Heal th Financia			AND NURSING		u of Form CMS-2540-10
This report is	required by law (42 USC 1395g; 42 CFR 413.	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: 315257	Peri od:	Worksheet S
COMPLEX COST RE	PORT CERTIFICATION AND SETTLEMENT SUMMARY				Parts I, II & III
				To 12/31/2023	Date/Time Prepared: 5/20/2024 3:03 pm
PART I - COST F	REPORT STATUS				372072024 3.03 pm
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/20/20	24 Time: 3:03 pm
use only	2. [] Manually prepared cost report	501 0		Date: 0/20/20	
use only	3. [0] If this is an amended report en	tar the number	r of times the provide	r resubmitted thi	s cost report
	3. 01 [] No Medicare Utilization. Enter '			i resubili tteu tili	s cost report
Contractor	4. [1] Cost Report Status	6. Contractor			
use only	(1) As Submitted		t Cost Report for this		
	(2) Settled without audit	8.[N] Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened	10.[0]IfI	ine 4, column 1 is "4"	: Enter number of	times reopened
	(5) Amended		r Vendor Code		·
	5. Date Received:	12.[F] Medi	care Utilization. Ente	 er "F" for full. '	'L" for low. or "N"
			no utilization.		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CEDAR GROVE RESPIRATORY AND NURSING (315257) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	Henr	ny Grunfeld	Ť	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	Henny Grunfeld			2
3	Signatory Title	FI NANCE SUPERVI SOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
Cost Center Descriptio	n	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMAR	RY					
1.00 SKILLED NURSING FACILITY		0	73, 859	111	0	1.00
2.00 NURSING FACILITY		0			0	2.00
3.00 ICF/IID					0	3.00
4.00 SNF - BASED HHA I		0	0	0		4.00
5.00 SNF - BASED RHC I		0		0		5.00
6.00 SNF - BASED FQHC I		0		0		6.00
7.00 SNF - BASED CMHC I		0		0		7.00
100. 00 TOTAL		0	73, 859	111	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.

JUMPLE	Financial Systems CEDAR GROVE D NURSING FACILITY AND SKILLED NURSING FACILITY HEALT X INDENTIFICATION DATA		Provi der No.	: 315257	Period: From 01/01/ To 12/31/	2023	Workshe Part I Date/Ti 5/20/20	et S-2 me Pre	pared:
	1.00	2.00		3.00			3720720	24 5.0	
	Skilled Nursing Facility and Skilled Nursing Facility	y Complex Ad	dress:						
1.00	Street: 1420 S. BLACK HORSE PIKE PO Box:								1.00
2.00	City: WILLIAMSTOWN State: 1		Zip Code: 080						2.00
3.00	5	de: 15804	Urban/Rural:	U					3.00
3.01	CBSA Coo	1				-			3.01
		Compor	ent Name	Provi der	Date		nt Syst		
				CCN	Certified	v	0, or N	í	-
		1	. 00	2.00	3.00	4.00	-		
	SNF and SNF-Based Component Identification:	I	. 00	2.00	5.00	4.00] 3.00	0.00	
4.00	SNF	CEDAR GROVE	E RESPIRATORY	315257	02/09/1988	N	Р	N	4.00
		AND NURSING							
5.00	Nursing Facility								5.00
5.00	I CF/I I D								6.00
7.00	SNF-Based HHA								7.00
3.00	SNF-Based RHC								8.00
9.00	SNF-Based FQHC								9.00
	SNF-Based CMHC								10.00
	SNF-Based OLTC SNF-Based HOSPICE			-					11.00
	SNF-Based HUSPICE SNF-Based CORF			-					12.00
5.00		1			From:		То		13.00
					1.00		2.0		1
14.00	Cost Reporting Period (mm/dd/yyyy)				01/01/2		12/31/		14.00
5.00	Type of Control (See Instructions)					5			15.00
							Y/	N	
	1						1.0	00	
	Type of Freestanding Skilled Nursing Facility								
6.00	Is this a distinct part skilled nursing facility that	t meets the	requirements	set forth	in 42 CFR		N		16.00
17 00	section 483.5?	allity that	maata tha raa	ul comonto	oot forth				17 00
17.00	Is this a composite distinct part skilled nursing fac 42 CFR section 483.5?	Sinty that	meets the req	urrements	set forth	in	N		17.00
18 00	Are there any costs included in Worksheet A that resu	ilted from t	ransactions w	ith relat	ed		Y		18.00
10.00	organizations as defined in CMS Pub. 15-1, chapter 10								10.00
	Miscellaneous Cost Reporting Information		· · · · · · ·			1			1
19.00	If this is a low Medicare utilization cost report, in	ndicate with	a "Y", for y	es, or "N	" for no.		N		19.00
19.01	If line 19 is yes, does this cost report meet your co			filing a	low Medicar	e	N		19.01
	utilization cost report, indicate with a "Y", for yes								
	Depreciation - Enter the amount of depreciation report	rted in this	SNF for the	method ir	dicated on	Li nes			
	Straight Line						C.	975, 614	
	Declining Balance							(21.00
	Sum of the Year's Digits Sum of line 20 through 22						() ערב ברע	22.00 23.00
	If depreciation is funded, enter the balance as of t	the end of t	bo poriod					975, 614	23.00
	Were there any disposal of capital assets during the		•	(\times / \mathbb{N})			Ν	,	24.00
	Was accelerated depreciation claimed on any assets in				porting peri	Sho i	N		26.00
2.00	(Y/N)		a., piro	2002.10					_0.00
	Did you cease to participate in the Medicare program	at end of t	he period to	which thi	s cost repo	rt	N		27.00
27.00									1
	applies? (Y/N)								
	Was there a substantial decrease in health insurance	proporti on	of allowable	cost from	prior cost		N		28.00
		proporti on	of allowable	cost from	•		_		28.00
	Was there a substantial decrease in health insurance	proporti on	of allowable	cost from	•	Part	APart B	Other	28.00
	Was there a substantial decrease in health insurance reports? (Y/N)	· ·			•	Part 1.00	APart B 2.00	0ther 3.00	28.00
	Was there a substantial decrease in health insurance	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl	A Part B 2.00 icatior	0ther 3.00	28.00
	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public prov	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl	A Part B 2.00 icatior	0ther 3.00	28.00
28.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl	A Part B 2.00 icatior	0ther 3.00	28.00
28.00 29.00 60.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl ies fo	A Part B 2.00 ication or the	0ther 3.00	29.00 30.00
28.00 29.00 30.00 31.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/IID	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl ies fo	A Part B 2.00 ication or the N	0ther 3.00	29.00 30.00 31.00
28.00 29.00 30.00 31.00 32.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl ies fo	A Part B 2.00 ication or the	0ther 3.00	29.00 30.00 31.00 32.00
29.00 30.00 31.00 32.00 33.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public prov of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl ies fo	A Part B 2.00 ication or the N	0ther 3.00	29.00 30.00 31.00 32.00 33.00
29.00 30.00 31.00 32.00 33.00 34.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FOHC	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC	vider that q	ualifies for	an exempt	ion from th	Part 1.00 e appl ies fo	A Part B 2.00 ication or the N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00 35.00
29.00 30.00 31.00 32.00 33.00 34.00 35.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FOHC	vider that q	ualifies for	an exempt	ion from th that qualif	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00
29.00 (0.00) (1.00) (2.00) (3.00) (4.00) (5.00)	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC	vider that q	ualifies for	an exempt	ion from th that qualif	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00 35.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FOHC SNF-Based OLTC	vider that q ach componen	ualifies for t and type of	an exempt È service	ion from th that qualif	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00 35.00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC	vider that q ach componen	ualifies for t and type of s the provide	an exempt È service	ion from th that qualif	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based RHC SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran	vider that q ach componen nat certifie XIX patient nce? (Y/N)	ualifies for t and type of s the provide s? (Y/N)	an exempt È service	ion from th that qualif	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based COHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insurar Is the malpractice a "claims-made" or "occurrence" po	vider that q ach componen nat certifie XIX patient nce? (Y/N) plicy? If th	ualifies for t and type of s the provide s? (Y/N)	an exempt È service	ion from th that qualif	Part 1.00 e appl ies fo	A Part B 2.00 icatior or the N N	0ther 3.00	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based RHC SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran	vider that q ach componen nat certifie XIX patient nce? (Y/N) plicy? If th	ualifies for t and type of s the provide s? (Y/N) e policy is	an exempt Èservice :r as a SN	ion from th that qualif Y/N 1.00 F Y N	Part 1.00 e appl ies fo N N	A Part B 2.00 icatior or the N N N 2.0	0ther 3.00 N	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro- of the lower of the costs or charges enter "Y" for ea exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based COHC SNF-Based OLTC Is the skilled nursing facility located in a state th regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insurar Is the malpractice a "claims-made" or "occurrence" po	vider that q ach componen nat certifie XIX patient nce? (Y/N) plicy? If th	ualifies for t and type of s the provide s? (Y/N) e policy is	an exempt È service	ion from th that qualif	Part 1.00 e appl ies fo N N	A Part B 2.00 icatior or the N N	Other 3.00 N	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00

Heal th	Financial Systems	CEDAR GROVE RESPIRATORY	AND NURSING		In Lie	u of Form CMS	S-2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:	315257	Period:	Worksheet S	-2
COMPLE	X INDENTIFICATION DATA				From 01/01/2023 To 12/31/2023	Part I Date/Time P	roparad
					10 12/31/2023	5/20/2024 3	
						Y/N	
						1.00	
42.00						N	42.00
	center? Enter Y or N. If yes, check box	κ, and submit supporting s	schedule listin	g cost c	enters 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 a	ddress o	of 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 or	ganization, enter the name	e and address o	of the ho	ome office on the	lines	
	bel ow.						
45.00	Name:	Contractor's Name:		Contract	or's Number:		45.00
46.00	Street:	PO Box:					46.00
47.00	Ci ty:	State:		Zip Code	:		47.00

MPL	ED NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE	Provi der	No.: 315257	Period:	Worksheet S-	-2
	EX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023 To 12/31/2023	Date/Time Pr	
					Y/N	5/20/2024 3: Date	:03 pm
					1.00	2.00	
	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" fo	r Yes or "N"	for No. For all	the date	
00	Provider Organization and Operation Has the provider changed ownership immediated				N		1.
	reporting period? If column 1 is "Y", enter instructions)	the date of the chang	je in col				
				Y/N 1.00	Date 2.00	V/I 3.00	_
00	Has the provider terminated participation in	the Medicare Program	n?lf	N 1.00	2.00	3.00	2.
	column 1 is yes, enter in column 2 the date of	of termination and ir	n column				
00	contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or	the provider involved in business transactions, including management intracts, with individuals or entities (e.g., chain home offices, drug medical supply companies) that are related to the provider or its ficers, medical staff, management personnel, or members of the board directors through ownership, control, or family and other similar elationships? (see instructions)					3.
				Y/N	Туре	Date	
				1.00	2.00	3.00	
00	Column 1: Were the financial statements prepa	ared by a Certified F	Public	Y	С		4.
00	Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total	or 9 5.	N	C		5.	
50	those on the filed financial statements? If a			IN			5
	reconciliation.				Y/N	Legal Oper.	
					1.00	2.00	
)0	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho		lo the	nnovidan tha	N	N	6
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program:	. ,		provider the	N	IN	7
00	Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so	ng the cost reporting		for Nursing	N		8
						Y/N	
						1.00	+
	Bad Debts						
	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb				st reporting		
00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	t collection policy of	hange du	ring this cos		1.00 Y	10
00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	t collection policy o	change du ved? If "	ring this cos Y", see inst	ructions.	1.00 Y N	10
00 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	t collection policy of d/or coinsurance waiv	change du ved? If "	ring this cos Y", see instr ", see instru P	ructions. uctions. art A	1.00 Y N N Part B	10
00 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	t collection policy of d/or coinsurance wait cost reporting perio Description	change du ved? If "	ring this cos Y", see instr ", see instru P Y/N	ructions. art A Date	1.00 Y N N Part B Y/N	10
00 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	t collection policy of d/or coinsurance waiv	change du ved? If "	ring this cos Y", see instr ", see instru P	ructions. uctions. art A	1.00 Y N N Part B	10
00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior 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	t collection policy of d/or coinsurance wait cost reporting perio Description	change du ved? If "	ring this cos Y", see instr ", see instru P Y/N	ructions. art A Date	1.00 Y N N Part B Y/N	10 11 12
00 00 00 00 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior 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 4. (see Instructions.)	t collection policy of d/or coinsurance waix cost reporting perio Description 0	change du ved? If "	ring this cos Y", see instru , see instru P Y/N 1.00	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13
00 00 00 00 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debi- period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior 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 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" 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",	t collection policy of d/or coinsurance wain cost reporting perio Description 0	change du ved? If "	ring this cos Y", see instru ", see instru P Y/N 1.00 Y	ructions.	1.00 Y N N Part B Y/N 3.00 Y	10. 11. 12. 13. 14.
. 00 . 00 . 00 . 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debi- period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior 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 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" 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	t collection policy of d/or coinsurance wain cost reporting perio Description 0	change du ved? If "	ring this cos Y", see instru ", see instru P Y/N 1.00 Y	ructions.	1.00 Y N N Part B Y/N 3.00 Y	9, 10. 11. 12. 13. 14. 15. 16.
. 00 . 00 . 00 . 00 . 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debi- period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior 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 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" 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.	t collection policy of d/or coinsurance wain cost reporting perio Description 0	change du ved? If "	ring this cos Y", see instru ", see instru P Y/N 1.00 Y N	ructions.	1.00 Y N N Part B Y/N 3.00 Y N	10 11 12 13 13 14 15

Heal th	Financial Systems	CEDAR GROVE RESPIR	ATORY	AND NURSI	NG	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE		Provi der		Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					From 01/01/2023 To 12/31/2023		pared: 3 pm
				1.	00	2.	00	
	Cost Report Preparer Contact Informatic	in						
19.00	Enter the first name, last name and the	e title/position	CHRI S	5		GUI LBAULT		19.00
	held by the cost report preparer in co	umns 1, 2, and 3,						
	respecti vel y.							
20.00	Enter the employer/company name of the	cost report	HEAL	TH CARE RE	SOURCES			20.00
	preparer.							
21.00	Enter the telephone number and email a	dress of the cost	609-9	987-1440		CHRI S. GUI LBAULT	Г@HCRNJ. NET	21.00
	report preparer in columns 1 and 2, re	specti vel y.						

