Heal th Financia			UTE NURSING		u of Form CMS-2540-10
This report is	required by law (42 USC 1395g; 42 CFR 413.3	20(b)). Failu	re to report can resul	t in all interim	FORM APPROVED
payments made s	since the beginning of the cost reporting p	eriod being d	eemed overpayments (42	USC 1395g).	OMB NO. 0938-0463
					Expires: 12/31/2021
SKILLED NURSING	G FACILITY AND SKILLED NURSING FACILITY HEA	LTH CARE	Provider CCN: 315508	Peri od:	Worksheet S
COMPLEX COST RE	EPORT CERTIFICATION AND SETTLEMENT SUMMARY			From 04/01/2022	
				To 12/31/2022	Date/Time Prepared: 5/30/2023 12:33 pm
PART I - COST F	REPORT STATUS			1	
Provi der	1. [X]Electronically prepared cost rep	port		Date: 5/30/20	23 Time: 12:33 pm
use only	2. [ ] Manually prepared cost report				
	3. [0] If this is an amended report en	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [ ] No Medicare Utilization. Enter '	'Y" for yes o	r leave blank for no.		
Contractor	4.[ 1]Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N]Firs	t Cost Report for this	Provider CCN	
	<ol><li>Settled without audit</li></ol>	8.[N]Last	Cost Report for this	Provider CCN	
	<ol><li>(3) Settled with audit</li></ol>	9. NPR Date:	·		
	(4) Reopened	10 [ 0 ] I f I	ine 4, column 1 is "4"	. Enter number of	times reopened
	(5) Amended		r Vendor Code	A	trilles respense
	5. Date Received:		care Utilization. Ente	<u> </u>	'l" for low or "N"
			no utilization.	a rorrun,	L TOT TOW, OF N
		1 101			

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 PELICAN POINTE POST-ACUTE NURSING (315508) for the cost reporting period beginning 04/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Joe Blachorsky		ř	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 electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	204, 230	2, 936	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
7.10	SNF - BASED CORF I	0		0		7.10
100.00	TOTAL	0	204, 230	2, 936	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.

	D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA	TY HEALTH	I CARE	Provider No	o.: 315508	Period: From 04/01/	/2022	Workshe Part I	eet S-2	2
						To 12/31/	2022			
	1.00		2. 00		3.00			5/30/20	)23 12:	<u>33 pi</u>
	Skilled Nursing Facility and Skilled Nursing			ldress:	3.00					
00	Street: 3809 BAYSHORE ROAD	PO Box:								1.
00	City: NORTH CAPE MAY	State: N	J	Zip Code: 0	8204					2.
00	County: ATLANTIC	CBSA Code		Urban/Rura						3.
01		CBSA Code								3.
		1		ent Name	Provi der	Date	Pavme	ent Syst	em (P.	
					CCN	Certified		0, or N		
							V	XVIII	Í XI X	1
			1	. 00	2.00	3.00	4.00		6.00	
	SNF and SNF-Based Component Identification:				2.00	0.00	1	10100	1 0.00	
0	SNF		PELICAN POI	NTE	315508	05/03/2011	N	Р	0	4.
			POST-ACUTE							
0	Nursing Facility									5.
00	ICF/IID									6.
0	SNF-Based HHA									7.
0	SNF-Based RHC									8.
0	SNF-Based FQHC									9.
	SNF-Based CMHC									10.
	SNF-Based OLTC									111.
	SNF-Based HOSPICE									12.
	SNF-Based CORF									13.
50			1			From:		То		13.
						1.00		2. (		-
00	Cost Reporting Period (mm/dd/yyyy)					04/01/2		12/31/		14.
	Type of Control (See Instructions)					04/01/2		12/31/	2022	14.
00	Type of control (see this fue trolls)						4	Y/	N	15.
								1. (		-
	Type of Freestanding Skilled Nursing Facility							1.0	0	
00	Type of Freestanding Skilled Nursing Facility		maata tha	rogui romont	o oot forth	in 42 CED		•	1	1/
00	Is this a distinct part skilled nursing facil	iity that	meets the	requirement	s set forth	IN 42 CFR		Ν	I	16.
~~	section 483.5?									47
00	Is this a composite distinct part skilled nur	rsing fac	ility that	meets the r	equirements	set forth	in	Ν	l	17.
~~	42 CFR section 483.5?								,	10
00	Are there any costs included in Worksheet A							Y		18.
	organizations as defined in CMS Pub. 15-1, ch	napter 10	? IT yes,	complete wo	rksneet A-8	-1.				-
~ ~	Miscellaneous Cost Reporting Information									
	If this is a low Medicare utilization cost re							N		19.
01	If line 19 is yes, does this cost report meet				r filing a	low Medicar	e	Ν	1	19.
	utilization cost report, indicate with a "Y",	TOR VAS								
	Demonstration - Entry the enclosed of demonstration						1 :	20 27	<u> </u>	-
~~	Depreciation - Enter the amount of depreciation				e method ir	dicated on	Li nes	20 - 22		
	Straight Line				e method in	dicated on	Li nes	20 - 22	(	
00	Straight Line Declining Balance				e method ir	dicated on	Li nes	20 - 22	(	0 21.
00 00	Straight Line Declining Balance Sum of the Year's Digits				e method ir	dicated on	Li nes	20 - 22	(	0 21. 0 22.
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	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC	ion repor e as of th ring the a assets in program a nsurance p blic prov Y" for ea	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type	(Y/N) ior cost re o which thi e cost from or an exempt of service	porting per s cost repo prior cost ion from th that qualif	i od? rt <u>Part</u> <u>1.00</u> ie app ies f N N	N N N N N I i cati or or the N N	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets du Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "' exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a	ion repor e as of th ring the d assets in program a nsurance p blic prov Y" for ea state tha	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type s the provi	(Y/N) ior cost re o which thi e cost from or an exempt of service	porting per s cost repo prior cost ion from th that qualif	i od? rt <u>Part</u> <u>1.00</u> ie app ies f N N	N N N N N N N N N	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets du Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "' exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based RHC SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a regardless of the level of care given for Tim	e as of th ring the d assets in program a nsurance p blic prov Y" for ea state that tles V & 2	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type s the provi	(Y/N) ior cost re o which thi e cost from or an exempt of service	porting per s cost repo prior cost ion from th that qualif <u>Y/N</u> 1.00 F Y	i od? rt <u>Part</u> <u>1.00</u> ie app ies f N N	N N N N N N N N N	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. - - - - - - - - - - - - -
	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a regardless of the level of care given for Ti Are you legally-required to carry malpractice	e as of the case o	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type s the provi s? (Y/N)	(Y/N) ior cost re o which thi e cost from or an exempt of service der as a SN	porting per s cost repo prior cost ion from th that qualif <u>Y/N</u> <u>1.00</u> F Y N	i od? rt <u>Part</u> <u>1.00</u> ie app ies f N N	N N N N N N N N N	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38.
	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "" exemption. Skilled Nursing Facility Nursing Facility ICF/ILD SNF-Based RHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a regardless of the level of care given for Ti- Are you legally-required to carry malpracticc Is the malpractice a "claims-made" or "occur	e as of ti ring the o assets in program a nsurance p blic prov Y" for ea state tha tles V & 2 e insurance rence" pol	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type s the provi s? (Y/N)	(Y/N) ior cost re o which thi e cost from or an exempt of service der as a SN	porting per s cost repo prior cost ion from th that qualif <u>Y/N</u> 1.00 F Y	i od? rt <u>Part</u> <u>1.00</u> ie app ies f N N	N N N N N N N N N	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. - - - - - - - - - - - - -
	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a regardless of the level of care given for Ti Are you legally-required to carry malpractice	e as of ti ring the o assets in program a nsurance p blic prov Y" for ea state tha tles V & 2 e insurance rence" pol	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type s the provi s? (Y/N)	(Y/N) ior cost re o which thi e cost from or an exempt of service der as a SN	porting per s cost repo prior cost ion from th that qualif Hat qualif Y/N 1.00 F Y N 1	i od? rt <u>Part</u> 1.00 e app i es f N N	N N N N N N N N 2.00 I i cati or or the N N N 2.0	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39.
	Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pul of the lower of the costs or charges enter "" exemption. Skilled Nursing Facility Nursing Facility ICF/ILD SNF-Based RHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a regardless of the level of care given for Ti- Are you legally-required to carry malpracticc Is the malpractice a "claims-made" or "occur	e as of ti ring the o assets in program a nsurance p blic prov Y" for ea state tha tles V & 2 e insurance rence" pol	ted in this he end of t cost report the curren at end of t proportion ider that q ch componen ider that q ch componen	SNF for the period. ing period? t or any pr he period t of allowabl ualifies fo t and type s the provi s? (Y/N)	(Y/N) ior cost re o which thi e cost from or an exempt of service der as a SN	porting per s cost repo prior cost ion from th that qualif <u>Y/N</u> <u>1.00</u> F Y N	i od? rt <u>Part</u> 1.00 e app i es f N N	N N N N N N N N N	0 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	2 21. 2 22. 2 23. 2 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39.

Heal th	In Lie	u of Form C	MS-2540-10					
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		Period:	Worksheet	S-2	
COMPLE	X INDENTIFICATION DATA				From 04/01/2022 To 12/31/2022		Droparad	
					10 12/31/2022	5/30/2023		
						Y/N		
						1.00		
	Are malpractice premiums and paid losse					N	42.00	
	center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and							
	amounts.							
	Are there any home office costs as defi					N	43.00	
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and ad	dress o	f the home		44.00	
-	office on lines 45, 46 and 47.							
	1.00	2.00			3.00			
	If this facility is part of a chain org	ganization, enter the nam	e and address of	f the ho	me office on the	lines		
	bel ow.	1						
45.00	Name:	Contractor's Name:	C	Contracto	or's Number:		45.00	
46.00	Street:	PO Box:					46.00	
47.00	Ci ty:	State:	Z	Zip Code:			47.00	

MPL	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	IY HEALIH CARE Provider		Period: From 04/01/2022		
				To 12/31/2022	Date/Time Pre 5/30/2023 12:	
				Y/N	Date	-
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1, "Y" f	for Yes or "N"	1.00 for No. For all	2.00 the date	
00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter 1 instructions)	y prior to the beginning of the date of the change in cc	olumn 2. (see	Y	04/01/2022	1.
			Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.		N	2.00	3.00	2.
00	or medical supply companies) that are related officers, medical staff, management personnel	ontracts, with individuals or entities (e.g., chain home offices, drug redical supply companies) that are related to the provider or its fficers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar elationships? (see instructions) Y/N 1.00				
				Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If of	' for Audited, "C" for te copy or enter date no, see instructions. revenues different from	Y N	С		4. 5.
	reconciliation.			Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs		e provider the	N	N	6. 7.
00	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se		l for Nursing	N	Y/N	8.
	Bad Debts				1.00	
00 00	Is the provider seeking reimbursement for bac			t reporting	Y N	9. 10.
00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance waived? If	"Y", see instr	uctions.	N	11.
00	Have total beds available changed from prior	cost reporting period? If "	Y", see instru	ctions.	N	12
		Description	Y/N	Date	Part B Y/N	-
		0	1.00	2.00	3.00	
00	PS&R Data 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		Y	04/24/2023	Y	13
	4. (see Instructions.) 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"		Ν		N	14
00	enter the paid through date of the $PS\&R$ used to prepare this cost report in columns 2 and					
	enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 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",		Ν		N	15.
00	enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report		N		N	15.
. 00 . 00 . 00	enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 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. 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.					

Health Financial Systems	PELICAN POINTE POST-A	CUTE NURSING	In Lieu	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE		Period: From 04/01/2022	Worksheet S-2 Part II	
COMPLEX REIMBURSEMENT QUESTIONNAIRE				Date/Time Pre	pared:
				5/30/2023 12:	<u>33 pm</u>
		1.00	2. (	00	
Cost Report Preparer Contact Informatic	n				
19.00 Enter the first name, last name and the	e title/position CHAF	RLES	REED		19.00
held by the cost report preparer in col	umns 1, 2, and 3,				
respecti vel y.					
20.00 Enter the employer/company name of the	cost report EXEC	CUCARE ASSOCI ATES			20.00
preparer.					
21.00 Enter the telephone number and email ac	dress of the cost (609	9)738-3200	CRWASSC@NETSCAF	PE. NET	21.00
report preparer in columns 1 and 2, res	specti vel y.				

