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

OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315322	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 4/9/2024 4:46 pm

			4/ 7.	/2024 4.4	to pili	
PART I - COST I	REPORT STATUS					
Provi der	1. [ X ] Electronically prepared cost rep	oort	Date: 4/9/2024	Ti me:	4:46 pm	
use only	2. [ ] Manually prepared cost report					
	3. [ 0 ] If this is an amended report ent	er the number of times the provide	r resubmitted this co	st repor	t	
	3.01 [ ] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.				
Contractor	4.[ 1 ]Cost Report Status	6. Contractor No.	<u></u>			
use only		7.[ N ] First Cost Report for this Provider CCN				
	(2) Settled without audit	8.[ N ] Last Cost Report for this	Provider CCN			
	(3) Settled with audit	9. NPR Date:				
	(4) Reopened	10.[ 0 ]If line 4, column 1 is "4"	 : Enter number of tim	es reope	ned	
	(5) Amended	11. Contractor Vendor Code	4			
	5. Date Received:	12.[ F ] Medicare Utilization. Enter for no utilization.	er "F" for full, "L" f	or low,	or "N"	

## 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 INGLEMOOR CARE CENTER ( 315322 ) 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		
	1		2	SI GNATURE STATEMENT	
1	St	eve I zzo	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Steve Izzo			2
3	Signatory Title	ADMI NI STRATOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	7, 498	3, 073	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	7, 498	3, 073	0	100. 00

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

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

Health Financial Systems INGLEMOOR CARE CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315322 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 4/9/2024 4: 46 pm 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 311 SOUTH LIVINGSTON AVENUE PO Box: 1.00 2.00 City: LIVINGSTON State: NJ Zi p Code: 07039 2.00 3.00 County: ESSEX CBSA Code: 35084 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF INGLEMOOR CARE CENTER 315322 01/01/1996 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related N 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 255, 125 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 255, 125 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38, 00 39.00 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 0 41 00

Heal th	Health Financial Systems INGLEMOOR CARE CENTER In Lie					u of Form CMS-	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3		Peri od:	Worksheet S-2	
COMPLE	IPLEX INDENTIFICATION DATA From 01/01/2023					Part I	
					Date/Time Pre 4/9/2024 4:46		
							pm
						Y/N	
						1. 00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administra	tive and	General cost	N	42.00
	center? Enter Y or N. If yes, check box	κ, and submit supporting s	schedule listino	g cost c	enters and		
	amounts.						
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?			N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and ad	ddress o	f the home		44.00
	office on lines 45, 46 and 47.						
	1.00	2.00			3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address o	f 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:	Z	Zip Code	:		47. 00

	D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE Provider		Peri od:	eu of Form CMS- Worksheet S-2	
OMPLE	X REIMBURSEMENT QUESTIONNAIRE			From 01/01/2023 Fo 12/31/2023		
				Y/N	Date	DIII
	General Instruction: For all column 1 respons	ses enter in column 1. "Y" f	or Yes or "N" f	1.00 for No. For all	the date	
	responses the format will be (mm/dd/yyyy)  Completed by All Skilled Nursing Facilites  Provider Organization and Operation					
. 00	Has the provider changed ownership immediatel	y prior to the beginning of	the cost	N		1.0
	reporting period? If column 1 is "Y", enter instructions)	the date of the change in co	lumn 2. (see			
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in		1. 00 N	2. 00	3. 00	2.0
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and in column				
. 00	Is the provider involved in business transact		N			3. 0
	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 to					
	relationships? (see instructions)		Y/N	Typo	Data	
			1.00	7ype 2. 00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prepare	ared by a Certified Public	Т	С		4.0
. 00	Accountant? (Y/N) Column 2: If yes, enter "A'	' for Audited, "C" for				
	Compiled, or "R" for Reviewed. Submit completavailable in column 3. (see instructions) If					
. 00	Are the cost report total expenses and total those on the filed financial statements? If of		N			5. 0
	reconciliation.					
				Y/N 1. 00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	and 2 (V/N) Column 2: Is the	provider the	N	N	6. (
	legal operator of the program? (Y/N)	, ,	provider the		IN IN	
. 00 . 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during		for Nursina	N N		7. 0
	School and/or Allied Health Program? (Y/N) se					1 0.0
	School and/or Affred Hearth Programs (1714) Se	ee instructions.			V /N	0.0
		ee instructions.			Y/N 1.00	0. 0
. 00	Bad Debts		ons.			
	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb	d debts? (Y/N) see instructi		t reporting	1. 00	9. 0
0. 00	Bad Debts Is the provider seeking reimbursement for bad 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	d debts? (Y/N) see instructi t collection policy change d	uring this cost		1. 00 Y	9. 0
0. 00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d debts? (Y/N) see instructi t collection policy change d d/or coinsurance waived? If	uring this cost	ucti ons.	1. 00 Y N	9. 0 10. 0
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1. 00 1. 00 2. 00 33. 00	Bad Debts  Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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	d debts? (Y/N) see instructi t collection policy change d d/or coinsurance waived? If cost reporting period? If "	uring this cost "Y", see instruct Y", see instruct Pa Y/N 1.00   N	ctions.  ctions.  rt A  Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9. C 10. C 11. C 12. C
1. 00 1. 00 2. 00 33. 00 4. 00	Bad Debts  Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt 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.  If line 13 or 14 is "Y", then were	d debts? (Y/N) see instructi t collection policy change d d/or coinsurance waived? If cost reporting period? If "	uring this cost "Y", see instruct Y", see instruct Pa Y/N 1.00   N	ctions.  ctions.  rt A  Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9. 0 10. 0 11. 0 12. 0 14. 0 15. 0
0. 00	Bad Debts  Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prion  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.	d debts? (Y/N) see instructi t collection policy change d d/or coinsurance waived? If cost reporting period? If "	uring this cost "Y", see instruct Y", see instruct Party/N 1.00  Y  N  N	ctions.  ctions.  rt A  Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y N N N	9. 0 10. 0 11. 0 12. 0 13. 0 14. 0

Health Financial Systems INGLEMOO			E CENTER		In Lieu of Form CMS-2540-1		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		HEALTH CARE	Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
		<u> </u>	1	00	2.0	<u></u>	
	Cost Report Preparer Contact Information			00	2.	00	
19. 00	Enter the first name, last name and the title/poheld by the cost report preparer in columns 1, 2 respectively.		IRI S		GUI LBAULT		19. 00
20. 00	Enter the employer/company name of the cost repopreparer.	ort HE	ALTH CARE RE	SOURCES			20. 00
21. 00	Enter the telephone number and email address of report preparer in columns 1 and 2, respectively		9-987-1440		CHRI S. GUI LBAULT	「@HCRNJ. NET	21. 00

Health Financial Systems INGLEMOOR CARE CENTER In Lieu of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE
Provider No.: 315322
From 01/01/2023
From 01/

COMILE	A REFWIDORSEWENT COESTFORMATIKE			To 12/31/2023	Date/Time Prepared: 4/9/2024 4:46 pm
		Part B			
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	03/27/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				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	, , , , , , , , , , , , , , , , , , , ,				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					16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
47.00	information? If yes, see instructions.				17.00
17.00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
40.00	Describe the other adjustments:				10.00
18.00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3. 00		
	Cost Report Preparer Contact Information	I.	0.00		
19.00	Enter the first name, last name and the title	e/position	PREPARER		19. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
	respectively.				
20.00	Enter the employer/company name of the cost r	report			20. 00
	preparer.	•			
21.00	Enter the telephone number and email address	of the cost			21. 00
	report preparer in columns 1 and 2, respective	/el y.			

In Lieu of Form CMS-2540-10 INGLEMOOR CARE CENTER Provi der No.: 315322

 
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 FACI LITY
 HEALTH CARE
 COMPLEX STATISTICAL DATA

						4/9/2024 4: 46	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	138 0 0	50, 370 0 0	0	7, 570	9, 868 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7.00	HOSPI CE	0	0	0	О	0	7. 00
8. 00	Total (Sum of lines 1-7)	138 Inpatient [	50, 370	0	7, 570 Di scharges	9, 868	8. 00
		Impatrent i	ays/ VI SI LS		Di Schai ges		
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1. 00	SKILLED NURSING FACILITY	6. 00	7. 00 34, 454	8. 00	9. 00	10. 00	1. 00
2. 00 3. 00 4. 00 5. 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	0 0	0	0	307	0	2. 00 3. 00 4. 00 5. 00
6. 00 7. 00	SNF-Based CMHC HOSPI CE	0	0	0	0	0	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	17, 016	34, 454	0	309	16	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1. 00	SKILLED NURSING FACILITY	11. 00	12. 00 526	13.00	14. 00 24. 50	15. 00 616. 75	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	0	0	0. 00		0. 00 0. 00	2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 8. 00	Total (Sum of lines 1-7)	201	0 526	0. 00 0. 00		0. 00 616. 75	7. 00 8. 00
		Average Length		Admi s	si ons		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
		16. 00	17. 00	18. 00	19. 00	20.00	
1. 00 2. 00 3. 00 4. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	65. 50 0. 00 0. 00	0	372	2 0 0	151 0 0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0. 00				0	5. 00 6. 00
7.00	HOSPI CE	0.00	O	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	65.50 Admissions	Full Time	372 Equi val ent	2	151	8. 00
	Component	Total	Employees on	Nonpai d			
	Сопрологи	21. 00	Payrol I 22. 00	Workers 23.00			
1.00	SKILLED NURSING FACILITY NURSING FACILITY	525 0	116. 30 0. 00	0. 00 0. 00			1. 00
3. 00 4. 00 5. 00 6. 00	ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	0	0.00				3. 00 4. 00 5. 00 6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0 525	0. 00 116. 30				7. 00 8. 00

				Ť	0 12/31/2023	Date/Time Prep 4/9/2024 4:46	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6		Salary in col.	col . 4)	
				,	3	,	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	7, 400, 219	0	7, 400, 219	· ·		1. 00
2.00	Physician salaries-Part A	0	0	0	0.00		2. 00
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00	0.00	4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	7, 400, 219	0	7, 400, 219	241, 749. 00	30. 61	6. 00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST						8. 00
9.00	CMHC						9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	7, 400, 219	0	7, 400, 219	241, 749. 00	30. 61	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	1, 537, 284	0	1, 537, 284			
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15. 00
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00		1, 650, 571	0	1, 650, 571			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20.00	Physician Part A - WRC	0	0	0			20. 00
21. 00		0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 650, 571	0	1, 650, 571			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION INGLEMOOR CARE CENTER

Provider No.: 315322 | Period: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared:

				Ţ	o 12/31/2023	Date/Time Prep 4/9/2024 4:46	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		'	Worksheet A-6		Salary in col.		
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	847, 603	0	847, 603	16, 868. 00	50. 25	2. 00
3.00	Plant Operation, Maintenance & Repairs	140, 195	0	140, 195	4, 080. 00	34. 36	3. 00
4.00	Laundry & Linen Service	93, 208	0	93, 208	5, 770. 00	16. 15	4. 00
5.00	Housekeepi ng	303, 323	0	303, 323	16, 387. 00		5. 00
6.00	Di etary	624, 669	0	624, 669	32, 303. 00	19. 34	6. 00
7.00	Nursing Administration	756, 605	0	756, 605	13, 802. 00	54. 82	7. 00
8.00	Central Services and Supply	0	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	0.00	0.00	10.00
11. 00	Soci al Servi ce	154, 895	0	154, 895	4, 252. 00	36. 43	1
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	180, 211	l e	180, 211	9, 543. 00	18. 88	13. 00
14.00	Total (sum lines 1 thru 13)	3, 100, 709	0	3, 100, 709	103, 005. 00	30. 10	14. 00

Health Financial Systems	INGLEMOOR CARE CENTER	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315322	From 01/01/2023	Worksheet S-3 Part IV Date/Time Prep 4/9/2024 4:46	pared:
·			Amount	

		To 12/31/2	023 Date/Time Pre 4/9/2024 4:46	
			Amount	
			Reported	
			1. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		40, 396	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3. 00
4.00	Prior Year Pension Service Cost		0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		786, 591	8. 00
9.00	Prescription Drug Plan		0	9. 00
10.00	Dental, Hearing and Vision Plan		19, 227	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		8, 907	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14. 00
15.00	Workers' Compensation Insurance		162, 359	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required by FASB 106	0	16. 00
	Non cumulative portion)			
	TAXES			
17. 00	FICA-Employers Portion Only		543, 471	17. 00
18.00	Medicare Taxes - Employers Portion Only		0	18. 00
19.00	Unemployment Insurance		0	19. 00
20.00	State or Federal Unemployment Taxes		89, 620	20. 00
	OTHER			
21.00	Executive Deferred Compensation		0	21. 00
22. 00	Day Care Cost and Allowances		0	22. 00
23.00	Tuition Reimbursement		0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)		1, 650, 571	24. 00
			Amount	
			Reported	
			1. 00	
	Part B - Other than Core Related Cost			
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25. 00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No.: 315322 Peri od: Worksheet S-3 From 01/01/2023 Part V

0.00

0.00

0.00 26.00

12/31/2023 Date/Time Prepared: 4/9/2024 4: 46 pm Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Sal ari es (col Related to Reported Wage (col. 3 col . 4) 1 + col. 2Salary in col 3.00 5.00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 1.148.666 260, 403 1, 409, 069 25, 879. 00 54. 45 1.00 Licensed Practical Nurses (LPNs) 1, 237, 944 280, 642 1, 518, 586 31, 095. 00 48.84 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 1, 254, 781 284, 459 1, 539, 240 66, 476. 00 23.15 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 3, 641, 391 825, 504 4, 466, 895 123, 450. 00 36.18 4.00 5.00 31, 385 2, 718, 00 62.48 5.00 Physical Therapists 138 441 169, 826 Physical Therapy Assistants 40.87 6.00 132, 647 30,071 162, 718 3, 981. 00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 8.00 131, 370 29, 785 161, 155 4, 716, 00 34.17 8.00 40.40 9.00 75, 944 17, 217 93, 161 2, 306. 00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 11.00 Speech Therapists 73, 255 16, 607 89, 862 1, 575. 00 57.06 11.00 Respiratory Therapists 12.00 0.00 12 00 0 00 0 0 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 5, 560 14 00 Registered Nurses (RNs) 80.00 69 50 14 00 5, 560 15.00 Licensed Practical Nurses (LPNs) 441, 782 441, 782 7, 338. 00 60.20 15.00 Certified Nursing Assistant/Nursing 1, 089, 942 1, 089, 942 28, 030. 00 38. 88 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 1, 537, 284 1, 537, 284 35, 448. 00 43.37 17.00 18.00 Physical Therapists 0.00 0.00 18.00 0 0 19.00 Physical Therapy Assistants 0 0.00 0.00 19.00 00000000 Physical Therapy Aides 20.00 0 0.00 0.00 20.00 Occupational Therapists 0.00 21.00 0 0.00 21.00 Occupational Therapy Assistants 0 22.00 0.00 0.00 22.00 Occupational Therapy Aides 0.00 0.00 23.00 23.00 0 24.00 Speech Therapists 0.00 0.00 24.00 0 Respiratory Therapists 0.00 25.00