	J	R GROVE RESPIRAT	ORY AND NURSING	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.: 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/20/2024 3:0	pared:
		Part B				
		Date				
		4.00				
	PS&R Data	00 (10 (000 1				1 4 9 9 9 9
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter	03/13/2024				13.00
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
	4. (see Instructions.)					
14.00	Was the cost report prepared using the PS&R					14.00
	for total and the provider's records for					
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
	4.					
15.00	If line 13 or 14 is "Y", were adjustments					15.00
	made to PS&R data for additional claims that					
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y", see Instructions.					
16 00	If line 13 or 14 is "Y", then were					16.00
10.00	adjustments made to PS&R data for					10.00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17.00	If line 13 or 14 is "Y", then were					17.00
	adjustments made to PS&R data for Other?					
	Describe the other adjustments:					
18.00	Was the cost report prepared only using the					18.00
	provider's records? If "Y" see Instructions.					
			0.00			
			3.00			
	Cost Report Preparer Contact Information					19.00
19.00	Enter the first name, last name and the title held by the cost report preparer in columns 1		REPARER			19.00
	respectively.	, 2, anu 3,				
20.00	Enter the employer/company name of the cost r	report				20.00
20.00	preparer.	opo. (20.00
21.00	Enter the telephone number and email address	of the cost				21.00

	ED NURSING FACILITY AND SKILLED NURSING EX STATISTICAL DATA	FACILITY HEALTH CARE	Provi der	F	In Lie eriod: rom 01/01/2023 o 12/31/2023	Worksheet S-3 Part I Date/Time Prep 5/20/2024 3:03	
				l np	atient Days/Vis	sits	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	T	1.00	2.00	3.00	4.00	5.00	
. 00 . 00 . 00 . 00 . 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	180 0 0	65, 700 0 0	0	8, 706	46, 021 0 0	1.0 2.0 3.0 4.0 5.0 6.0
. 00	HOSPICE	0	0	0		0	7.0
. 00	Total (Sum of lines 1-7)	180 Inpatient D	65, 700 ays/Vi si ts	0	8, 706 Di scharges	46, 021	8.0
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	7, 742 0	62, 469 0	0	152	293 0	1. C 2. C
. 00 . 00 . 00 . 00	ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	0	0			0	3. (4. (5. (6. (
7.00 8.00	HOSPICE Total (Sum of lines 1–7)	0 7, 742	0 62, 469	0	0 152	0 293	7. (8. (
		Di scha	arges	Aver	age Length of	Stay	
	Component	0ther 11.00	Total 12.00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
. 00	SKILLED NURSING FACILITY NURSING FACILITY	369	814	0.00	57.28	157.07 0.00	1. C 2. C
. 00 . 00 . 00	ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	0	0			0.00	3. C 4. C 5. C
. 00	SNF-Based CMHC HOSPI CE	0	0	0.00	0.00	0.00	6. C 7. C
. 00	Total (Sum of lines 1-7)	369 Average Length	814	0.00		157.07	8. (
		of Stay					
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
. 00	SKILLED NURSING FACILITY	76. 74	0		286	272	1. (
. 00 . 00	NURSING FACILITY	0. 00 0. 00	0		0	0 0	2.0 3.0 4.0
. 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	0.00				0	4. (5. (6. (
. 00 . 00	HOSPICE Total (Sum of lines 1–7)	0. 00 76. 74	0 0			0 272	7. (8. (
		Admissions	Full Time	Equi val ent			
	Component	Total	Employees on Payroll	Nonpaid Workers	-		
. 00	SKILLED NURSING FACILITY	21.00	22.00 201.40	23.00 0.00			1. (
. 00	NURSING FACILITY	0	0.00	0.00			2. (
. 00	ICF/IID	0	0.00	0.00			3.0
. 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0. 00 0. 00				4. 5.
. 00 . 00 . 00	SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	0 800	0.00 0.00 201.40	0.00			6. 7. 8.

NF WA	GE INDEX INFORMATION				Period: From 01/01/2023 Fo 12/31/2023	Date/Time Prep 5/20/2024 3:03	pared: 3 pm
		Amount	Reclass. of	Adjusted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART I I – DI RECT SALARI ES						
	SALARIES		-				
00	Total salaries (See Instructions)	8, 626, 061	0	-//			
00	Physician salaries-Part A	0	0		0.00		
00	Physician salaries-Part B	0	0		0.00		
. 00	Home office personnel	0	0		0.00		
. 00	Sum of lines 2 through 4	0 (2) 0(1	0		0.00		
00	Revised wages (line 1 minus line 5)	8, 626, 061	0	8, 626, 06			6. C 7. C
00	Other Long Term Care HOME HEALTH AGENCY COST	0	0		0.00	0.00	8.0
. 00 . 00	CMHC	0	0		0.00	0.00	
0.00	HOSPI CF	0	0		0.00		
1.00	Other excluded areas	0	0		0.00		
	Subtotal Excluded salary (Sum of lines 7	0	0		0.00		12.0
2.00	through 11)	0	0		0.00	0.00	12.0
3.00	Total Adjusted Salaries (line 6 minus line	8, 626, 061	0	8, 626, 06	419, 038. 00	20. 59	13.0
	12) OTHER WAGES & RELATED COSTS						
1 00	Contract Labor: Patient Related & Mgmt	3, 846, 189	0	3, 846, 189	95, 814.00	40, 14	14. C
4.00 5.00	Contract Labor: Physician services-Part A	3, 840, 189	0		95,814.00		
	Home office salaries & wage related costs	0	0		0.00		
0.00	WAGE-RELATED COSTS	0	0	<u> </u>	0.00	0.00	10.0
7.00	Wage-related costs core (See Part IV)	1, 216, 177	0	1, 216, 17	7		17. C
8.00	Wage-related costs other (See Part IV)	0	0		D		18. C
9.00	Wage related costs (excluded units)	0	0	(D		19.0
0.00	Physician Part A - WRC	0	0	(D		20.0
1.00	Physician Part B - WRC	0	0	(D		21.0
2.00	Total Adjusted Wage Related cost (see	1, 216, 177	0	1, 216, 17	7		22.0
	instructions)						1

Heal th	Financial Systems CEE	AR GROVE RESPIRA	ATORY AND NURSI	NG	In Lie	eu of Form CMS-:	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023		narod
					10 12/31/2023	5/20/2024 3:0	3 pm
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col	. Related to	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	-		1	1		
1.00	Employee Benefits	0	0		0 0.00		
2.00	Administrative & General	627, 227		627, 22			2.00
3.00	Plant Operation, Maintenance & Repairs	144, 735	0	144, 73	5 5, 042. 00	28.71	3.00
4.00	Laundry & Linen Service	35, 107	0	35, 10	7 2, 742. 00	12.80	4.00
5.00	Housekeepi ng	471, 018	0	471, 01	8 34, 175. 00	13.78	5.00
6.00	Dietary	547,606	0	547,60	6 41, 340. 00	13.25	6.00
7.00	Nursing Administration	1, 046, 201	0	1, 046, 20	1 21, 782. 00	48.03	7.00
8.00	Central Services and Supply	0	0)	0.00	0.00	8.00
9.00	Pharmacy	0	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	118, 483	0	118, 48	3 3, 898. 00	30.40	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	203, 493	0	203, 49	3 11, 940. 00	17.04	13.00
14.00	Total (sum lines 1 thru 13)	3, 193, 870	a	3, 193, 87	0 139, 302. 00	22.93	14.00

SNF WA	GE RELATED COSTS	Provider No.: 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Prep 5/20/2024 3:03	pare
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
00	401K Employer Contributions			14, 152	1
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2
00	Qualified and Non-Qualified Pension Plan Cost			0	3
00	Prior Year Pension Service Cost			0	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			-	_
00	401K/TSA Plan Administration fees			0	5
00	Legal /Accounting/Management Fees-Pension Plan			0	6
00	Employee Managed Care Program Administration Fees			0	7
	HEALTH AND INSURANCE COST				
	Health Insurance (Purchased or Self Funded)			204, 724	8
00	Prescription Drug Plan			0	
	Dental, Hearing and Vision Plan			-248	
	Life Insurance (If employee is owner or beneficiary)			0	11
	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	14
	Workers' Compensation Insurance			204, 247	15
6.00	Retirement Health Care Cost (Only current year, not the extraord	linary accrual require	d by FASB 106.	0	16
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			657, 865	
	Medicare Taxes - Employers Portion Only			0	
	Unemployment Insurance			125, 384	
0. 00	State or Federal Unemployment Taxes			10, 053	20
00	OTHER				0.1
	Executive Deferred Compensation			0	21
	Day Care Cost and Allowances			0	22
	Tuition Reimbursement			0	23
4.00	Total Wage Related cost (Sum of lines 1 - 23)			1, 216, 177	24
				Amount	
				Reported 1.00	
	Part B - Other than Core Related Cost			1.00	

Heal th	Financial Systems CEDA	R GROVE RESPIRA	TORY AND NURSI	NG	In Lie	eu of Form CMS-2	2540-10
SNF RE	PORTING OF DIRECT CARE EXPENDITURES		Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	780, 715	117, 185	897, 90	0 18, 191. 00	49.36	1.00
2.00	Licensed Practical Nurses (LPNs)	2, 369, 616	355, 679	2, 725, 29	5 107, 403. 00	25.37	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2, 281, 860	342, 507	2, 624, 36	7 154, 141. 00	17.03	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5, 432, 191	815, 371	6, 247, 56	2 279, 735. 00	22. 33	4.00
5.00	Physical Therapists	0	0		0.00	0.00	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	0	C		0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	C)	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0)	0.00	0.00	10.00
11.00	Speech Therapi sts	0	C)	0 0.00	0.00	11.00

8.	00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.	00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10	0. 00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11	I. 00	Speech Therapists	0	0	0	0.00	0.00	11.00
12	2.00	Respi ratory Therapi sts	0	0	0	0.00	0.00	12.00
13	3.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
		Contract Labor						
		Nursing Occupations						
14	1.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15	5.00	Licensed Practical Nurses (LPNs)	609, 488		609, 488	12, 778. 00	47.70	15.00
16	5.00	Certified Nursing Assistant/Nursing	1, 965, 591		1, 965, 591	65, 947. 00	29.81	16.00
		Assi stants/Ai des						
17	7.00	Total Nursing (sum of lines 14 through 16)	2, 575, 079		2, 575, 079	78, 725. 00	32.71	17.00
	3.00	Physical Therapists	542, 722		542, 722	6, 942. 00	78.18	18.00
19	9.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20	0. 00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21	I. 00	Occupational Therapists	589, 789		589, 789	8, 492. 00	69.45	21.00
22	2.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23	3.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24	1.00	Speech Therapists	138, 599		138, 599	1, 655. 00	83.75	24.00
25	5.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26	5.00	Other Medical Staff	0		0	0.00	0.00	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	CEDAR GROVE RESPIRATORY AND NURSING Provider No.:		eu of Form CMS-2540- Worksheet S-7
		From 01/01/202 To 12/31/202	3
			5/20/2024 3:03 pm
		<u>Group</u> 1.00	Days 2.00
1.00		RUX	1.0
2.00		RUL	2.0
3.00 4.00		RVX RVL	3. 0
5.00		RHX	5.0
6.00		RHL	6.0
7.00		RMX	7.0
8.00		RML	8.0
9.00		RLX RUC	9. C 10. C
11.00		RUB	11.0
12.00		RUA	12.0
13.00		RVC	13.0
14. 00 15. 00		RVB RVA	14. C 15. C
16.00		RHC	16.0
17.00		RHB	17.0
18.00		RHA	18. C
19.00		RMC	19.0
20. 00 21. 00		RMB RMA	20.0
22.00		RLB	21.0
23.00		RLA	23.0
24.00		ES3	24.0
25. 00 26. 00		ES2 ES1	25. C 26. C
27.00		HE2	27.0
28.00		HE1	28.0
29.00		HD2	29.0
30. 00		HD1	30.0
31. 00 32. 00		HC2 HC1	31. C 32. C
33.00		HB2	33.0
34.00		HB1	34.0
35.00		LE2	35. C
36. 00 37. 00		LE1 LD2	36. C 37. C
38.00		LD2 LD1	38.0
39.00		LC2	39.0
40.00		LC1	40. C
41.00		LB2	41.0
42. 00 43. 00		LB1 CE2	42. C 43. C
44.00		CE1	44.0
45.00		CD2	45. C
46.00		CD1	46.0
47.00 48.00		CC2 CC1	47. C 48. C
49.00		CB2	48.0
50.00		CB1	50. C
51.00		CA2	51. C
52. 00 53. 00		CA1 SE3	52. C 53. C
53.00		SE2	53. C
55. 00		SE1	55. C
56.00		SSC	56. C
57.00		SSB	57. C
58.00 59.00		SSA I B2	58. C 59. C
60.00		I B2	60.0
61. 00		I A2	61.0
62.00		I A1	62.0
63. 00 64. 00		BB2 BB1	63. C 64. C
65. 00		BA2	65. C
66. 00		BA1	66. C
67.00		PE2	67.0
68.00		PE1	68. C
69. 00 70. 00		PD2 PD1	69. C 70. C
70.00		PD1 PC2	70.0
72.00		PC1	71.0
73.00		PB2	73.0
74.00		PB1	74.0