Heal th	Financial Systems PEL	ICAN POINTE POS	T-ACUTE NURSING	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No.: 315508	Period: From 04/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 12:	pared:
		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.)	04/24/2023				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
	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
		-	2.00	_		
	Cost Report Preparer Contact Information		3.00			
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		/I CE - PRESI DENT			19.00
20.00	Enter the employer/company name of the cost r	report				20.00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems D NURSING FACILITY AND SKILLED NURSIN	PELICAN POINTE POS NG FACILITY HEALTH CARE		No.: 315508 Pe	eri od:	u of Form CMS-2 Worksheet S-3	2540-10
COMPLE	EX STATI STI CAL DATA			Te		Part I Date/Time Prep 5/30/2023 12:3	
				l npa	atient Days/Vis	its	
	Component	Number of Beds	Bed Days Avai LabLe	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	120	33, 000	0	3, 652	17, 540	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
. 00	SNF-Based CMHC						6.00
b. 10	SNF-Based CORF		0		0	0	6.10
. 00	HOSPICE	0	0	0	0	17 540	7.00
. 00	Total (Sum of lines 1-7)	120 Inpatient D	33,000	0		17, 540	8.00
		Inpatrent D	ays/visits		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
. 00	SKILLED NURSING FACILITY	3, 624	24, 816	0	92	65	1.00
. 00	NURSING FACILITY	0	0	0		0	2.00
. 00	ICF/IID	0	0			0	3.00
. 00	HOME HEALTH AGENCY COST	0	0				4.00
. 00	Other Long Term Care	0	0				5.OC
. 00	SNF-Based CMHC						6.00
o. 10	SNF-Based CORF						6.10
. 00	HOSPI CE	0	0	0	0	0	7.OC
8.00	Total (Sum of lines 1-7)	3, 624	24, 816	0	92	65	8.00
		Discha	arges	Aver	age Length of S	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
. 00	SKILLED NURSING FACILITY	76	233	0.00	39. 70	269.85	1.00
. 00	NURSING FACILITY	0	0	0.00		0.00	2.00
8.00	ICF/IID	0	0			0.00	3.00
1.00	HOME HEALTH AGENCY COST						4. OC
5.00	Other Long Term Care	0	0				5.00
o. 00	SNF-Based CMHC						6.00
5. 10	SNF-Based CORF						6.10
. 00	HOSPICE	0	0	0.00	0.00	0.00	7.00
3.00	Total (Sum of lines 1-7)	76 Average Length	233	0.00 Admis	39.70 ci opc	269.85	8.00
		of Stay		Auliii S	51 0115		
	Component	Total	Title V	Title XVIII	Title VIV	Other	
						ULIEI	
		16.00	17.00	18.00	Title XIX 19.00	20.00	
. 00	SKILLED NURSING FACILITY	16.00 106.51					1. 00
. 00	NURSING FACILITY	106. 51 0. 00	17.00	18.00	19.00	20.00 56 0	2.00
. 00 . 00	NURSING FACILITY ICF/IID	106. 51	17.00	18.00	19.00 43	20.00 56	2.00 3.00
. 00 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	106. 51 0. 00 0. 00	17.00	18.00	19.00 43 0	20.00 56 0 0	2.00 3.00 4.00
. 00 . 00 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	106. 51 0. 00	17.00	18.00	19.00 43 0	20.00 56 0	2.00 3.00 4.00 5.00
. 00 . 00 . 00 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	106. 51 0. 00 0. 00	17.00	18.00	19.00 43 0	20.00 56 0 0	2.00 3.00 4.00 5.00
2. 00 5. 00 5. 00 5. 00 5. 00 5. 10	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF	106. 51 0. 00 0. 00 0. 00	17.00 0 0	<u>18.00</u> 127	19.00 43 0 0	20.00 56 0 0	2.00 3.00 4.00 5.00 6.00 6.10
. 00 . 00 . 00 . 00 . 00 . 10 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE	106. 51 0. 00 0. 00 0. 00 0. 00	17.00	<u>18.00</u> 127 0	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00
. 00 . 00 . 00 . 00 . 00 . 10 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF	106. 51 0. 00 0. 00 0. 00 0. 00 106. 51	17.00 0 0 0 0 0	18.00 127 0 127	19.00 43 0 0	20.00 56 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00
2.00 3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE	106. 51 0. 00 0. 00 0. 00 0. 00	17.00 0 0	18.00 127 0 127	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00
2.00 2.00 3.00 5.00 5.00 5.00 5.00 5.00 5.00 7.00 8.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE	106. 51 0. 00 0. 00 0. 00 0. 00 106. 51	17.00 0 0 0 Full Time Employees on	18.00 127 0 127	19.00 43 0 0	20.00 56 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 6. 10 7. 00 8. 00
. 00 . 00 . 00 . 00 . 00 . 10 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of lines 1-7)	106. 51 0. 00 0. 00 0. 00 0. 00 106. 51 Admi ssi ons Total	17.00 0 0 0 Full Time Employees on Payrol I	18.00 127 0 127 Equi val ent Nonpai d Workers	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00
. 00 . 00 . 00 . 00 . 00 . 00 . 10 . 00 . 0	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component	106.51 0.00 0.00 0.00 0.00 106.51 Admi ssi ons Total 21.00	17.00 0 0 0 Full Time Employees on Payrol1 22.00	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00	19.00 43 0 0	20.00 56 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 6. 10 7. 00 <u>8. 00</u>
. 00 . 00 . 00 . 00 . 00 . 10 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component	106.51 0.00 0.00 0.00 0.00 106.51 Admi ssi ons Total 21.00 226	17.00 0 0 0 Full Time Employees on Payrol1 22.00 80.33	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00 8.00
2. 00 3. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 5. 00 7.	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	106.51 0.00 0.00 0.00 0.00 106.51 Admissions Total 21.00 226 0	17.00 0 0 0 0 Full Time Employees on Payrol I 22.00 80.33 0.00	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00 8.00 1.00 2.00
. 00 . 00 . 00 . 00 . 10 . 00 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	106.51 0.00 0.00 0.00 0.00 106.51 Admi ssi ons Total 21.00 226	17.00 0 0 0 0 Full Time Employees on Payrol1 22.00 80.33 0.00 0.00	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00 8.00 1.00 2.00 3.00
. 00 . 00 . 00 . 00 . 00 . 10 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	106.51           0.00           0.00           0.00           0.00           0.00           106.51           Admissions           Total           21.00           0           0           0	17.00 0 0 0 Full Time Employees on Payrol1 22.00 80.33 0.00 0.00 0.00	18.00 127 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00 8.00 1.00 2.00 3.00 4.00
. 00 . 00 . 00 . 00 . 00 . 10 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	106.51 0.00 0.00 0.00 0.00 106.51 Admissions Total 21.00 226 0	17.00 0 0 0 Full Time Employees on Payrol I 22.00 80.33 0.00 0.00 0.00 0.00	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00	19.00 43 0 0	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.10 7.00 8.00 1.00 2.00 3.00 4.00 5.00
. 00 . 00 . 00 . 00 . 00 . 10 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	106.51           0.00           0.00           0.00           0.00           0.00           106.51           Admissions           Total           21.00           0           0           0	17.00 0 0 0 Full Time Employees on Payrol I 22.00 80.33 0.00 0.00 0.00 0.00 0.00	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	19.00 43 0 0 43	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.00 6.10 7.00 8.00 1.00 2.00 3.00 4.00 5.00 6.00
2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 5. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 7. 00 8. 00 9.	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF	106.51 0.00 0.00 0.00 0.00 106.51 Admi ssi ons Total 21.00 226 0 0 0	17.00 0 0 0 Full Time Employees on Payrol 1 22.00 80.33 0.00 0.00 0.00 0.00 0.00 0.00	18.00 127 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	19.00 43 0 0 43 0 43	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.10 7.00 8.00 1.00 2.00 3.00 4.00 5.00 6.10
. 00 . 00 . 00 . 00 . 00 . 10 . 00 . 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC SNF-Based CORF HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	106.51           0.00           0.00           0.00           0.00           0.00           106.51           Admissions           Total           21.00           0           0           0	17.00 0 0 0 Full Time Employees on Payrol I 22.00 80.33 0.00 0.00 0.00 0.00 0.00	18.00 127 0 127 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	19.00 43 0 0 0 43	20.00 56 0 0 0	2.00 3.00 4.00 5.00 6.10 7.00 8.00 1.00 2.00 3.00 4.00 5.00 6.00

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	GE INDEX INFORMATION		Dravidar	No.: 315508	Peri od:	Worksheet S-3	2340-10
SINF WA	GE INDEX INFORMATION		Provider		From 04/01/2022		
					To 12/31/2022		nared
					10 12/31/2022	5/30/2023 12:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3	, , , , , , , , , , , , , , , , , , ,	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES			_			
1.00	Total salaries (See Instructions)	3, 271, 811	C	3, 271, 81	1 128, 524. 00	25.46	1.00
2.00	Physician salaries-Part A	0	c c		0 0.00	0.00	2.00
3.00	Physician salaries-Part B	0	c c		0 0.00	0.00	3.00
4.00	Home office personnel	0	c c		0 0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	c c		0 0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	3, 271, 811	c c	3, 271, 81	1 128, 524.00	25.46	6.00
7.00	Other Long Term Care	0	c c		0 0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	l c		0 0.00	0.00	8.00
9.00	СМНС	0	l c		0 0.00	0.00	9.00
9.10	CORF						9.10
10.00	HOSPICE	0	l c		0 0.00	0.00	10.00
11.00	Other excluded areas	0	l c		0 0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	l c		0 0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	3, 271, 811	c c	3, 271, 81	1 128, 524.00	25.46	13.00
	12)						
	OTHER WAGES & RELATED COSTS	_	_				
14.00	Contract Labor: Patient Related & Mgmt	839, 591	C	839, 59	1 24, 235. 00	34.64	14.00
15.00	Contract Labor: Physician services-Part A	0	C		0 0.00		15.00
16.00	Home office salaries & wage related costs	0	C		0 0.00	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	689, 718	C	689, 71	8		17.00
18.00	Wage-related costs other (See Part IV)	0	C		0		18.00
19.00	Wage related costs (excluded units)	0	C	)	0		19.00
20.00	Physician Part A - WRC	0	C	)	0		20.00
21.00	Physician Part B - WRC	0	C	)	0		21.00
22.00	Total Adjusted Wage Related cost (see	689, 718	C	689, 71	8		22.00
	instructions)						1

Heal th	Financial Systems PEL	ICAN POINTE POS	ST-ACUTE NURSIN	١G	In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 04/01/2022		
					To 12/31/2022	Date/Time Pre 5/30/2023 12:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	i					
1.00	Employee Benefits	0	0		0.00	0.00	1.00
2.00	Administrative & General	211, 271	0	211, 27	1 6, 409. 00	32.96	2.00
3.00	Plant Operation, Maintenance & Repairs	68, 248	0	68, 24	3 2, 688. 00	25.39	3.00
4.00	Laundry & Linen Service	0	0	(	0.00	0.00	4.00
5.00	Housekeepi ng	251, 706	0	251, 70	6 17, 051. 00	14.76	5.00
6.00	Dietary	300, 634	0	300, 63	4 17, 207. 00	17.47	6.00
7.00	Nursing Administration	399, 787	0	399, 78	7 8, 910. 00	44.87	7.00
8.00	Central Services and Supply	0	0	(	0.00	0.00	8.00
9.00	Pharmacy	0	0	(	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(	0.00	0.00	10.00
11.00	Soci al Servi ce	44, 665	0	44, 66	5 1, 480. 00	30.18	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	98, 978	0	98, 97	5, 883. 00	16.82	13.00
14.00	Total (sum lines 1 thru 13)	1, 375, 289	0	1, 375, 28	9 59, 628. 00	23.06	14.00

SNF WA	GE RELATED COSTS	Provider No.: 315508	Period: From 04/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Pre 5/30/2023 12:	eparec
				Amount	
			-	Reported	
	Γ			1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				-
	RETIREMENT COST				
. 00	401K Employer Contributions			0	
. 00	Tax Sheltered Annuity (TSA) Employer Contribution			0	
. 00	Qualified and Non-Qualified Pension Plan Cost			0	
. 00	Prior Year Pension Service Cost			0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
. 00	401K/TSA Plan Administration fees			0	
. 00	Legal/Accounting/Management Fees-Pension Plan			0	
. 00	Employee Managed Care Program Administration Fees			0	7.
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			125, 758	
00	Prescription Drug Plan			0	
	Dental, Hearing and Vision Plan			1, 935	
	Life Insurance (If employee is owner or beneficiary)			135, 702	
	Accident Insurance (If employee is owner or beneficiary)			0	
	Disability Insurance (If employee is owner or beneficiary)			0	
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	1
	Workers' Compensation Insurance			94, 774	
5.00	Retirement Health Care Cost (Only current year, not the extraord	dinary accrual require	d by FASB 106.	0	16.
	Non cumulative portion)				
	TAXES				1
	FICA-Employers Portion Only			329, 838	
	Medicare Taxes - Employers Portion Only			0	
	Unemployment Insurance			0	1
0. 00	State or Federal Unemployment Taxes			1, 711	20.
	OTHER				
	Executive Deferred Compensation			0	1 - · ·
	Day Care Cost and Allowances			0	
	Tuition Reimbursement			0	
4.00	Total Wage Related cost (Sum of lines 1 - 23)			<u>689, 718</u>	24.
				Amount	
			-	Reported 1.00	
	Part B - Other than Core Related Cost			1.00	-