25.00

26.00 Other Medical Staff

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA In Lieu of Form CMS-2540-10
Worksheet S-7 Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 4/9/2024 4: 46 pm Provi der No.: 315322

			4/9/2024 4: 46 pm	1
1.00		Group	Davs	
1.00				
2.00				
3.00   NOV	1.00	RUX	1	1. 00
3.00   NOV	2 00	RUI	1 2	2 00
4.00				
STOO				
6 - 00	4.00	RVL	4	4. 00
6 - 00	5.00	RHX	5	5 00
7 00				
S. 00				
9.00 110.	7. 00	RMX	7	7. 00
9.00 110.	8.00	RML	l 8	8. 00
10.00   RIG				
11.00   RUB   11.00   RUB   11.00   RUB   11.00   RUB				
12 00	10. 00	RUC	10	0. 00
12 00	11.00	RUB	11	1. 00
13.00   RVC   11.00   RVC   11.00   RVC   11.00   RVC   11.00   RVC   11.00   RVC   RVC   11.00   RVC   RV				
14.00   RWS   114.00   RWA   115.00   RWA   115.00   RWC   RWA   115.00   RWC   RW				
15.00   RVA	13. 00	RVC	13	3.00
15.00   RVA	14. 00	RVB	14	4. 00
16.00   RHC	15.00	RVΔ	15	5 00
17. 00     RHB				
18. 00				
18. 00	17. 00	RHB	17	7. 00
19,00   RMC				
20,00   RMB				
21.00   RIMB   22.00   RIMB   23.00   RIMB   23.0				
RLB   22 00     RLB   22 00     RLB   23 00   24 00     ES3   24 00     ES3   25 00	20. 00	RMB	20	0. 00
RLB   22 00     RLB   22 00     RLB   23 00   24 00     ES3   24 00     ES3   25 00				
23.00				
24.00   ES3   24.00   ES3   25.00   26.00   ES1   28.00   ES1   ES2   27.00   ES1   ES2   27.00   ES1   ES2   ES2   ES2   ES2   ES2   ES3				
25.00   ES2   25.00   27.00   ES3   26.00   ES3   27.00   ES3   ES3	23. 00	RLA	23	3. 00
25.00   ES2   25.00   27.00   ES3   26.00   ES3   27.00   ES3   ES3	24. 00	FS3	24	4. 00
26. 00   ES1   26. 00   28. 00   HE2   27. 00   29. 00   HE1   28. 00   30. 00   HII   28. 00   30. 00   HII   30. 00   31. 00   HII   30. 00   32. 00   HII   31. 00   32. 00   HII   32. 00   33. 00   HII   32. 00   33. 00   HII   33. 00   35. 00   HII   35. 00   36. 00   HII   38. 00   37. 00   HII   38. 00   38. 00   HII   38. 00   39. 00   LI   21. 36. 00   39. 00   LI   21. 36. 00   39. 00   LI   22. 37. 00   39. 00   LI   23. 30. 00   39. 00   LI   24. 38. 00   41. 00   LI   24. 38. 00   41. 00   LI   24. 38. 00   42. 00   LI   24. 38. 00   43. 00   LI   24. 38. 00   44. 00   LI   24. 38. 00   45. 00   LI   24. 38. 00   46. 00   LI   24. 38. 00   47. 00   CI   24. 38. 00   48. 00   CI   24. 38. 00   49. 00				
27.00 29.00 102.00 102.00 102.00 102.00 102.00 103.00 103.00 103.00 104.02 131.00 106.02 131.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.				
28. 00 30. 00 30. 00 30. 00 30. 00 30. 00 4HD1 30. 00 32. 00 32. 00 34. 00 4HC1 32. 00 34. 00 34. 00 36. 00 4HB1 34. 00 36. 00 4HB1 34. 00 36. 00 4LE1 36. 00 37. 00 38. 00 40. 00 40. 00 40. 00 40. 00 41. 00 42. 00 42. 00 43. 00 44. 00 42. 00 43. 00 44. 00 45. 00 46. 00 67. 00 68. 00 69. 0	26. 00	ES1	26	6. 00
28. 00 30. 00 30. 00 30. 00 30. 00 30. 00 40. 00 32. 00 34. 00 34. 00 34. 00 36. 00 36. 00 36. 00 36. 00 36. 00 36. 00 37. 00 38. 00 40. 00 40. 00 40. 00 40. 00 40. 00 41. 00 42. 00 42. 00 43. 00 44. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 48. 00 48. 00 48. 00 48. 00 48. 00 59. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50	27. 00	HF2	27	7. 00
29,00   HD2   29,00   HD1   30,00   HD1   30,00   HD2   31,00   HD2   31,00   HD2   32,00   HC2   31,100   HD1   32,00   HC2   31,00   HD1   32,00   HD1   32,00   HD1   32,00   HD1   32,00   HD1   34,00   HD1   34,00   HD1   36,00   HD1				
30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 34. 00 34. 00 35. 00 36. 00 36. 00 36. 00 37. 00 38. 00 40. 00 40. 00 40. 00 40. 00 41. 00 42. 00 42. 00 41. 00 42. 00 42. 00 43. 00 44. 00 42. 00 42. 00 43. 00 44. 00 65. 00 68. 00 69. 00 69. 00 69. 00 69. 00 66. 00 67. 00 68. 00 69				
31.00   HC2   31.00   HC1   32.00   HC1   32.00   HC1   32.00   HC1   32.00   HC1   32.00   HC2   33.00   HC2   33.00   HC2   35.00   HC2   35.00   LE1   36.00   LE2   35.00   LC2   37.00   37.00   LD2   37.00   LD1   38.00   LD2   37.00   LC2   39.00   LD2   37.00			29	9. 00
31.00   HC2   31.00   HC1   32.00   HC1   32.00   HC1   32.00   HC1   32.00   HC1   32.00   HC2   33.00   HC2   33.00   HC2   35.00   HC2   35.00   LE1   36.00   LE2   35.00   LC2   37.00   37.00   LD2   37.00   LD1   38.00   LD2   37.00   LC2   39.00   LD2   37.00	30. 00	HD1	30	0. 00
32.00 34.00 34.00 34.00 35.00 36.00 36.00 36.00 36.00 36.00 38.00				
33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 LD1 38.00 39.00 LD2 37.00 39.00 LC2 39.00 LC1 40.00 LC2 39.00 41.00 LC2 39.00 41.00 LB2 41.00 42.00 43.00 44.00 45.00 46.00 47.00 46.00 47.00 48.00 47.00 48.00 49.00 51.00 52.00 53.00 55.00 56.00 57.00 58.00 58.00 59.00 60				
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35. 00   LE2   35. 00   CF1   36. 00   37. 00   38. 00   LD2   37. 00   38. 00   LD2   37. 00   39. 00   LD2   37. 00   LD2   39. 00   LD2   40. 00   LD2   41. 00   LD2   41. 00   LD2   43. 00   LD3   44. 00   LD3   LD3			34	4 00
36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 46. 00 47. 00 48. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 51. 00 51. 00 52. 00 53. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 56. 00 57. 00 58. 00 58. 00 59. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50				
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43.00				
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45. 00				
46.00				
47.00   CC2				
48.00   CC1   48.00   49.00   CB2   49.00   CB1   50.00   CB1   50.00   CB1   50.00   CB1   50.00   CB1   50.00   CB1   50.00   CA2   51.00   52.00   CA1   52.00   CA1   52.00   CA2   51.00   SE3   SE3   53.00   SE2   SE3   SE	46. 00	CD1	46	6. 00
48.00   CC1   48.00   49.00   CB2   49.00   CB1   50.00   CB1   50.00   CB1   50.00   CB1   50.00   CB1   50.00   CB1   50.00   CA2   51.00   52.00   CA1   52.00   CA1   52.00   CA2   51.00   SE3   SE3   53.00   SE2   SE3   SE	47 00	CC2	47	7 00
49.00   CB2				
50.00       CB1       50.00         51.00       CA2       51.00         52.00       CA1       52.00         53.00       SE3       53.00         54.00       SE2       54.00         55.00       SE1       55.00         56.00       SSC       56.00         57.00       SSB       57.00         58.00       SSA       58.00         59.00       IB2       59.00         60.00       IB1       60.00         61.00       IA2       61.00         62.00       IA1       62.00         63.00       BB2       63.00         64.00       BB1       64.00         65.00       BA1       66.00         67.00       BA2       65.00         66.00       PE1       68.00         69.00       PD2       69.00         70.00       PD1       70.00         71.00       PC2       71.00         72.00       PC3       72.00         73.00       PB1       74.00				
51.00       CA2       51.00         52.00       SE3       52.00         53.00       SE3       53.00         54.00       SE2       54.00         55.00       SE1       55.00         56.00       SSC       56.00         57.00       SSB       57.00         58.00       SSB       57.00         59.00       SSA       58.00         59.00       IB2       59.00         60.00       I B1       60.00         61.00       I B1       60.00         62.00       I A1       62.00         63.00       BB2       63.00         64.00       BB1       64.00         65.00       BA2       65.00         66.00       BA1       66.00         67.00       BA1       66.00         69.00       PE1       68.00         69.00       PD2       69.00         70.00       PD1       70.00         71.00       PC2       71.00         72.00       PB2       73.00         74.00       PB1       74.00	49. 00	CB2	49	9.00
51.00       CA2       51.00         52.00       SE3       52.00         53.00       SE3       53.00         54.00       SE2       54.00         55.00       SE1       55.00         56.00       SSC       56.00         57.00       SSB       57.00         58.00       SSB       57.00         59.00       SSA       58.00         59.00       IB2       59.00         60.00       I B1       60.00         61.00       I B1       60.00         62.00       I A1       62.00         63.00       BB2       63.00         64.00       BB1       64.00         65.00       BA2       65.00         66.00       BA1       66.00         67.00       BA1       66.00         69.00       PE1       68.00         69.00       PD2       69.00         70.00       PD1       70.00         71.00       PC2       71.00         72.00       PB2       73.00         74.00       PB1       74.00	50. 00	CB1	50	0. 00
52. 00     CA1     52. 00       53. 00     SE3     53. 00       54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SE1     55. 00       57. 00     SSC     56. 00       58. 00     SSA     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     I B1     60. 00       61. 00     I A2     61. 00       62. 00     I A1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE2     67. 00       68. 00     PPE1     68. 00       69. 00     PD1     70. 00       70. 00     PC2     71. 00       72. 00     PC1     72. 00       73. 00     PB2     73. 00       74. 00     PB1     74. 00			51	1 00
53. 00       SE3       53. 00         54. 00       SE2       54. 00         55. 00       SE1       55. 00         56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA1       62. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PPD       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB2       73. 00         74. 00       PB1       74. 00			51	2.00
54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       62. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA2     65. 00       68. 00     PE2     67. 00       68. 00     PE1     68. 00       69. 00     PD1     70. 00       70. 00     PC2     71. 00       72. 00     PC2     71. 00       72. 00     PB2     73. 00       74. 00     PB1     74. 00				
54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       62. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA2     65. 00       68. 00     PE2     67. 00       68. 00     PE1     68. 00       69. 00     PD1     70. 00       70. 00     PC2     71. 00       72. 00     PC2     71. 00       72. 00     PB2     73. 00       74. 00     PB1     74. 00		SE3		
55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       63. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB2     65. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE2     67. 00       68. 00     PD2     69. 00       70. 00     PD1     70. 00       71. 00     PC2     71. 00       72. 00     PB2     73. 00       74. 00     PB1     74. 00	54. 00	SE2	54	4. 00
56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PP1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00				
57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       64. 00       65. 00         64. 00       65. 00       66. 00         67. 00       66. 00       67. 00         68. 00       PE2       67. 00         68. 00       PD1       68. 00         69. 00       PD1       70. 00         70. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB2       73. 00         74. 00       PB1       74. 00				
58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       BA1       66. 00         68. 00       PE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB2       73. 00         74. 00       PB1       74. 00			56	o. UU
58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       BA1       66. 00         68. 00       PE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB2       73. 00         74. 00       PB1       74. 00	57. 00	SSB	57	7. 00
59. 00         60. 00         61. 00         62. 00         62. 00         63. 00         64. 00         65. 00         66. 00         67. 00         68. 00         69. 00         70. 00         70. 00         71. 00         72. 00         73. 00         74. 00	58. 00			
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72. 00 73. 00 74. 00 PB1 72. 00 PB1 74. 00	71. 00	PC2	71	1. 00
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74. 00 PB1 74. 00				
	74. 00	PB1	74	4. 00
172 75.00				
		1 /12	173	

Health Financial Systems	INGLEMOOR CARE (	ENTER		In Lie	u of Form CMS-	2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Peri od:	Worksheet S-	7	
				From 01/01/2023 To 12/31/2023	Date/Time Pro 4/9/2024 4:40		
				Group	Days		
				1. 00	2. 00		
76. 00				PA1		76. 00	
99. 00				AAA		99. 00	
100. 00 TOTAL						100. 00	
			Expenses	Percentage	Y/N		
			1. 00	2. 00	3. 00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Iir	ne 1, column 3)					101. 00 102. 00 103. 00 104. 00 105. 00 106. 00	