Health Financial Systems	CEDAR GROVE RESPIRATOR	Y AND NURS	ING	In Lie	u of Form CM	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DAT	ГА	Provi der	No.: 315257	Peri od:	Worksheet S	-7
				From 01/01/2023 To 12/31/2023		
				Group	Days	
				1.00	2.00	
76.00				PA1		76.00
99.00				AAA		99.00
100. 00 TOTAL			-			100.00
			Expenses	Percentage	Y/N	
			1.00	2.00	3.00	
A notice published in the Federal Re payments beginning 10/01/2003. Congr expenses. For lines 101 through 106: column 2 the percentage of total exp line 1, column 3. Indicate in column with direct patient care and related (See instructions)	ess expected this increase Enter in column 1 the amo enses for each category to 3 "Y" for yes or "N" for	to be used unt of the total SNF no if the s	l for direct expense for revenue from pending refl	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, Pa	rt I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

RECLAS	Financial Systems CEDA SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315257	Period:	Worksheet A	2540-10
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/20/2024 3:0	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati	Reclassi fi ed	
				+ col. 2)	ons	Trial Balance	
				· · · · ·	Increase/Decre		
					ase (Fr Wkst	col. 4)	
					A-6)		
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		6, 328, 942	6, 328, 94	12 0	6, 328, 942	1.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 295, 160	1, 295, 16		1, 295, 160	
4.00	00400 ADMI NI STRATI VE & GENERAL	627, 227	4, 056, 199	4, 683, 42		4, 683, 426	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	144, 735	677, 728	822, 46		822, 463	1
6.00	00600 LAUNDRY & LINEN SERVICE	35, 107	27, 192	62, 29		62, 299	
7.00	00700 HOUSEKEEPI NG	471, 018	45, 879	516, 89		516, 897	7.00
8.00	00800 DI ETARY	547, 606	600, 118	1, 147, 72	24 0	1, 147, 724	8.00
9.00	00900 NURSING ADMINISTRATION	1, 046, 201	27, 841	1, 074, 04	12 0	1, 074, 042	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	658, 108	658, 10	0 80	658, 108	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	12.00
13.00	01300 SOCI AL SERVI CE	118, 483	6, 644	125, 12		125, 127	13.00
15.00	01500 PATIENT ACTIVITIES	203, 493	49, 698	253, 19	91 0	253, 191	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	5, 432, 191	2, 698, 096	8, 130, 28		8, 130, 287	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 I CF/I I D	0	0		0 0	0	
33.00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	21, 492	21, 49	92 0	21, 492	40.00
40.00	04100 LABORATORY	0	21, 492	21, 49		21, 492	
41.00	04200 I NTRAVENOUS THERAPY	0	21, 301	21, 30		21, 301	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	18, 812	18, 81		18, 812	
44.00	04400 PHYSI CAL THERAPY	0	546, 401	546, 40		546, 401	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	589, 789	589, 78		589, 789	
46.00	04600 SPEECH PATHOLOGY	0	138, 599	138, 59		138, 599	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75, 992	75, 99	02 0	75, 992	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	423, 930	423, 93	30 0	423, 930	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
	OTHER REIMBURSABLE COST CENTERS						
71.00	07100 AMBULANCE	0	52, 696	52, 69		52, 696	
73.00	07300 CMHC	0	0		0 0	0	73.00
~~ ~~	SPECIAL PURPOSE COST CENTERS	1				-	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	
81.00	08100 I NTEREST EXPENSE		0		0 0	0	81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF	0	0		0 0	0	82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	8, 626, 061	0 18, 360, 697	26, 986, 75	0	0	83.00 89.00
07.00	NONREIMBURSABLE COST CENTERS	0,020,001	10, 300, 097	20, 900, 75	0	26, 986, 758	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
90.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPAID WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
94.00							

RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provider No.:	From 01/01/2023	sheet A
				To 12/31/2023 Date 5/20/	/2024 3:03 pm
	Cost Center Description	Adjustments to Expenses (Fr Wkst A-8)			
		6.00	<u>col. 6)</u> 7.00		
	GENERAL SERVICE COST CENTERS	0.00	1100		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-51, 573	6, 277, 369		1.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 295, 160		3.00
4.00	00400 ADMINI STRATI VE & GENERAL	-1, 149, 746	3, 533, 680		4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	822, 463		5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	62, 299		6.00
7.00	00700 HOUSEKEEPI NG	0	516, 897		7.00
8.00	00800 DI ETARY	-538	1, 147, 186		8.00
9.00	00900 NURSING ADMINISTRATION	0	1,074,042		9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	658, 108		10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		12.00
13.00	01300 SOCI AL SERVI CE	0	125, 127		13.00
15.00	01500 PATIENT ACTIVITIES	0	253, 191		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	. <u>.</u>			
30.00	03000 SKILLED NURSING FACILITY	-10, 570	8, 119, 717		30.00
31.00	03100 NURSING FACILITY	0	0		31.00
32.00	03200 I CF/I I D	0	o		32.00
33.00	03300 OTHER LONG TERM CARE	0	0		33.00
	ANCI LLARY SERVI CE COST CENTERS	. <u> </u>			
40.00	04000 RADI OLOGY	0	21, 492		40.00
41.00	04100 LABORATORY	0	21, 381		41.00
42.00	04200 INTRAVENOUS THERAPY	0	0		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	18, 812		43.00
44.00	04400 PHYSI CAL THERAPY	0	546, 401		44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	589, 789		45.00
46.00	04600 SPEECH PATHOLOGY	0	138, 599		46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75, 992		48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	423, 930		49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	O		50.00
51.00	05100 SUPPORT SURFACES	0	0		51.00
	OTHER REIMBURSABLE COST CENTERS				
	07100 AMBULANCE	0	52, 696		71.00
73.00	07300 CMHC	0	0		73.00
	SPECIAL PURPOSE COST CENTERS				
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80.00
81.00	08100 INTEREST EXPENSE	0	0		81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		82.00
83.00	08300 HOSPI CE	0	0		83.00
89.00	SUBTOTALS (sum of lines 1-84)	-1, 212, 427	25, 774, 331		89.00
	NONREI MBURSABLE COST CENTERS				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92.00
	09300 NONPALD WORKERS	0	0		93.00
94.00	09400 PATIENTS LAUNDRY	0	0		94.00
100.00	TOTAL	-1, 212, 427	25, 774, 331		100.00

Health Financial Systems CEL	AR GROVE RESPIRA	TORY AND NURSI	NG	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315257	Peri od:	Worksheet A-6)
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 3:0	epared: 03 pm
			Increases			
	Cost Co	enter	Line #	Sal ary	Non Salary	
	2.0	0	3.00	4.00	5.00	
TOTALS						
100. 00	Total Reclassif of columns 4 an equal sum of co 9)	d 5 must È		0	0	100.00

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

Health Financial Systems C	EDAR GROVE RESPIRATORY	AND NURSI	NG	In Lie	u of Form CMS	-2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315257	Period: From 01/01/2023	Worksheet A-	6
					Date/Time Pr 5/20/2024 3:	
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS						
100.00				0	(0 100. 00

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

RECON	n Financial Systems Cl CILIATION OF CAPITAL COSTS CENTERS	EDAR GROVE RESPIRA		No.: 315257	Peri od:	u of Form CMS-2 Worksheet A-7	
					From 01/01/2023 To 12/31/2023	Date/Time Prep 5/20/2024 3:03	bared: 3 pm
				Acqui si ti on	S		
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALAN	CES					
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	2, 722, 088	114, 747		0 114, 747	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	274, 588	65, 666		0 65, 666	0	6.00
7.00	Subtotal (sum of lines 1-6)	2, 996, 676	180, 413		0 180, 413	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	2, 996, 676	180, 413		0 180, 413	0	9.00
	Description	Endi ng Bal ance	Fully				
		_	Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALAN	CES					
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	2, 836, 835	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	340, 254	0				6.00
7.00	Subtotal (sum of lines 1-6)	3, 177, 089	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	3, 177, 089	0				9.00

ADJUST	Financial Systems CEDA MENTS TO EXPENSES	R GROVE RESPIRA		No.: 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Pre 5/20/2024 3:0	pared:
					lassification on ch the Amount is	Worksheet A	
	Description (1)	(2) Basis For Adjustment	Amount	Cost	t Center	Line No.	
1 00	Investment income on restricted funds	1.00	2.00		3.00	4.00	1.00
1.00	Investment income on restricted funds (chapter 2)	В	-68, 782	CAP REL COST	S - BLDGS &	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0			0.00	3.00
4.00	Rental of provider space by suppliers (chapter 8)		0			0.00	4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	5.00
6.00	Television and radio service (chapter 21)		0			0.00	6.00
7.00 8.00	Parking lot (chapter 21) Remuneration applicable to provider-based	A-8-2	0 0			0.00	7.00 8.00
0 00	physician adjustment					0.00	
9.00 10.00	Home office cost (chapter 21) Sale of scrap, waste, etc. (chapter 23)		0			0.00 0.00	
11.00	Nonallowable costs related to certain		0			0.00	
12.00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	-364, 508				12.00
	related organizations (chapter 10)		_				
13.00 14.00	Laundry and linen service Revenue - Employee meals		0				13.00
15.00	Cost of meals - Guests		0				15.00
16. 00	Sale of medical supplies to other than		0			0.00	16.00
17.00	patients Sale of drugs to other than patients		0			0.00	17.00
18.00	Sale of medical records and abstracts	В	- 320	ADMI NI STRATI	VE & GENERAL	4.00	
19. 00	Vending machines	В	-538	DI ETARY		8.00	1
20. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00	Interest expense on Medicare overpayments		0			0.00	21.00
	and borrowings to repay Medicare						
22. 00			0	UTI LI ZATI ON	REVIEW - SNF	82.00	22.00
23.00	(chapter 21) Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.00
24.00	Depreciationmovable equipment		Ω	FIXTURES *** Cost Cen	ter Deleted ***	2 00	24.00
	Other adjustment (specify)		0				25.00
25.01	BAD DEBTS	A		ADMI NI STRATI		4.00	25.01
25.02	CORPORATE TAX	A		ADMI NI STRATI		4.00	
25.03	MARKETI NG	A		ADMI NI STRATI		4.00	
25.04 25.05	DONATIONS RESIDENT MISSING ITEMS	A A		ADMI NI STRATI ADMI NI STRATI		4.00 4.00	
25.05	FINES & PENALTIES	A		ADMI NI STRATI		4.00	
25.07	PSYCH FEES	A		SKILLED NURS		30.00	25.07
	OTHER REVENUE - MISC	В		ADMI NI STRATI	VE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1, 212, 427				100.00
(1) De	scription - all chapter references in this co	lumn pertain to	CMS Pub. 15-1	і І.			1
(2) Ba	sis for adjustment (see instructions).						
	osts - if cost, including applicable overhead						

Health Fi	nancial Systems CEDA	R GROVE RESPIRA	ATORY AND NURSI	NG	In Lie	eu of Form CMS	-2540-10
STATEMENT OFFICE CO	T OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME			Period: From 01/01/2023 To 12/31/2023		repared:
		Line No.	Cost (Center	Expense	e Items	
		1.00	2.	00	3.	00	
	RT I. COSTS INCURRED AND ADJUSTMENTS REQUIR AIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	S OR	
1.00			CAP REL COSTS FIXTURES		RENT		1.00
2.00		4.00	ADMI NI STRATI VE	& GENERAL	REALTY ADMIN C	OSTS	2.00
3.00		4.00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT		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
)TALS (sum of lines 1-9). Transfer column line 100 to Worksheet A-8, column 3, line						10.00
12							
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minu	s		
		Cost	Wkst. A, col.	col. 5)			
			5	· ·			
		4.00	5.00	6.00			
	RT I. COSTS INCURRED AND ADJUSTMENTS REQUIR AIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	S OR	
1.00		5, 417, 209	5, 400, 000	17, 20)9		1.00
2.00		13, 454	0	13, 45	54		2.00
3.00		987, 022	1, 382, 193	-395, 17	71		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 TO)TALS (sum of lines 1-9). Transfer column line 100 to Worksheet A-8, column 3, line 2.	6, 417, 685	6, 782, 193	-364, 50	8		10.00

Health Financial Systems CEDA	R GROVE RESPIRAT	ORY AND NURSING	In Lie	u of Form CMS-2	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ/ OFFICE COSTS	ATIONS AND HOME	Provi der No. : 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8- Parts I-II Date/Time Prep 5/20/2024 3:03	ared:
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2.00	3.00		

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

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

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

1.00	A	PHIL BAK	28.00	1.00
2.00	A	SAM GOLDBERGER	28.00	2.00
3.00	A	MARK SONNENSCHINE	28.00	3.00
4.00	A	PHIL BAK	28.00	4.00
5.00	A	SAM GOLDBERGER	28.00	5.00
6.00	A	MARK SONNENSCHINE	28.00	6.00
7.00	A	DAVID HERZKA	15.00	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.