## Health Financial Systems

#### PELICAN POINTE POST-ACUTE NURSING

Heal th	Financial Systems PEL	ICAN POINTE POS	T-ACUTE NURSIN	IG	In Lie	eu of Form CMS-2	2540-10
SNF RE	PORTING OF DIRECT CARE EXPENDITURES		Provi der		Period: From 04/01/2022		
					To 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: <u>33 pm</u>
	Occupational Category	Amount	Fri nge	Adj usted		Average Hourly	
		Reported	Benefits	Salaries (col		Wage (col. 3 ÷	
				1 + col. 2)	Salary in col.	col. 4)	
		1.00	2.00	2.00	3	F 00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	5.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	449, 582	95, 618	545, 20	0 11, 323. 00	48.15	1.00
2.00	Licensed Practical Nurses (LPNs)	468, 166	99, 570	567, 73			2.00
3.00	Certified Nursing Assistant/Nursing	608, 082	129, 328	737, 410	32, 763. 00	22.51	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	1, 525, 830	324, 516	1, 850, 34	6 59, 943. 00	30.87	4.00
5.00	Physical Therapists	201, 899	42, 940	244, 83	9 4, 478. 00	54.68	5.00
6.00	Physical Therapy Assistants	0	0	(	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	(	0.00	0.00	7.00
8.00	Occupational Therapists	153, 091	32, 560	185, 65	1 4, 224. 00	43.95	8.00
9.00	Occupational Therapy Assistants	0	0	(	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	(	0.00	0.00	10.00
11.00	Speech Therapists	15, 702	3, 340	19, 04:	2 251.00	75.86	11.00
12.00	Respiratory Therapists	0	0	(	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	(	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	· · · · · ·					
	Registered Nurses (RNs)	0			0.00		
	Licensed Practical Nurses (LPNs)	281, 897		281, 89			
16.00	Certified Nursing Assistant/Nursing	557, 694		557, 69	4 19, 254. 00	28.97	16.00
	Assi stants/Ai des						
	Total Nursing (sum of lines 14 through 16)	839, 591		839, 59			
	Physical Therapists	0		(	0.00		
	Physical Therapy Assistants	0			0.00		
	Physical Therapy Aides	0			0.00		20.00
	Occupational Therapists	0		(	0.00		
	Occupational Therapy Assistants	0		(	0.00		
	Occupational Therapy Aides	0		(	0.00		
	Speech Therapists	0		(	0.00		
25.00	Respiratory Therapists	0			0.00		
26.00	Other Medical Staff	0		(	0.00	0.00	26.00

	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider No.: 315508	Peri od:	Worksheet S	
			From 04/01/2022 To 12/31/2022		
				5/30/2023 1	
			<u>Group</u> 1.00	Days 2.00	
1.00			RUX		1.00
2.00			RUL		2.00
3.00 4.00			RVX RVL		3.00
5.00			RHX		5.00
6.00			RHL		6.00
7.00 8.00			RMX RML		7.00
9.00			RLX		9.00
10.00			RUC		10.00
11. 00 12. 00			RUB RUA		11.00
13.00			RVC		13.00
14.00			RVB		14.00
15.00 16.00			RVA RHC		15.00
17.00			RHB		17.00
18.00			RHA		18.00
19.00 20.00			RMC RMB		19.00 20.00
20.00			RMA		20.00
22.00			RLB		22.00
23.00			RLA ES3		23.00
24.00 25.00			ES2		24.00 25.00
26.00			ES1		26.00
27.00			HE2		27.00
28.00 29.00			HE1 HD2		28.00
30.00			HD1		30.00
31.00			HC2		31.00
32.00 33.00			HC1 HB2		32.00
34.00			HB1		34.00
35.00			LE2		35.00
36.00 37.00			LE1 LD2		36.00
37.00			LD2 LD1		37.00
39.00			LC2		39.00
40.00			LC1		40.00
41.00 42.00			LB2 LB1		41.00
43.00			CE2		43.00
44.00			CE1		44.00
45.00 46.00			CD2 CD1		45.00 46.00
47.00			CC2		47.00
48.00			CC1		48.00
49.00 50.00			CB2 CB1		49.00 50.00
50.00			CA2		51.00
52.00			CA1		52.00
53.00 54.00			SE3 SE2		53.00 54.00
54.00 55.00			SE2 SE1		54.00
56.00			SSC		56.00
57.00			SSB		57.00
58.00 59.00			SSA I B2		58.00 59.00
60.00			I B1		60.00
61.00			I A2		61.00
62.00 63.00			I A1 BB2		62.00 63.00
64.00			BB1		64.00
65.00			BA2		65.00
66.00 67.00			BA1 PE2		66.00 67.00
67.00 68.00			PE2 PE1		68.00
69.00			PD2		69.00
70.00			PD1		70.00
71.00 72.00			PC2 PC1		71.00 72.00
73.00			PB2		73.00
74.00			PB1		74.00

Health Financial Systems PELICAN POINTE POST-AG	CUTE NURSIN	IG	In Lie	u of Form CMS	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315508	Period:	Worksheet S	-7
			From 04/01/2022 To 12/31/2022		
			Group	Days	
			1.00	2.00	
76.00			PA1		76.00
99.00			AAA		99.00
100. 00 TOTAL					100.00
		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 A payments beginning 10/01/2003. Congress expected this increase expenses. For lines 101 through 106: Enter in column 1 the amou column 2 the percentage of total expenses for each category to line 1, column 3. Indicate in column 3 "Y" for yes or "N" for n with direct patient care and related expenses for each category (See instructions)	to be used int of the total SNF io if the s	for direct expense for revenue from pending refle	batient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

CLASS	IFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period:	Worksheet A	
					From 04/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ENERAL SERVICE COST CENTERS	1		1			
	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 497, 235	1, 497, 23		1, 497, 235	
	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		0 0	0	2.
	00300 EMPLOYEE BENEFITS	0	695, 853	695, 85		695, 853	3.
	00400 ADMINISTRATIVE & GENERAL	211, 271	1, 099, 007	1, 310, 27		1, 310, 278	4.
	00500 PLANT OPERATION, MAINT. & REPAIRS	68, 248	390, 714			458, 962	
	00600 LAUNDRY & LINEN SERVICE	0	11, 013	11, 01		11, 013	
	00700 HOUSEKEEPI NG	251, 706	38, 606	290, 31		290, 312	
	00800 DI ETARY	300, 634	254, 845	555, 47		555, 479	
	00900 NURSI NG ADMI NI STRATI ON	399, 787	29, 598	429, 38		429, 385	
	1000 CENTRAL SERVICES & SUPPLY	0	139, 050	139, 05		139, 050	
	1100 PHARMACY	0	40, 123	40, 12		40, 123	
	1200 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	
	1300 SOCIAL SERVICE	44, 665	0	44, 66		44, 665	
	1400 NURSING AND ALLIED HEALTH EDUCATION	0	0	110 50	0 0	0	14
		98, 978	20, 619	119, 59	7 0	119, 597	15
	NPATIENT ROUTINE SERVICE COST CENTERS	4 505 000	000 504	0.015.40		0.0/5.404	1
	3000 SKILLED NURSING FACILITY	1, 525, 830	839, 591	2, 365, 42		2, 365, 421	30
	3100 NURSING FACILITY	0	0		0 0	0	31
	3200 I CF/I I D	0	0		0 0	0	32
	03300 OTHER LONG TERM CARE	0	0		0 0	0	33
	NCI LLARY SERVICE COST CENTERS	0	0		0 0	0	1 10
	04000 RADI OLOGY 04100 LABORATORY	0	5,655	5, 65			40
	04200 I NTRAVENOUS THERAPY	0	5, 855 759	5, 85		5, 655 759	
	4200 OXYGEN (INHALATION) THERAPY	0	/39		0 0	0	42
	14300 OATGEN (TINHALATTON) THERAPT	201, 899	56, 876	258, 77		258, 775	
	04500 OCCUPATIONAL THERAPY	153, 091	50, 870	153, 09		153, 091	44
	4600 SPEECH PATHOLOGY	15, 702	0	15, 70		15, 702	
	4700 ELECTROCARDI OLOGY	13, 702	0		0 0	0	47
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48
	04900 DRUGS CHARGED TO PATIENTS	0	113, 399	113, 39	9 0	113, 399	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50
	05100 SUPPORT SURFACES	0	0		0 0	0	51
	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	
	UTPATIENT SERVICE COST CENTERS		0	<u> </u>	<u> </u>		0-
	06000 CLINIC	0	0		0 0	0	1 60
	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
	06200 FQHC						62
. 00 0	6300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	63
0	THER REIMBURSABLE COST CENTERS	· · · · ·					
	7000 HOME HEALTH AGENCY COST	0	0		0 0	0	1 70
	7100 AMBULANCE	0	0		0 0	0	
1	07200 CORF	0	0		0 0	0	
	07300 CMHC	0	0		0 0	0	73
1	7400 OTHER REIMBURSABLE COST	0	0		0 0	0	
	PECIAL PURPOSE COST CENTERS						
00 0	8000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80
	08100 INTEREST EXPENSE		0		0 0	0	81
00 0	08200 UTI LI ZATI ON REVIEW	0	0		0 0	0	82
00 0	18300 HOSPI CE	0	0		0 0	0	83
00 0	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	84
. 00 🗋	SUBTOTALS (sum of lines 1-84)	3, 271, 811	5, 232, 943	8, 504, 75	4 0	8, 504, 754	89
	ONREIMBURSABLE COST CENTERS						4
	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90
	9100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
	9200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92
1	9300 NONPALD WORKERS	0	0		0 0	0	
	9400 PATIENTS LAUNDRY	0	0		0 0	0	
	9500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	
0.00	TOTAL	3, 271, 811	5, 232, 943	8, 504, 75	4 0	8, 504, 754	1100

	Financial Systems PEI SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	LICAN POINTE POS F EXPENSES		No.: 315508		u of Form CMS-254 Worksheet A	
					To 12/31/2022	Date/Time Prepa 5/30/2023 12:33	
	Cost Center Description	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)	1		575072023 12.55	<u>5 pm</u>
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	0(0.001	4 007 044	1			4.0
. 00 . 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	-269, 891	1, 227, 344	1			1.0 2.0
. 00	00300 EMPLOYEE BENEFITS	0	695, 853	•			2.0
. 00	00400 ADMI NI STRATI VE & GENERAL	-436, 210		•			4.0
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	458, 962	1			5.0
. 00	00600 LAUNDRY & LINEN SERVICE	0	11, 013	1			6.0
. 00	00700 HOUSEKEEPI NG	0	290, 312				7.0
. 00	00800 DI ETARY	0	555, 479				8.0
. 00	00900 NURSI NG ADMI NI STRATI ON	0	429, 385	1			9.0
	01000 CENTRAL SERVICES & SUPPLY	0	139, 050	1			10.0
		0	40, 123	1			11.0
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	44 446	1			12.0 13.0
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	44, 665				14.0
	01500 ACTI VI TI ES	0	119, 597				15.0
0.00	INPATIENT ROUTINE SERVICE COST CENTERS		,,	1			
D. 00	03000 SKILLED NURSING FACILITY	0	2, 365, 421			3	30. 0
1.00	03100 NURSING FACILITY	0	C			3	31.0
2.00	03200   CF/I   D	0	C			3	32.0
3.00	03300 OTHER LONG TERM CARE	0	0				33.0
	ANCI LLARY SERVICE COST CENTERS	-	-	1			
	04000 RADI OLOGY	0	0	•			40.0
	04100 LABORATORY	0	5, 655	1			41.0
	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0	759	1			42.0 43.0
	04400 PHYSI CAL THERAPY	0	258, 775	•			44.0
	04500 OCCUPATI ONAL THERAPY	0	153, 091	1			45.0
	04600 SPEECH PATHOLOGY	0	15, 702	1			46.0
7.00	04700 ELECTROCARDI OLOGY	0	C			4	47. C
B. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C			4	48.0
	04900 DRUGS CHARGED TO PATIENTS	0	113, 399	1			49. C
	05000 DENTAL CARE - TITLE XIX ONLY	0	C	•			50. C
	05100 SUPPORT SURFACES	0	0	1			51. C
2.00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0	)		5	52. C
D. 00	06000 CLINIC	0	C			F	60. C
	06100 RURAL HEALTH CLINIC	0	0	•			61. C
	06200 FQHC						62.0
3.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C			6	63.0
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0		1			70.0
	07100 AMBULANCE	0	C	1			71.0
	07200 CORF	0	0	1			72.0
	07300 CMHC 07400 OTHER REIMBURSABLE COST	0					73.0 74.0
+. 00	SPECIAL PURPOSE COST CENTERS	0	L L	′I		/	74. U
0, 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C			F	80. 0
	08100 I NTEREST EXPENSE	0	(				81.0
	08200 UTI LI ZATI ON REVI EW	0	C				82.0
3.00	08300 HOSPI CE	0	C				83.0
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	C				84.0
9.00	SUBTOTALS (sum of lines 1-84)	-706, 101	7, 798, 653			8	89. 0
	NONREI MBURSABLE COST CENTERS	-					~ ~
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.0
	09100 BARBER AND BEAUTY SHOP	0					91.0
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0					92.0 93.0
	09400 PATIENTS LAUNDRY						93. 0 94. 0
	09500 OTHER NONREIMBURSABLE COST CENTERS	0	( (				95. O
	I STATE AND A STAT		7, 798, 653	1		10	

Heal th	Financial Systems PEL	ICAN POINTE POS	ST-ACUTE NURSIN	IG	In Lie	u of Form CMS-2	2540-10
	ILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315508	Peri od:	Worksheet A-7	
					From 04/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 12:	
				Acqui si ti on	s		
	Description	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	0	18, 246		0 18, 246	0	6.00
7.00	Subtotal (sum of lines 1–6)	0	18, 246		0 18, 246	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	0	18, 246		0 18, 246	0	9.00
	Description	Endi ng Bal ance					
			Depreci ated				
		( 00	Assets				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	6.00	7.00				
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
2.00	Buildings and Fixtures	0	0				3.00
3.00 4.00	Building Improvements	0	0				4.00
4.00 5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	18, 246	0				6.00
7.00	Subtotal (sum of lines 1-6)	18, 240					7.00
8.00	Reconciling Items	10, 240	0				8.00
9,00	Total (line 7 minus line 8)	18, 246	0				9,00
2.00		10,240	0	I			1 7.00