Cost Center Description   Salaries	Health Financial Systems	INGLEMOOR CARE	CENTER		In Lie	u of Form CMS-2	2540-10
Cost Center Description	RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der			Worksheet A	
A   A   A   A   A   A   B   A							
Cost Center Description					10 12/31/2023	Date/IIme Pre	pared:
COLOR   COLO	Cost Center Description	Salaries	Other	Total (col. 1	Paclassi fi cati		Pili
Control   Cont	cost center bescription	Sai ai i es	other				
See   Fr Wist   Col. 4   A   Col. 4   Col. 4   A   Col. 4   Col. 4   A   Col. 4   Col. 4   A				+ (01. 2)			
CENERAL SERVICE COST CENTERS							
1.00   2.00   3.00   4.00   5.00						(01. 4)	
GENERAL SERVICE COST CENTERS   1,080,896		1 00	2 00	3 00		5.00	
1.00	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
3. 00   00300  EMPLOYEE BENEFITS   0   1,677,803   1,677,803   3. 00   0. 00500  PLANT OPERATION, MAINT & REPAIRS   140,195   670,203   810,398   0   810,398   5. 00   0. 00500  PLANT OPERATION, MAINT & REPAIRS   140,195   670,203   810,398   0   810,398   5. 00   0. 00500  PLANT OPERATION, MAINT & REPAIRS   140,195   670,203   810,398   0   810,398   5. 00   0. 00500  PLANT OPERATION, MAINT & REPAIRS   140,195   670,203   810,398   0   810,398   5. 00   0. 00500  LAUNDRY & LINEN SERVICE   93,208   7. 897   101,105   0. 00500  LAUNDRY & 100,000   0. 005000  0. 00500			1, 080, 896	1, 080, 89	5 0	1, 080, 896	1.00
4 00 00400 ADMINISTRATIVE & GENERAL 847, 603 2, 431, 443 3, 279, 046 0 3, 279, 046 4 0 0 6.00 00600 PLANT OPERATION, MANT & REPAIRS 140, 195 670, 203 810, 398 0 810, 398 0 810, 398 5 0 6.00 00600 PLANT OPERATION, MANT & REPAIRS 140, 195 670, 203 810, 398 0 810, 398 0 810, 398 5 0 6.00 00600 PLANT OPERATION, MANT & REPAIRS 140, 195 670, 203 7, 897 101, 105 0 101, 105 6 00 7, 00 00700 PLOSEXCEFUNED  303, 323 7, 897 101, 105 0 371, 233 7, 00 8.00 0 00800 PLEARY 6.00 00800 PLEARY 6.00 0 0 0 0 756, 605 0 756, 605 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0					
5.00   00500   PLANT OPERATION, MAINT. & REPAIRS   140, 195   670, 203   810, 398   0   810, 398   5.00		1 -1					1
6.00   00600   LAUNDRY & LINEN SERVICE   93, 208   7, 897   101, 105   0   101, 105   6.00   7.00   00700   HOUSEKEEPING   303, 323   67, 910   371, 233   0   371, 233   0   371, 233   0   8.00   00800   DISTARY   624, 669   459, 732   1, 084, 401   0   1, 084, 401   8.00   9.00   00900   NURSING ADMINISTRATION   756, 605   0   756, 605   0   0   756, 605   9, 00   10.00   010000   CENTRAL SERVICES & SUPPLY   0   0   0   0   0   0   0   12, 00   12.00   012000   MURLING RECORDS & LIBRARY   0   0   0   0   0   0   0   12, 00   13.00   01300   SOCIAL SERVICE   154, 895   0   154, 895   0   154, 895   0   154, 895   13, 00   15.00   015000   PATIENT ACTIVITIES   180, 211   31, 790   212, 001   0   212, 001   15, 00    NPATIENT ROUTIN SERVICE COST CENTERS  30.00   03000   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   0   31.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   0   33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   0   0   34.00   04000   RADIOLOGY   0   41, 385   41, 385   41, 385   0   41, 385   41, 305   44.00   04000   RADIOLOGY   0   14, 385   41, 385   0   41, 385   41, 305   0   44.00   04400   PAYSICAL THERAPY   37, 551   96, 540   474, 091   0   474, 091   44, 500   44.00   04400   PAYSICAL THERAPY   37, 551   96, 540   474, 091   0   474, 091   44, 500   44.00   04400   PAYSICAL THERAPY   37, 551   96, 540   474, 091   0   474, 091   44, 500   44.00   04400   PAYSICAL THERAPY   37, 551   96, 540   474, 091   0   474, 091   44, 500   45.00   04500   OUGPTAINOMAL THERAPY   37, 551   96, 540   474, 091   0   474, 091   40, 00   46.00   04600   SPECH PATHOLOGY   73, 255   0   73, 255   0   73, 255   0   73, 255   0   47.00   07000   0000   0000   0000   0000   0000   0000   0000   48.00   04900   DAUGUS CHARGED TO PATHENTS   0   264, 051   49, 0000   49.00   04900   DAUGUS CHARGED TO PATHENTS   0   264, 051   49, 0000   49.00   04900   04900   04000   05000   05000   00000   00000   49.00   04900   04900   04900   050000   050000   0500000000000000		1 ' 1					
7. 00   00700   HOUSEKEEPING   303, 323   67, 910   371, 233   0   371, 233   7, 00   8. 00   00800   DIETARY   624, 669   459, 732   1, 084, 401   0   1, 084, 401   8, 00   9. 00   00900   NURSING ADMINISTRATION   756, 605   0   756, 605   0   756, 605   0   10. 00   01000   CENTRAL SERVICE'S & SUPPLY   0   351, 691   351, 691   0   351, 691   10, 00   12. 00   01200   MOLICALE RECORDS & LIBRARY   0   0   0   0   0   0   0   13. 00   01300   SOCIAL SERVICE   154, 895   0   154, 895   0   154, 895   13, 00   15. 00   01500   PATIENT ACTIVITIES   180, 211   31, 790   212, 001   0   212, 001   15, 00   1NPATIENT ROUTINE SERVICE COST CENTERS   180, 211   31, 790   212, 001   0   212, 001   15, 00   1NPATIENT ROUTINE SERVICE COST CENTERS   130, 00   3000   SKILLED NURSING FACILITY   3, 641, 390   1, 610, 593   5, 251, 983   0   5, 251, 983   30, 00   32. 00   03200   ICF/IID   0   0   0   0   0   0   0   0   32, 00   33. 00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   33, 00   33. 00   33300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   33, 00   4NCILLARY SERVICE COST CENTERS   0   30, 164   30, 164   0   0   0   0   0   0   41. 00   04100   LABORATORY   0   41, 385   41, 385   0   41, 385   41, 385   0   41, 385   41, 385   0   41, 385   41, 385   41, 385   0   41, 385   41, 385   41, 385   0   41, 385							1
8. 00 00800   DIETARY   624, 669   459, 732   1,084, 401   0   1,084, 401   8. 00   0. 00 0000   NURSING ADMINISTRATION   756, 605   0   756, 605   0   0   756, 605   9, 00   10. 00		1 ' 1		· ·			
9.00 00900 NURSING ADMINISTRATION 756,605 0 351,691 351,691 0 756,605 0 9.00 10.00 010000 CENTRAL SERVICES & SUPPLY 0 0 351,691 351,691 0 351,691 10.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 154,895 0 154,895 13.00 13.00 01300 OSIGAL SERVICE 154,895 13.00 15.00 01500 PATIENT ACTIVITIES 180,211 31,790 212,001 0 2212,001 15.00 1NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 (SKILLED NURSING FACILITY 3,641,390 1,610,593 5,251,983 0 5,251,983 30.00 31.00 03000 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 32,00 33.00 03200 ICF/I D 0 0 0 0 0 0 0 0 32,00 33.00 03200 ICF/I D 0 0 0 0 0 0 0 0 0 32,00 33.00 03200 ICF/I D 0 0 0 0 0 0 0 0 0 32,00 33.00 03200 ICF/I D 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1					
10. 00		1 ' 1					
12. 00   01200   MEDI CAL RECORDS & LI BRARY   0   0   0   154, 895   13. 00		1 1	٧				
13.00   01300   SOCI AL SERVICE   154, 895   0   154, 895   0   212, 001   0   212, 001   15.00   1500   PATIENT ACTIVITIES   180, 211   31, 790   212, 001   0   212, 001   15.00   15.00   15.00   PATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   SKI LLED NURSI NG FACI LITY   3, 641, 390   1, 610, 593   5, 251, 983   0   5, 251, 983   30.00   31.00   31.00   03000   NORSI NG FACI LITY   0   0   0   0   0   0   0   0   31.00   32.00   32.00   03200   ICF/IID   0   0   0   0   0   0   0   0   32.00   33.00   33.00   0718   10.00		0	331, 091	331, 09	0		
15. 00   01500   PATIENT ACTIVITIES   180, 211   31, 790   212, 001   0   212, 001   15. 00   1NPATIENT ROUTINE SERVICE COST CENTERS   3. 641, 390   1, 610, 593   5, 251, 983   0   5, 251, 983   30. 00   31. 00   0   0   0   0   0   0   0   0   0		154 005	0	154 00			
IMPATIENT ROUTINE SERVICE COST CENTERS			21 700				
30. 00   03000   SKILLED NURSING FACILITY   3,641,390   1,610,593   5,251,983   0   5,251,983   30. 00   31. 00   03100   NURSING FACILITY   0   0   0   0   0   0   0   32. 00   03200   ICF/I ID   0   0   0   0   0   0   0   0   32. 00   03200   ICF/I ID   0   0   0   0   0   0   0   0   0		180, 211	31, 790	212, 00	1 0	212,001	15.00
31. 00   03100   NURSI NG FACILITY   0   0   0   0   0   0   31. 00   32. 00   03200   CIF/I ID   0   0   0   0   0   0   0   33. 00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   33. 00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   40. 00   04000   RADIOLOGY   0   41. 385   41. 385   0   41. 385   0   41. 385   41. 00   41. 00   04100   LABORATORY   0   41. 385   41. 385   0   41. 385   0   41. 385   41. 00   42. 00   04200   INTRAVENOUS THERAPY   0   73. 206   73. 206   0   73. 206   42. 00   43. 00   04300   OXYGEN (I NHALATION) THERAPY   0   73. 326   73. 206   0   73. 206   42. 00   44. 00   04400   PHYSI CAL THERAPY   377. 551   96. 540   474. 091   0   474. 091   40. 00   45. 00   04500   OCCUPATIONAL THERAPY   207. 314   0   207. 314   0   207. 314   45. 00   46. 00   04500   OCCUPATIONAL THERAPY   207. 314   0   207. 314   0   207. 314   45. 00   47. 00   04500   OCCUPATIONAL THERAPY   377. 555   0   73. 255   0   73. 255   47. 00   04500   OCCUPATIONAL THERAPY   377. 555   0   37. 255   0   73. 255   48. 00   04600   SPEECH PATHOLOGY   73. 255   0   73. 255   0   73. 255   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   264, 051   264, 051   0   264, 051   49. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   264, 051   264, 051   0   264, 051   0   51. 00   O5100   SUPPORT SURFACES   0   10, 683   10, 683   0   10, 683   51. 00   51. 00   O5100   SUPPORT SURFACES   0   1, 089   1, 089   0   1, 089   71. 00   51. 00   O5100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   51. 00   O9100   BARBER AND BEAUTY SHOP   0   20, 335   20, 335   0   20, 335   91. 00   51. 00   O9100   BARBER AND BEAUTY SHOP   0   20, 335   20, 335   0   20, 335   91. 00   51. 00   O9100   O9100   DARBER AND BEAUTY SHOP   0   0   0   0   0   0   0   51. 00   O9100   O9100   O9100   O9100   O9100   O   0   0   0   51. 00   O9400   O9400   PATIENTS LAUNDRY   0   0   0   0   0   0   0   51. 00   O9400   O9400   PATIEN		2 (41 200	1 (10 502	E 251 00		E 251 002	20.00
32.00   03200   ICF/II D   0   0   0   0   0   0   32.00   33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   33.00    ANCILLARY SERVICE COST CENTERS  40.00   04000   RADIOLOGY   0   30,164   30,164   0   30,164   40.00   41.00   04100   LABORATORY   0   41,385   41,385   0   41,385   41.00   42.00   04200   INTRAVENOUS THERAPY   0   73,206   73,206   0   73,206   42.00   43.00   04300   0XYGEN (INHALATION) THERAPY   0   19,382   19,382   0   19,382   43.00   44.00   04400   PHYSI CAL THERAPY   377,551   96,540   474,091   0   474,091   44.00   46.00   04600   PHYSI CAL THERAPY   207,314   0   207,314   0   207,314   0   207,314   0   207,314   45.00   47.00   04500   0CUPATIONAL THERAPY   277,314   0   207,314   0   207,314   0   207,314   0   0   0   0   0   47.00   04600   SPECH PATHOLOGY   73,255   0   73,255   0   73,255   46.00   47.00   04700   ELECTROCARDIOLOGY   73,255   0   0   0   0   0   0   0   49.00   04900   DRUGS CHARGED TO PATIENTS   0   264,051   264,051   0   264,051   49.00   49.00   04900   DRUGS CHARGED TO PATIENTS   0   264,051   264,051   0   264,051   49.00   51.00   05100   SUPPORT SURFACES   0   10,683   10,683   0   10,683   51.00   50THER REIMBURSABLE COST CENTERS  71.00   07100   AMBULANCE   0   1,089   1,089   0   1,089   71.00   89.00   SUBTOTALS (sum of lines 1-84)   7,400,219   8,926,458   16,326,677   0   16,326,677    90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   91.00   09100   BARBER AND BEAUTY SHOP   0   20,335   20,335   0   20,335   91.00   92.00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   0   93.00   09400   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   0   94.00   09400   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   94.00   09400   09400   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   94.00   09400   09400   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   94.00   09400   09400   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   94.00   09400   09400			1, 610, 593				•
33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   33.00			0	(	٦		
ANCILLARY SERVICE COST CENTERS		1 -1	0	(	-	_	
40.00   04000   RADI OLOGY   0   30, 164   30, 164   0   30, 164   41.00   04100   LABORATORY   0   41, 385   41, 385   0   41, 385   41.00   04200   INTRAVENOUS THERAPY   0   73, 206   73, 206   073, 206		0	0		) 0	0	33.00
41.00			00.444				
42.00				· ·	1	,	
43. 00		1 1		· ·			1
44. 00		١					
45. 00		١		· ·			
46. 00 04600 SPEECH PATHOLOGY 73, 255 0 73, 255 0 73, 255 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 48. 00 49. 00 04900 DRUGS CHARGED TO PATI ENTS 0 0 264, 051 264, 051 0 264, 051 49. 00 05100 SUPPORT SURFACES 0 10, 683 10, 683 0 10, 683 51. 00 07HER REI MBURSABLE COST CENTERS  71. 00 05100 JAMBULANCE 0 1, 089 1, 089 0 1, 089 71. 00 SPECIAL PURPOSE COST CENTERS  83. 00 08300 HOSPI CE 0 0 0 0 0 0 0 16, 326, 677 0 16, 326, 677 0 16, 326, 677 0 16, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 677 0 0 10, 326, 326, 677 0 0 10, 326, 326, 326, 326, 326, 326, 326, 326							•
47. 00			0				
48. 00		1	0	73, 25	5 0		1
49. 00		0	0	(	0	_	
51.00   05100   SUPPORT SURFACES   0   10,683   10,683   0   10,683   51.00		0	0	(	0	0	
OTHER REIMBURSABLE COST CENTERS   0		0	264, 051	264, 05°	1 0	264, 051	49. 00
71. 00   07100   AMBULANCE   0   1, 089   1, 089   0   1, 089   71. 00		0	10, 683	10, 68	3 0	10, 683	51. 00
SPECIAL PURPOSE COST CENTERS   S3. 00   O8300   HOSPI CE   SUBTOTALS (sum of lines 1-84)   7,400,219   8,926,458   16,326,677   0   16,326,677   89. 00   NONREI MBURSABLE COST CENTERS   S0. 00   O9000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   O   O   O   O   O   O   O   O   O					_		
83. 00   08300   HOSPI CE   0   0   0   0   0   0   0   83. 00   89. 00     SUBTOTALS (sum of lines 1-84)   7,400,219   8,926,458   16,326,677   0   16,326,677   89. 00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0		0	1, 089	1, 08	9 0	1, 089	71. 00
89. 00   SUBTOTALS (sum of lines 1-84)   7,400,219   8,926,458   16,326,677   0   16,326,677   89. 00					_		
NONREI MBURSABLE COST CENTERS   90.00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0		1	0				1
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0		7, 400, 219	8, 926, 458	16, 326, 67	7 0	16, 326, 677	89. 00
91. 00   09100   BARBER AND BEAUTY SHOP   0   20, 335   20, 335   0   20, 335   91. 00   92. 00   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   93. 00   94. 00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   94. 00   0   0   0   0   0   0   0   0   0							
92. 00   09200   PHYSI CIANS PRI VATE OFFI CES   0 0 0 0 0 0 92. 00 93. 00   93.00   NONPAI D WORKERS   0 0 0 0 0 0 93. 00 94. 00   94. 00   94. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	·	,		
93. 00   09300   NONPAI D WORKERS   0 0 0 0 0 93. 00 94. 00   94. 00   09400   PATI ENTS LAUNDRY   0 0 0 0 0 94. 00		0	20, 335	20, 33	5 0		
94. 00 09400 PATIENTS LAUNDRY 0 0 0 94. 00		0	0		0		1
		0	0		0	0	93. 00
100. 00   TOTAL   7, 400, 219   8, 946, 793   16, 347, 012   0   16, 347, 012   100. 00	94.00  09400 PATIENTS LAUNDRY	0	0		0	0	94. 00
	100. 00   T0TAL	7, 400, 219	8, 946, 793	16, 347, 01:	2 0	16, 347, 012	100. 00