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of	Type of Business	
		Ownershi p		
	4.00	5.00	6.00	
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(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	MEADOW HEIGHTS REALTY, LLC	28.00	1.00
2.00	MEADOW HEIGHTS REALTY, LLC	28.00	2.00
3.00	MEADOW HEIGHTS REALTY, LLC	28.00	3.00
4.00	ATLAS HEALTHCARE MANAGEMENT	33.30	4.00
5.00	ATLAS HEALTHCARE MANAGEMENT	33.40	5.00
6.00	ATLAS HEALTHCARE MANAGEMENT	33.30	6.00
7.00	MEADOW HEIGHTS REALTY, LLC	15.00	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.

IN T20	Financial Systems CEDA LOCATION - GENERAL SERVICE COSTS		TORY AND NURSI		Period:	eu of Form CMS-: Worksheet B	2540-1
JUST AL	LUCATION - GENERAL SERVICE COSTS		Provider		From 01/01/2023 To 12/31/2023	Part I	pared: 3 pm
			CAPI TAL			0/20/2021 010	
	Cost Costos Description		RELATED COSTS		Cubtetel		
	Cost Center Description	Net Expenses for Cost	BLDGS & FI XTURES	EMPLOYEE BENEFI TS	Subtotal	ADMI NI STRATI VE & GENERAL	
		Allocation	TIXTURES	DENLITIS		& GENERAL	
		(from Wkst A					
		col. 7)					
		0	1.00	3.00	3A	4.00	
	GENERAL SERVICE COST CENTERS	L L					
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES	6, 277, 369	6, 277, 369				1.0
. 00	00300 EMPLOYEE BENEFITS	1, 295, 160	0	1, 295, 16	0		3.0
. 00	00400 ADMINISTRATIVE & GENERAL	3, 533, 680	366, 985	94, 17	5 3, 994, 840	3, 994, 840	4.0
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	822, 463	231, 922	21, 73	1 1, 076, 116	197, 383	5.0
. 00	00600 LAUNDRY & LINEN SERVICE	62, 299	104, 645		0 166, 944	30, 621	6.0
. 00	00700 HOUSEKEEPI NG	516, 897	67, 895	75, 99	2 660, 784	121, 202	7.0
. 00	00800 DI ETARY	1, 147, 186	553, 956	82, 22	0 1, 783, 362	327, 108	8.0
. 00	00900 NURSI NG ADMI NI STRATI ON	1, 074, 042	0	157, 08	2 1, 231, 124	225, 815	9.0
0. 00	01000 CENTRAL SERVICES & SUPPLY	658, 108	49, 831		0 707, 939	129, 852	10.0
2.00	01200 MEDICAL RECORDS & LIBRARY	0	22, 839		0 22, 839	4, 189	12.0
3.00	01300 SOCIAL SERVICE	125, 127	21, 593	17, 79	0 164, 510	30, 175	13. C
	01500 PATIENT ACTIVITIES	253, 191	306, 461	30, 55	3 590, 205	108, 257	15.0
[INPATIENT ROUTINE SERVICE COST CENTERS						
D. 00 [03000 SKILLED NURSING FACILITY	8, 119, 717	4, 443, 274	815, 61	7 13, 378, 608	2, 453, 932	30.0
	03100 NURSING FACILITY	0	0		0 0	0	31. C
2.00	03200 I CF/I I D	0	0		0 0	0	32.0
3.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.0
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	21, 492	0		0 21, 492	3, 942	40.0
	04100 LABORATORY	21, 381	0		0 21, 381	3, 922	
	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.0
	04300 OXYGEN (INHALATION) THERAPY	18, 812	0		0 18, 812		
	04400 PHYSI CAL THERAPY	546, 401	78, 069		0 624, 470	114, 542	44.0
	04500 OCCUPATI ONAL THERAPY	589, 789	0		0 589, 789		
	04600 SPEECH PATHOLOGY	138, 599	0		0 138, 599		
	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.C
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	75, 992	0		0 75, 992		
	04900 DRUGS CHARGED TO PATIENTS	423, 930	0		0 423, 930		
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	-	50.0
	05100 SUPPORT SURFACES	0	0		0 0	0	51.0
	OTHER REIMBURSABLE COST CENTERS	F2 (0)	0		0 52 (0)	0.///	71 0
	07100 AMBULANCE	52, 696	0		0 52, 696		
H		0	0		0 0	0	73.0
	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1					
							80.0
	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. C
	08200 HILLZATION REVIEW - SNF 08300 HOSPICE	0	0		0	_	0.000
3.00 9.00	SUBTOTALS (sum of lines 1-84)	25, 774, 331	6, 247, 470	1, 295, 16	0 25, 744, 432	0 3, 989, 356	
	NONREIMBURSABLE COST CENTERS	25,774,331	0,247,470	1, 290, 10	20, 744, 432	3, 707, 330	09.0
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.0
	09000 BARBER AND BEAUTY SHOP	0	29, 899		0 29,899		
	09200 PHYSICIANS PRIVATE OFFICES	0	27,099		27,099	0, 484 J	91.0
	09200 PHYSICIANS PRIVATE OFFICES	0	0				92. C 93. C
	09400 PATIENTS LAUNDRY	0	0			0	93. C
4.00 8.00	Cross Foot Adjustments	0	0				94.0
9.00	Negative Cost Centers	0	0				98. C
		0	0		U U	0	77.U
9.00 00.00	TOTAL	25, 774, 331	6, 277, 369	1, 295, 16	0 25, 774, 331	3, 994, 840	100 0

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315257	Peri od: From 01/01/2023 To 12/31/2023		
	Cost Center Description	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		NURSI NG ADMI NI STRATI ON	
		REPAI RS	(00	7.00	0.00	0.00	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 273, 499					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	23, 469					6.00
7.00	00700 HOUSEKEEPI NG	15, 227		1	13		7.00
8.00	00800 DI ETARY	124, 235					8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	1, 456, 939	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	11, 176	0	7, 2'	15 0	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	5, 122				0	12.00
13.00	01300 SOCIAL SERVICE	4, 843					13.00
15.00	01500 PATIENT ACTIVITIES	68, 730					
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	996, 484	221, 034	643, 3	50 2, 314, 913	1, 456, 939	30.00
31.00	03100 NURSING FACILITY	0			0 0	0	31.00
32.00	03200 I CF/I I D	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 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	04300 OXYGEN (INHALATION) THERAPY	0	0)	0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	17, 508	0	11, 30	04 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0)	0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			0 0		50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OTHER REIMBURSABLE COST CENTERS	1		1	1	r	
71.00	07100 AMBULANCE	0			0 0		71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS	1		1			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	1, 266, 794	221, 034	792, 88	2, 314, 913	1, 456, 939	89.00
00.05	NONREI MBURSABLE COST CENTERS	-	-	1	0 -	-	00.07
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	6, 705	0	4, 32	29 0	-	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	1	0	0	92.00
93.00	09300 NONPAID WORKERS	0	0	1	0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	1	0	0	94.00
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00 100.00	Negative Cost Centers	0	0		0 0	0	99.00
	TOTAL	1, 273, 499	221,034	797, 2	13 2, 314, 913	1, 456, 939	1100 00

	Financial Systems CEDA LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre	
					OTHER GENERAL	5/20/2024 3:0	13 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI	CE PATIENT ACTIVITIES	Subtotal	
		10.00	12.00	13.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1		T			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
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	00700 HOUSEKEEPING						7.00
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	856, 182					10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	030, 182	35, 457	,			12.00
13.00	01300 SOCIAL SERVICE	0	33, 437 C		55		13.00
15.00	01500 PATIENT ACTIVITIES	0	C		0 811, 565		15.00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		́и	0 011, 303		15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	486, 568	35, 457	202,6	55 811, 565	23, 001, 505	30.00
31.00	03100 NURSING FACILITY	0	C 00, 10,		0 0	0	1
32.00	03200 I CF/I I D	0	C		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	C		0 0	0	
	ANCI LLARY SERVI CE COST CENTERS			1			
40.00	04000 RADI OLOGY	0	C		0 0	25, 434	40.00
41.00	04100 LABORATORY	0	C		0 0	25, 303	
42.00	04200 I NTRAVENOUS THERAPY	0	C		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C		0 0	22, 263	43.00
44.00	04400 PHYSI CAL THERAPY	0	C		0 0	767, 824	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	C		0 0	697, 969	45.00
46.00	04600 SPEECH PATHOLOGY	0	C		0 0	164, 021	46.00
47.00	04700 ELECTROCARDI OLOGY	0	C		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	56, 184	C		0 0	146, 115	
49.00	04900 DRUGS CHARGED TO PATIENTS	313, 430	C	D.	0 0	815, 118	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	D	0 0	0	
51.00	05100 SUPPORT SURFACES	0	C		0 0	0	51.00
74 00	OTHER REIMBURSABLE COST CENTERS					(0.0(0	74 00
71.00 73.00	07100 AMBULANCE	0	C		0 0	62, 362	
/3.00	07300 CMHC	0	C	<u>и</u>	0 0	0	73.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
80.00	08100 INTEREST EXPENSE						80.00
81.00	08200 UTILIZATION REVIEW - SNF						81.00
83.00	08300 H0SPI CE	0	C		0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	856, 182	35, 457	202,6	55 811, 565	25, 727, 914	1
07.00	NONREI MBURSABLE COST CENTERS	000, 102	00, 107	202,0	011,000	20,727,711	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	C		0 0	46, 417	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C C		0 0	40, 417	1
93.00	09300 NONPAI D WORKERS	0	C		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	C C		0 0	0	
98.00	Cross Foot Adjustments	0			0	0	
99.00	Negative Cost Centers	0	C	þ	0 0	0	1

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		AK GROVE RESFIRA					2340-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315257	Period: From 01/01/2023 To 12/31/2023		pared:
					10 12/01/2020	5/20/2024 3:0	3 pm
	Cost Center Description	Post Stepdown	Total				
		Adjustments					
		17.00	18.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
15.00	01500 PATIENT ACTIVITIES						15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		22 001 505	1			1 20 00
30.00	03000 SKILLED NURSING FACILITY	0	23, 001, 505	1			30.00
31.00	03100 NURSING FACILITY	0	0				31.00
32.00 33.00	03200 I CF/I I D	0	0	•			32.00
33.00	O3300 OTHER LONG TERM CARE	0	0	1			33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	25, 434				40.00
40.00	04100 LABORATORY	0	25, 434	1			40.00
41.00	04200 INTRAVENOUS THERAPY	0	25, 303	1			41.00
42.00	04300 OXYGEN (INHALATION) THERAPY	0	22, 263	1			42.00
43.00	04400 PHYSI CAL THERAPY	0	767, 824	1			43.00
45.00	04500 OCCUPATI ONAL THERAPY	0	697, 969	1			45.00
46.00	04600 SPEECH PATHOLOGY	0	164, 021				46.00
47.00	04700 ELECTROCARDI OLOGY	0	104, 021	1			47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	146, 115				48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	815, 118				49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	010, 110				50.00
51.00	05100 SUPPORT SURFACES	0	0				51.00
011.00	OTHER REIMBURSABLE COST CENTERS	1 0		1			
71.00	07100 AMBULANCE	0	62, 362				71.00
73.00	07300 CMHC	0	0				73.00
	SPECIAL PURPOSE COST CENTERS	- I					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0				83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	25, 727, 914				89.00
	NONREI MBURSABLE COST CENTERS						1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	46, 417				91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0				92.00
93.00	09300 NONPAID WORKERS	0	0				93.00
94.00	09400 PATIENTS LAUNDRY	0	0				94.00
98.00	Cross Foot Adjustments	0	0				98.00
99.00	Negative Cost Centers	0	0				99.00
100.00	TOTAL	0	25, 774, 331				100.00

Heal th	Financial Systems CEDA	AR GROVE RESPIRA	ATORY AND NURSI	NG	In Lie	u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2023 To 12/31/2023		pared: 3 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDGS & FI XTURES	Subtotal	EMPLOYEE BENEFI TS	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	3.00	4.00	
	GENERAL SERVICE COST CENTERS	Т	1	1	1	L	
1.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS	0	0	0	0	244 005	1.00 3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	366, 985 231, 922			366, 985 18, 133	4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	104, 645			2, 813	
7.00	00700 HOUSEKEEPI NG	0	67, 895	67, 895	5 O	11, 134	7.00
8.00	00800 DI ETARY	0	553, 956	553, 956	0	30, 050	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	C	-	-	20, 744	
	01000 CENTRAL SERVICES & SUPPLY	0	49, 831	49, 831		11, 929	
	01200 MEDICAL RECORDS & LIBRARY	0	22, 839			385	
	01300 SOCIAL SERVICE 01500 PATIENT ACTIVITIES		21, 593 306, 461			2, 772	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	300, 401	300, 401	0	9,943	15.00
30.00	03000 SKILLED NURSING FACILITY	0	4, 443, 274	4, 443, 274	0	225, 431	30.00
	03100 NURSING FACILITY	0				0	
32.00	03200 CF/I D	0	C	C	0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	C	C	0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS	1	1	1	Т		
	04000 RADI OLOGY	0	0	-			
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0			, e	360	1
	04200 OXYGEN (INHALATION) THERAPY					317	
	04400 PHYSI CAL THERAPY	0	78, 069	78, 069	0	10, 522	1
	04500 OCCUPATI ONAL THERAPY	0	0	C		9, 938	1
	04600 SPEECH PATHOLOGY	0	C	C	0 0	2, 335	
47.00	04700 ELECTROCARDI OLOGY	0	C	C	0 0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	1, 280	
	04900 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	7, 143	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C		0	
51.00	05100 SUPPORT SURFACES OTHER REIMBURSABLE COST CENTERS	0	C	C	0 0	0	51.00
71.00	07100 AMBULANCE	0	C	C	0 0	888	71.00
	07300 CMHC	0					
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83.00 89.00	08300 HOSPI CE	0			0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	6, 247, 470	6, 247, 470	0	366, 481	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0) ()	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	29, 899	29, 899	0		
	09200 PHYSI CLANS PRI VATE OFFI CES	0	C	C	0	0	
	09300 NONPAID WORKERS	0	0	C	0 0	0	
	09400 PATIENTS LAUNDRY	0	0	C	0	0	
98.00	Cross Foot Adjustments		_	C C			98.00
99. 00 100. 00	Negative Cost Centers TOTAL	0	6, 277, 369	6, 277, 369			
100.00	INTRE	1 0	0,211,309	0,211,309	, U	J 300, 703	1.00.00