MCRI F32 - 10. 12. 175. 6

Heal th	Fi nan	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

In Lieu of Form CMS-2540-10

	MENTS TO EXPENSES	TOAN TOTALE TO			Period: From 04/01/2022	Date/Time Pre	pared:
					assification on h the Amount is		33 pm
						-	
	Description (1)	(2) Basis For Adjustment	Amount	Cost	Center	Line No.	
		1.00	2.00	3	3. 00	4.00	
1.00	Investment income on restricted funds	В	-965	ADMI NI STRATI V	/E & GENERAL	4.00	1.00
2.00	(chapter 2) 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	
8.00	Remuneration applicable to provider-based	A-8-2	0				8.00
9.00	physician adjustment Home office cost (chapter 21)		o			0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
11.00	Nonallowable costs related to certain		0			0.00	
	Capital expenditures (chapter 24)						
12.00	Adjustment resulting from transactions with	A-8-1	-245, 131				12.00
13.00	related organizations (chapter 10) Laundry and linen service		o			0.00	13.00
14.00	Revenue - Employee meals		0			0.00	
15.00	Cost of meals - Guests		0	)		0.00	
16.00	Sale of medical supplies to other than		0			0.00	16.00
47 00	patients						17.00
17.00	Sale of drugs to other than patients		0			0.00	
18.00 19.00	Sale of medical records and abstracts Vending machines					0.00	
20.00	Income from imposition of interest, finance		0			0.00	
201.00	or penalty charges (chapter 21)						20100
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21.00
22.00	overpayments Utilization reviewphysicians' compensation (chapter 21)		0	UTILIZATION F	REVIEW	82.00	22.00
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS	S - BLDGS &	1.00	23.00
24.00	Depreciationmovable equipment		0	CAP REL COSTS	S - MOVABLE	2.00	24.00
25.00	MANAGEMENT FEE	A	-428, 509	ADMI NI STRATI V	/E & GENERAL	4.00	25.00
25.01	ADVERTI SI NG	A		ADMI NI STRATI V		4.00	
25.02	ADVERTI SI NG PROMOTI ONAL	A		ADMI NI STRATI V		4.00	
25.03	PENALTI ES	A		ADMI NI STRATI V		4.00	
25. 04 25. 05	NJ CORP TAX HMO WX	A		ADMI NI STRATI V ADMI NI STRATI V		4.00	
	OTHER REV. MISC.	B		ADMINI STRATI V		4.00	
	Total (sum of lines 1 through 99) (Transfer		-706, 101		TE & ULNERAL	4.00	100.00
(1) De	to Worksheet A, col. 6, line 100) scription – all chapter references in this co	  umn pertain to	 ) CMS Pub. 15-1	  .		I	I

(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.

Health Financial Systems PEL	ICAN POINTE POS	T-ACUTE NURSIN	IG	In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME		No.: 315508	Period: From 04/01/2022 To 12/31/2022	Worksheet A- Parts I-II Date/Time Pr 5/30/2023 12	epared:
	Line No.	Cost (	Center	Expense	e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	OR	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	RENT		1.00
2.00	1.00	CAP REL COSTS	- BLDGS &	REAL ESTATE TAX	KES	2.00
3.00		ADMI NI STRATI VE	& GENERAL	REALTY ADMIN		3.00
4.00	0.00					4.00
5.00	0.00					5.00
6.00	0.00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line 12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	s		
	Cost	Wkst. A, col. 5	col. 5)			
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	6 OR	
1.00	1, 147, 192	1, 500, 000				1.00
2.00	66, 060	-16, 857				2.00
3.00	24, 760	0	24, 76	50		3.00
4.00	0	0		0		4.00
5.00	0	0		0		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	1, 238, 012	1, 483, 143	-245, 13	31		10.00
12.						I

Health Financial Systems PEL	ICAN POINTE POST	-ACUTE NURSING	In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provi der No. : 315508	From 04/01/2022	Worksheet A-8 Parts I-II Date/Time Pre 5/30/2023 12:	pared:
	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	LIBBI MENDELOVITZ	100.00	1.00
2.00		D	JONATHAN ROSENBERG	0.00	2.00
3.00		D	MOSHE ROSENBERG	0.00	3.00
4.00		D	ZVI ROSENBERG	0.00	4.00
5.00		D	AVRAHAM ROSENBERG	0.00	5.00
6.00		D	RACHEL SAHAR	0.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial)			0.00	100.00
	specify:				

(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 Organi	zation(s) and/	or Home Office					
	Name	Percentage of	Type of Business	1				
		Ownership	51					
	4.00	5.00	6.00	1				
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	FACI LI TY	0.00	1.00
2.00	3809 BAYSHORE RD LLC	20. 00 REALTY	2.00
3.00	3809 BAYSHORE RD LLC	20. 00 REALTY	3.00
4.00	3809 BAYSHORE RD LLC	20. 00 REALTY	4.00
5.00	3809 BAYSHORE RD LLC	20. 00 REALTY	5.00
6.00	3809 BAYSHORE RD LLC	20. 00 REALTY	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 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.

Heal th	Financial Systems PEI	LICAN POINTE POST	-ACUTE NURSIN	IG		In Lie	u of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315508		i od: m 04/01/2022 12/31/2022	Worksheet B Part I Date/Time Pre 5/30/2023 12:	pared:
			CAPI TAL REL	ATED COSTS			573072023 12.	
			0,0,1,1,1,2,1,22	51125 00010				
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FI XTURES	MOVABLE EQUI PMENT		EMPLOYEE BENEFI TS	Subtotal	
		<u>col. 7)</u>	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00		3.00	JA	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1, 227, 344	1, 227, 344					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	1, 227, 344	1,227,044		0			2.00
3.00	00300 EMPLOYEE BENEFITS	695, 853	38, 471		0	734, 324		3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	874,068	28, 011		Ö	47, 418	949, 497	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	458, 962	41, 797		Ö	15, 318	516, 077	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	11, 013	48, 012		Ö	0	59, 025	
7.00	00700 HOUSEKEEPI NG	290, 312	7, 528		0	56, 493	354, 333	•
8.00	00800 DI ETARY	555, 479	70, 552		0	67, 474	693, 505	•
9.00	00900 NURSI NG ADMI NI STRATI ON	429, 385	21, 883		0	89, 728	540, 996	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	139,050	0		0	0	139, 050	10.00
11.00	01100 PHARMACY	40, 123	0		0	0	40, 123	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	0	12.00
13.00	01300 SOCIAL SERVICE	44, 665	12, 999		0	10, 025	67, 689	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	14.00
15.00	01500 ACTI VI TI ES	119, 597	30, 768		0	22, 215	172, 580	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 SKI LLED NURSI NG FACI LI TY	2, 365, 421	848, 018		0	342, 455	3, 555, 894	•
31.00	03100 NURSING FACILITY	0	0		0	0	0	31.00
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0		0	0	0	
33.00	ANCI LLARY SERVICE COST CENTERS	0	0		U	0	0	33.00
40.00	04000 RADI OLOGY	0	0		0	0	0	40.00
40.00	04100 LABORATORY	5, 655	0		0	0	5, 655	
42.00	04200 I NTRAVENOUS THERAPY	759	0		0	0	759	
43.00	04300 OXYGEN (INHALATION) THERAPY	, 3,	0		0	0	0	
44.00	04400 PHYSI CAL THERAPY	258, 775	8, 228		0	45, 314	312, 317	
45.00	04500 OCCUPATI ONAL THERAPY	153, 091	8, 228		0	34, 360	195, 679	
46.00	04600 SPEECH PATHOLOGY	15, 702	8, 228		0	3, 524	27, 454	1
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48, 362		0	0	48, 362	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	113, 399	6, 259		0	0	119, 658	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
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS							1 / 0 . 00
60.00	06000 CLINIC	0	0		0	0	0	
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0	0	0	61.00 62.00
62.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	0	•
03.00	OTHER REIMBURSABLE COST CENTERS	<u>Ч</u>	9		0	<u>Ч</u>	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
71.00	07100 AMBULANCE	0	o		0	ō	0	•
72.00	07200 CORF	0	0		0	0	0	•
73.00	07300 CMHC	0	0		0	0	0	•
74.00	07400 OTHER REIMBURSABLE COST	0	0		0	0	0	74.00
	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							82.00
83.00	08300 HOSPI CE	0	0		0	0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	7, 798, 653	1, 227, 344		0	734, 324	7, 798, 653	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	o	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	90.00
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES		0		0	0	0	91.00
92.00 93.00	09300 NONPALD WORKERS	0	0		0	0	0	92.00
94.00	09400 PATIENTS LAUNDRY	0	0		ŏ	0	0	
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0		õ	0	0	
98.00	Cross Foot Adjustments	0	0		Ō	0	0	•
99.00	Negative Cost Centers	Ő	o		0	o	0	
100.00		7, 798, 653	1, 227, 344		0	734, 324	7, 798, 653	
								-

Heal th	Financial Systems PEI	ICAN POINTE POS	T-ACUTE NURSI	NG	In Lie	u of Form CMS-:	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 04/01/2022 o 12/31/2022	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	5/30/2023 12: DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1		I	,ı		
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION	949, 497 71, 544 8, 183 49, 121 96, 141 74, 998	587, 621 25, 211 3, 953 37, 047 11, 491	92, 419 0 0		853, 719 0	1
10.00 11.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	19, 277 5, 562	0 0		0	0	10.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0 9, 384	0 6, 826		0 4, 979	0 0	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0 23, 925	0 16, 156	0	-	0	
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	492, 951 0	445, 293 0	0	0	853, 719 0	31.00
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	-		0	
40.00	04000 RADI OLOGY	0	C	0	0	0	40.00
41.00	04100 LABORATORY	784	0		0	0	
42.00	04200 I NTRAVENOUS THERAPY	105	0	0	0	0	
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 43, 297	4 221		2 152	0	
44.00	04400 PHISICAL THERAPT	43, 297 27, 127	4, 321 4, 321		3, 152 3, 152	0	1
46.00	04600 SPEECH PATHOLOGY	3,806	4, 321			0	
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 704	25, 395	0	18, 526	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	16, 588	3, 286	0	2, 397	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	-	0	0	
51.00	05100 SUPPORT SURFACES	0	0		-	0	
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	-	-	0	
62.00	06200 FQHC	0	0		0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C	0 0	0	0	
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	/ <sup>0</sup>	0	0	1
	07100 AMBULANCE	0	0	0	0	0	
	07200 CORF 07300 CMHC	0	0		0	0	
	07400 OTHER REIMBURSABLE COST	0	0	-		0	1
/ 11 00	SPECIAL PURPOSE COST CENTERS			1			1
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW	_	-	-	_	-	82.00
83.00 84.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	
84.00 89.00	SUBTOTALS (sum of lines 1-84)	949, 497	587, 621	92, 419	407, 407	853, 719	1
07.00	NONREI MBURSABLE COST CENTERS	1 77, 77	307, 021	1 72, 417	407,407	000,717	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	C	0	0	0	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	0 0	0	0	
	09300 NONPALD WORKERS	0	0	0	0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
95.00 98.00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0		0	0	
99.00 99.00	Negative Cost Centers	0	0	0	0	0	
100.00		949, 497	587, 621	92, 419	407, 407	853, 719	1
		•					

	Financial Systems PEL LLOCATION - GENERAL SERVICE COSTS	LICAN POINTE POS			In Lie eriod:	u of Form CMS-2 Worksheet B	2540-10
00017					rom 04/01/2022	Part I	pared: 33 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
4 00	GENERAL SERVICE COST CENTERS	1					1 4 00
1.00 2.00 3.00 4.00 5.00 6.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						1.00 2.00 3.00 4.00 5.00 6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY	(					8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	635, 868	150 227				9.00
11.00	01100 PHARMACY	0	158, 327 0	45, 685			10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0		12.00
13.00	01300 SOCIAL SERVICE	0	0	0	0	88, 878	•
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	0	0	0	0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	(25.0/0	150.007	45 (05	0	00.070	1 20 00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	635, 868 0	158, 327 0	45, 685 0	0	88, 878 0	30.00 31.00
31.00	03200 I CF/I I D	0	0	0	0	0	31.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS	1 -1			-		
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	0	0	0	43.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50.00 51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	51.00
02.00	OUTPATIENT SERVICE COST CENTERS					ŭ	02.00
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC				_	_	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	0	0	0	0	71.00
72.00	07200 CORF	0	0	0	0	0	•
	07300 CMHC	0	0	0	0	0	•
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
00 00	SPECIAL PURPOSE COST CENTERS						00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	о	0	0	0	•
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	635, 868	158, 327	45, 685	0	88, 878	89.00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	90.00 91.00
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES		0	0	0	0	
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	1
94.00	09400 PATIENTS LAUNDRY	0	Ō	0	0	0	
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	
98.00	Cross Foot Adjustments	0	0				98.00
99.00 100.00	Negative Cost Centers TOTAL	L 25 040	150 227		0	0 00 070	99.00 100.00
100.00		635, 868	158, 327	45, 685	U	00,0/8	1100.00