INGLEMOOR CARE CENTER In Lieu of Form CMS-2540-10

 
 Heal th Financial
 Systems
 INGLEMO

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315322

				To 12/31/202	3 Date/Time Prepared: 4/9/2024 4:46 pm
	Cost Center Description	Adjustments to	Net Expenses		17 77 2021 1. 10 011
	<b>'</b>		For Allocation		
		Wkst A-8)	(col. 5 +-		
		ŕ	col . 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	1, 080, 896		1. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 677, 803		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	-1, 038, 832	2, 240, 214		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	810, 398		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	101, 105		6. 00
7.00	00700 HOUSEKEEPI NG	0	371, 233		7. 00
8.00	00800 DI ETARY	-1, 409	1, 082, 992		8. 00
9.00	00900 NURSING ADMINISTRATION	0	756, 605		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	351, 691		10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		12. 00
13.00	01300 SOCIAL SERVICE	0	154, 895		13.00
15.00	01500 PATIENT ACTIVITIES	0	212, 001		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	0	5, 251, 983		30. 00
31.00	03100 NURSING FACILITY	0	0		31.00
32.00	03200   CF/IID	0	0		32.00
33.00	03300 OTHER LONG TERM CARE	0	0		33.00
	ANCILLARY SERVICE COST CENTERS				
40. 00	04000 RADI OLOGY	0	30, 164		40. 00
41. 00	04100 LABORATORY	0	41, 385		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	73, 206		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	19, 382		43. 00
44. 00	04400 PHYSI CAL THERAPY	0	474, 091		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	207, 314		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	73, 255		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	264, 051		49. 00
51. 00	05100 SUPPORT SURFACES	0	10, 683		51. 00
	OTHER REIMBURSABLE COST CENTERS	1 _1			
71. 00	07100 AMBULANCE	0	1, 089		71. 00
	SPECIAL PURPOSE COST CENTERS	1	al		
83. 00	08300 H0SPI CE	0	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 040, 241	15, 286, 436		89. 00
00.00	NONREI MBURSABLE COST CENTERS	1 2			00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0 225		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	20, 335		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92.00
93.00	09300 NONPALD WORKERS	0	0		93. 00
94.00	09400 PATIENTS LAUNDRY	0	0		94.00
100.00	) TOTAL	-1, 040, 241	15, 306, 771		100.00

Health Financial Systems	INGLEMOOR CARE C	ENTER		In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS		Provi der	No.: 315322	Peri od: From 01/01/2023	Worksheet A-6	
	_			To 12/31/2023	Date/Time Pre 4/9/2024 4:46	
	Increases					
	Cost Center	r	Li ne #	Sal ary	Non Salary	
	2. 00		3. 00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassificat	ions (Sum		0	0	100. 00
	of columns 4 and 5 must					
	equal sum of column	s 8 and				
	9)					

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	INGLEMOOR CARE CE	NTER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315322		Worksheet A-6	)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					4/9/2024 4: 46	pm
	Decreases					
	Cost Center		Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS INGLEMOOR CARE CENTER In Lieu of Form CMS-2540-10

				T	o 12/31/2023	Date/Time Prep 4/9/2024 4:46	pared:
				Acqui si ti ons		47 77 2024 4. 40	рііі
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	The second secon	Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	466, 928	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	3, 727, 147	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	2, 717, 668	8, 156	0	8, 156	0	6. 00
7.00	Subtotal (sum of lines 1-6)	6, 911, 743	8, 156	0	8, 156	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	6, 911, 743	8, 156	0	8, 156	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5	_1				
1.00	Land	0	0				1.00
2.00	Land Improvements	466, 928	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	3, 727, 147	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6. 00	Movable Equipment	2, 725, 824	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	6, 919, 899	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	6, 919, 899	0			ļ	9. 00

Provi der No.: 315322

Peri od: Worksheet A-8

From 01/01/2023 | Worksheet A-8 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	Date/lime Pre    4/9/2024 4:46	
				Expense Classification on		рііі
				To/From Which the Amount is		
				TOTT OIL WITCH THE AMOUNT 13	to be haj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	Cost center	LITIC NO.	
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds	B		ADMI NI STRATI VE & GENERAL	4. 00	1. 00
1.00	(chapter 2)		-003	ADMINISTRATIVE & GENERAL	4.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0. 00	2. 00
2.00	8)				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		0	1	0.00	4. 00
4.00	(chapter 8)			1	0.00	4.00
5.00	Tel ephone services (pay stations excluded)	В	-14 061	ADMINISTRATIVE & GENERAL	4.00	5. 00
0.00	(chapter 21)		,		1.00	0.00
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7. 00	Parking lot (chapter 21)		Ö	1	0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	0	1	0.00	8. 00
0.00	physician adjustment	0 2				0.00
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10. 00	Sale of scrap, waste, etc. (chapter 23)		Ö		0.00	
11. 00	Nonallowable costs related to certain		0	1	0.00	
	Capital expenditures (chapter 24)				0.00	
12.00	Adjustment resulting from transactions with	A-8-1	0			12. 00
	related organizations (chapter 10)					
13.00	Laundry and Linen service		0		0.00	13. 00
14.00	Revenue - Employee meals	В	-1, 409	DI ETARY	8. 00	
15. 00	Cost of meals - Guests		0			15. 00
16. 00	Sale of medical supplies to other than		Ö		0.00	
	patients					
17.00	Sale of drugs to other than patients		0		0.00	17. 00
18.00	Sale of medical records and abstracts		0		0.00	18. 00
19.00	Vending machines		0		0.00	
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	*** Cost Center Deleted ***	82. 00	22. 00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1. 00	23.00
				FI XTURES		
24.00	Depreciationmovable equipment		0	*** Cost Center Deleted ***	2. 00	24.00
25.00	Other adjustment (specify)		0		0.00	25.00
25. 02	MANGEMENT FEES	A	-796, 625	ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	CONTRI BUTI ONS	A	-10, 654	ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	PUBLI C RELATIONS	A	-39, 194	ADMINISTRATIVE & GENERAL	4.00	
25. 05	BAD DEBTS	A	-21, 094	ADMINISTRATIVE & GENERAL	4.00	25. 05
25. 06	PERSONAL ITEMS	A	-19, 622	ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 07	NJ CBT	A	-136, 719	ADMINISTRATIVE & GENERAL	4.00	
25. 08			0		0.00	25. 08
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 040, 241			100. 00
	to Worksheet A, col. 6, line 100)					
(1) Do	comination all shorter references in this co	luma secteia te	CMC Dub 1F 1	i		

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315322

				10	12/31/2023	1/9/2024 4:46	
			CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FI XTURES	BENEFITS		& GENERAL	
		Allocation					
		(from Wkst A					
		col . 7)					
	T	0	1. 00	3. 00	3A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1, 080, 896	1, 080, 896				1. 00
3.00	00300 EMPLOYEE BENEFITS	1, 677, 803	0	1, 677, 803			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 240, 214	127, 140		2, 559, 525	2, 559, 525	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	810, 398	32, 773	· ·	874, 956	175, 682	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	101, 105	26, 555		148, 792	29, 876	6. 00
7.00	00700 HOUSEKEEPI NG	371, 233	5, 346		445, 349	89, 422	7. 00
8.00	00800 DI ETARY	1, 082, 992	112, 584	141, 627	1, 337, 203	268, 497	8. 00
9. 00	00900 NURSING ADMINISTRATION	756, 605	10, 227	171, 540	938, 372	188, 416	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	351, 691	0	- 1	351, 691	70, 616	10. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	154, 895	4, 155	·	194, 168	38, 987	13. 00
15. 00	01500 PATIENT ACTIVITIES	212, 001	12, 697	40, 858	265, 556	53, 321	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00	03000 SKILLED NURSING FACILITY	5, 251, 983	711, 707	825, 591	6, 789, 281	1, 363, 223	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200   CF/    D	0	0	- 1	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	[ 0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				00.4/4		
40.00	04000 RADI OLOGY	30, 164	0		30, 164	6, 057	40. 00
41. 00	04100 LABORATORY	41, 385	0		41, 385	8, 310	41.00
42.00	04200   NTRAVENOUS THERAPY	73, 206	0	0	73, 206	14, 699	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	19, 382	0	05 500	19, 382	3, 892	43. 00
44.00	04400 PHYSI CAL THERAPY	474, 091	15, 282	85, 599	574, 972	115, 449	44. 00
45. 00	04500 OCCUPATIONAL THERAPY	207, 314	12, 668		266, 985	53, 608	45. 00
46. 00	04600 SPEECH PATHOLOGY	73, 255	0	16, 609	89, 864	18, 044	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0(4.054	4 500	0	0 (0, 500	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	264, 051	4, 532	0	268, 583	53, 929	49. 00
51. 00	05100 SUPPORT SURFACES	10, 683	0	0	10, 683	2, 145	51. 00
71 00	OTHER REIMBURSABLE COST CENTERS	1 000	0		1 000	210	71 00
71. 00	07100 AMBULANCE	1, 089	0	0	1, 089	219	71. 00
02.00	SPECIAL PURPOSE COST CENTERS		0			0	02.00
83.00	08300 HOSPI CE	15 207 427	0	- 1	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	15, 286, 436	1, 075, 666	1, 677, 803	15, 281, 206	2, 554, 392	89. 00
00.00	NONREI MBURSABLE COST CENTERS		0		0	0	00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	20, 335	5, 230	0	25, 565	5, 133	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	92.00
93. 00	09300 NONPAI D WORKERS	0	0		0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0		0	0	94. 00
98.00	Cross Foot Adjustments	0	0		0	0	98. 00
99.00	Negative Cost Centers	15 204 774	1 000 001	1 (77 000	15 207 331	0	99. 00
100.00	) TOTAL	15, 306, 771	1, 080, 896	1, 677, 803	15, 306, 771	2, 559, 525	100.00