Heal th	Financial Systems CEDA	R GROVE RESPIR	ATORY AND NURSI	NG	In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
					From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	narod
					10 12/31/2023	5/20/2024 3:0	3 pm
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	·	OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1	1		1		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	250, 055					5.00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	4,608			0		6.00
7.00 8.00	00800 DI ETARY	2,990		82, 01			7.00 8.00
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	24, 394		8, 25	2 616, 652 0 0	20, 744	9.00
9.00 10.00	01000 CENTRAL SERVICES & SUPPLY	2, 194	-	74	0	20, 744	9.00
10.00	01200 MEDICAL RECORDS & LIBRARY	1, 006		34	-	0	10.00
12.00	01300 SOCIAL SERVICE	951		32		0	12.00
15.00	01500 PATIENT ACTIVITIES	13, 495			-	0	15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	15,475	0	4, 30	5 0	0	15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	195, 662	112, 066	66, 19	0 616, 652	20, 744	30.00
31.00	03100 NURSI NG FACI LI TY	0			0 0	20,711	31.00
32.00	03200 I CF/I I D				0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE				0 0	0	33.00
00.00	ANCI LLARY SERVICE COST CENTERS		1 0		0		00.00
40.00	04000 RADI OLOGY	0	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	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	3, 438	0	1, 16	3 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0 0		0 0	0	51.00
	OTHER REIMBURSABLE COST CENTERS	I.	I				
71.00	07100 AMBULANCE	0			0 0	0	71.00
73.00	07300 CMHC	0	0 0		0 0	0	73.00
~~ ~~	SPECIAL PURPOSE COST CENTERS	1	1				
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0	i i	01 57	0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	248, 738	112, 066	81, 57	4 616, 652	20, 744	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP	1, 317		44		0	90.00
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	1, 317			0 0	0	91.00
92.00 93.00	09300 NONPAID WORKERS		-		0 0	0	92.00
93.00 94.00	09400 PATIENTS LAUNDRY					0	93.00
94.00 98.00	Cross Foot Adjustments		0			0	94.00 98.00
99.00	Negative Cost Centers	0	, o		0 0	0	99.00
100.00	5	250, 055	u u		0	20, 744	
	1	200,000	1 12,000	02,01	- 010,002	20, 744	1.00.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/20/2024 3:0	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVIO	OTHER GENERAL SERVICE CE PATIENT ACTIVITIES	Subtotal	
		10.00	12.00	13.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	[]		1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	64, 696					10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	24, 570)			12.00
13.00	01300 SOCIAL SERVICE	0	C	25, 63	38		13.00
15.00	01500 PATIENT ACTIVITIES	0	C)	0 334, 466		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	36, 767	24, 570	25, 63	38 334, 466	6, 101, 460	30.00
31.00	03100 NURSING FACILITY	0	C		0 0	0	31.00
	03200 I CF/I I D	o	C		0 0	0	32.00
	03300 OTHER LONG TERM CARE	0	Ċ		0 0	0	
	ANCILLARY SERVICE COST CENTERS	· · · · ·		1	-1 -1		
40.00	04000 RADI OLOGY	0	(0 0	362	40.00
	04100 LABORATORY	0	Ċ		0 0	360	
42.00	04200 I NTRAVENOUS THERAPY	0	Ċ		0 0	0	1
	04300 OXYGEN (INHALATION) THERAPY	0	(0 0	317	1
44.00	04400 PHYSI CAL THERAPY	0	(0 0	93, 192	1
	04500 OCCUPATI ONAL THERAPY	0	(0 0	9, 938	
	04600 SPEECH PATHOLOGY	0	(0 0	2, 335	
	04700 ELECTROCARDI OLOGY	0	(0 0	2,000	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 245	(0 0	5, 525	
49.00	04900 DRUGS CHARGED TO PATIENTS	23, 684	(0 0	30, 827	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	23,004	(0 0	0	
51.00	05100 SUPPORT SURFACES	0	C		0 0	0	1
51.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	,	<u>′</u>	<u> </u>	0	31.00
71.00	07100 AMBULANCE	0	(0 0	888	71.00
	07300 CMHC	0	(0 0	000	
75.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	C. C.	<u>′</u>	<u> </u>	0	/ 3. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
80.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF		-			~	82.00
83.00	08300 HOSPICE	0				0	
89.00	SUBTOTALS (sum of lines 1-84)	64, 696	24, 570	25, 63	38 334, 466	6, 245, 204	89.00
00 00	NONREI MBURSABLE COST CENTERS			1			00.05
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	
	09100 BARBER AND BEAUTY SHOP	0	C		0 0	32, 165	
	09200 PHYSICIANS PRIVATE OFFICES	0	C		0 0	0	
	09300 NONPAI D WORKERS	0	C		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	C		0 0	0	
98.00	Cross Foot Adjustments	0			0	0	
99.00	Negative Cost Centers	0	C)	0 0	0	99.00
100.00		64, 696				6, 277, 369	

Heal th	Fi nan	ci al	Syste	ems	
ALL 00A					0

	TION OF CAPITAL RELATED COSTS			No. : 315257	Period: From 01/01/2023	Worksheet B Part II	
					To 12/31/2023	Date/Time Prep 5/20/2024 3:03	
	Cost Center Description	Post Step-Down	Total			072072024 0.05	
		Adjustments					
		17.00	18.00	1			
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
15.00	01500 PATIENT ACTIVITIES						15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	6, 101, 460				30.00
31.00	03100 NURSING FACILITY	0	0	•			31.00
32.00	03200 I CF/I I D	0	0	•			32.00
33.00	03300 OTHER LONG TERM CARE	0	0				33.00
	ANCI LLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	362				40.00
41.00		0	360				41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	•			42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	317				43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	93, 192				44.00 45.00
45.00	04600 SPEECH PATHOLOGY	0	9, 938 2, 335				45.00 46.00
48.00	04700 ELECTROCARDI OLOGY	0	2, 335	1			48.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 525				47.00
48.00	04900 DRUGS CHARGED TO PATIENTS	0	30, 827				48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	30, 827				49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0				51.00
51.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	1			51.00
71.00	07100 AMBULANCE	0	888				71.00
73.00	07300 CMHC	0	0				73.00
/0/00	SPECIAL PURPOSE COST CENTERS						/0/00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0				83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	6, 245, 204				89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	32, 165				91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0				92.00
93.00	09300 NONPAI D WORKERS	0	0				93.00
94.00	09400 PATIENTS LAUNDRY	0	0				94.00
98.00	Cross Foot Adjustments	0	0				98.00
99.00	Negative Cost Centers	0	0				99.00
100.00	TOTAL	0	6, 277, 369			1	100.00

COST A	Financial Systems CEDA LLOCATION - STATISTICAL BASIS	R GROVE RESPIRA			Period:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
	Cost Center Description	CAPI TAL RELATED COSTS BLDGS & FI XTURES (SQUARE FEET)	EMPLOYEE BENEFI TS (GROSS SALARI ES)	Reconciliatior	ADMI NI STRATI VE & GENERAL (ACCUM COST)	5/20/2024 3:0 PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	3 pm
		1.00	3.00	4A	4.00	5.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	60, 467 0 3, 535 2, 234	8, 626, 061 627, 227 144, 735	-3, 994, 840		54, 698	1.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	1, 008 654 5, 336 0	0 506, 125 547, 606 1, 046, 201		166, 944 660, 784 1, 783, 362 1, 231, 124	1, 008 654 5, 336 0	6.00 7.00 8.00 9.00
12. 00 13. 00	01000 CENTRAL SERVICES & SUPPLY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	480 220 208 2, 952	0 0 118, 483 203, 493		22, 839 164, 510	480 220 208 2, 952	12.00 13.00
31. 00 32. 00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY 03200 I CF/I I D 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	42,800 0 0 0	5, 432, 191 C C C			42, 800 0 0 0	31.00 32.00
41.00 42.00 43.00 44.00 45.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0 0 0 752 0 0		C	21, 381 0 18, 812 624, 470 589, 789	0 0 0 752 0 0	41.00 42.00 43.00 44.00 45.00
48.00 49.00 50.00 51.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TI TLE XI X ONLY 05100 SUPPORT SURFACES OTHER REI MBURSABLE COST CENTERS	0 0 0 0			75, 992 423, 930	0 0 0 0	48.00 49.00 50.00
71.00	07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0	C C			0	
81.00 82.00 83.00 89.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 60, 179	C 8, 626, 061	(-3, 994, 840	, v	0 54, 410	80.00 81.00 82.00 83.00 89.00
90.00 91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments	0 288 0 0 0	0 0 0 0 0	C	29, 899 0 0	0 288 0 0 0	91.00 92.00 93.00
99. 00 102. 00 103. 00	Part I)	6, 277, 369 103. 814792	1, 295, 160 0. 150145		3, 994, 840 0. 183422	1, 273, 499 23. 282369	
103.00 104.00 105.00	Cost to be allocated (per Wkst. B, Part II)	100.014772	0. 000000		366, 985 0. 016850	250, 055 4. 571557	104.00

ST A	Financial Systems CEDA LLOCATION - STATISTICAL BASIS		Provi der	No.: 315257	Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2023	D 1 (T) D	
					To 12/31/2023	Date/Time Pre 5/20/2024 3:0	
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DIETARY	NURSI NG	CENTRAL	T
				(MEALS SERVE) ADMI NI STRATI ON	SERVICES &	
		(PATI ENT				SUPPLY	
		CENSUS)			(DI RECT	(COSTED	
					NURSI NG)	REQUIS.)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	T	I	1			
00	00100 CAP REL COSTS - BLDGS & FIXTURES						1
00	00300 EMPLOYEE BENEFITS						
0	00400 ADMINISTRATIVE & GENERAL						4
00	00500 PLANT OPERATION, MAINT. & REPAIRS						5
0	00600 LAUNDRY & LINEN SERVICE	62, 469					6
0	00700 HOUSEKEEPI NG	0	53, 036				
00	00800 DI ETARY	0	5, 336				8
00	00900 NURSI NG ADMI NI STRATI ON	0	C		0 358, 459		
00	01000 CENTRAL SERVICES & SUPPLY	0	480		0 0	1, 158, 030	
00	01200 MEDI CAL RECORDS & LI BRARY	0	220		0 0	0	
00	01300 SOCI AL SERVI CE	0			0 0	0	
00	01500 PATIENT ACTIVITIES	0	2, 952		0 0	0	1
~ ~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			107.11		(50.400	1
00	03000 SKI LLED NURSI NG FACI LI TY	62, 469	42, 800			658, 108	
00	03100 NURSING FACILITY	0	0		0 0	0	
00	03200 CF/I D	0			0 0	0	
00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	3
~~	ANCI LLARY SERVICE COST CENTERS	-				-	1.
00	04000 RADI OLOGY	0			0 0	0	
00	04100 LABORATORY	0			0 0	0	
00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	1
00	04300 OXYGEN (INHALATION) THERAPY	0	C		0 0	0	
00	04400 PHYSI CAL THERAPY	0	752		0 0	0	
00	04500 OCCUPATI ONAL THERAPY	0	C		0 0	0	
00	04600 SPEECH PATHOLOGY	0	0		0 0	0	
00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	75, 992	
00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	423, 930	
00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	
00	05100 SUPPORT SURFACES	0	0	1	0 0	0	5
~~	OTHER REIMBURSABLE COST CENTERS					0	
00	07100 AMBULANCE	0			0 0	0	
00	07300 CMHC	0	0		0 0	0	7
~~	SPECIAL PURPOSE COST CENTERS			1			١.,
00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						8
00	08100 INTEREST EXPENSE						8
00	08200 UTILIZATION REVIEW - SNF				0	0	8
00	08300 HOSPICE	0	E2 740	107 4	0 0	1 150 020	
00	SUBTOTALS (sum of lines 1-84)	62, 469	52, 748	187, 40	358, 459	1, 158, 030	8
00	NONREIMBURSABLE COST CENTERS				0 0	0	
00 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0			0 0	0	
00	09200 PHYSICIANS PRIVATE OFFICES	0	288	1	0 0	0	
00	09300 NONPAID WORKERS				0 0	0	
00	09400 PATIENTS LAUNDRY					0	
00	Cross Foot Adjustments	0				0	9
	5	-					9
00	Negative Cost Centers	221 024	107 010	2 214 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0E4 100	
. 00	Cost to be allocated (per Wkst. B, Part I)	221, 034	797, 213	2, 314, 9	13 1, 456, 939	856, 182	10
. 00		3. 538299	15. 031545	12.35232	4. 064451	0. 739344	10
1. 00		3. 538299				0. 739344 64, 696	
t. UU	Part II)	112,000	02,019	010,0	20, 744	04, 090	'l'''
5.00		1. 793946	1. 546478	3. 2904	43 0. 057870	0. 055867	10
,. UU		1. / 73740	1.540470	3. 27044	· · · · · · · · · · · · · · · · · · ·	0.00007	1.05

