private room days applicable to the Program		0	4.00	
5.00	Total general inpatient routine service cost		13,565,036	5.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
6.00	General inpatient routine service charges		15,855,523	6.00	
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.855540	7.00	
8.00	Enter private room charges from your records		0	8.00	
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00	
10.00	Enter semi-private room charges from your records		0	10.00	
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00	
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00	
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00	
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00	
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		13,565,036	15.00	
PROGRAM INPATIENT ROUTINE SERVICE COSTS					
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		244.02	16.00	
17.00	Program routine service cost (Line 3 times line 16)		11,520,672	17.00	
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00	
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		11,520,672	19.00	
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		873,840	20.00	
21.00	Per diem capital related costs (Line 20 divided by line 1)		15.72	21.00	
22.00	Program capital related cost (Line 3 times line 21)		742,173	22.00	
23.00	Inpatient routine service cost (Line 19 minus line 22)		10,778,499	23.00	
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00	
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		10,778,499	25.00	
26.00	Enter the per diem limitation (1)		0.00	26.00	
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		0	27.00	
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		11,520,672	28.00	

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

				1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH					
1.00	Total SNF inpatient days		55,589	1.00	
2.00	Program inpatient days (see instructions)		47,212	2.00	
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)		0	3.00	
4.00	Nursing & allied health ratio. (line 2 divided by line 1)		0.849305	4.00	
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIIII		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 12: 22 pm
		Title XVIIII	Skilled Nursing Facility	PPS

			1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT				
1.00	Inpatient PPS amount (See Instructions)		2,167,570	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)		2,167,570	3.00
4.00	Primary payor amounts		0	4.00
5.00	Coinsurance		376,552	5.00
6.00	Allowable bad debts (From your records)		373,120	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)		156,203	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)		242,528	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)		2,033,546	11.00
12.00	Interim payments (See instructions)		2,064,499	12.00
13.00	Tentative adjustment		0	13.00
14.00	OTHER adjustment (See instructions)		0	14.00
14.50	Demonstration payment adjustment amount before sequestration		0	14.50
14.55	Demonstration payment adjustment amount after sequestration		0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)		3,056	14.75
14.99	Sequestration amount (see instructions)		24,667	14.99
15.00	Balance due provider/program (see Instructions)		-58,676	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIIII ONLY				
17.00	Ancillary services Part B		0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)		26,376	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)		26,376	19.00
20.00	Medicare Part B ancillary charges (See instructions)		20,048	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)		20,048	21.00
22.00	Primary payor amounts		0	22.00
23.00	Coinsurance and deductibles		0	23.00
24.00	Allowable bad debts (From your records)		0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)		20,048	25.00
26.00	Interim payments (See instructions)		17,681	26.00
27.00	Tentative adjustment		0	27.00
28.00	Other Adjustments (See instructions) Specify		0	28.00
28.50	Demonstration payment adjustment amount before sequestration		0	28.50
28.55	Demonstration payment adjustment amount after sequestration		0	28.55
28.99	Sequestration amount (see instructions)		252	28.99
29.00	Balance due provider/program (see instructions)		2,115	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY		Provider No. : 315177	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part II Date/Time Prepared: 5/30/2023 12: 22 pm
		Title XIX	Skilled Nursing Facility	Cost
				1.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)		0	2.00
3.00	Outpatient services		0	3.00
4.00	Inpatient routine services (see instructions)		11,520,672	4.00
5.00	Utilization review--physicians' compensation (from provider records)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)		11,520,672	6.00
7.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)		11,520,672	8.00
9.00	Primary payor amounts		0	9.00
10.00	Total Reasonable Cost (Line 8 minus line 9)		11,520,672	10.00
REASONABLE CHARGES				
11.00	Inpatient ancillary service charges		0	11.00
12.00	Outpatient service charges		0	12.00
13.00	Inpatient routine service charges		0	13.00
14.00	Differential in charges between semi private accommodations and less than semi private accommodations		0	14.00
15.00	Total reasonable charges		0	15.00
CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	16.00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	17.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)		0.000000	18.00
19.00	Total customary charges (see instructions)		0	19.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)		0	20.00
21.00	Deductibles		0	21.00
22.00	Subtotal (Line 20 minus line 21)		0	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (Line 22 minus line 23)		0	24.00
25.00	Allowable bad debts (from your records)		0	25.00
26.00	Subtotal (sum of lines 24 and 25)		0	26.00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		0	27.00
28.00	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		0	28.00
29.00	Other Adjustments (see instructions) Specify		0	29.00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		0	30.00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		0	31.00
32.00	Interim payments		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)		0	33.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet E-1

Date/Time Prepared:
5/30/2023 12:22 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		1,766,351		17,681	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		268,411		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/16/2022	29,737		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		29,737		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		2,064,499		17,681	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		0		2,115	6.01
6.02	PROVIDER TO PROGRAM		58,676		0	6.02
7.00	Total Medicare program liability (see instructions)		2,005,823		19,796	7.00
				Contractor Name		Contractor Number
				1.00		2.00
8.00	Name of Contractor					8.00

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet G

Date/Time Prepared:
5/30/2023 12:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	904,946	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,442,171	0	0	0	4.00
5.00	Other receivables	1,124,828	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-523,414	0	0	0	6.00
7.00	Inventory	4,000	0	0	0	7.00
8.00	Prepaid expenses	-823,847	0	0	0	8.00
9.00	Other current assets	-741	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	3,127,943	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,975,458	0	0	0	17.00
18.00	Less: Accumulated Amortization	-1,370,091	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,524,057	0	0	0	23.00
24.00	Less: Accumulated depreciation	-1,514,220	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	615,204	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	12,975	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	12,975	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	3,756,122	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,855,314	0	0	0	35.00
36.00	Salaries, wages, and fees payable	0	0	0	0	36.00
37.00	Payroll taxes payable	12,825	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	0	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	1,068,865	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2,937,004	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	0	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	2,937,004	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	819,118	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	819,118	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	3,756,122	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-1

Date/Time Prepared:
5/30/2023 12:22 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		1,047,136		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-228,017			2.00
3.00	Total (sum of line 1 and line 2)		819,119		0	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		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		819,119		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00	ROUNDING	1		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		819,118		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					12.00
13.00	ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 13 - 17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/30/2023 12:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	15,855,523		15,855,523	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	15,855,523		15,855,523	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	944,262	0	944,262	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	16,799,785	0	16,799,785	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			16,610,120	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			16,610,120	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 315177

Period:
From 01/01/2022
To 12/31/2022

Worksheet G-3

Date/Time Prepared:
5/30/2023 12: 22 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	16,799,785	1.00
2.00	Less: contractual allowances and discounts on patients accounts	600,236	2.00
3.00	Net patient revenues (Line 1 minus line 2)	16,199,549	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	16,610,120	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-410,571	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,920	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REV - MISC.	8,500	24.00
24.01	SALE OF ELECTRICITY	164,502	24.01
24.50	COVID-19 PHE Funding	7,926	24.50
25.00	Total other income (Sum of lines 6 - 24)	182,848	25.00
26.00	Total (Line 5 plus line 25)	-227,723	26.00
27.00	REIM EXP	294	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	294	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-228,017	31.00