				То	12/31/2023	Date/Time Pre 4/9/2024 4:46	
	Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	рш
		5. 00	6. 00	7. 00	8. 00	9. 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	1, 050, 638					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	30, 294					6.00
7.00	00700 HOUSEKEEPI NG	6, 099	0	540, 870	1 000 /04		7.00
8.00	00800 DI ETARY	128, 434	0	68, 490	1, 802, 624	1 144 /77	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	11, 667	0	6, 222	0	1, 144, 677 0	9.00
10. 00 12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	10. 00 12. 00
13. 00	01300 SOCIAL SERVICE	_	0	2 520	0	0	13.00
15. 00	01500 PATIENT ACTIVITIES	4, 740 14, 484	0	2, 528 7, 724	0	0	15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	14, 404		1,124	0	U	15.00
30. 00	03000 SKILLED NURSING FACILITY	811, 899	208, 962	432, 965	1, 802, 624	1, 144, 677	30. 00
31. 00	03100 NURSING FACILITY	011,077	200, 702	432, 703	1, 002, 024	1, 144, 077	31.00
32. 00		0	0	0	0	0	32.00
33. 00		0	0	0	0	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS			0		0	00.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	О	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	17, 434	0	9, 297	0	0	44. 00
45.00	04500 OCCUPATIONAL THERAPY	14, 451	0	7, 706	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	5, 170	0	2, 757	0	0	49. 00
51.00		0	0	0	0	0	51.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00		0	0	0	0	0	71. 00
	SPECIAL PURPOSE COST CENTERS	1 -	г	T			
83. 00		0	-	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	1, 044, 672	208, 962	537, 689	1, 802, 624	1, 144, 677	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	5, 966	-	3, 181	0	0	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	3, 700	0	3, 101	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94. 00	I I	0	١	١	0	0	94.00
98. 00	Cross Foot Adjustments	1 0	١	١	0	0	98. 00
99. 00	1 1	1 0	ا م	١	n	0	99. 00
100.0	1 1 9	1, 050, 638	208, 962	540, 870	1, 802, 624	_	
	•	•	,				•

Provi der No.: 315322

					4/9/2024 4: 46	pm
				OTHER GENERAL		
Cook Cooker Bookerinting	CENTRAL	MEDI CAL	COCLAL CEDVICE	SERVI CE	C - + - + -	
Cost Center Description	SERVICES &	RECORDS &	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	
	SUPPLY	LI BRARY		ACTIVITIES		
	10.00	12. 00	13.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00 00300 EMPLOYEE BENEFITS						3. 00
4.00   OO4OO   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 O0900 NURSING ADMINISTRATION						9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	422, 307					10.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	(	1			12.00
13. 00   01300   SOCI AL   SERVI CE	0	(	240, 423			13. 00
15. 00 01500 PATIENT ACTIVITIES	0	(		341, 085		15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 SKI LLED NURSI NG FACI LI TY	241 207	(	240 423	241 005	13, 376, 346	30.00
31. 00   03000   SKILLED NORSING FACILITY	241, 207	(	1 2.07.20			30.00
31.00   03100   NORSTNG FACTETTY 32.00   03200   CF/IID	0	(	1	1 1	0	31.00
33. 00   03200   TCF/TTD   33. 00   03300   OTHER LONG TERM CARE	0	(	1	-	0	32.00
ANCILLARY SERVICE COST CENTERS	<u> </u>		7	<u> </u>	0	33.00
40. 00 04000 RADI OLOGY	0	(		0	36, 221	40.00
41. 00   04100   LABORATORY	0	(			49, 695	41. 00
42.00 04200 I NTRAVENOUS THERAPY	0	(			87, 905	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	O	(		o	23, 274	43.00
44. 00 04400 PHYSI CAL THERAPY	O	(		ol	717, 152	44.00
45. 00 04500 OCCUPATIONAL THERAPY	O	(		o	342, 750	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	(		o	107, 908	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	(		0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(		0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	181, 100	(	1	-	511, 539	49. 00
51. 00 05100 SUPPORT SURFACES	0	(		0	12, 828	51.00
OTHER REIMBURSABLE COST CENTERS	T -1		.1			
71. 00 07100 AMBULANCE	0	(		0	1, 308	71. 00
SPECIAL PURPOSE COST CENTERS					0	02.00
83.00   08300   HOSPICE 89.00   SUBTOTALS (sum of lines 1-84)	0 422, 307	(	•	1	0 15, 266, 926	83. 00 89. 00
NONREI MBURSABLE COST CENTERS	422, 307	(	240, 423	341,085	15, 200, 920	89.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0	0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP	0	(	1	- 1	39, 845	91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	(			07, 010	92. 00
93. 00   09300   NONPAI D   WORKERS	0	(			0	93. 00
94. 00 09400 PATIENTS LAUNDRY		(			0	94. 00
98.00 Cross Foot Adjustments		·		ol	0	98. 00
99.00 Negative Cost Centers		(		ol ol	0	99. 00
100. 00 TOTAL	422, 307	(	240, 423	341, 085	15, 306, 771	
•					•	•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS INGLEMOOR CARE CENTER In Lieu of Form CMS-2540-10 Provi der No.: 315322

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 4/9/2024 4:46 pm

Cost Center Description				4/9/2024 4: 40	6 pm
17.00   18.00   18.00	Cost Center Description		Total		
SENERAL SERVICE COST CENTERS		Adjustments			
1. 00		17. 00	18. 00		
3. 00   00300   EMPLOYEE BENEFITS					
4. 00   00400   00400   ADMINI STRATI VE & GENERAL   5. 00   00500   PLANT OPERATION, MAINT & REPAIRS   5. 00   00500   PLANT OPERATION, MAINT & REPAIRS   6. 00   00500   PLANT OPERATION, MAINT & REPAIRS   7. 00   00700   000500   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   000500   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   000500   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   000500   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   000500   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   PLATE OPERATION, MAINT & REPAIRS   7. 00   00700   PLATE OPERATION, MAINT & REPAIRS   7. 00   0					1. 00
5.00	3.00   00300   EMPLOYEE BENEFITS				3. 00
6. 00 0600 LAUNDRY & LINEN SERVICE 7. 00 0700 DOOD ONDESSEEPING 8. 00 09. 00 09					4. 00
7. 00	5.00   00500   PLANT OPERATION, MAINT. & REPAIRS				5. 00
8. 00 00800   DITARY 9. 00 10.	6.00  00600 LAUNDRY & LINEN SERVICE				6. 00
9. 00 00900 NURSING ADMINISTRATION 10. 00 1000 CENTRAL SERVI CES & SUPPLY 10. 00 1200 MEDI CAL RECORDS & LIBRARY 12. 00 13. 00 01300 SOCI AL SERVI CE	7. 00   00700   HOUSEKEEPI NG				7. 00
10. 00   10.					
12.00   01200   MEDI CAL RECORDS & LIBRARY					9. 00
13. 00   01300   SOCI AL SERVICE     13. 00   15. 00   01500   PATI ENT ACTIVITIES     15. 00   17.					10. 00
15. 00					12. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS   30. 00   300	13. 00   01300   SOCIAL SERVICE				13. 00
30. 00 03000 SKILLED NURSING FACILITY 0 13,376,346 31. 00 31. 00 031. 00 031. 00 031. 00 03200 ICF/IID 0 0 0 32. 00 32. 00 3300 OTHER LONG TERM CARE 0 0 0 0 32. 00 33. 00 3300 OTHER LONG TERM CARE 0 0 0 0 33. 00 AMOUNT CLARY SERVICE COST CENTERS 33. 00 04000 RADI OLOGY 0 49,695 41. 00 41.	15.00 01500 PATIENT ACTIVITIES				15. 00
31. 00   03100   NURSI NG FACILITY					
32.00   03200   CF/I I D   0   0   0   32.00   33.00   OTHER LONG TERM CARE   0   0   0   40.00   04000   RADI OLOGY   0   36, 221   40.00   41.00   04100   LABORATORY   0   87, 905   41.00   42.00   04200   INTRAVENOUS THERAPY   0   87, 905   42.00   43.00   04300   OXYGEN (I INHALATI ON) THERAPY   0   717, 152   43.00   44.00   04400   PHYSI CAL THERAPY   0   717, 152   44.00   45.00   04500   OCCUPATI ONAL THERAPY   0   342, 750   45.00   46.00   04600   SPEECH PATHOLOGY   0   107, 908   46.00   47.00   04700   ELECTROCARDI OLOGY   0   0   0   48.00   04800   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   48.00   04800   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   49.00   04900   DRUGS CHARGED TO PATI ENTS   0   0   511, 539   49, 00   51.00   OTHER REI MBURSABLE COST CENTERS   0   12, 828   51.00   71.00   OTHER REI MBURSABLE COST CENTERS   0   1, 308   71.00   83.00   SUBTOTALS (sum of lines 1-84)   0   15, 266, 926   89, 00   89.00   NONRE IMBURSABLE COST CENTERS   0   0   0   91.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   92.00   09000   PHYSI CI ANS PRI VATE OFFICES   0   0   0   93.00   09300   NORPAT DI WORKERS   0   0   0   94.00   09400   PATI ENTS LAUNDRY   0   0   0   94.00   09400   PATI ENTS LAUNDRY   0   0   0   98.00   Negati ve Cost Centers   0   0   99.00   090		0	13, 376, 346		30. 00
33.00   3300   OTHER LONG TERM CARE   0   0   0		0	0		31.00
ANCILLARY SERVICE COST CENTERS		0	0		32. 00
40. 00   04000   RADI 0LOGY   0   36, 221   40. 00   41. 00   04100   LABORATORY   0   49, 695   41. 00   42. 00   04200   INTRAVENOUS THERAPY   0   87, 905   42. 00   43. 00   04300   OXYGEN (INHALATION) THERAPY   0   23, 274   43. 00   44. 00   04400   PHYSI CAI THERAPY   0   342, 750   45. 00   46. 00   04500   OCCUPATI ONAL THERAPY   0   342, 750   45. 00   46. 00   04600   SPEECH PATHOLOGY   0   107, 908   46. 00   47. 00   04700   ELECTROCARDI OLOGY   0   107, 908   46. 00   49. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   49. 00   04900   DRUGS CHARGED TO PATI ENTS   0   511, 539   49. 00   51. 00   05100   SUPPORT SURFACES   0   12, 828   51   51. 00   OTHER REI MBURSABLE COST CENTERS   0   1, 308   51   83. 00   08300   HOSPI CE   0   0   1, 308   51   89. 00   SUBTOTALS (sum of 1 i nes 1-84)   0   15, 266, 926   89. 00   90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   91. 00   09000   BABBER AND BEAUTY SHOP   0   39, 845   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   93. 00   09300   NONPAID WORKERS   0   0   0   94. 00   PHYSI CI ANS PRI VATE OFFICES   0   0   95. 00   09400   PATI ENTS LAUNDRY   0   0   96. 00   09400   PATI ENTS LAUNDRY   0   0   97. 00   09400   PATI ENTS LAUNDRY   0   0   98. 00   NonPAID WORKERS   0   0   99. 00   NonPAID WORKERS   0   0   99. 00   NonPAID WORKERS   0   0   99. 00   09400   PATI ENTS LAUNDRY   0   0   99. 00   0400   PATI ENTS LAUNDRY   0   0   99. 00   0400   0400   0400   0400   0400   99. 00   0400   0400   0400   0400   0400   99. 00   0400   0400   0400   0400   0400   0400   99. 00   0400   0400   0400   0400   0400   0400   99. 00   0400   0400   0400   0400   0400   0400   0400   99. 00   0400   0400   0400   0400   0400   0400   0400   0400   0400   0400   0400	33.00 03300 OTHER LONG TERM CARE	0	0		33. 00
41. 00	ANCILLARY SERVICE COST CENTERS				
42. 00 04200   INTRAVENOUS THERAPY		0	36, 221		40. 00
43. 00 04300 0XYGEN (I NHALATION) THERAPY 0 23, 274 44. 00 04400 PHYSI CAL THERAPY 0 717, 152 44. 00 04400 PHYSI CAL THERAPY 0 717, 152 44. 00 04500 0CCUPATI ONAL THERAPY 0 342, 750 45. 00 04500 0CCUPATI ONAL THERAPY 0 107, 908 46. 00 04600 SPEECH PATHOLOGY 0 107, 908 46. 00 04600 SPEECH PATHOLOGY 0 0 107, 908 46. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 47. 00 04900 PRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41. 00  04100 LABORATORY	0	49, 695		41. 00
44. 00		0			•
45. 00	43.00   04300   OXYGEN (INHALATION) THERAPY	0	23, 274		43.00
46. 00		0	717, 152		44. 00
47. 00 04700   ELECTROCARDI OLOGY	· · · · · · · · · · · · · · · · · · ·	0			•
48. 00		0	107, 908		
49. 00       04900 DRUGS CHARGED TO PATIENTS       0       511, 539       49. 00         51. 00       05100 SUPPORT SURFACES       0       12, 828       51. 00         OTHER REIMBURSABLE COST CENTERS         71. 00       ON ONABULANCE       0       1, 308       71. 00         SPECIAL PURPOSE COST CENTERS         83. 00       O8300 HOSPI CE       0       0       83. 00         89. 00       SUBTOTALS (sum of lines 1-84)       0       15, 266, 926       89. 00         NONREI MBURSABLE COST CENTERS         90. 00       09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN       0       0       90. 00         91. 00       09100 BARBER AND BEAUTY SHOP       0       39, 845       91. 00         92. 00       09200 PHYSI CI ANS PRI VATE OFFI CES       0       0       92. 00         93. 00       09300 NONPAI D WORKERS       0       0       93. 00         94. 00       09400 PATIENTS LAUNDRY       0       0       94. 00         99. 00       Negative Cost Centers       0       0       99. 00		-1	0		•
51.00   05100   SUPPORT SURFACES   0   12,828   51.00		5   0	0		•
OTHER REIMBURSABLE COST CENTERS   0		1 1			•
71. 00   07100   AMBULANCE   0   1, 308		0	12, 828		51. 00
SPECIAL PURPOSE COST CENTERS					
83. 00 89. 00   SUBTOTALS (sum of lines 1-84)   0   15, 266, 926   89. 00     NONREI MBURSABLE COST CENTERS   90. 00   90. 00   90. 00     91. 00   09100   BARBER AND BEAUTY SHOP   0   39, 845   91. 00     92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   92. 00     93. 00   09300   NONPAI D WORKERS   0   0   93. 00     94. 00   09400   PATI ENTS LAUNDRY   0   0   0     98. 00   Cross Foot Adjustments   0   0   0     99. 00   Negative Cost Centers   0   0   0     99. 00   99. 00   0     83. 00   89. 00   90. 00     83. 00   0   0   0     84. 00   0   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0   0     99. 00   0     99. 00   0   0		0	1, 308		71. 00
SUBTOTALS (sum of lines 1-84)   0   15, 266, 926   89. 00					
NONREI MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0			- 1		
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0		0	15, 266, 926		89. 00
91. 00   09100   BARBER AND BEAUTY SHOP   0   39,845   91. 00   92. 00   93. 00   93. 00   93. 00   94. 00   94. 00   98. 00   98. 00   Nonpai be Rote Rote Rote Rote Rote Rote Rote Rot					
92. 00   92.00   94.00   95.00   97.00		N   O			
93. 00   09300   NONPAI D WORKERS   0 0 0 94.00   94.00   98.00   Cross Foot Adjustments   0 0 0 99.00   Negative Cost Centers   0 0 0 99.00   0 0 99.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	39, 845		
94. 00   94. 00   94. 00   98. 00   99. 00		0	0		•
98.00   Cross Foot Adjustments		0	0		
99.00   Negative Cost Centers   0   0   99.00		0	0		
	1 1		0		
100. 00   TOTAL   0  15, 306, 771   100. 00	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1	0		
	100. 00   T0TAL	0	15, 306, 771		J100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315322