	ILLOCATION - GENERAL SERVICE COSTS	LICAN PUTNTE PUS	Provi der	No.: 315508 P F	veriod: rom 04/01/2022 o 12/31/2022	Worksheet B Part I Date/Time Pre 5/30/2023 12:	pared:
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
4	GENERAL SERVICE COST CENTERS	1		1			4
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 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTI VI TI ES	0	224, 447				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 SKILLED NURSING FACILITY	0	224, 447	6, 918, 335		6, 918, 335	1
31.00	03100 NURSING FACILITY	0	0	C	-	0	
32.00	03200 I CF/I I D	0	0			0	
33.00	03300 OTHER LONG TERM CARE	0	0	C	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS	-	-	-	-	-	
40.00	04000 RADI OLOGY	0	0		-	0	
41.00	04100 LABORATORY	0	0	6, 439		6, 439	
42.00	04200 I NTRAVENOUS THERAPY	0	0	864		864	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	-	0	
44.00	04400 PHYSI CAL THERAPY	0	0	363, 087		363, 087	
45.00	04500 OCCUPATIONAL THERAPY	0	0	230, 279		230, 279	
46.00	04600 SPEECH PATHOLOGY	0	0	38, 733		38, 733	
47.00	04700 ELECTROCARDI OLOGY	0	0		-	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	98, 987		98, 987	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	141, 929	0	141, 929	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	1
51.00 52.00	05100 SUPPORT SURFACES	0	0			0	1
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	52.00
60.00	06000 CLINIC	0	0	С	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0			0	
62.00	06200 FQHC	0	0		0	0	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	c	0	0	
00.00	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	05.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70.00
	07100 AMBULANCE	0	0		0	0	1
72.00	07200 CORF	0	0		0	0	
73.00	07300 CMHC	0	0		-	0	
74.00	07400 OTHER REIMBURSABLE COST	0	0			0	1
	SPECIAL PURPOSE COST CENTERS			-	-		
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	0	c c	0	0	1
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	c c	0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	224, 447	7, 798, 653		7, 798, 653	1
	NONREI MBURSABLE COST CENTERS						1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	c	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0	C	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	C	0	0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	95.00
98.00	Cross Foot Adjustments	0	0	C	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	
100.00	TOTAL	0	224, 447	7, 798, 653	0	7, 798, 653	100.00

Heal th	Fi na	nci	al	Syste	ems		
		OF	C۸		DEL	ATED	C

Heal th	Financial Systems PE	LICAN POINTE POS	T-ACUTE NURSIN	IG	In Lie	u of Form CMS-	2540-10
ALLOCA	ITION OF CAPITAL RELATED COSTS		Provi der	No.: 315508	Period: From 04/01/2022 To 12/31/2022	Date/Time Pre	pared:
			CAPITAL REI	ATED COSTS		5/30/2023 12:	
			0/11/1/12 1/21	2.1120 00010			
	Cost Center Description	Directly Assigned New Capital	BLDGS & FI XTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		Related Costs	1.00	0.00		0.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	3.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS	0	38, 471		0 38, 471	38, 471	3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	28, 011		0 28, 011		
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	41, 797		0 41, 797		
6.00	00600 LAUNDRY & LINEN SERVICE	0	48, 012		0 48,012		1
7.00	00700 HOUSEKEEPI NG	0	7, 528		0 7, 528	2, 960	7.00
8.00	00800 DI ETARY	0	70, 552		0 70, 552	3, 535	8.00
9.00	00900 NURSING ADMINISTRATION	0	21, 883		0 21, 883	4, 701	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	10.00
11.00	01100 PHARMACY	0	0		0 0	0	
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
	01300 SOCIAL SERVICE	0	12, 999		0 12, 999		
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	30, 768		0 30, 768	1, 164	15.00
30.00	03000 SKILLED NURSING FACILITY	0	848, 018	I	0 848, 018	17, 941	30.00
30.00	03100 NURSING FACILITY	0	040, 010		0 040,010	0	1
31.00	03200 I CF/I I D	0	0		0 0	-	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0		
00.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		<u> </u>	<u>_</u>	00.00
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	1
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 PHYSI CAL THERAPY	0	8, 228		0 8, 228	2, 374	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	8, 228		0 8, 228		
46.00	04600 SPEECH PATHOLOGY	0	8, 228		0 8, 228		
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	-	
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	48, 362		0 48, 362		
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	6, 259 0		0 6, 259 0 0	0	
50.00	05100 SUPPORT SURFACES	0	0		0 0		
51.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0		
02.00	OUTPATIENT SERVICE COST CENTERS	1 0			<u> </u>		02.00
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 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	Т Т		1		I	-
		0	0		0 0	0	
71.00	07100 AMBULANCE	0	0		0 0	0	
72.00	07200 CORF	0	0		0 0	0	
73.00 74.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0		0 0	0	
74.00	SPECIAL PURPOSE COST CENTERS	U U	0		0 0	0	74.00
80.00							80.00
81.00	08100 I NTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1, 227, 344		0 1, 227, 344	38, 471	89.00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0		
	09100 BARBER AND BEAUTY SHOP	0	0		0	0	
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	
93.00	09300 NONPALD WORKERS	0	0		0 0	0	1
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS		0				
95.00 98.00	Cross Foot Adjustments	0	0		0	0	95.00
98.00 99.00	Negative Cost Centers		Ω		0 0	0	
100.00		0	1, 227, 344		0 1, 227, 344		100.00
	1 1	, oj	., _2., 011	I	.,, 011		

LOCA	TION OF CAPITAL RELATED COSTS			FI		Worksheet B Part II Date/Time Pre 5/30/2023 12:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES				I		1.0
)0 )0 )0 )0 )0	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFI TS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS 00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	30, 495 2, 298 263 1, 577	44, 897 1, 926 302	50, 201	12, 367		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
00	00800 DI ETARY	3, 087	2, 831	0	820	80, 825	8.0
00	00900 NURSI NG ADMI NI STRATI ON	2, 409	878	0	254	0	9.0
	01000 CENTRAL SERVICES & SUPPLY	619	0	0	0	0	10.0
	01100 PHARMACY	179	0	-	0	0	
	01200 MEDI CAL RECORDS & LI BRARY	0	0	-	0	0	
	01300 SOCIAL SERVICE	301	522		151	0	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	-	0	0	
	01500 ACTIVITIES	768	1, 234	0	358	0	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	15, 835	34, 023	50, 201	9, 861	80, 825	30.0
	03100 NURSING FACILITY	15, 835	34, 023		9, 801	0, 823	
	03200   CF/I   D	0	0		0	0	
	03300 OTHER LONG TERM CARE	0	0	-	0	0	
00	ANCI LLARY SERVICE COST CENTERS						
00	04000 RADI OLOGY	0	0	0	0	0	40.0
00	04100 LABORATORY	25	0	0	0	0	41.0
00	04200 I NTRAVENOUS THERAPY	3	0	0	0	0	42.0
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.0
	04400 PHYSI CAL THERAPY	1, 390	330		96	0	
	04500 OCCUPATI ONAL THERAPY	871	330		96	0	
	04600 SPEECH PATHOLOGY	122	330		96	0	
	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 215	0 1, 940	-	0 562	0	
	04900 DRUGS CHARGED TO PATIENTS	533	251	0	73	0	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	-	, 9	0	
	05100 SUPPORT SURFACES	0	0	-	0	0	
00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.0
	OUTPATIENT SERVICE COST CENTERS						
	06000 CLI NI C	0	0	0	0	0	60.0
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	
	06200 FQHC						62.0
	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.0
	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.0
	07100 AMBULANCE		0	0	0	0	
	07200 CORF	0	0	0	0	0	
	07300 CMHC	0	0	0	0	0	
	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS						1
00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 0
00	08100 INTEREST EXPENSE						81. C
	08200 UTILIZATION REVIEW						82. C
	08300 HOSPI CE	0	0	0	0	0	
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	
00	SUBTOTALS (sum of lines 1-84)	30, 495	44, 897	50, 201	12, 367	80, 825	89.0
00	NONREIMBURSABLE COST CENTERS						00 0
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	1
	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
	09300 NONPAID WORKERS		0	0	0	0	
	09400 PATIENTS LAUNDRY		0	0	0	0	
	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	
00	Cross Foot Adjustments		0	0	0	0	
	5			-	0		
00	Negative Cost Centers	01	0	0	01	0 80, 825	

LLUCATI	ON OF CAPITAL RELATED COSTS		Provi der	F	Period: From 04/01/2022		
				1	To 12/31/2022	Date/Time Prep 5/30/2023 12:3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
00 0 00 0 00 0 00 0	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS - BLDGS & FIXTURES 0200 CAP REL COSTS - MOVABLE EQUIPMENT 0300 EMPLOYEE BENEFITS 0400 ADMINISTRATIVE & GENERAL 0500 PLANT OPERATION, MAINT. & REPAIRS 0600 LAUNDRY & LINEN SERVICE						1.0 2.0 3.0 4.0 5.0
00 0	0700 HOUSEKEEPI NG 0800 DI ETARY 0900 NURSI NG ADMI NI STRATI ON	30, 125					7.0 8.0 9.0
. 00 0	1000 CENTRAL SERVICES & SUPPLY 1100 PHARMACY 1200 MEDICAL RECORDS & LIBRARY	0	619 0 0	179			10. C 11. C 12. C
0     0       0     0       0     0       0     0	1300 SOCIAL SERVICE 1400 NURSING AND ALLIED HEALTH EDUCATION 1500 ACTIVITIES	0 0 0	0 0 0	(	0 0	14, 498 0 0	14.C
	NPATIENT ROUTINE SERVICE COST CENTERS 3000 SKILLED NURSING FACILITY	30, 125	619	179	2 0	14, 498	30. C
. 00 0 2. 00 0	3100 NURSING FACILITY 3200 ICF/IID 3300 OTHER LONG TERM CARE	0	0 0 0 0	(	0 0 0 0	0	31. C 32. C
A	NCILLARY SERVICE COST CENTERS		-		-		
. 00 0	4000 RADI OLOGY 4100 LABORATORY 4200 I NTRAVENOUS THERAPY	0	0 0 0	(	-	0 0 0	41. C
. 00 0 . 00 0	4300 OXYGEN (I NHALATI ON) THERAPY 4400 PHYSI CAL THERAPY 4500 OCCUPATI ONAL THERAPY	0	0 0	(		0 0 0	43. C
. 00 0 . 00 0	4600 SPEECH PATHOLOGY 4700 ELECTROCARDI OLOGY	0	0	(		0	46. C 47. C
9.00 0 0.00 0	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS 4900 DRUGS CHARGED TO PATIENTS 5000 DENTAL CARE - TITLE XIX ONLY	0	0 0 0	(		0 0 0	48. C 49. C 50. C
2.00 0 01	5100 SUPPORT SURFACES 5200 OTHER ANCI LLARY SERVI CE COST CENTERS UTPATI ENT SERVI CE COST CENTERS	00	0 0	(	-	0 0	
. 00 0	6000 CLINIC 6100 RURAL HEALTH CLINIC 6200 FQHC	0	0 0	(	0 0 0 0	0 0	
0	6300 OTHER OUTPATIENT SERVICE COST CENTER THER REIMBURSABLE COST CENTERS 7000 HOME HEALTH AGENCY COST		0	(		0	
. 00 0 . 00 0	7100 AMBULANCE 7200 CORF 7300 CMHC	0	0 0 0	(	0 0 0 0	0 0 0	71. C 72. C
. 00 0 SI	7400 OTHER REIMBURSABLE COST PECIAL PURPOSE COST CENTERS		0	(			74.C
. 00 0 . 00 0	8000 MALPRACTI CE PREMI UMS & PAI D LOSSES 8100 I NTEREST EXPENSE 8200 UTI LI ZATI ON REVI EW						80. C 81. C 82. C
. 00 0	8300 HOSPICE 8400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0 0 30, 125	0 0 619	( ( 179	0 0	0 0 14, 498	84. C
. 00 0 . 00 0	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 9100 BARBER AND BEAUTY SHOP 9200 PHYSICIANS PRIVATE OFFICES	0000	0	(		0 0	91. C
. 00 0 . 00 0	9300 NONPAI D WORKERS 9400 PATIENTS LAUNDRY	0	0	(		0 0 0	93. C 94. C
. 00  0 . 00   . 00	9500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0	0	(		0	98. C

Heal th	Fi na	nci al	Syste	ems	
		OF C			D COSTS

In Lieu of Form CMS-2540-10 Worksheet B

ALLOC	ATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
					From 04/01/2022 To 12/31/2022		narod
					10 12/31/2022	5/30/2023 12:	
	·		OTHER GENERAL				
			SERVI CE	_			
	Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION 14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	10.00	
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 ADMINI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY						7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00		0	34, 292	2			15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	0	24.202	1 1 2 4 1	7 0	1 124 117	30.00
30.00	03100 NURSING FACILITY	0	34, 292		0 0		30.00
32.00		0			0 0	-	32.00
33.00		0			0 0	-	33.00
	ANCI LLARY SERVI CE COST CENTERS			1			
40.00	04000 RADI OLOGY	0	C	)	0 0	0	40.00
41.00	04100 LABORATORY	0	C	2			
42.00	04200 I NTRAVENOUS THERAPY	0	C	2	3 0	3	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	10 41	0 0	0	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0		12, 41		12, 418 11, 325	
45.00	04600 SPEECH PATHOLOGY	0		) 11, 32 ) 8, 96		8, 961	
47.00	04700 ELECTROCARDI OLOGY	0			0 0	0, 701	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	51, 07	9 0	51, 079	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C	7, 11	6 0	7, 116	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	D	0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	C		0 0		51.00
52.00		0	C	)	0 0	0	52.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	C		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0			0 0		61.00
62.00	06200 FQHC	0			о 0	Ŭ	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0 0	0	
	OTHER REIMBURSABLE COST CENTERS						
70.00		0	C	D	0 0	-	
	07100 AMBULANCE	0	C	D	0 0		71.00
	07200 CORF	0	C	2	0 0	0	72.00
	07300 CMHC	0			0 0 0 0		73.00 74.00
74.00	07400 0THER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	U	<u>и</u>	0 0	0	74.00
80.00							80.00
81.00							81.00
82.00	08200 UTI LI ZATI ON REVI EW						82.00
83.00	08300 HOSPI CE	0	C		0 0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	C	D .	0 0		84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	34, 292	2 1, 227, 34	4 0	1, 227, 344	89.00
90.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	0	90.00
90.00 91.00					0 0	-	90.00
91.00	09200 PHYSICIANS PRIVATE OFFICES			ő		0	91.00
93.00	09300 NONPAI D WORKERS	0			0 0	0	93.00
94.00		0	C		0 0	0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	C		0 0	0	95.00
98.00	5	0	C		0 0	0	98.00
99.00		0		1 227 24	0 0		99.00
100.00	D   TOTAL	0	34, 292	2 1, 227, 34	4 0	1, 227, 344	100.00