	Financial Systems CEDA LOCATION - STATISTICAL BASIS		ATORY AND NURSI	No.: 315257	In Lieu of Form Period: Workshee	
JUST AL	LUCATION - STATISTICAL DASIS		FIOVICE	NO 315257	From 01/01/2023	ST D-1
						ne Prepared: 24 3:03 pm
				OTHER GENERA		<u>.4 0.05 pm</u>
				SERVI CE	_	
	Cost Center Description	MEDICAL RECORDS &	SOCI AL SERVI CE	ACTI VI TI ES		
		LIBRARY	(PATI ENT	(PATIENT		
		(PATI ENT	CENSUS)	CENSUS)		
		CENSUS)				
		12.00	13.00	15.00		
+	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES					1.0
	00300 EMPLOYEE BENEFITS					3.0
	00400 ADMI NI STRATI VE & GENERAL					4.0
	00500 PLANT OPERATION, MAINT. & REPAIRS					5.0
	00600 LAUNDRY & LINEN SERVICE					6. 0
00	00700 HOUSEKEEPI NG					7.0
	00800 DI ETARY					8.0
	00900 NURSI NG ADMI NI STRATI ON					9. (
	01000 CENTRAL SERVICES & SUPPLY					10. (
	01200 MEDI CAL RECORDS & LI BRARY	62, 469				12.0
	01300 SOCIAL SERVICE	0	62, 469			13. (
H	01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	62,46	59	15.0
	03000 SKILLED NURSING FACILITY	62, 469	62, 469	62, 46	59	30.0
	03100 NURSING FACILITY	02,407	02,407		0	31.0
	03200 CF/I D	0	0	1	0	32.0
	03300 OTHER LONG TERM CARE	0	0	1	0	33. (
Ī	ANCI LLARY SERVICE COST CENTERS					
D. 00 🏾	04000 RADI OLOGY	0	0		0	40.0
	04100 LABORATORY	0	0		0	41.0
	04200 I NTRAVENOUS THERAPY	0	0)	0	42.0
	04300 OXYGEN (INHALATION) THERAPY	0	0		0	43.0
		0	0		0	44.0
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0	45.0
	04700 ELECTROCARDI OLOGY	0	0		0	47.0
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	48.0
	04900 DRUGS CHARGED TO PATIENTS	0	0		0	49.0
1	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	50.0
1.00	05100 SUPPORT SURFACES	0	0)	0	51.0
	OTHER REIMBURSABLE COST CENTERS			1		
	07100 AMBULANCE	0			0	71.0
		0	0)	0	73. (
	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES					80. (
	08000 MALPRACTICE PREMIUMS & PAID LUSSES 08100 INTEREST EXPENSE					80.0
	08200 UTILIZATION REVIEW - SNF					82. 0
	08300 HOSPI CE	0	0		0	83. (
9.00	SUBTOTALS (sum of lines 1-84)	62, 469	62, 469	62, 46	59	89.0
	NONREI MBURSABLE COST CENTERS					
D. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0)	0	90. (
	09100 BARBER AND BEAUTY SHOP	0	0		0	91. (
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	92. (
	09300 NONPAID WORKERS	0	0		0	93. (
	09400 PATIENTS LAUNDRY	0	0		0	94.0
3.00	Cross Foot Adjustments					98.0
2.00	Negative Cost Centers	25 157	202 455	011 5	5	99. (
02.00	Cost to be allocated (per Wkst. B, Part I)	35, 457	202, 655	811, 56		102. (
03. 00	Unit cost multiplier (Wkst. B, Part I)	0. 567594	3. 244089	12.99148	34	103. (
04.00	Cost to be allocated (per Wkst. B,	24, 570				103.0
00	Part II)	21,070	20,000			01.0
05.00	Unit cost multiplier (Wkst. B, Part	0. 393315	0. 410412	5. 3541	12	105. C
	11)			1		

Health Financial Systems CEDAR GROVE RESPIRATORY AND NUR	SENG	In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provide		Peri od:	Worksheet C	
		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/20/2024 3:0	pared: 3 pm
Cost Center Description	Total (from	Total Charges	Ratio (col. 1	
	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	_			
40. 00 04000 RADI OLOGY	25, 43			
41. 00 04100 LABORATORY	25, 30	3 16, 092		
42. 00 04200 I NTRAVENOUS THERAPY		0 0	0. 000000	
43.00 04300 0XYGEN (INHALATION) THERAPY	22, 26	3 0	0.000000	43.00
44.00 04400 PHYSI CAL THERAPY	767, 82	4 719, 439	1.067254	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	697, 96	9 874, 022	0. 798571	45.00
46.00 04600 SPEECH PATHOLOGY	164, 02	1 277, 643	0. 590762	46.00
47. 00 04700 ELECTROCARDI OLOGY		0 0	0.00000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	146, 11	5 0	0.00000	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	815, 11	8 297, 799	2.737141	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY		0 0	0.00000	50.00
51.00 05100 SUPPORT SURFACES		0 0	0.00000	51.00
OUTPATIENT SERVICE COST CENTERS				
71.00 07100 AMBULANCE	62, 36	2 0	0.00000	71.00
100. 00 Total	2, 726, 40	9 2, 193, 637		100. 00

Health Financial Systems	CEDAR GROVE RESPIRA	ATORY AND NURSI	NG	In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	5	Provi der	No.: 315257	Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pi	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	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 OU	IPATIENT COST					-
ANCI LLARY SERVICE COST CENTERS	0.040040	4 457	1	0 40.004		1 40 00
40. 00 04000 RADI 0L0GY	2. 943069			0 12, 234		
41. 00 04100 LABORATORY	1. 572396			0 1,877		
42.00 04200 I NTRAVENOUS THERAPY	0. 000000			0 0	0	
43. 00 04300 0XYGEN (INHALATION) THERAPY	0.00000			0 0	0	
44. 00 04400 PHYSI CAL THERAPY	1.067254			0 345, 992		1
45. 00 04500 OCCUPATIONAL THERAPY	0. 798571			0 267, 724		
46. 00 04600 SPEECH PATHOLOGY	0. 590762			0 70, 549		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENT				0 0	0	1 .0.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	2. 737141			0 647, 796	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0	1	0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS	0,00000		1	0		71.00
71.00 07100 AMBULANCE (2)	0. 000000			0 1 244 172		
100.00 Total (Sum of lines 40 - 71)	. 1	1, 020, 884	1	0 1, 346, 172	1 0	100.00
(1) For title V and XIX use columns 1, 2, and 4	only.					

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

Health Financial Systems CEDA	R GROVE RESPIRA	ATORY AND NURSI	NG	In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00Drugs charged to patients - ratio of co2.00Program vaccine charges (From your reco3.00Program costs (Line 1 x line 2) (TitleE, Part I, line 18)	rds, or the PS&	&R)			2. 737141 1, 128 3, 087	
Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	(From Wkst. B,		I I, CoI. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				-
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	25 424	0	0.00000	0 10 004	0	40.00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY	25, 434 25, 303 0	C C	0. 00000 0. 00000 0. 00000	0 1, 877 0 0	0 0 0	41.00
43. 00 04300 0XYGEN (I NHALATI 0N) THERAPY 44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 OCCUPATI ONAL THERAPY	22, 263 767, 824 697, 969		0. 00000 0. 00000 0. 00000	0 345, 992	0 0 0	101.00
46.00 04600 SPEECH PATHOLOGY 47.00 04700 ELECTROCARDI OLOGY 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	164, 021 0 146, 115	C C C	0. 00000 0. 00000 0. 00000	0 0	0 0 0	1
49.00 04900 DRUGS CHARGED TO PATIENTS 50.00 05000 DENTAL CARE - TITLE XIX ONLY 51.00 05100 SUPPORT SURFACES 100.00 Total (Sum of Lines 40 - 52)	815, 118 0 0 2, 664, 047		0.00000 0.00000 0.00000	0 0	0 0 0	1

omput.	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315257	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/20/2024 3:0	pared
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	INPATIENT DAYS				
. 00	Inpatient days including private room days			62, 469	1. (
. 00	Private room days			0	2.
. 00	Inpatient days including private room days applicable to the	e Program		8, 706	3.
. 00	Medically necessary private room days applicable to the Prog	gram		0	4.
. 00	Total general inpatient routine service cost			23, 001, 505	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				1
. 00	General inpatient routine service charges			27, 055, 624	6.
00	General inpatient routine service cost/charge ratio (Line !	5 divided by line 6)		0.850156	7.
00	Enter private room charges from your records			0	8.
00	Average private room per diem charge (Private room charges 1 2)	line 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 roo semi-private room days)	om charges line 10, divide	d by	0.00	11.
2.00	Average per diem private room charge differential (Line 9 mi	inus line 11)		0.00	12.
8.00	Average per diem private room cost differential (Line 7 time	es line 12)		0.00	13.
. 00	Private room cost differential adjustment (Line 2 times line	e 13)		0	14
. 00	General inpatient routine service cost net of private room of PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus line 14)	23, 001, 505	15
. 00	Adjusted general inpatient service cost per diem (Line 15 o	divided by line 1)		368.21	16
	Program routine service cost (Line 3 times line 16)	2		3, 205, 636	17
. 00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18
	Total program general inpatient routine service cost (Line			3, 205, 636	19
. 00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	6, 101, 460	20
. 00	Per diem capital related costs (Line 20 divided by line 1)			97.67	21
. 00	Program capital related cost (Line 3 times line 21)			850, 315	22
. 00	Inpatient routine service cost (Line 19 minus line 22)			2, 355, 321	23
. 00	Aggregate charges to beneficiaries for excess costs (From)	provider records)		0	24
. 00	Total program routine service costs for comparison to the co	ost limitation (Line 23 mi	nus line 24)	2, 355, 321	25
. 00	Enter the per diem limitation (1)				26
. 00	Inpatient routine service cost limitation (Line 3 times the	per diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, Line 4) (See instructions	the lesser of line 25 or			28