				To	12/31/2023	Date/Time Prep 4/9/2024 4:46	
			CAPI TAL			77 77 2024 4. 40	Pili
			RELATED COSTS				
	Cost Center Description	Di rectly	BLDGS &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	·	Assigned New	FI XTURES		BENEFITS	& GENERAL	
		Capi tal					
		Related Costs					
		0	1.00	2A	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	0		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	127, 140	127, 140	0	127, 140	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	32, 773	32, 773	0	8, 727	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	26, 555	26, 555	0	1, 484	6. 00
7.00	00700 HOUSEKEEPI NG	0	5, 346	5, 346	0	4, 442	7. 00
8.00	00800 DI ETARY	0	112, 584	112, 584	0	13, 337	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	10, 227	10, 227	0	9, 359	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	3, 508	10. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12. 00
13.00	01300 SOCIAL SERVICE	0	4, 155	4, 155	0	1, 937	13. 00
15.00	01500 PATIENT ACTIVITIES	0	12, 697	12, 697	0	2, 649	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	711, 707	711, 707	0	67, 714	30. 00
31.00	03100 NURSING FACILITY	O	0	0	0	0	31. 00
32.00	03200   CF/IID	O	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	301	40. 00
41.00	04100 LABORATORY	0	0	0	0	413	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	730	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	193	43.00
44.00	04400 PHYSI CAL THERAPY	0	15, 282	15, 282	0	5, 735	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	12, 668	12, 668	0	2, 663	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	896	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	4, 532	4, 532	0	2, 679	49. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	107	51.00
	OTHER REIMBURSABLE COST CENTERS						
71.00	07100 AMBULANCE	0	0	0	0	11	71.00
	SPECIAL PURPOSE COST CENTERS						
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 075, 666	1, 075, 666	0	126, 885	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	5, 230	5, 230	0	255	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	o	0	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	o	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	o	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments			0			98. 00
99. 00	Negative Cost Centers		0	0	0	0	99. 00
100.00	TOTAL	0	1, 080, 896	1, 080, 896	0	127, 140	100.00
	•			. '	'		-

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315322

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared:

				10	12/31/2023	4/9/2024 4:46	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	P
	'	OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
	I	5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	1	ı	1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	00400 ADMI NI STRATI VE & GENERAL	41 500					4. 00 5. 00
6. 00	OO500	41, 500 1, 197	29, 236				6.00
7. 00	00700 HOUSEKEEPING	241	29, 230	1			7. 00
8. 00	00800 DI ETARY	5, 073	0	10, 029	132, 264		8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	461		1, 270	132, 204	20, 162	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	401		0	0	20, 102	10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY			0	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	187		47	0	Ö	13. 00
15. 00	01500 PATIENT ACTIVITIES	572	0	1	0	0	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	072		110		0	10.00
30.00	03000 SKILLED NURSING FACILITY	32, 069	29, 236	8, 029	132, 264	20, 162	30.00
31. 00	03100 NURSING FACILITY	0	0		0		31. 00
32.00	03200   CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0		0	-	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	689	0	172	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	571	0	143	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	204	0	51	0	0	49. 00
51. 00	05100   SUPPORT SURFACES   OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	51. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
71.00	SPECIAL PURPOSE COST CENTERS	0		ıj U	0	U	71.00
83. 00	08300 H0SPI CE	1 0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	41, 264		- 1	132, 264	20, 162	89. 00
07.00	NONREI MBURSABLE COST CENTERS	11,201	27,200	7, 770	102, 201	20, 102	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	236	0	59	0	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	41, 500	29, 236	10, 029	132, 264	20, 162	100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315322

					10 12/31/20.	23   Date/IIMe Pre 4/9/2024 4:46	
					OTHER GENERA		, p
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCI AL SERVI	CE PATIENT	Subtotal	
	·	SERVICES &	RECORDS &		ACTI VI TI ES		
		SUPPLY	LI BRARY				
		10.00	12.00	13.00	15. 00	16.00	
	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 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	3, 508					10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	o	(	ol			12.00
13. 00	01300 SOCIAL SERVICE	ol		6, 3	326		13. 00
15. 00	01500 PATIENT ACTIVITIES	ol		ol	0 16, 0	61	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	٥,	·	<u> </u>	- 10,0	<u> </u>	10.00
30.00	03000 SKILLED NURSING FACILITY	2,004		0 6, 3	326 16, 0	61 1, 025, 572	30.00
31. 00	03100 NURSING FACILITY	_,		ol s, s	0	0 0	1
32. 00	03200   CF/11D	ام		ol	0		
33. 00	03300 OTHER LONG TERM CARE	٥			Ö		
00.00	ANCILLARY SERVICE COST CENTERS	<u>ا</u>		<u> </u>		<u> </u>	00.00
40.00	04000 RADI OLOGY	ol		ol	0	0 301	40.00
41. 00	04100 LABORATORY	ol		ol	0	0 413	
42. 00	04200 I NTRAVENOUS THERAPY	ol		ol	0	0 730	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	ol		ol	0	0 193	1
44. 00	04400 PHYSI CAL THERAPY	أم		ol	0	0 21, 878	1
45. 00	04500 OCCUPATI ONAL THERAPY	ol			0	0 16, 045	
46. 00	04600 SPEECH PATHOLOGY	ol			0	0 896	1
47. 00	04700 ELECTROCARDI OLOGY	ol			0		1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	ام		ol	0		
49. 00	04900 DRUGS CHARGED TO PATIENTS	1, 504			Ö	0 8, 970	1
51. 00	05100 SUPPORT SURFACES	0			Ö	0 107	1
01.00	OTHER REIMBURSABLE COST CENTERS	<u>ا</u>		9	<u> </u>	0  107	01.00
71. 00	07100 AMBULANCE	ol		o	0	0 11	71. 00
, ,, ,,	SPECIAL PURPOSE COST CENTERS	٥,	·	<u> </u>	<u> </u>	<u> </u>	1 00
83. 00	08300 HOSPI CE	ol		ol	0	0 0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	3, 508		6, 3			1
	NONREI MBURSABLE COST CENTERS	2, 222					
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O		ol	0	0 0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	ol		ol	0	0 5, 780	
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	ol		ol	0	0 0	1
93. 00	09300 NONPALD WORKERS	ol		ol	0	ol o	1
94. 00	09400 PATIENTS LAUNDRY	ام			0		
98. 00	Cross Foot Adjustments	ام	·	-	-		1
99. 00	Negative Cost Centers	ام			0		1
100.00	1 1 0	3, 508	· ·	6, 3	326 16, 0		
100.00	/	3, 300	· ·	0, 0	10,0	1, 000, 070	1.55.55

Health Financial Systems INGLEMOOR CARE CENTER In Lieu of Form CMS-2540-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315322 Period:

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

100.00

4/9/2024 4: 46 pm Cost Center Description Post Step-Down 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 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9.00 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 01300 SOCIAL SERVICE 13.00 13 00 15.00 01500 PATIENT ACTIVITIES 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 1, 025, 572 30.00 31.00 03100 NURSING FACILITY 31.00 32.00 03200 | CF/IID 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 0 40.00 04000 RADI OLOGY 301 41.00 04100 LABORATORY 00000000 413 41.00 04200 I NTRAVENOUS THERAPY 42.00 730 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 193 44. 00 04400 PHYSI CAL THERAPY 21,878 44.00 45.00 04500 OCCUPATIONAL THERAPY 16,045 45.00 04600 SPEECH PATHOLOGY 46.00 896 46.00 04700 ELECTROCARDI OLOGY 47.00 Λ 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 48.00 04900 DRUGS CHARGED TO PATIENTS 0 8, 970 49.00 49.00 05100 SUPPORT SURFACES 51.00 107 51.00 OTHER REIMBURSABLE COST CENTERS 71.00 07100 AMBULANCE 0 11 71.00 SPECIAL PURPOSE COST CENTERS 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 0 1, 075, 116 89.00 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 09100 BARBER AND BEAUTY SHOP 00000 91.00 91.00 5, 780 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 09300 NONPALD WORKERS 93.00 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 94.00 98.00 Cross Foot Adjustments 0 98.00 99.00 Negative Cost Centers 99.00

1, 080, 896

100.00

TOTAL

Provider No.: 315322 | Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					1 .	o 12/31/2023	Date/Time Pre 4/9/2024 4:46	
		Cost Center Description	CAPITAL RELATED COSTS BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	
			1.00	3. 00	4A	4. 00	5. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS - BLDGS & FIXTURES	37, 203					1. 00
3.00		EMPLOYEE BENEFITS	0	7, 400, 219		40 747 044		3.00
4.00		ADMINISTRATIVE & GENERAL	4, 376	847, 603			21 (00	4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	1, 128 914	140, 195	1		31, 699 914	5. 00 6. 00
7. 00		HOUSEKEEPING	184	93, 208 303, 323	1		184	7. 00
8. 00		DI ETARY	3, 875	624, 669	1		3, 875	8.00
9. 00		NURSING ADMINISTRATION	352	756, 605	1		3, 873	9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	730, 603	1	·	0	10.00
12. 00		MEDICAL RECORDS & LIBRARY	0	0			0	12. 00
13.00		SOCIAL SERVICE	143	154, 895	1		143	
15.00	01500	PATIENT ACTIVITIES	437	180, 211	0		437	15. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		SKILLED NURSING FACILITY	24, 496	3, 641, 390	0	6, 789, 281	24, 496	
31. 00		NURSING FACILITY	0	0	· ·	-	0	31. 00
32. 00		I CF/I I D	0	0			0	32. 00
33. 00		OTHER LONG TERM CARE	0	0	0	0	0	33. 00
		LARY SERVICE COST CENTERS			1			
40. 00		RADI OLOGY	0	0			0	
41. 00 42. 00		LABORATORY I NTRAVENOUS THERAPY	0	0			0	41. 00 42. 00
43.00		OXYGEN (INHALATION) THERAPY	0	0	· ·	·	0	42.00
44. 00		PHYSICAL THERAPY	526	377, 551	_		526	
45. 00		OCCUPATIONAL THERAPY	436	207, 314			436	
46. 00		SPEECH PATHOLOGY	0	73, 255			0	
47. 00		ELECTROCARDI OLOGY	0	0,0,200			0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49.00		DRUGS CHARGED TO PATIENTS	156	O	1		156	49. 00
51.00	05100	SUPPORT SURFACES	0	0	0	10, 683	0	51. 00
		REIMBURSABLE COST CENTERS						
71. 00		AMBULANCE	0	0	0	1, 089	0	71. 00
		AL PURPOSE COST CENTERS	_1		1	_		
83. 00	08300	HOSPI CE	0	7 400 010			0	
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	37, 023	7, 400, 219	-2, 559, 525	12, 721, 681	31, 519	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00		BARBER AND BEAUTY SHOP	180	0			180	
92. 00		PHYSICIANS PRIVATE OFFICES	0	0	· -	23, 303	0	92.00
93. 00		NONPALD WORKERS	0	0	_	0	0	93. 00
94. 00		PATIENTS LAUNDRY	o	0		0	0	94. 00
98.00		Cross Foot Adjustments						98. 00
99.00		Negative Cost Centers						99. 00
102.00	)	Cost to be allocated (per Wkst. B,	1, 080, 896	1, 677, 803		2, 559, 525	1, 050, 638	102. 00
		Part I)						
103.00	4	Unit cost multiplier (Wkst. B, Part I)	29. 054001	0. 226723	1	0. 200790	33. 144200	
104.00	וי	Cost to be allocated (per Wkst. B,		0	1	127, 140	41, 500	104. 00
105.00		Part II) Unit cost multiplier (Wkst. B, Part		0. 000000		0. 009974	1. 309190	105 00
105.00	1	II)		0. 000000	[	0.009974	1. 309 190	100.00
	Ţ	1117	ı I		I			ļ