	2	ICAN POINTE POS				u of Form CMS-	
OST AL	LLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 04/01/2022 o 12/31/2022		pared
			LATED COSTS			5/30/2023 12:	33 pm
		CAPITAL REL	LATED CUSTS				
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
		<b>FI XTURES</b>	EQUI PMENT	<b>BENEFITS</b>		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM. COST)	
		. ,	,	SALARI ES)		· · ·	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS			1			I
	00100 CAP REL COSTS - BLDGS & FIXTURES	28, 043					1.0
	00200 CAP REL COSTS - MOVABLE EQUI PMENT	070	28, 043				2.0
	00300 EMPLOYEE BENEFITS	879		1			3.0
	00400 ADMINISTRATIVE & GENERAL	640		1			
	00500 PLANT OPERATION, MAINT. & REPAIRS	955		1		516, 077	
	00600 LAUNDRY & LINEN SERVICE	1,097	1, 097		-	59, 025	
	00700 HOUSEKEEPI NG	172	172			354, 333	
	00800 DI ETARY	1, 612	1, 612			693, 505	
	00900 NURSING ADMINISTRATION	500	500	399, 787	0	540, 996	
	01000 CENTRAL SERVICES & SUPPLY	0	(	0 0	0	139, 050	
	01100 PHARMACY	0	(	0 0	0	40, 123	
	01200 MEDICAL RECORDS & LIBRARY	0	(	0 0	0	0	
	01300 SOCIAL SERVICE	297	297	44, 665		67, 689	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	(	0 0	0		
		703	703	98, 978	0	172, 580	15.
	INPATIENT ROUTINE SERVICE COST CENTERS	10.07/	10.07	1 505 000	0	2 555 004	1 20
	03000 SKILLED NURSING FACILITY	19, 376	19, 376	1, 525, 830			
	03100 NURSING FACILITY	0			0	0	
	03200 I CF/I I D	0	(	-	-	0	
	03300 OTHER LONG TERM CARE	0	(	) C	0	0	33.
	ANCI LLARY SERVICE COST CENTERS						1 10
	04000 RADI OLOGY	0	(	-		-	
	04100 LABORATORY	0	(	-			
	04200 I NTRAVENOUS THERAPY	0	(	0 0	0	759	
	04300 OXYGEN (INHALATION) THERAPY	0	(	0 0	0	0	
	04400 PHYSI CAL THERAPY	188				312, 317	
	04500 OCCUPATI ONAL THERAPY	188		1		195, 679	
	04600 SPEECH PATHOLOGY	188				27, 454	
	04700 ELECTROCARDI OLOGY	0	(	-	0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 105			0	48, 362	
	04900 DRUGS CHARGED TO PATIENTS	143	143		0	119, 658	
	05000 DENTAL CARE - TITLE XIX ONLY	0	(	-	0 0	0	
	05100 SUPPORT SURFACES	0	(	°	-	0	
	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	(	) C	0	0	52.
	OUTPATIENT SERVICE COST CENTERS	-					1
	06000 CLINIC	0	(				
	06100 RURAL HEALTH CLINIC	0	(	C	0 0	0	
							62.
	06300 OTHER OUTPATIENT SERVICE COST CENTER	0		) C	0	0	63.
	OTHER REIMBURSABLE COST CENTERS				0	0	1 70
	07000 HOME HEALTH AGENCY COST	0	(	-		0	
	07100 AMBULANCE	0			0	0	1
	07200 CORF	0			0	0	
		0			-	0	
	07400 OTHER REIMBURSABLE COST	0		) C	0	0	74.
	SPECIAL PURPOSE COST CENTERS			1			1 00
-	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.
	08100 INTEREST EXPENSE						81.
-	08200 UTILIZATION REVIEW	-			-	_	82.
		0			0	0	
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0			0	0	84.
. 00	SUBTOTALS (sum of lines 1-84)	28, 043	28, 043	3, 271, 811	-949, 497	6, 849, 156	89.
	NONREI MBURSABLE COST CENTERS			,			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0					
	09100 BARBER AND BEAUTY SHOP	0			0		
	09200 PHYSI CLANS PRI VATE OFFI CES	0			0	0	
	09300 NONPALD WORKERS	0	(	) C	0	0	
	09400 PATIENTS LAUNDRY	0	(	C C	0	0	1
	09500 OTHER NONREI MBURSABLE COST CENTERS	0	(	) C	0	0	
. 00	Cross Foot Adjustments						98.
. 00	Negative Cost Centers						99.
2.00	Cost to be allocated (per Wkst. B,	1, 227, 344	(	734, 324		949, 497	102.
	Part I)						
03.00	Unit cost multiplier (Wkst. B, Part I)	43. 766501	0. 000000			0. 138630	
04.00	Cost to be allocated (per Wkst. B,			38, 471		30, 495	104.
	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part			0.011758		0.004452	105.

DST AL	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 04/01/2022	Worksheet B-1	
					o 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (TOTAL PATI ENT DAYS)			NURSI NG ADMI NI STRATI ON (TOTAL PATI ENT DAYS)	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
	00100 CAP REL COSTS - BLDGS & FIXTURES						1.
00 00 00 00 00 00 00 00 00 00 00 00 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	25, 569 1, 097 172 1, 612 500 0 0 0 297 0 703	24, 816 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24, 300 1, 612 500 0 0 297 0 703	74, 448 0 0 0 0 0 0 0 0	24, 816 0 0 0 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15.
	03000 SKI LLED NURSI NG FACI LI TY	19, 376	24, 816	19, 376	74, 448	24, 816	30.
	03100 NURSING FACILITY	C	0	0	0	0	31.
	03200 I CF/I I D 03300 OTHER LONG TERM CARE		-	0	0	0	32. 33.
	ANCI LLARY SERVICE COST CENTERS	-					
	04000 RADI OLOGY	C	-	0	-	0	40.
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	C	0	0	0	0	41
	04200 OXYGEN (INHALATION) THERAPY				0	0	42
	04400 PHYSI CAL THERAPY	188		188	0	0	44
. 00	04500 OCCUPATI ONAL THERAPY	188	0	188	0	0	45
	04600 SPEECH PATHOLOGY	188		188	0	0	46
	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C 1, 105	-	0 1, 105	0	0	47 48
	04900 DRUGS CHARGED TO PATIENTS	143		143	0	0	40
	05000 DENTAL CARE - TITLE XIX ONLY	C		0	0	0	50
	05100 SUPPORT SURFACES	C	-	0	0	0	51
	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	C	0	0	0	0	52
	06000 CLINIC	C	0	0		0	60
	06100 RURAL HEALTH CLINIC	C	-	0	0	0	61
	06200 FQHC						62
	06300 OTHER OUTPATIENT SERVICE COST CENTER	C	0	0	0	0	63
	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0	0	0	0	70
	07100 AMBULANCE		0	0	0	0	71
. 00	07200 CORF	C	0	0	0	0	72
		C	0	0	0	0	73
	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS		0	0	0	0	74
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80
	08100 INTEREST EXPENSE						81
	08200 UTI LI ZATI ON REVI EW	-	_	_	_		82
	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS				0	0	83 84
. 00	SUBTOTALS (sum of lines 1-84)	25, 569	24, 816	24, 300	74, 448	24, 816	
	NONREI MBURSABLE COST CENTERS	L.	1	1	1		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C		0	0	0	90
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES				0	0	91 92
	09300 NONPALD WORKERS	C	0	0	0	0	93
	09400 PATIENTS LAUNDRY	C	0	0	0	0	94
	09500 OTHER NONREIMBURSABLE COST CENTERS	C	0	0	0	0	95
. 00 . 00	Cross Foot Adjustments Negative Cost Centers						98 99
2.00	Cost to be allocated (per Wkst. B,	587, 621	92, 419	407, 407	853, 719	635, 868	
	Part I)					000,000	22
03.00	Unit cost multiplier (Wkst. B, Part I)	22. 981775					
04.00	Cost to be allocated (per Wkst. B, Part II)	44, 897	50, 201	12, 367	80, 825	30, 125	104
05.00		1. 755915	2. 022929	0. 508930	1. 085657	1. 213935	105
·ວ. ບ.ບ			/				

	ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				F	rom 04/01/2022 o 12/31/2022	Date/Time Pre	pared:
			DUADUAOV	MEDLOAL		5/30/2023 12:	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUI S. )	MEDI CAL RECORDS & LI BRARY (GROSS	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED	
		REQUIS.)	11 00	CHARGES)	12 00	TI ME)	<u> </u>
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.0
. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.0
. 00	00300 EMPLOYEE BENEFITS						3.0
. 00	00400 ADMINISTRATIVE & GENERAL						4.0
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.0
. 00	00600 LAUNDRY & LINEN SERVICE						6.0
'. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY						7.0
9.00 9.00	00900 NURSI NG ADMI NI STRATI ON						8.0 9.0
0.00	01000 CENTRAL SERVICES & SUPPLY	139, 050					10.0
1.00	01100 PHARMACY	0	40, 123				11.0
2.00	01200 MEDICAL RECORDS & LIBRARY	0	0	C			12.0
3.00	01300 SOCIAL SERVICE	0	0	C	24, 816		13.0
4.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0 0	0	14. (
5.00	01500 ACTI VI TI ES	0	0	0	0 0	0	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00	03000 SKILLED NURSING FACILITY	139, 050	40, 123	C		0	30.0
1.00	03100 NURSING FACILITY	0	0	C	-	0	31.0
2.00	03200 I CF/I I D	0	0	0		0	32.0
3. 00	03300 OTHER LONG TERM CARE	0	0	(	0 0	0	33. (
0.00	ANCI LLARY SERVICE COST CENTERS 04000 RADI OLOGY	0	0	C	0	0	40. (
1.00	04000 RADI OLOGI 04100 LABORATORY	0	0			0	40.
2.00	04200 I NTRAVENOUS THERAPY	0	0			0	42.
3.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(	0	0	43.0
4.00		Ő	0	0	o o	0	44.0
5.00	04500 OCCUPATI ONAL THERAPY	0	0	C	0 0	0	45.
6.00	04600 SPEECH PATHOLOGY	0	0	C	0 0	0	46.0
7.00	04700 ELECTROCARDI OLOGY	0	0	C	0 0	0	47.0
8.00	04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	C	0 0	0	48.0
9.00	04900 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	0	49.0
0.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	0 0	0	50.
1.00	05100 SUPPORT SURFACES	0	0	(	0	0	51.
2.00	05200 OTHER ANCI LLARY SERVI CE COST CENTERS OUTPATI ENT SERVI CE COST CENTERS	0	0	(	0 0	0	52.
0. 00	06000 CLINIC	0		(	0	0	60.
1.00	06100 RURAL HEALTH CLINIC	0	0	(		0	61.
2.00	06200 FQHC	Ŭ	0		, united and the second s	0	62.
3.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0 0	0	
	OTHER REIMBURSABLE COST CENTERS						
0. 00	07000 HOME HEALTH AGENCY COST	0	0	C	0 0	0	70. (
1.00	07100 AMBULANCE	0	0	C	0 0	0	71.
2.00	07200 CORF	0	0	C	0 0	0	
3.00		0	0	(	0	0	
4.00	07400 OTHER REIMBURSABLE COST	0	0	(	0 0	0	74.
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. (
1.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.0
2.00	08200 UTI LI ZATI ON REVI EW						82.0
3.00	08300 HOSPI CE	0	0	ſ		0	-
4.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	(	0	0	84.
9.00	SUBTOTALS (sum of lines 1-84)	139, 050	40, 123	C	24, 816	0	
	NONREI MBURSABLE COST CENTERS						
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0 0	0	90.
1.00	09100 BARBER AND BEAUTY SHOP	0	0	C	0 0	0	91.
2.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92.
3.00	09300 NONPAI D WORKERS	0	0	(	0	0	93.
4.00	09400 PATIENTS LAUNDRY	0	0			0	94.
5.00 8.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	C	0	0	95. 98.
8.00 9.00	Cross Foot Adjustments Negative Cost Centers						98. 99.
9.00 02.00	0	158, 327	45, 685	r	88, 878	0	102.
U2. UL	Part I)	130, 327	40,000	L C	, 00,070	0	102.
03.00		1. 138634	1. 138624	0.00000	3. 581480	0.000000	103.
04.00		619	179	(	14, 498		104. (
	Part II)					, i i i i i i i i i i i i i i i i i i i	,
		0. 004452	0. 004461	0.00000	0. 584220	0.00000	105. (
05.00							