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	62, 469	1.00
2.00	Program inpatient days (see instructions)	8, 706	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. 139365	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII Provider No.: 315257 Period: From 01/01/2023 To 12/31/2023 Worksheet E Part I Date/Time Prepared: 5/20/2024 3:03 pm Title XVIII Skilled Nursing Facility PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00 Inpatient PPS amount (See Instructions) 6, 427, 851 1.00 2.00 Nursing and Allied Heal th Education Activities (pass through payments) 0 6, 427, 851 1.00 3.00 Subtotal (Sum of lines 1 and 2) 0 0 4.00 0 4.00 5.00 6.427, 851 1.00 0 4.00 5.00 Allowable bad debts (From your records) 1.317, 600 5.00 7.00 Allowable bad debts - for statistical records only 0 0 7.00 7.00 800 871, 152 8.00 0 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< th=""><th>Heal th</th><th>Financial Systems CEDAR GROVE RESPIRAT</th><th>ORY AND NURSING</th><th>In Lie</th><th>u of Form CMS-2</th><th>2540-10</th></t<>	Heal th	Financial Systems CEDAR GROVE RESPIRAT	ORY AND NURSING	In Lie	u of Form CMS-2	2540-10
To To T2/31/2023 Date/Time Prepared: 5/20/2024 3:03 pm PART A IMPATLENT SERVICE PPS PROVIDER COMPUTATION OF RELINDURSEMENT 1.00 PPS 1.00 Inpatient (PPS amount (See Instructions) 0.427,851 1.00 2.00 Numsing and Aliad Healt E Education Activities (pass through payments) 0.427,851 0.02 2.00 Subtratal (Sum of Lines 1 and 2) 0.427,851 3.00 0.40 0.00 Alionable bad debts (from your records) 1.317,600 6.427,851 3.00 0.00 Alionable bad debts for dual eligible beneficiaries (See instructions) 871,152 8.00 9.00 Recovery of bad debts - for statistical records only 0.130,02 9.00 0.01 Subtrati (See instructions) 5,981,403 11.00 11.00 Trative adjustment 0.14,50 13.40,224 6.00 11.01 Sequestration anount before sequestration 0.789,901 10.00 11.00 Sequestration anount fore resquestration 0.14,50 14,50 11.00 Sequestration anount ster instructions) 10.22,251,41,99 10.22,251,41,99	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315257		Worksheet E	
Title XVIII Skilled Nursing PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00 1.00 Inpatient PPS amount (See Instructions) 6.427,851 1.00 Subtrail (Sum of lines 1 and 2) 6.427,851 0.00 Reing and Allie Healt Education Activities (pass through payments) 6.427,851 0.00 Consurance 1.317,600 0.01 All omable bad debts (From your records) 1.340,224 0.00 Nursing in payment abile bad debts. (See instructions) 871,122 0.00 Nursing in payment abile bad debts. (See instructions) 871,122 0.00 Nursing in payment abile bad debts. (See instructions) 871,122 0.01 Nursing in payment abile bad debts. (See instructions) 871,122 0.01 Nursing in payment abile bad debts. (See instructions) 871,431 0.01 Nursing and Allie Bad debts. (See instructions) 871,431 0.01 Nursing and Allie Bad debts. (See instructions) 871,431 0.01 Nursing and Allie Bad debts. (See instructions) 9,790 0.01 Nursing and Allie Bad debts. (See instructions) 9,790						
Title XVIII Skilled Nursing Facility PPS PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00				10 12/31/2023		
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00 1.00 Inpatient PPS amount (See Instructions) 6.427,851 1.00 2.00 Nursing and Alled Heal th Education Activities (pass through payments) 6.427,851 1.00 3.00 Subtotal (Sum of Lines 1 and 2) 6.427,851 3.00 0 5.00 Coinsurance 1.317,600 5.00 6.427,851 3.00 5.00 Allowable Bad debts (From your records) 1.317,600 5.00 7.00 Allowable Bad debts (From your records) 7.84,901 7.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.01 0.00 0.01 10.00 10.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.01 0.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 <td< td=""><td></td><td></td><td>Title XVIII</td><td>Skilled Nursing</td><td></td><td>s pili</td></td<>			Title XVIII	Skilled Nursing		s pili
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00 100 Inpatient PPS amount (See Instructions) 6, 427, 851 1.00 200 Nursing and Allied Health Education Activities (pass through payments) 6, 427, 851 3.00 000 Subtotal (Sum of lines 1 and 2) 6, 427, 851 3.00 000 Subtotal (Sum of lines 1 and 2) 1, 317, 600 4.00 0100 Allowable bad debts (From your records) 1, 340, 224 6, 00 0100 Allowable bad debts (From your records) 7, 700 7, 00 Allowable bad debts (From your records only 0, 00 9, 00 0100 Wetled reinbursable bad debts. (See instructions) 87, 152 8, 00 9, 00 0100 Wetle reinbursable bad debts. (See instructions) 5, 981, 403 11.00 10, 00 0100 Wetle reinbursable bad debts. (See instructions) 5, 787, 961 10, 00 01112 See instructions) 5, 781, 403 11, 00 0114.00 Therm payment adjustment anount after sequestration 0 14, 50 14, 55 Sequestration for non-claims based amounts (see instruc					115	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF RELIMBURSEMENT1.00Inpatient PPS amount (See Instructions)6.427.8512.00Nursing and Allied Health Education Activities (pass through payments)6.427.8513.00Subtortal (Sum of Lines 1 and 2)6.427.8514.00Primary payor amounts1.317.6005.00Allowable bad debts (From your records)1.316.0057.00Allowable bad debts for dual eligible beneficiaries (See instructions)875.9017.00Allowable bad debts for dual eligible cords only00.00Weiter reinbursable bad debts. (See instructions)878.9017.00Recovery of bad debts. (See instructions)5.981,4030.00Weitiration payment S(See instructions)5.87.9711.00Tentative adjustment01.00Utilization review01.00Tentative adjustment amount before sequestration01.4.55Demonstration payment adjustment amount after sequestration01.4.55Sequestration mount (see instructions)11.4231.4.55Sequestration on structions)11.4231.4.55Sequestration on mount (see instructions)11.4231.4.55Sequestration on payment adjustment amount after sequestration01.4.55Sequestration on mount (see instructions)11.4231.4.55Sequestration on mount (see instructions)11.4251.4.55Sequestration on mount (see instructions)11.4251.4.55Sequestration on mount (see instructions)11.425 <tr< td=""><td></td><td></td><td></td><td>- I doi i i t</td><td></td><td></td></tr<>				- I doi i i t		
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF RELIMBURSEMENT1.00Inpatient PPS amount (See Instructions)6.427.8512.00Nursing and Allied Health Education Activities (pass through payments)6.427.8513.00Subtortal (Sum of Lines 1 and 2)6.427.8514.00Primary payor amounts1.317.6005.00Allowable bad debts (From your records)1.316.0057.00Allowable bad debts for dual eligible beneficiaries (See instructions)875.9017.00Allowable bad debts for dual eligible cords only00.00Weiter reinbursable bad debts. (See instructions)878.9017.00Recovery of bad debts. (See instructions)5.981,4030.00Weitiration payment S(See instructions)5.87.9711.00Tentative adjustment01.00Utilization review01.00Tentative adjustment amount before sequestration01.4.55Demonstration payment adjustment amount after sequestration01.4.55Sequestration mount (see instructions)11.4231.4.55Sequestration on structions)11.4231.4.55Sequestration on mount (see instructions)11.4231.4.55Sequestration on payment adjustment amount after sequestration01.4.55Sequestration on mount (see instructions)11.4231.4.55Sequestration on mount (see instructions)11.4251.4.55Sequestration on mount (see instructions)11.4251.4.55Sequestration on mount (see instructions)11.425 <tr< td=""><td></td><td></td><td></td><td></td><td>1.00</td><td></td></tr<>					1.00	
2.00 Nursing and Allied Heal th Education Activities (pass through payments) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBU	JRSEMENT			
3.00Subtortail (Sum of Lines 1 and 2)6,427,8513,004.00Primary payor amounts0,4005.00Coinsurance1,317,6005,006.00All owable bad debts (From your records)1,340,2346,007.00All owable bad debts for dual eligible beneficiaries (See instructions)1,340,2346,008.00Adjusted reimbursable bad debts.(See instructions)871,1528,009.00Recovery of bad debts - for statistical records only09,0010.00Utilization review010,0011.00Subtortail (See instructions)5,881,40311,0012.00Interim payment s (See instructions)5,787,91612,0013.00Tentative adjustment amount before sequestration014,0014.00OTHER adjustment (See instructions)11,42314,7514.75Sequestration for non-clains based amounts (see instructions)11,42314,7514.76Sequestration amount (see instructions)11,42314,7515.00Balance due provider/program (see Instructions)11,22016.00Protested amounts (Nonal Iowable cost report items in accordance with CMS Pub. 15-2, section 115,2)016,0017.00Ancillary service Seart B3,06718,003,06718,0018.00Vaccine cost (From West D, Part Haursbetkett LESSER OF COST OR CHARGES - TITLE XVIII ONLY17,0017,0017.00Ancillary service Seart B01,222,001,228018.00Vacci	1.00	Inpatient PPS amount (See Instructions)			6, 427, 851	1.00
4.00Primary payor amounts4.005.00Coinsurance1,317,6005.00Allowable Bad debts (From your records)1,340,2347.00Allowable Bad debts for dual eligible beneficiaries (See instructions)785,9017.00Allowable Bad debts - for statistical records only08.00Adjusted reimbursable bad debts.6009.00Recovery of bad debts - for statistical records only00.00Utilization review00.01OUSubtotal(See instructions)1.01Subtotal (See instructions)5,871,9161.02Interin payments (See instructions)14.001.03OuTentative adjustment01.04OTentative adjustment amount before sequestration14.501.45Demonstration payment adjustment amount after sequestration14.501.47Sequestration for non-claims based amounts (see instructions)17.4231.47Sequestration amount (see instructions)17.4231.48OThe amount s(Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)16.001.48OTotal reasonable costs (Sum of lines 17 and 18)3.0871.40OTotal reasonable costs (Sum of lines 17 and 18)3.0871.40Meditare Part B ankillary charges (See instructions)1.12820.001.40OTotal reasonable costs (Sum of lines 17 and 18)22.002.40Mindube Bad debts (from your records)1.12820.002.41O <td>2.00</td> <td>Nursing and Allied Health Education Activities (pass through</td> <td>payments)</td> <td></td> <td>0</td> <td>2.00</td>	2.00	Nursing and Allied Health Education Activities (pass through	payments)		0	2.00
5.00 Coinsurancé 1.317.600 5.00 1.340.234 6.00 6.00 Allowable bad debts (from your records) 1.340.234 6.00 7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 871.152 8.00 8.00 Adjusted reimbursable bad debts. (See instructions) 871.152 8.00 9.00 Recovery of bad debts. for statistical records only 0 9.00 10.00 Utilization review 0 9.00 10.00 Interim payments (See instructions) 5.981.403 11.00 11.00 Subtotal (See instructions) 5.787.916 12.00 13.00 11.01 Subtotal (See instructions) 13.00 14.00 14.00 14.00 14.01 DHER adjustment amount after sequestration 0 14.50 14.90 15.05 Demonstration payment adjustment amount after sequestration 14.55 14.23 14.75 15.47.55 Sequestration amount (see instructions) 12.205 14.99 54000 14.55 16.00 Protested amounts (Monallowable cost report item	3.00	Subtotal (Sum of lines 1 and 2)			6, 427, 851	3.00
6.00Allowable bad debts (From your records)1.340,2346.007.00Allowable bad debts for dual eligible beneficiaries (See instructions)765,9017.008.00Adjusted reimbursable bad debts.(See instructions)871,1528.009.00Recovery of bad debts - for statistical records only0000.00Utilization review010.000.01Subtotal (See instructions)5,981,40311.000.01Ottoring payments (See instructions)5,787,91612.000.01Tentarin payments (See instructions)014.500.01Tentative adjustment014.500.01Demonstration payment adjustment amount before sequestration014.5014.55Demonstration payment adjustment amount s(see instructions)17.42314.7514.75Sequestration for non-clains based amounts (see instructions)17.42314.7515.00Protested amounts (See Instructions)17.42314.7516.00Protested amounts (See Instructions)17.42314.7517.00Ancillary services Part 8017.0017.01Ancillary services Computation OF REIMBURSEMENT LESSER OF COST OF CHARGES - TITLE XVIII ONLY17.0017.00Ancillary services (Lesser of line 19 or line 20)11.12820.0017.00Part B ancillary charges (See instructions)022.0010.00Ottal reasonable costs (Sum of lines 17 and 18)22.0022.0010.00Part B ancillary charges (See instructi	4.00	Primary payor amounts			0	4.00
7.00 Allowable Bad debts for dual eligible beneficiaries (See instructions) 785,901 7.00 8.00 Adjusted reimbursable bad debts. (See instructions) 871,152 8.00 9.00 Recovery of bad debts - for statistical records only 0 9.00 10.00 Utilization review 0 10.00 9.01 10.00 Interim payments (See instructions) 5.981,403 11.00 10.00 Interim payments (See instructions) 5.787,916 12.00 10.00 Ofternative adjustment (See instructions) 13.00 14.50 11.00 Demonstration payment adjustment amount before sequestration 14.50 14.50 12.57 Sequestration for non-claims based amounts (see instructions) 17.423 14.55 15.00 Balance due provider/program (see Instructions) 17.423 14.55 15.00 Patested amounts (Nonal Insube Cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16.00 Protested amounts (Nonal Insub 7 and 18) 3.087 18.00 17.00 Ancillary services Part B 3.087 18.00 19.00	5.00	Coinsurance			1, 317, 600	5.00
8:00Adjusted reimbursable bad debts. (See instructions)871,1528.009:00Recovery of bad debts - for statistical records only000:00Utilization review000:00Subtotal (See instructions)5,981,40311.001:00Interim payments (See instructions)5,787,91612.001:00Tentative adjustment014.001:00Offfer adjustment (See instructions)14.501:00Demonstration payment adjustment amount after sequestration01:15Demonstration payment adjustment amount after sequestration14.501:15Demonstration payment adjustment amount after sequestrations)17.4231:15Sequestration amount (see instructions)17.4231:16Demonstration payment adjustment amount after sequestration100.2051:17Sequestration amount (see instructions)17.4231:18Demonstration payment adjustment amount after sequestration102.2051:19Demonstration payment adjustment amount after sequestration102.2051:10Demonstration amount (see instructions)17.4231:10Demonstration amount (see instructions)102.2051:10Demonstration amount secondance with CMS Pub. 15-2, section 115.2)01:10Demonstration amount secondance with CMS Pub. 15-2, section 115.2)01:10Demonstration payment adjustment amount after sequestration3.0871:10Demonstration3.08719.001:10Demonstration payment adjustme	6.00	Allowable bad debts (From your records)			1, 340, 234	6.00
9.00Recovery of bad debts - for statistical records only0010.00Utilization review00.0010.00Utilization review10.0010.00Interim payments (See instructions)5,981,40311.0012.00Interim payments (See instructions)12.0010.00OTHER adjustment (See instructions)14.5014.00OTHER adjustment (See instructions)14.5014.55Demonstration payment adjustment amount after sequestration14.5014.55Sequestration for non-claims based amounts (see instructions)102.20514.75Sequestration amount (see instructions)102.20515.00Balance due provider/program (see Instructions)102.20516.00Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)016.00Protested amounts (See instructions)17.0017.00Ancillary services Part B3,08718.0010.00Vaccine cost (From Wkst D, Part II, line 3)3,08719.0010.00Cost of covered services (Lesser of line 19 or line 20)1,12820.0023.00Cost of covered services (Lesser of line 19 or lines 22 and 23)23.0024.0124.00Allowable Bad debts (From your records)024.0125.00Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)1,12825.0026.00Interim payments (See instructions)24.0124.0027.00Certaries adjustment024.0226.00Interimi	7.00	Allowable Bad debts for dual eligible beneficiaries (See inst	tructions)		785, 901	7.00
10.00Utilization review010.0011.00Subtotal (See instructions)5,981,40311.0012.00Interim payments (See instructions)5,787,91612.0013.00Tentative adjustment014.0014.00OTHER adjustment (See instructions)014.5014.00Demonstration payment adjustment amount after sequestration014.5014.75Sequestration for non-claims based amounts (see instructions)17,42314.7514.99Sequestration amount (see instructions)102,20514.9916.00Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)016.0017.00Ancillary Services Part B017.0010.0018.00Vaccine cost (From Wkst D, Part II, line 3)3,08719.0019.00Total reasonable costs (Sum of lines 17 and 18)3,08719.0020.00Primary payor amounts022.0022.0021.00Cost of covered services (Lesser of line 19 or line 20)1,12820.0022.00Coinsurance and deductibles024.0024.0024.00Allowable Bad debts for dual eligible beneficiaries (see instructions)024.0025.00Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)1,12825.0026.00Interim payments (See instructions)024.0027.00Frintary payor amounts024.0026.00Interim payments (See instructions)024.00<	8.00	Adjusted reimbursable bad debts. (See instructions)			871, 152	8.00
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13.00Tentative adjustment013.0014.00OTHER adjustment (See instructions)014.0014.50Demonstration payment adjustment amount before sequestration014.0014.55Demonstration payment adjustment amount after sequestration014.5514.75Sequestration for non-claims based amounts (see instructions)17,42314.7514.99Sequestration amount (see instructions)102,20514.9915.00Balance due provider/program (see Instructions)102,20514.9916.00Protested amounts (Nonal lowable cost report i tems in accordance with CMS Pub. 15-2, section 115.2)016.00PART B - ANCILLARY SERVICE COMPUTATION OF RELIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY17.0017.00Ancillary services Part B3,08718.0019.00Vaccine cost (From Wkst D, Part II, line 3)3,08718.0010.00Cost of covered services (Lesser of line 19 or line 20)1,12820.0021.00Cost of covered services (Lesser of line 19 or line 20)1,12821.0023.00Coin surance and deductibles024.0024.00Allowable Bad debts for dual eligible beneficiaries (see instructions)024.0024.00Justment3024.0024.0025.00Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)1,12825.0026.00Other Adjustment024.0027.0026.00Other Adjustment028.0028.0026.00Ot	11.00	Subtotal (See instructions)			5, 981, 403	11.00
14.00OTHER adjustment (See instructions)014.0014.50Demonstration payment adjustment amount before sequestration014.5014.55Demonstration payment adjustment amount after sequestration014.5514.75Sequestration for non-claims based amounts (see instructions)117.42314.7514.99Sequestration amount (see instructions)102.20514.9915.00Bal ance due provider/program (see Instructions)102.20514.9916.00Protested amounts (Nonal lowable cost report items in accordance with CMS Pub. 15-2, section 115.2)016.00PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY17.0017.00Ancillary services Part B017.0018.00Vaccine cost (From Wkst D, Part II, line 3)3,08719.0019.00Total reasonable costs (Sum of lines 17 and 18)3,08719.0020.00Medicare Part B ancillary charges (See instructions)1,12820.0021.00Cost of covered services (Lesser of line 19 or line 20)1,12821.0023.00Coinsurance and deductibles024.0024.01Allowable Bad debts (From your records)024.0024.02Adjusted reimbursable bad debts (see instructions)024.0025.00Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)1,12825.0026.00Iterim payment adjustment amount before sequestration028.5026.00Other Adjustments (See instructions)0	12.00	Interim payments (See instructions)			5, 787, 916	12.00
14.50Demonstration payment adjustment amount before sequestration014.5014.55Demonstration payment adjustment amount after sequestration014.5514.75Sequestration for non-claims based amounts (see instructions)17.42314.7514.99Sequestration amount (see instructions)102,20514.9915.00Balance due provider/program (see Instructions)102,20514.9916.00Protested amounts (Nonall owable cost report items in accordance with CMS Pub. 15-2, section 115.2)0017.00Ancillary services Part B017.0018.00Vaccine cost (From Wkst D, Part II, line 3)3,08718.0019.00Total reasonable costs (Sum of lines 17 and 18)3,08719.0020.00Medicare Part B ancillary charges (See instructions)1,12820.0021.00Cost of covered services (Lesser of line 19 or line 20)1,12821.0022.00Primary payor amounts024.0023.00Coinsurance and deductibles024.0024.01Allowable Bad debts for dual eligible beneficiaries (see instructions)024.0024.02Adjusted reimbursable bad debts (see instructions)024.0025.00Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)1,12825.0026.00Interim payments (See instructions)024.0027.00Tentative adjustment027.0028.50Demonstration payment adjustment amount before sequestration028.5029.00 </td <td></td> <td>Tentati ve adjustment</td> <td></td> <td></td> <td>0</td> <td>13.00</td>		Tentati ve adjustment			0	13.00
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29.00Balance due provider/program (see instructions)11129.00						
			ance with CMS Pub.15-2. s	ection 115.2		

ALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315257	Period: From 01/01/202 To 12/31/202		pare
		Ti tl	e XVIII	Skilled Nursin Facility		0 011
		Inpatien	t Part A		art 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		5, 680, 7	0 0	994 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	06/16/2023	107, 1	68	0	3.
02		00/ 10/ 2020		0	0	3.
03				0	0	3
04				0	0	3
)5				0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM		1	0	0	3
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		107, 1	68	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)		5, 787, 9	216	994	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
	Program to Provider		1			
)1)2	TENTATI VE TO PROVI DER			0	0	5
)2)3				0	0	
	Provider to Program		1	<u> </u>	0	
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	5
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5
00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER		73, 8	359	111	6
)2	PROVIDER TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		5, 861, 7		1, 105	7
			Contr	actor Name	Contractor	
				1 00	Number	
	Name of Contractor			1.00	2.00	6

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Pre 5/20/2024 3:0	epared
•		General Fund	Speci fi c	Endowment Fund		<u>J3 pm</u>
		1.00	Purpose Fund 2.00	3.00	4.00	
	Assets					-
0	CURRENT ASSETS Cash on hand and in banks	1, 660, 912		0 0	0	1.
0	Temporary investments	0 1,000,712		0 0	0	
0	Notes receivable	0		0 0	0	
0	Accounts receivable	7, 340, 020		0 0	0	4.
0	Other receivables	135, 605		0 0	0	
0	Less: allowances for uncollectible notes and accounts	-121, 794		0 0	0	6.
0	recei vabl e I nventory	0		0	0	7.
0	Prepaid expenses	184, 069		0 0	0	
0	Other current assets	36, 995		0 0	0	
00	Due from other funds	0		0 0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	9, 235, 807		0 0	0) 11.
	FIXED ASSETS	1				
00	Land	0		0 0	0	
00	Land improvements	0		0 0	0	
00 00	Less: Accumulated depreciation Buildings	0		0 0 0 0	0	
00	Less Accumulated depreciation	0		0 0	0	
00	Leasehold improvements	2, 836, 835		0 0	0	
00	Less: Accumulated Amortization	-383, 494		0 0	0	
00	Fixed equipment	0		0 0	0	19
00	Less: Accumulated depreciation	0		0 0	0	20
00	Automobiles and trucks	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00	Major movable equipment	340, 253		0 0	0	
00	Less: Accumulated depreciation	-144, 469		0 0 0 0	0	
00 00	Minor equipment – Depreciable Minor equipment nondepreciable	0		0 0	0	
00	Other fixed assets	0		0 0	0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 649, 125		0 0	0	
	OTHER ASSETS		1			
00	Investments	3, 254, 036		0 0	0	
00	Deposits on Leases	105, 492		0 0	0	
00	Due from owners/officers	1, 654, 083		0 0	0	
00 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	59, 407 5, 073, 018		0 0 0 0	0	
00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	16, 957, 950		0 0	0	
00	Liabilities and Fund Balances	10,707,700			0	1 .
	CURRENT LI ABI LI TI ES					
00	Accounts payable	2, 625, 847		0 0	0	35
00	Salaries, wages, and fees payable	484, 975		0 0	0	
00	Payroll taxes payable	40, 886		0 0	0	
	Notes & Loans payable (Short term)	1, 628, 935		0 0	0	
00 00	Deferred income Accelerated payments	1,009,922		0 0	0) 39 40
00	Due to other funds	0		0 0	0	
00	Other current liabilities	0		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 790, 565		0 0	0	
	LONG TERM LI ABI LI TI ES					
00	Mortgage payable	0		0 0	0	44
00	Notes payable	0		0 0	0	
00	Unsecured Loans	0		0 0	0	
00	Loans from owners:	0		0 0	0	
00 00	Other long term liabilities OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49			0 0	0	
	TOTAL LIABILITIES (Sum of lines 43 and 50)	5, 790, 565		0 0	0	
	CAPITAL ACCOUNTS			-, -,		1
00	General fund balance	11, 167, 385				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					
00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	11, 167, 385		0 0	0	59

Health Financial Systems CEDAR GROVE RESPIRAT STATEMENT OF CHANGES IN FUND BALANCES CEDAR GROVE RESPIRAT			Provider No.: 315257		Peri od:	u of Form CMS-2540-10 Worksheet G-1		
					From 01/01/2023 To 12/31/2023		epared:	
		General	Fund	Special F	Purpose Fund	Endowment Fund		
		1.00	2.00	2.00	4.00	F 00		
1.00	Fund balances at beginning of period	1.00	2.00 16,705,721	3.00	4.00	5.00	1.00	
2.00	Net income (loss) (from Wkst. G-3, line 31)		657, 102		0		2.00	
3.00	Total (sum of line 1 and line 2)		17, 362, 823		0		3.00	
4.00	Additions (credit adjustments)						4.00	
5.00		0			0	0		
6.00		0			0	0		
7.00		0			0	0		
8.00		0			0	0		
9.00	Total additions (sum of line E 0)	0	0		0	0		
10.00 11.00	Total additions (sum of line 5 – 9) Subtotal (line 3 plus line 10)		0 17, 362, 823		0		10.00	
12.00	Deductions (debit adjustments)		17, 302, 023		0		12.00	
13.00		0			0	0		
14.00	RETURN OF CAPITAL	6, 195, 438			0	0		
15.00		0			0	0	15.00	
16.00		0			0	0	16.00	
17.00		0			0	0		
18.00	Total deductions (sum of lines 13 - 17)		6, 195, 438		0		18.00	
19.00	Fund balance at end of period per balance		11, 167, 385		0		19.00	
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund				
					_			
		6.00	7.00	8.00			1.00	
1 ()()	Fund halances at beginning of period	0			0			
	Fund balances at beginning of period Net income (Loss) (from Wkst G-3 line 31)	0			0		1.00	
2.00	Net income (loss) (from Wkst. G-3, line 31)	0			0		2.00	
2.00 3.00	Net income (loss) (from WKst. G-3, line 31) Total (sum of line 1 and line 2)		0				2.00 3.00	
2.00 3.00 4.00	Net income (loss) (from WKst. G-3, line 31) Total (sum of line 1 and line 2)		0				2.00 3.00 4.00	
2.00 3.00 4.00 5.00 6.00 7.00	Net income (loss) (from WKst. G-3, line 31) Total (sum of line 1 and line 2)		0				2.00 3.00 4.00 5.00 6.00 7.00	
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from WKst. G-3, line 31) Total (sum of line 1 and line 2)		-				2.00 3.00 4.00 5.00 6.00 7.00 8.00	
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0	0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9)		0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9)	0	0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 9.00 10.00 11.00 12.00 13.00 14.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) 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		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) RETURN OF CAPITAL Total deductions (sum of lines 13 - 17)	0	0 0 0 0 0 0 0 0		0000		2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (From Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) RETURN OF CAPITAL	0 0 0	0 0 0 0 0 0 0 0		0		2.00 3.00 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	

Heal th	Financial Systems CEDAR GROVE RESPIRATOR	Y AND NURS	ING		In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315257		eriod: com 01/01/2023 o 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/20/2024 3:0	pared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY		27, 055, 6	24		27, 055, 624	1.00
2.00	NURSING FACILITY			0		0	2.00
3.00	ICF/IID			0		0	3.00
4.00	OTHER LONG TERM CARE			0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		27, 055, 6	24		27, 055, 624	5.00
	All Other Care Services		1				
6.00	ANCI LLARY SERVI CES		2, 193, 6	37	0	2, 193, 637	6.00
7.00	CLINIC				0	0	7.00
8.00	HOME HEALTH AGENCY COST				0	0	8.00
9.00	AMBULANCE				0	0	9.00
10.00	RURAL HEALTH CLINIC				0	0	10.00
	FQHC				0	0	10. 10
	СМНС				0	0	11.00
	HOSPICE			0	0	0	12.00
	ROUTINE CHARGES / BED HOLD		2,0		0	2, 065	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 Worksheet G-3, Line 1)	s to	29, 251, 3	26	0	29, 251, 326	14.00
	Cost Center Description						
	·				1.00	2.00	
	PART II - OPERATING EXPENSES						
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					26, 986, 758	1.00
2.00	Add (Specify)				0		2.00
3.00					0		3.00
4.00					0		4.00
5.00					0		5.00
6.00					0		6.00
7.00					0		7.00
8.00	Total Additions (Sum of lines 2 - 7)					0	8.00
9.00	Deduct (Specify)				0		9.00
10.00					0		10.00
11.00					0		11.00
12.00					0		12.00
13.00					0		13.00
	Total Deductions (Sum of lines 9 - 13)					0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)					26, 986, 758	15.00

Heal th	Financial Systems CEDAR GROVE RESPIRATO	RY AND NURSING	In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No. : 315257	Peri od:	Worksheet G-3	
			From 01/01/2023		
			To 12/31/2023		
				5/20/2024 3:0	3 pm
				1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		29, 251, 326	1.00
2.00	Less: contractual allowances and discounts on patients accounts				2.00
3.00	Net patient revenues (Line 1 minus line 2)				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)				5.00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			68, 782	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	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			320	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21.00	Rental of vending machines			538	
22.00	Rental of skilled nursing space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	NON PATIENT REVENUE			1, 394	
24.50	COVI D-19 PHE Funding			0	
25.00	Total other income (Sum of lines 6 - 24)			71, 034	25.00
26.00	Total (Line 5 plus line 25)			657, 102	26.00
27.00	Other expenses (specify)			0	27.00
28.00				0	28.00
29.00				0	29.00
30.00				0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)			657, 102	31.00