Provider No.: 315322 | Period: | Worksheet B-1 | From 01/01/2023 | To 12/21/2022 | Company | Period: | Per Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

						o 12/31/2023	Date/Time Pre 4/9/2024 4:46	
		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	
			LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	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	
4 00		AL SERVICE COST CENTERS			1			4 00
1.00	1	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00		EMPLOYEE BENEFITS						3.00
4.00		ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	24 454					5. 00 6. 00
		HOUSEKEEPING	34, 454	20 (01				
7.00	1	DIETARY	0	30, 601	l .			7. 00
8. 00 9. 00		NURSING ADMINISTRATION	0	3, 875 352				8. 00 9. 00
10.00		l e e e e e e e e e e e e e e e e e e e	0	352	l .		(15 740	1
12. 00		CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	0				615, 742 0	1
		SOCIAL SERVICE	0				0	1
13. 00 15. 00		PATIENT ACTIVITIES	0	143 437	· ·		0	1
15.00		IENT ROUTINE SERVICE COST CENTERS	U	437		y U		15.00
30. 00		SKILLED NURSING FACILITY	34, 454	24, 496	103, 362	158, 898	351, 691	30.00
31.00		NURSING FACILITY	34, 434	24, 470		· · · · · · · · · · · · · · · · · · ·	0 0	
32. 00		ICF/IID	0	0	1		0	1
33. 00		OTHER LONG TERM CARE	0	0			0	
33.00		LARY SERVICE COST CENTERS	U	0	<u> </u>	yı O		33.00
40. 00		RADI OLOGY	0	0	0	ol	0	40.00
41. 00		LABORATORY	0	Ö			0	
42. 00	1	INTRAVENOUS THERAPY	o o	0			0	
43. 00		OXYGEN (INHALATION) THERAPY	o o	0	· ·		0	
44. 00		PHYSI CAL THERAPY	o o	526	· ·		0	
45. 00		OCCUPATI ONAL THERAPY	0	436	1	ol	0	1
46. 00		SPEECH PATHOLOGY	0	0	1	ol	0	46.00
47.00		ELECTROCARDI OLOGY	0	0	1	o	0	1
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	O	o	0	48. 00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	156	0	o	264, 051	49. 00
51.00		SUPPORT SURFACES	0	0	0	o	0	51.00
	OTHER	REIMBURSABLE COST CENTERS						1
71.00	07100	AMBULANCE	0	0	0	0	0	71. 00
		AL PURPOSE COST CENTERS						
83.00	08300	HOSPI CE	0	-			0	
89. 00		SUBTOTALS (sum of lines 1-84)	34, 454	30, 421	103, 362	158, 898	615, 742	89. 00
		IMBURSABLE COST CENTERS			1			
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		_	0	
91. 00		BARBER AND BEAUTY SHOP	0	180			0	
92. 00		PHYSICIANS PRIVATE OFFICES	0	0	_	-	0	
93. 00	1	NONPAI D WORKERS	0	0	1	-	0	
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	
98. 00		Cross Foot Adjustments						98. 00
99. 00		Negative Cost Centers	000 0/0	F 40 070	4 000 (04	4 444 (77	400 007	99.00
102.00	ין	Cost to be allocated (per Wkst. B,	208, 962	540, 870	1, 802, 624	1, 144, 677	422, 307	102.00
103.00		Part I) Unit cost multiplier (Wkst. B, Part I)	6. 064956	17. 674913	17. 439910	7. 203848	0. 685851	103 00
103.00	1	Cost to be allocated (per Wkst. B,	29, 236		l .			103.00
104.00	1	Part II)	27, 230	10,029	132, 204	20, 102	3, 300	104.00
105.00		Unit cost multiplier (Wkst. B, Part	0. 848552	0. 327734	1. 279619	0. 126886	0. 005697	105, 00
							,	
		•			•			

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315322 | Peri od: From 01/01/2023 | To 12/31/2023

Worksheet B-1

Date/Time Prepared:

4/9/2024 4: 46 pm OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCIAL SERVICE PATI ENT ACTI VI TI ES RECORDS & LI BRARY (PATI ENT (PATI ENT (PATI ENT CENSUS) CENSUS) CENSUS) 12.00 13.00 15.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS - BLDGS & FLXTURES 1 00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 01200 MEDICAL RECORDS & LIBRARY 34, 454 12.00 12.00 01300 SOCIAL SERVICE 13.00 13.00 34, 454 01500 PATIENT ACTIVITIES 34, 454 15.00 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 34, 454 34, 454 34, 454 30.00 03100 NURSING FACILITY 31.00 31.00 0 32 00 03200 | CF/IID 0 C 0 32 00 33.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 0 41.00 04100 LABORATORY C 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 000000 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 44.00 0 0 44.00 0 45.00 04500 OCCUPATIONAL THERAPY 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 C 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 49.00 05100 SUPPORT SURFACES 51.00 0 51.00 OTHER REIMBURSABLE COST CENTERS 71.00 07100 AMBULANCE 0 0 0 71.00 SPECIAL PURPOSE COST CENTERS 83.00 08300 HOSPI CE 83.00 0 0 SUBTOTALS (sum of lines 1-84) 34, 454 34, 454 89.00 34, 454 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 09100 BARBER AND BEAUTY SHOP 0 91 00 C 91 00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 C 92.00 93.00 09300 NONPALD WORKERS 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 C 0 94.00 98 00 Cross Foot Adjustments 98 00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, 240, 423 341, 085 102.00 Part I) 103.00 103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 6. 978087 9.899721 104.00 Cost to be allocated (per Wkst. B, 6, 326 16,061 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.183607 0.466158 105.00 II)

Health Financial Systems	INGLEMOOR CARE C	ENTER		In Lie	u of Form CMS-:	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT	COST CENTERS	Provi der		Peri od:	Worksheet C	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	
					4/9/2024 4: 46	pm
Cost Center Description			Total (from			
			Wkst. B, Pt I	,	di vi ded by	
			col . 18)		col. 2	
			1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY			36, 22	1 25, 670	1. 411025	40. 00
41. 00   04100   LABORATORY			49, 69	5 32, 830	1. 513707	41.00
42.00 04200 INTRAVENOUS THERAPY			87, 90	5 16, 299	5. 393276	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY			23, 27	4 0	0.000000	43.00
44. 00 04400 PHYSI CAL THERAPY			717, 15	2 845, 700	0. 847998	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY			342, 75	0 789, 643	0. 434057	45. 00
46.00 04600 SPEECH PATHOLOGY			107, 90	8 188, 341	0. 572940	46. 00
47. 00 04700 ELECTROCARDI OLOGY				0	0.000000	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				0 16, 955	0.000000	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS			511, 53	9 334, 190	1. 530683	49. 00
51. 00 05100 SUPPORT SURFACES			12, 82	8 0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS			·	•		
71. 00 07100 AMBULANCE			1, 30	8 0	0.000000	71. 00
100. 00   Total			1, 890, 58	0 2, 249, 628		100. 00

Health Financial Systems	INGLEMOOR CA	ARE CENTER		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 01/01/2023	Worksheet D Part I	
				To 12/31/2023		pared:
		Title	XVIII (1)	Skilled Nursing		
			21	Facility		
		Heal th Care Pr	rogram Charges	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)					
DART I CALCULATION OF ANOLITARY AND OUTDAT	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENI COST					1
ANCI LLARY SERVI CE COST CENTERS  40, 00 O4000 RADI OLOGY	1. 411025	21, 105		0 29, 780	0	40.00
41. 00   04100  KADI OLOGY 41. 00   04100  LABORATORY	1. 513707			0 29, 780	0	
42. 00   04200   NTRAVENOUS THERAPY	5. 393276			0 47, 217		
43. 00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0 07, 703	0	1
44. 00 04400 PHYSI CAL THERAPY	0. 847998			0 426, 198	1	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 434057			0 220, 845		
46. 00   04600   SPEECH PATHOLOGY	0. 572940			0 72, 907	0	1
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 0	0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 530683	255, 735		0 391, 449	0	49. 00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	71. 00
100.00   Total (Sum of lines 40 - 71)		1, 464, 289		0 1, 278, 301	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	у.					

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

Heal th	Financial Systems	I NGLEMOOR CA	ARE CENTER		In Lie	eu of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		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. 00 2. 00 3. 00	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) Program vaccine charges (From your records, or the PS&R)						1. 00 2. 00 3. 00
	E, Part I, line 18)	,				24, 001	
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	·	(From Wkst. B,	Allied Health	Nursing &	Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,			Health Costs	
		18		Costs to Tota	, , , , , , , , , , , , , , , , , , , ,	for Pass	
				Costs - Part		Through (Col.	
				(Col. 2 / Col		3 x Col. 4)	
				1)			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALIH				
	ANCILLARY SERVICE COST CENTERS	0, 004			00.700		40.00
	04000 RADI OLOGY	36, 221		1 0.0000			
	04100 LABORATORY	49, 695		0.00000		l .	41. 00 42. 00
	04200 I NTRAVENOUS THERAPY	87, 905		0.00000 0.00000			42.00
	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	23, 274		0.00000			44.00
	04500 OCCUPATIONAL THERAPY	717, 152		0.00000			45.00
	04600 SPEECH PATHOLOGY	342, 750 107, 908		0.00000		l .	46.00
	04700 ELECTROCARDI OLOGY	107, 908		0.00000		0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.00000		0	48.00
	04900 DRUGS CHARGED TO PATTENTS	511, 539		0.00000		_	49. 00
	05100 SUPPORT SURFACES	12, 828		0.00000		0	
100.00		1, 889, 272			1, 278, 301	_	100.00
100.00	1 10 (30) (11) (11) (3 40 32)	1,007,272	1	1	1, 270, 301	1	1100.00

	nancial Systems INGLEMOOR CA			u of Form CMS-2	
)MPUTATI (	ON OF INPATIENT ROUTINE COSTS	Provi der No.: 315322	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 4/9/2024 4:46	pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1 00	
PAR <sup>3</sup>	T I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	ATIENT DAYS				
	patient days including private room days			34, 454	
	vate room days	_		0	
	patient days including private room days applicable to the			7, 570	
	dically necessary private room days applicable to the Pro tal general inpatient routine service cost	gram		0 13, 376, 346	
	VATE ROOM DIFFERENTIAL ADJUSTMENT			13, 370, 340	~
	neral inpatient routine service charges			15, 419, 884	6
0 Gen	neral inpatient routine service cost/charge ratio (Line	5 divided by line 6)		0.867474	7
	ter private room charges from your records			0	
0 Ave 2)	erage private room per diem charge (Private room charges	line 8 divided by private	room days, line	0. 00	9
	ter semi-private room charges from your records			0	10
4	erage semi-private room per diem charge (Semi-private ro	om charges line 10, divide	d by	0.00	
sem					
00 Ave	0. 00				
00 Ave		0.00			
00 Pri 00 Gen	minus Lino 14)	0 13, 376, 346	1		
	neral inpatient routine service cost net of private room GRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Effic 5	III IIus IIIIc I+)	13, 370, 340	'
	usted general inpatient service cost per diem (Line 15	divided by line 1)		388. 24	16
	ogram routine service cost (Line 3 times line 16)			2, 938, 977	
	dically necessary private room cost applicable to program			0	1
	tal program general inpatient routine service cost (Line bital related cost allocated to inpatient routine service		+ II column 10	2, 938, 977 1, 025, 572	
	ne 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	COSTS (FIOIII WEST. B, Pai	t II COTUIIII 16,	1,025,572	20
	diem capital related costs (Line 20 divided by line 1)			29. 77	21
00 Pro	ogram capital related cost (Line 3 times line 21)			225, 359	22
	patient routine service cost (Line 19 minus line 22)			2, 713, 618	
	gregate charges to beneficiaries for excess costs (From		04)	0 710 (10	
4	tal program routine service costs for comparison to the cater the per diem limitation (1)	ost limitation (Line 23 mi	nus line 24)	2, 713, 618	25 26
	patient routine service cost limitation (Line 3 times the	per diem limitation line	26) (1)		27
	mbursable inpatient routine service costs (Line 22 plus				28
(Tr	ransfer to Worksheet E, Part II, line 4) (See instruction	s)	, i		
Li nes	26 and 27 are not applicable for title XVIII, but may be	used for title V and or t	itle XIX		
				1. 00	
PAR	T II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH CO	STS FOR PPS PASS-THROUGH			
0 Tot	al SNF inpatient days			34, 454	
	ogram inpatient days (see instructions)			7, 570	
OD Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)					
00 Nur	rsing & allied health ratio. (line 2 divided by line 1)			0. 219713	5

Health Financial Systems	INGLEMOOR CARE C	CENTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	FOR TITLE XVIII	Provi der No.: 315322	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 4/9/2024 4:46 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	рш	
		II the Aviii	Facility	PP3		
			Taciffty			
			-	1. 00		
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSE	MENT		1.00		
1.00	Inpatient PPS amount (See Instructions)			5, 329, 840	1.00	
2.00	Nursing and Allied Health Education Activities (pass through pay	vments)		0	1	
3. 00	Subtotal (Sum of lines 1 and 2)	,,		5, 329, 840		
4.00	Primary payor amounts			0	4. 00	
	5. 00   Coi nsurance					
6.00						
7.00	Allowable Bad debts for dual eligible beneficiaries (See instruc	ctions)		11, 771 0	1	
8.00	Adjusted reimbursable bad debts. (See instructions)	,		7, 651	8. 00	
9.00	Recovery of bad debts - for statistical records only			0	1	
10.00	Utilization review			0	10.00	
11. 00	Subtotal (See instructions)			4, 861, 491		
12.00	Interim payments (See instructions)			4, 756, 763		
13.00	Tentati ve adjustment			0		
14.00	OTHER adjustment (See instructions)			0	14.00	
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50	
14. 55	· · · · · · · · · · · · · · · · · · ·					
14. 75					14. 75	
14. 99	· · · · · · · · · · · · · · · · · · ·				14. 99	
15.00	· · · · · · · · · · · · · · · · · · ·				15. 00	
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	0	16.00	
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (	OF COST OR CHARGES -	TITLE XVIII ONLY			
17. 00	Ancillary services Part B			0	17. 00	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			24, 001		
19. 00	Total reasonable costs (Sum of lines 17 and 18)			24, 001		
20. 00	Medicare Part B ancillary charges (See instructions)			15, 680	1	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			15, 680		
22. 00	Primary payor amounts			0		
23. 00	Coinsurance and deductibles			0		
24. 00	Allowable bad debts (From your records)			0		
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instruc	ctions)		0		
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02	
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			15, 680		
26. 00	Interim payments (See instructions)			12, 293 0		
27. 00						
28. 00					28. 00	
28. 50					28. 50	
28. 55					28. 55	
28. 99					28. 99	
29. 00	Balance due provider/program (see instructions)	with OMC Dub 15 0		3, 073		
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	Section 115.2	0	30.00	