	cial Systems PEL ION - STATISTICAL BASIS	LICAN POINTE POST-	Provi der No.: 315508	Peri od:	u of Form CMS-254 Worksheet B-1
				From 04/01/2022 To 12/31/2022	Date/Time Prepar
				10 12/31/2022	5/30/2023 12: 33
		OTHER GENERAL			
	Cast Contor Description	SERVI CE ACTI VI TI ES			
	Cost Center Description	(TOTAL PATIENT			
		DAYS)			
		15.00			
GENERA	AL SERVICE COST CENTERS				
	CAP REL COSTS - BLDGS & FIXTURES				
	CAP REL COSTS - MOVABLE EQUIPMENT				
	EMPLOYEE BENEFITS				
	ADMINISTRATIVE & GENERAL				
	PLANT OPERATION, MAINT. & REPAIRS				
1 1	LAUNDRY & LINEN SERVICE HOUSEKEEPING				
	DI ETARY				
	NURSI NG ADMI NI STRATI ON				
	CENTRAL SERVICES & SUPPLY				1
. 00 01100	PHARMACY				1
. 00 01200	MEDICAL RECORDS & LIBRARY				1
	SOCIAL SERVICE				1
	NURSING AND ALLIED HEALTH EDUCATION				1
	ACTIVITIES	24, 816			1
	ENT ROUTINE SERVICE COST CENTERS	24.01/			
	SKILLED NURSING FACILITY	24, 816			3
	NURSING FACILITY	0			3
1 1	OTHER LONG TERM CARE	0			3
	ARY SERVICE COST CENTERS				
	RADIOLOGY	0			4
. 00 04100	LABORATORY	0			4
. 00 04200	INTRAVENOUS THERAPY	0			4
	OXYGEN (INHALATION) THERAPY	0			4
	PHYSI CAL THERAPY	0			4
	OCCUPATIONAL THERAPY	0			4
1 1	SPEECH PATHOLOGY	0			4
1 1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0			4
1 1	DRUGS CHARGED TO PATTENTS	0			4
	DENTAL CARE - TITLE XIX ONLY	0			5
1 1	SUPPORT SURFACES	0			5
1 1	OTHER ANCILLARY SERVICE COST CENTERS	0			5
OUTPAT	TIENT SERVICE COST CENTERS				
	CLINIC	0			6
	RURAL HEALTH CLINIC	0			6
. 00 06200					6
	OTHER OUTPATIENT SERVICE COST CENTER	0			6
	REI MBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0			7
.00 07000		0			7
.00 07100		0			7.
. 00 07200		0			7
	OTHER REIMBURSABLE COST	0			7
	AL PURPOSE COST CENTERS				
	MALPRACTICE PREMIUMS & PAID LOSSES				8
1 1	INTEREST EXPENSE				8
	UTILIZATION REVIEW				8
. 00 08300		0			8
	OTHER SPECIAL PURPOSE COST CENTERS	0			8
	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	24, 816			8
	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			9
	BARBER AND BEAUTY SHOP	0			9
	PHYSI CI ANS PRI VATE OFFICES	0			9.
1 1	NONPAID WORKERS	0			9
	PATIENTS LAUNDRY	0			9
	OTHER NONREIMBURSABLE COST CENTERS	0			9
. 00	Cross Foot Adjustments				9
	Negative Cost Centers				9
2.00	Cost to be allocated (per Wkst. B,	224, 447			10.
	Part I)	0.044447			
03.00	Unit cost multiplier (Wkst. B, Part I)	9. 044447			10
04.00	Cost to be allocated (per Wkst. B,	34, 292			10
05.00	Part II) Unit cost multiplier (Wkst. B, Part	1. 381850			10
	II)	1. 301030			10

Health Financial Systems PELICAN POINTE POST-ACUTE NU	RSING	In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provid		Period:	Worksheet C	
		From 04/01/2022 To 12/31/2022	Date/Time Pre	narod
		10 12/31/2022	5/30/2023 12:	33 pm
Cost Center Description	Total (from	Total Charges		
	Wkst. B, Pt I	1	di vi ded by	
	col. 18)		col. 2	
	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS				1 40 00
40. 00 04000 RADI 0L0GY		0 0		
	6, 43			
42. 00 04200 INTRAVENOUS THERAPY	86	4 759		•
43.00 04300 0XYGEN (INHALATION) THERAPY	2/2.00	0 0	0.000000	•
44. 00 04400 PHYSI CAL THERAPY	363, 08			
45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY	230, 27 38, 73			
40. 00  04000 SPEECH PATHOLOGY 47. 00  04700  ELECTROCARDI OLOGY	30,73	3 00,042	0. 000000	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	98, 98	7 0	0. 000000	
49. 00 04900 DRUGS CHARGED TO PATIENTS	141, 92	-		
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	141, 72	0 113, 377	0.000000	
51. 00 05100 SUPPORT SURFACES			0.000000	
52. 00 05200 OTHER ANCI LLARY SERVICE COST CENTERS			0.000000	
OUTPATI ENT SERVICE COST CENTERS		<u> </u>	0100000	02100
60. 00 06000 CLINIC		0 0	0,000000	60.00
61.00 06100 RURAL HEALTH CLINIC				61.00
62.00 06200 FOHC				62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER		0 0	0. 000000	63.00
71. 00 07100 AMBULANCE		0 0	0. 000000	71.00
100. 00 Total	880, 31	8 967, 120		100.00

Health Financial Systems	PELICAN POINTE POS	ST-ACUTE NURSIN	١G	In Li	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315508	Period: From 04/01/2022 To 12/31/2022	2 Date/Time Pre 5/30/2023 12:	
		Title	XVIII (1)	Skilled Nursing	J PPS	
				Facility		
		Health Care P	rogram Charge	es Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col.	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUT	PATIENT COST					
ANCILLARY SERVICE COST CENTERS		I	1		1	
40. 00 04000 RADI OLOGY	0. 000000			0	0 0	1 101 00
41. 00 04100 LABORATORY	1. 138638			0 (	0 0	1
42.00 04200 I NTRAVENOUS THERAPY	1. 138340			0 (	0 0	1 .2.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0	0 0	
44. 00 04400 PHYSI CAL THERAPY	1. 247203			0 179, 82		1
45.00 04500 OCCUPATI ONAL THERAPY	0. 472325			0 84, 39		1 101 00
46.00 04600 SPEECH PATHOLOGY	0. 564276			0 17, 32		1 101 00
47.00 04700 ELECTROCARDI OLOGY	0. 000000			0	0 0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0 0	
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 251590			0	0 0	1 1 1 0 0
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			(	D	50.00
51.00 05100 SUPPORT SURFACES	0. 000000			0 0	0 0	
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	00	52.00
OUTPATIENT SERVICE COST CENTERS			1		1	
60. 00 06000 CLINIC	0. 000000	0		0 (	0 0	
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER				0	0 0	
71.00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00   Total (Sum of Lines 40 - 71)		353, 557		0 281, 542	<u>2 </u> 0	100.00
(1) For title V and XIX use columns 1, 2, and 4	onl y.					

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

Health Financial Systems PE	LICAN POINTE POS	T-ACUTE NURSI	١G	In Lie	eu of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315508	Period: From 04/01/2022 To 12/31/2022		
		Ti tl	e XVIII	Skilled Nursing	PPS	
Cost Center Description				Facility	r <u>I</u>	
cost center bescription					1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of c	cost to charges (	From Workshoo	t C column 3	line 40)	1. 251590	1.00
2.00 Program vaccine charges (From your rec			t c, corumn s	, 11116 49)	8, 475	2.00
3.00 Program costs (Line 1 x Line 2) (Title			er this amoun	t to Worksheet	10, 607	3.00
E, Part I, line 18)	, with, 115 prov				10,007	5.00
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,			Heal th Costs	
	18	Part I, Col.	Costs to Tota	al I, Col. 4)	for Pass	
		14)	Costs - Part		Through (Col.	
			(Col. 2 / Col		3 x Col. 4)	
			1)			
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	S FOR NURSING &	ALLIED HEALTH				
ANCI LLARY SERVI CE COST CENTERS	-			1 -	-	
40. 00 04000 RADI OLOGY	0	0	0.0000		0	
41. 00 04100 LABORATORY	6, 439	0	0.0000		0	
42.00 04200 I NTRAVENOUS THERAPY	864	0	0.0000		0	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	0	0.0000		0	43.00
44. 00 04400 PHYSI CAL THERAPY	363, 087	0	0.0000		0	44.00
45.00 04500 OCCUPATIONAL THERAPY	230, 279	0	0.0000			45.00
46. 00 04600 SPEECH PATHOLOGY	38, 733	0	0.0000		0	46.00
47.00 04700 ELECTROCARDI OLOGY	0	U	0.0000		0	47.00
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	98, 987 141, 929	0	0.0000		0	48.00 49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	141, 929	0	0.00000		0	49.00 50.00
51.00 05100 SUPPORT SURFACES	0	0	0.00000		0	
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000		0	
100.00 Total (Sum of Lines 40 - 52)	880, 318		0.0000	281, 542	-	52.00 100.00
100.00  10tal (300 01 111es 40 - 52)	000, 310	U	1	201, 342	U U	100.00

OMPUTATION OF INPATIENT ROUTINE COSTS		Provider No.: 315508	Period: From 04/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2023 12:	pared
		Title XVIII	Skilled Nursing Facility	PPS	
			-	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			24, 816	1.
. 00	Private room days			0	2.
. 00	Inpatient days including private room days applicable to the	Program		3, 652	3.
. 00	Medically necessary private room days applicable to the Progr	am		0	4.
. 00	Total general inpatient routine service cost			6, 918, 335	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges			8, 197, 591	6.
00	General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		0.843947	7
00	Enter private room charges from your records			0	8
00	Average private room per diem charge (Private room charges li 2)	ne 8 divided by private	room days, line	0.00	9
. 00	Enter semi-private room charges from your records			0	10
. 00	Average semi-private room per diem charge (Semi-private room semi-private room days)	n charges line 10, divide	d by	0.00	11
	Average per diem private room charge differential (Line 9 mir			0.00	12
	Average per diem private room cost differential (Line 7 times			0.00	13
	Private room cost differential adjustment (Line 2 times line			0	1
5. 00	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	ost differential (Line 5	minus line 14)	6, 918, 335	15
6.00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		278.79	
	Program routine service cost (Line 3 times line 16)			1, 018, 141	17
	Medically necessary private room cost applicable to program			0	18
9.00	Total program general inpatient routine service cost (Line 1			1, 018, 141	19
). 00	Capital related cost allocated to inpatient routine service on line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	1, 136, 417	20
	Per diem capital related costs (Line 20 divided by line 1)			45.79	
	Program capital related cost (Line 3 times line 21)			167, 225	
	Inpatient routine service cost (Line 19 minus line 22)			850, 916	
	Aggregate charges to beneficiaries for excess costs (From pr			0	
5.00	Total program routine service costs for comparison to the cos	st limitation (Line 23 mi	nus line 24)	850, 916	25
	Enter the per diem limitation (1)				26
	Inpatient routine service cost limitation (Line 3 times the p				27
3. 00	Reimbursable inpatient routine service costs (Line 22 plus 1		line 27)		28
	(Transfer to Worksheet E, Part II, line 4) (See instructions)				1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	24, 816	1.00
2.00	Program inpatient days (see instructions)	3, 652	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. 147163	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

OMPUTATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315508	Period: From 04/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2023 12:	pared
		Title XIX	Skilled Nursing Facility	Cost	
			-	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		I		
	I NPATI ENT DAYS				1
. 00	Inpatient days including private room days			24, 816	1 1.
. 00	Private room days			0	2
00	Inpatient days including private room days applicable to the	Program		17, 540	3
00	Medically necessary private room days applicable to the Progr	am		0	4
00	Total general inpatient routine service cost			6, 918, 335	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				1
00	General inpatient routine service charges			8, 197, 591	6
00	General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		0.843947	7
00	Enter private room charges from your records			0	8
00	Average private room per diem charge (Private room charges li 2)	ne 8 divided by private	room days, line	0.00	9
. 00	Enter semi-private room charges from your records			0	10
I. 00	Average semi-private room per diem charge (Semi-private room semi-private room days)	charges line 10, divide	d by	0.00	11
2.00	Average per diem private room charge differential (Line 9 min	us line 11)		0.00	12
	Average per diem private room cost differential (Line 7 times			0.00	13
. 00	Private room cost differential adjustment (Line 2 times line	13)		0	14
	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS		minus line 14)	6, 918, 335	15
5.00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		278. 79	1 16
	Program routine service cost (Line 3 times line 16)	vided by Time T		4, 889, 977	
	Medically necessary private room cost applicable to program	(line 4 times line 13)		4,007,777	
	Total program general inpatient routine service cost (Line 1			4, 889, 977	
	Capital related cost allocated to inpatient routine service c		t II column 18.	1, 136, 417	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	,			
1.00	Per diem capital related costs (Line 20 divided by line 1)			45.79	21
	Program capital related cost (Line 3 times line 21)			803, 157	
	Inpatient routine service cost (Line 19 minus line 22)			4, 086, 820	
	Aggregate charges to beneficiaries for excess costs (From pr	ovider records)		0	
	Total program routine service costs for comparison to the cos		nus line 24)	4, 086, 820	25
	Enter the per diem limitation (1)	•	,	0.00	
	Inpatient routine service cost limitation (Line 3 times the p	er diem limitation line	26) (1)	0	
	Reimbursable inpatient routine service costs (Line 22 plus t			4, 889, 977	
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		-		1