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315322
Period:
From 01/01/2023
To 12/31/2023
Date/Time Prepared:
4/9/2024 4: 46 pm
Provider No.: 315322
Pro

Inpati ent Pert A			11 (1)	e AVIII	Facility	PP3	
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00			Inpatien	t Part A		t B	
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00			mm /dd /\n\n\	Amount	mm /dd /\n\n\	Amount	
Total interim payments paid to provider   1,293   1,000   2,00   1,000   1,000   2,00   1,000   1,000   2,00   2,00							
InterIm payments payable on Individual Bills, either submitted or to be submitted for the cost reporting period. If none, enter zero   1.00	1. 00	Total interim payments paid to provider	1.00		0.00		1. 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero   3.00				0			
enter zero   anount 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)							
3.00   List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		1					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00						3. 00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider   ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER							
3.02	2 01			0			2 01
3.03		ADJUSTIMENTS TO PROVIDER				_	
3. 04   0							
3.05						_	
Provider to Program				-			
ADJUSTMENTS TO PROGRAM	0.00	Provider to Program					0.00
3.52   3.53   3.54   3.99   3.52   3.53   3.54   3.99   3.52   3.99   3.53   3.54   3.99   3.53   3.54   3.99   3.54   3.99   3.54   3.99   3.54   3.99   3.55   3.55   3.98   3.55   3.98   3.55   3.98   3.55   3.98   3.55   3.98   3.55   3.98   3.55   3.99	3.50			0		0	3.50
3.53	3.51			0		0	3. 51
3.54   3.99   Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   3.54	3.52			0		0	3. 52
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   3.99	3.53			0		0	3. 53
- 3.98   Total interim payments (sum of lines 1, 2, and 3.99)				0		0	
A	3. 99			0		0	3. 99
CTransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)   TO BE COMPLETED BY CONTRACTOR							
26 for Part B)   TO BE COMPLETED BY CONTRACTOR	4.00			4, 756, 763		12, 293	4. 00
TO BE COMPLETED BY CONTRACTOR							
Solid							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1)   Program to Provider   TENTATIVE TO PROVIDER   0   0   0   5.01	3.00						3.00
Program to Provider							
Solidar to Program   Solidar		Program to Provider					
5.03   Provider to Program   5.50   TENTATIVE TO PROGRAM   0   0   5.50     5.51   0   0   0   5.51     5.52   0   0   0   5.52     5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   0   5.59     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   7,498   3,073   6.01     6.01   PROGRAM TO PROVIDER   7,498   3,073   6.01     6.02   PROVIDER TO PROGRAM   0   0   6.02     7.00   Total Medicare program liability (see instructions)   4,764,261   15,366   7.00     8.00   Name of Contractor   8.00	5.01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM	5.03			0		0	5.03
5.51   5.52   5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   0   5.52     5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   0   5.59     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   7,498   3,073   6.01     6.01   PROGRAM TO PROVIDER   7,498   3,073   6.01     6.02   PROVIDER TO PROGRAM   0   0   6.02     7.00   Total Medicare program liability (see instructions)   4,764,261   15,366   7.00     8.00   Name of Contractor   8.00							
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATI VE TO PROGRAM					
5. 99       Subtotal (Sum of lines 5. 01 - 5. 49 minus sum of lines 5. 50 - 5. 98)       0       0       5. 99         6. 00       Determined net settlement amount (balance due) based on the cost report. (1)       6. 01       7. 498       3, 073       6. 01         6. 01       PROGRAM TO PROGRAM OPROVIDER       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
- 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  - 5.98)  - 7.498 - 7.498 - 9.00 O		Cultural (Cum of Lines F 01		0			
6.00   Determined net settlement amount (balance due) based on the cost report. (1) 6.01   PROGRAM TO PROVIDER 6.02   PROVIDER TO PROGRAM 7, 498   3, 073   6. 01 9   O   O   O   O   O   O   15, 366   7. 00    Contractor Name   C	5. 99			U		ا	5. 99
the cost report. (1) 6. 01 PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7, 498 9 ROVIDER TO PROGRAM 10 0 6. 02 7. 00 Total Medicare program liability (see instructions)  Contractor Name Contractor Name Contractor Number 1. 00 2. 00 8. 00 Name of Contractor 8. 00	6 00						6 00
6. 01 PROGRAM TO PROVIDER (	0.00						0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Number 1.00 2.00  8.00 Name of Contractor 8.00	6. 01			7, 498		3, 073	6, 01
7.00         Total Medicare program liability (see instructions)         4,764,261         15,366         7.00           Contractor Name         Contractor Number           1.00         2.00           8.00         Name of Contractor         8.00		I I		0		0	
Contractor Name   Contractor   Number   1.00   2.00   8.00   Name of Contractor   8.00		i l		4, 764, 261		15, 366	
8.00 Name of Contractor 8.00   1.00   2.00   8.00					tor Name		
8.00 Name of Contractor 8.00							
				1.	00	2.00	
		·					8. 00

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

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

Provider No.: 315322 | Period: From 01/01/202

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 4/9/2024 4: 46 pm

11 y)					4/9/2024 4: 46	pm pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
	sets					4
	RRENT ASSETS ush on hand and in banks	1, 860, 325		0	0	1
- 1	emporary investments	80, 088	l .		1	
	ites recei vabl e	00,000			0	
	counts receivable	1, 020, 777		o o	Ō	
00 Ot	her recei vabl es	0	C	0	0	
	ess: allowances for uncollectible notes and accounts	0	C	0	0	
	ecei vabl e	_	_	_!	_	
	entory	F22 424		0	0	
	repaid expenses Ther current assets	523, 424 362, 146	1	0	0	
	ne from other funds	302, 140		0	0	
	TAL CURRENT ASSETS (Sum of lines 1 - 10)	3, 846, 760	1		1	
	XED ASSETS					
. 00 La	ınd	0	C	0	0	1
	and improvements	466, 928	C	0		
1	ess: Accumulated depreciation	0	O C		0	
	ıi l di ngs	3, 020, 072		0	0	
	ess Accumulated depreciation	-2, 323, 988		0	0	
	easehold improvements ess: Accumulated Amortization			0	0	1 '
- 1	xed equipment	707, 075	1		0	
	ess: Accumulated depreciation	707,079	,	0	0	
	itomobiles and trucks	26, 550	l c	0	0	
	ess: Accumulated depreciation	-26, 550		0	Ō	
. 00 Ma	ij or movable equi pment	2, 699, 274	.l c	0	0	) 2
	ss: Accumulated depreciation	-3, 021, 299	c c	0	0	2
. 00 Mi	nor equipment - Depreciable	0	C	0	0	
	nor equipment nondepreciable	0	C	0	0	
	ther fixed assets	0	C		1	
	OTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 548, 062	[	0	0	2
	HER ASSETS  IVESTMENTS	98, 485	0	) 0	0	2
4	eposits on Leases	70, 403			1	
	e from owners/officers	0	i c		Ö	
- 1	her assets	0	d	0	0	
. 00 TO	TAL OTHER ASSETS (Sum of lines 29 - 32)	98, 485	c	0	0	3
	TAL ASSETS (Sum of lines 11, 28, and 33)	5, 493, 307	C	0	0	3
	abilities and Fund Balances					
	RRENT LIABILITIES	1/2 /05				١,
	counts payable Ilaries, wages, and fees payable	463, 685 688, 699				
	narres, wages, and rees payabre Nyroll taxes payable	000, 099			0	
	ites & Loans payable (Short term)	0	,	0	Ö	
	eferred income	351, 249	ď	0	Ö	
- 1	ccel erated payments	0	j			4
. 00 Du	ue to other funds	0	C	0	0	4
2. 00 Ot	her current liabilities	4, 984	C	0	0	4
	TAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 508, 617	C	0	0	4
	NG TERM LIABILITIES		_		_	١.
- 1	ortgage payable	0	C		1	
	otes payable	0	C		0	
	secured loans pans from owners:			0	0	
- 1	ther long term liabilities		,	0	0	
4	HER (SPECIFY)			ا ا	0	
	TAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	Ö	0	0	
	TAL LIABILITIES (Sum of lines 43 and 50)	1, 508, 617	-		Ö	
CAF	PITAL ACCOUNTS					
- 1	neral fund balance	3, 984, 690	1			7 5
	pecific purpose fund		C	1		5
1	onor created - endowment fund balance - restricted			0		5
1	onor created - endowment fund balance - unrestricted			0		5
- 1	overning body created - endowment fund balance			0	_	5
- 1	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement, placement, and expansion				0	5
	pracement, and expansion TAL FUND BALANCES (Sum of Lines 52 thru 58)	3, 984, 690	,		0	5
	TAL FUND BALANCES (Sum of Times 52 thin 56) TAL LIABILITIES AND FUND BALANCES (Sum of Lines 51 and	5, 493, 307	1		0	
	E ELLILES MID LOND DIETHOLD (Sull OF LINES ST AND	0, 7,0,007				٠, ١

INGLEMOOR CARE CENTER

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2540-10
Worksheet G-1 Peri od: From 01/01/2023 Provi der No.: 315322

					То		Date/Ti me 4/9/2024 4		
		Genera	l Fund	Speci al	Pur	pose Fund	Endowment F	und	
		1.00		2.22					
		1.00	2. 00	3. 00		4. 00	5. 00		
1.00	Fund balances at beginning of period		4, 748, 926	l .		0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		1, 355, 768			0			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments)		6, 104, 694			0			3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments)	0			0			0	4. 00 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	Total additions (sum of line 5 - 9)		0		-	0		- 1	10. 00
11. 00	Subtotal (line 3 plus line 10)		6, 104, 694			0		İ	11. 00
12.00	Deductions (debit adjustments)								12.00
13.00	DI VI DENDS	2, 120, 000			0			0	13.00
14.00	ROUNDI NG	4			0			0	14.00
15.00		0			0			0	15.00
16.00		0			0			0	16.00
17. 00		0			0			0	17.00
18. 00	Total deductions (sum of lines 13 - 17)		2, 120, 004			0			18. 00
19. 00	Fund balance at end of period per balance		3, 984, 690			0			19. 00
	sheet (Line 11 - line 18)	Endowment Fund	DI ant	Fund					
		Endowner Tana	Trant	Tuna					
		6.00	7. 00	8. 00					
1.00	Fund balances at beginning of period	0			0				1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)	_							2. 00
3.00	Total (sum of line 1 and line 2)	0			0				3. 00
4. 00 5. 00	Additions (credit adjustments)		0						4. 00 5. 00
6. 00			0						6. 00
7. 00			0					ł	7. 00
8. 00			0					l	8. 00
9. 00			0						9. 00
10.00	Total additions (sum of line 5 - 9)	0	_		0			İ	10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0				11. 00
12.00	Deductions (debit adjustments)							İ	12.00
13.00	DI VI DENDS		0						13.00
14.00	ROUNDI NG		0						14.00
15. 00			0						15. 00
16. 00			0						16. 00
17. 00			0						17. 00
18.00	Total deductions (sum of lines 13 - 17)	0			0				18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0			0				19. 00
	Silect (Line II - IIIle 10)	1 1		I				- 1	

	Financial Systems INGLEMOOR CARE (		N- 215222		eu of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Peri od: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 4/9/2024 4:46	
	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		15, 419, 88	34	15, 419, 884	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		15, 419, 88	34	15, 419, 884	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		2, 249, 62	.8	2, 249, 628	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
	CMHC			0	0	11. 00
	HOSPI CE			0	0	12. 00
	ROUTINE CHARGES / BED HOLD		69, 93		69, 933	
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	17, 739, 44	.5 0	17, 739, 445	14. 00

	Worksheet G-3, Line 1)			
	Cost Center Description			
		1. 00	2. 00	
·	PART II - OPERATING EXPENSES			
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		16, 347, 012	1.00
2.00	Add (Specify)	0		2.00
3.00		0		3.00
4.00		0		4.00
5.00		0		5.00
6.00		0		6.00
7.00		0		7.00
8.00	Total Additions (Sum of lines 2 - 7)		0	8.00
9.00	Deduct (Specify)	0		9. 00
10.00		0		10.00
11. 00		0		11.00
12.00		0		12.00
13.00		0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)		0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)		16, 347, 012	15.00

Heal th	Financial Systems INGLEMOOR	CARE CENTER	In Lie	u of Form CMS-2	2540-10
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315322	Peri od: From 01/01/2023	Worksheet G-3	
				Date/Time Prep 4/9/2024 4:46	pm
	<u> </u>				
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, I	ine 14)		17, 739, 445	1. 00
2.00	Less: contractual allowances and discounts on patients acc	counts		245, 374	2.00
3.00	Net patient revenues (Line 1 minus line 2)			17, 494, 071	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part I	I, line 15)		16, 347, 012	4.00
5.00	Net income from service to patients (Line 3 minus 4)			1, 147, 059	5.00
	Other income:				
6 00	Contributions donations beguests etc			0	6 00

		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17, 739, 445	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	245, 374	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	17, 494, 071	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	16, 347, 012	4.00
5.00	Net income from service to patients (Line 3 minus 4)	1, 147, 059	5. 00
	Other income:		l
6.00	Contributions, donations, bequests, etc	0	6. 00
7.00	Income from investments	86, 058	7. 00
8.00	Revenues from communications (Telephone and Internet service)	14, 061	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase discounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00	Parking lot receipts	0	12. 00
13.00	Revenue from laundry and linen service	0	13. 00
14.00	Revenue from meals sold to employees and guests	1, 409	14. 00
15. 00	Revenue from rental of living quarters	0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00
21. 00	Rental of vending machines	0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23.00	Governmental appropriations	0	23. 00
24.00	PRI OR YEAR	-19, 120	24. 00
24. 01	NON PATIENT REVENUE	101, 776	24. 01
24. 02	BARBER BEAUTY	24, 525	24. 02
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25.00	Total other income (Sum of lines 6 - 24)	208, 709	25. 00
26.00	Total (Line 5 plus line 25)	1, 355, 768	26. 00
27.00	Other expenses (specify)	0	27. 00
28.00		0	28. 00
29. 00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30. 00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	1, 355, 768	31. 00