16	1.00
40	2.00
0	3.00
02	4.00
0	5.00
	40 0 02

CALCU	Financial Systems PELICAN POINTE POST ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	-ACUTE NURSING Provider No.: 315508	Peri od:	u of Form CMS-2 Worksheet E	
CALCUL	ATTON OF REFINDORSEMENT SETTEEMENT FOR TITLE AVIIT		From 04/01/2022	Part I	
			To 12/31/2022	Date/Time Pre	
				5/30/2023 12:3	33 pm
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBL	IDSEMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	JNSEMENT		2, 257, 620	1.00
2.00	Nursing and Allied Health Education Activities (pass through	navments)		2, 237, 020	2.00
3.00	Subtotal (Sum of Lines 1 and 2)	paymentes		2, 257, 620	3.00
4.00	Primary payor amounts			18, 809	4.00
5.00	Coinsurance			415, 647	5.00
6.00	Allowable bad debts (From your records)			319, 535	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See ins	tructions)		21, 259	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			207, 698	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)			2,030,862	11.00
12.00	Interim payments (See instructions)			1, 792, 900	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestration			0	14.50
14.55	Demonstration payment adjustment amount after sequestration			0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)	)		3, 468	14.75
14.99	Sequestration amount (see instructions)			30, 264	14.99
15.00	Balance due provider/program (see Instructions)			204, 230	15.00
16.00	Protested amounts (Nonallowable cost report items in accordan			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSE	ER OF COST OR CHARGES - T	ITLE XVIII ONLY		
17.00	Ancillary services Part B			0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			10, 607	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)			10, 607	19.00
20.00	Medicare Part B ancillary charges (See instructions)			8, 475	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			8, 475	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 ins	tructions)		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)				25.00
26.00	Interim payments (See instructions)			5, 397	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50 28.55	Demonstration payment adjustment amount before sequestration			0	28.50 28.55
28.55 28.99	Demonstration payment adjustment amount after sequestration Sequestration amount (see instructions)			0 142	28.55
28.99	Balance due provider/program (see instructions)			2, 936	28.99
	Protested amounts (Nonallowable cost report items) in accorda	ance with CMS Pub 15-2 s	ection 115 2	2, 930	30.00
20.00				0	55.00

	Financial Systems PELICAN POINTE POST-A			u of Form CMS-2	2340-	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XIX ONLY	Provider No.: 315508	Period: From 04/01/2022 To 12/31/2022	Worksheet E Part II Date/Time Pre 5/30/2023 12:3	pared 33 pm	
		Title XIX	Skilled Nursing Facility	Cost	00 pm	
			Facility			
				1.00		
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00		
. 00	Inpatient ancillary services (see Instructions)			0	1.0	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, lin	e 5)		0		
3.00	Outpatient services			0		
1.00	Inpatient routine services (see instructions)					
5.00						
5.00	Cost of covered services (Sum of Lines 1 - 5)			4, 889, 977	6.0	
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7.0	
3. 00	SUBTOTAL (Line 6 minus line 7)	·		4, 889, 977	8. (	
9.00	Primary payor amounts			0	9.1	
0.00	Total Reasonable Cost (Line 8 minus line 9)			4, 889, 977	10.0	
	REASONABLE CHARGES				1	
1.00	Inpatient ancillary service charges			0	11.	
2.00	Outpatient service charges			0	12.	
3.00	Inpatient routine service charges			0	13.	
4.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14.	
5.00	Total reasonable charges			0	15.	
	CUSTOMARY CHARGES					
6.00	Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basis	0	16.	
7.00	Amounts that would have been realized from patients liable for		n a charge basis	0	17.	
	had such payment been made in accordance with 42 CFR 413.13(e)					
8.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.00000		
9.00	Total customary charges (see instructions)			0	19.	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
0.00	Cost of covered services (see Instructions)			0		
1.00	Deducti bl es			0		
2.00	Subtotal (Line 20 minus line 21)			0		
3.00	Coinsurance			0		
4.00	Subtotal (Line 22 minus line 23)			0		
5.00	Allowable bad debts (from your records)			0		
6.00	Subtotal (sum of lines 24 and 25)	ly collected becad on a	orrection of	0		
7.00	Unrefunded charges to beneficiaries for excess costs erroneous cost limit	Ty corrected based on c	orrection of	0	27.	
8. 00	Recovery of excess depreciation resulting from provider termin	ation or a decrease in	nrogram	0	28.	
0.00	utilization		pi ogi alli	0	20.	
9.00	Other Adjustments (see instructions) Specify			0	29.	
0.00	Amounts applicable to prior cost reporting periods resulting f	rom disposition of depr	eciable assets (	0		
	if minus, enter amount in parentheses)		00.0010 000000 (	0		
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31.	
32.00	Interim payments			0		
33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0		
	Instructions)	i j i i partere		-	1	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No.: 315508		Period: From 04/01/2022 To 12/31/2022		
		Ti tl	e XVIII	Skilled Nursing Facility		<u>oo p</u>
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider 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, 792, 9	0	5, 397 0	1. 2.
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) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
)3				0	0	3
)4				0	0	3
)5				0	0	3
0	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
1	ADJUSTIMENTS TO FROMAIM			0	0	
52				0	0	3
3				0	0	3
54				0	0	3
9	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50			0	0	3
	- 3.98)					
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)		1, 792, 9	200	5, 397	4
	TO BE COMPLETED BY CONTRACTOR					
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
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5
7	- 5.98)			5		
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER		204, 2	230	2, 936	6
)2	PROVIDER TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		1, 997, 1		8, 333	7
			Contr	actor Name	Contractor Number	
					Number	_

 8.00
 Name of Contractor

 (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.

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der		Period: From 04/01/2022 To 12/31/2022	Worksheet G Date/Time Pre 5/30/2023 12:	
		General Fund	Speci fi c	Endowment Fund		<u> </u>
		1.00	Purpose Fund 2.00	3.00	4.00	
	Assets		L			
~	CURRENT ASSETS	000 (1(				
0	Cash on hand and in banks	283, 646		0 0	0	
0 0	Temporary investments Notes receivable	0		0 0	0	
0	Accounts receivable	3, 539, 923		0 0	0	
0	Other receivables	6, 838		0 0	0	
0	Less: allowances for uncollectible notes and accounts	0,030		0 0	0	
0	recei vabl e				0	
0	Inventory	0		0 0	0	7  0
0	Prepaid expenses	238, 852		0 0	0	8
0	Other current assets	-239, 821		0 0	0	9
00	Due from other funds	0		0 0	0	10
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	3, 829, 438		0 0	0	11
	FI XED_ASSETS	1				÷.,
00	Land	0		0 0	0	
00	Land improvements	0		0 0	0	
00	Less: Accumulated depreciation			0 0	0	
00	Buildings				0	
00 00	Less Accumulated depreciation Leasehold improvements				0	
00	Less: Accumulated Amortization			0 0	0	
00	Fixed equipment	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00	Automobiles and trucks	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00	Major movable equipment	18, 246		o o	0	23
00	Less: Accumulated depreciation	0		0 0	0	24
00	Minor equipment - Depreciable	0		0 0	0	25
00	Minor equipment nondepreciable	0		0 0	0	26
00	Other fixed assets	0		0 0	0	27
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	18, 246		0 0	0	28
	OTHER ASSETS	-				1
00	Investments	0		0 0	0	
00	Deposits on Leases	0		0 0	0	
00 00	Due from owners/officers Other assets	0		0 0	0	
00	TOTAL OTHER ASSETS (Sum of Lines 29 - 32)			0 0	0	
00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	3, 847, 684		0 0	0	
	Liabilities and Fund Balances	0,011,001		0		
	CURRENT LI ABI LI TI ES					1
00	Accounts payable	411, 286		0 0	0	35
00	Salaries, wages, and fees payable	183, 723		0 0	0	36
00	Payroll taxes payable	14, 055		0 0	0	
00	Notes & loans payable (Short term)	0		0 0	0	
00	Deferred income	0		0 0	0	
00	Accel erated payments	0				40
00	Due to other funds	0		0 0	0	
00	Other current liabilities	3, 323, 809		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3, 932, 873		0 0	0	43
00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	0 44
00	Notes payable			0 0	0	
00	Unsecured Loans				0	
00	Loans from owners:			0 0	0	
00	Other long term liabilities	1 0		0 0	0	
	OTHER (SPECIFY)	0		o o	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0 0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	3, 932, 873		0 0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	-85, 189				52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	-	56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
00	replacement, and expansion	0E 100			0	
υU	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-85, 189 3, 847, 684			0	
00						

Health Financial Systems         PEL           STATEMENT OF CHANGES IN FUND BALANCES         PEL			ACUTE NURSING Provider No.: 315508		In Lie Period: From 04/01/2022	Worksheet G-1	
					To 12/31/2022		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	o piii
		1.00	0.00	0.00	1.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-83, 409		0		2.00
3.00	Total (sum of line 1 and line 2)		-83, 409		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00	CAPI TAL CONTRI BUTED	437, 050			0	0	5.00
6.00	ROUNDI NG	4			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	Total additions (sum of line 5 - 9)		437, 054		0		10.00
11.00	Subtotal (line 3 plus line 10)		353, 645		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00	CAPI TAL	438, 834			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00 17.00		0			0	0	16.00 17.00
17.00	Total deductions (sum of lines 13 - 17)	0	438, 834		0	-	17.00
19.00	Fund balance at end of period per balance		-85, 189		0		19.00
19.00	sheet (Line 11 - Line 18)		-05, 107		0		19.00
		Endowment Fund	PI ant	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
3.00					0		
4.00	Additions (credit adjustments)				0		
4.00 5.00	CAPI TAL CONTRI BUTED		0		0		5.00
4.00 5.00 6.00			0		0		5. 00 6. 00
4.00 5.00 6.00 7.00	CAPI TAL CONTRI BUTED		0				5.00 6.00 7.00
4.00 5.00 6.00 7.00 8.00	CAPI TAL CONTRI BUTED		-				5.00 6.00 7.00 8.00
4.00 5.00 6.00 7.00 8.00 9.00	CAPI TAL CONTRI BUTED		0				4.00 5.00 6.00 7.00 8.00 9.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9)	0	0		0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)		0				5.00 6.00 7.00 8.00 9.00 10.00 11.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0		0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0		0		5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0		0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0 0 0 0 0		0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0		0		5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) CAPITAL	0 0	0 0 0 0 0 0 0 0		0 0		5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	CAPITAL CONTRIBUTED ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) CAPITAL	0	0 0 0 0 0 0 0 0		0		5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00

Heal th	Financial Systems PELICAN POINTE POST-AG	CUTE NURSI	NG		In Lie	u of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315508	Peric From To	od: 04/01/2022 12/31/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/30/2023 12:	pared:
	Cost Center Description		Inpati ent	0	utpatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						1
1,00	SKILLED NURSING FACILITY		8, 197, 5	91		8, 197, 591	1.00
2.00	NURSING FACILITY			0		0	2.00
3.00	ICF/IID			0		0	
4,00	OTHER LONG TERM CARE			0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		8, 197, 5	91		8, 197, 591	5.00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES		967, 1	20	0	967, 120	6.00
7.00			1		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	СМНС				0	0	11.00
11.10	CORF				0	0	11.10
12.00	HOSPI CE			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	9, 164, 7	11	0	9, 164, 711	14.00
14.00	Worksheet G-3, Line 1)		, 104, 7		0	7, 104, 711	14.00
	Cost Center Description		1				
					1.00	2.00	
_	PART II - OPERATING EXPENSES				1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					8, 504, 754	1.00
2.00	Add (Specify)				0	0,001,701	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	0	
8.00 9.00	Deduct (Specify)				0	0	9.00
10,00	beduct (specify)				0		10.00
10.00					0		11.00
					0		12.00
12.00					0		
13.00	Tatal Daduations (Sum of Lines 0, 12)				0	0	13.00
14.00	Total Deductions (Sum of Lines 9 - 13)					0	
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			I	I	8, 504, 754	15.00

Heal th	u of Form CMS-2	2540-10				
	Health Financial Systems         PELICAN POINTE POST-ACUTE NURSING         In Lie           STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES         Provider No.: 315508         Period:					
	From 04/01/202					
	To 12/31/2022	Date/Time Pre				
				5/30/2023 12:	33 pm	
				1.00		
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		9, 164, 711	1.00	
2.00	Less: contractual allowances and discounts on patients account	ts		752, 831	2.00	
3.00	Net patient revenues (Line 1 minus line 2)			8, 411, 880	3.00	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)				4.00	
5.00	Net income from service to patients (Line 3 minus 4)			-92, 874	5.00	
	Other income:					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			965	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 di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00	
12.00	5			0	12.00	
13.00				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 the	han patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients			0	17.00	
18.00				0	18.00	
19.00				0	19.00	
20.00				0	20.00	
21.00	5			0	21.00	
22.00	Rental of skilled nursing space			0	22.00	
23.00	Governmental appropriations			0	23.00	
24.00	REV MI SC			8, 500	24.00	
24.50	COVI D-19 PHE Fundi ng			0	24.50	
25.00	Total other income (Sum of lines 6 - 24)			9, 465	25.00	
26.00	Total (Line 5 plus line 25)			-83, 409	26.00	
27.00	Other expenses (specify)			0	27.00	
28.00				0	28.00	
29.00				0	29.00	
30.00	Total other expenses (Sum of lines 27 - 29)			0	30.00	
31.00	Net income (or loss) for the period (Line 26 minus line 30)			-83, 409	31.00	