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

			EMPITODI IE/OI/EDE
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315111	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/28/2024 3:15 pm

				5/28	3/2024 3:	io piii
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/28/2024	Ti me:	3: 15 pr
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	ter the numbe	r of times the provide	r resubmitted this cos	st repor	t
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes o	r leave blank for no.			
Contractor	4. [1] Cost Report Status	6. Contractor	No	<u></u>		
use only	(1) As Submitted	7.[N] Firs	t 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 I	ine 4, column 1 is "4"	 : Enter number of time	es reope	ned
	(5) Amended	11.Contracto	r Vendor Code	4	•	
	5. Date Received:	12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"				
		for	no utilization.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PREFERRED CARE AT HAMILTON (315111) 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	Yo	sef Lewin	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	Yosef Lewin			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	250, 590	449	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	250, 590	449	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 PREFERRED CARE AT HAMILTON In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315111 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/28/2024 3:15 pm 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 1501 STATE HIGHWAY 33 PO Box: 1.00 2.00 Ci ty: TRENTON State: NJ Zi p Code: 08690 2.00 3.00 County: MERCER CBSA Code: 45940 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF PREFERRED CARE AT 315111 11/01/1988 N Р Ν 4.00 HAMI LTON 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 | SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12 00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 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? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 520 501 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 520, 501 23 00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility N 29.00 Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry mal practice insurance? (Y/N) Ν 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0 0

Heal th	Financial Systems	PREFERRED CARE AT I	HAMI LTON	In Lie	u of Form CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31	5111 Peri od:	Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023		
	Y/N					
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrati	ve and General cost	N	42. 00
	center? Enter Y or N. If yes, check bo	x, and submit supporting s	schedule listing	cost centers and		
	amounts.		_			
43.00	Are there any home office costs as def	ined 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 add	Iress of the home		44.00
	office on lines 45, 46 and 47.					
	1.00	2.00		3.00		
	If this facility is part of a chain or	ganization, enter the name	e and address of	the home office on the	lines	
	bel ow.					
45.00	Name: Contractor's Name: Contractor's Number:					45. 00
46.00	Street:	PO Box:	İ			46. 00
47.00	7. 00 City: Zip Code:					

Heal th	Financial Systems	PREFERRED CARE AT	HAMI LTON		In Li€	eu of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2023 To 12/31/2023		
					Y/N	5/28/2024 3:1 Date	15 pm
			4 11 6		1.00	2. 00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	I I, "Y" TO	r yes or "N"	FOR NO. FOR ALL	the date	
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the bea	i nni na of	the cost	N	I	1.00
	reporting period? If column 1 is "Y", enter instructions)			umn 2. (see			
				1.00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in			N			2. 00
3.00	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the lationships? (see instructions)	tions, including ma , chain home offic d to the provider o l, or members of th	nnagement ces, drug or its ne board	Y			3. 00
	7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			Y/N	Туре	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complet	' for Audited, "C" te copy or enter da	for ite	Y	R		4. 00
5.00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If creconciliation.	revenues different	from	N			5. 00
	reconcitration.				Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	and 2 (V/N) Column 3). Is the	providor the	N	l N	6. 00
	legal operator of the program? (Y/N)	, ,		provider the		ļ N	
7. 00 8. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	ng the cost reporti		for Nursing	N N		7. 00 8. 00
						Y/N 1.00	
0.00	Bad Debts	1 1 1 1 0 ()(//))					
9. 00 10. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				t reporting	Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wa	nived? If "	Y", see instr	uctions.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	iod? If "Y			N	12. 00
		Descriptio	on	Y/N Pa	rt A Date	Part B Y/N	
		0		1.00	2. 00	3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			Y	02/27/2024	Y	13. 00
14. 00	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			N		N	14. 00
15. 00	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",			N		N	15. 00
16. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			N		N	17. 00
18. 00	Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions.			N		N	18. 00

Heal th	Financial Systems	PREFERRED CARI	E AT	HAMI LTON		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE		Provi der	No.: 315111	Peri od: From 01/01/2023	Worksheet S-2 Part II	!
COMPLE	X REIMBURSEMENT QUESTIONNAIRE		_			To 12/31/2023		
				1.	00	2.	00	
	Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the titl	e/position	KI TT	Υ		BLI SSI T		19. 00
	held by the cost report preparer in columns	1, 2, and 3,						
	respecti vel y.							
20.00	Enter the employer/company name of the cost	report	HEAL	TH CARE RE	SOURCES			20. 00
	preparer.							
21.00	Enter the telephone number and email address	of the cost	609-	987-1440		KI TTY. BLI SSI T@ł	HCRNJ. NET	21. 00
	report preparer in columns 1 and 2, respecti	vel y.						

Health Financial Systems PREFERRED CARE AT HAMILTON In Lieu of Form CMS-2540-10

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

Provider No.: 315111 | Period: From 01/01/2023 | Part II | Date/Time Prepared:

Date/Time Prepared: 5/28/2024 3:15 pm Part B Date 4.00 PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to 02/27/2024 13.00 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 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 3.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position PREPARER 19.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 20.00 20.00 preparer.

21.00

21.00

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

 Heal th Financial
 Systems
 PREFERRED
 CARE

 SKILLED
 NURSING
 FACILITY HEALTH CARE
 COMPLEX STATISTICAL DATA

Provi der No.: 315111 Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/38/2024 3:15 pm

					7 12/31/2023	5/28/2024 3: 15	
				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	SKILLED NURSING FACILITY	128	46, 720		7, 711	26, 531	1.00
2.00	NURSING FACILITY	0	0			0	2. 00
3.00	I CF/II D	0	0			0	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	0				5. 00 6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	128	46, 720		7, 711	26, 531	8. 00
0.00	Total (Suil of Titles 1-7)	Inpatient [0	Di scharges	20, 331	0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	SKILLED NURSING FACILITY	5, 487	39, 729		135	92	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	I CF/IID HOME HEALTH AGENCY COST	0	0			0	3. 00
4.00		0	_				4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	U				5. 00 6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	5, 487	39, 729		135	92	8. 00
0.00	Total (sum of Times 1 7)	Di sch			age Length of		0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	11. 00	12. 00	13.00	14. 00	15.00	
1. 00	SKILLED NURSING FACILITY	153	380		57. 12	288. 38	1. 00
2. 00	NURSING FACILITY	0			37.12	0.00	2. 00
3. 00	ICF/IID	0	0			0.00	3. 00
4. 00	HOME HEALTH AGENCY COST		_				4. 00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	153	380			288. 38	8. 00
		Average Length of Stay		Admi s	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	Component	16. 00	17. 00	18. 00	19. 00	20.00	
1. 00	SKILLED NURSING FACILITY	104. 55			51	151	1. 00
2. 00	NURSING FACILITY	0. 00	0		0	0	2. 00
3.00	ICF/IID	0.00			0	0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0. 00				0	5.00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0.00		0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	104.55 Admi ssi ons	Full Time	167 Equi val ent	51	151	8. 00
				'			
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I	Workers			
1. 00	SKILLED NURSING FACILITY	21.00	22. 00 94. 80	23.00			1. 00
2.00	NURSING FACILITY	369					2. 00
3. 00	ICF/IID	0					3. 00
4. 00	HOME HEALTH AGENCY COST		0.00	0.00			4. 00
5. 00	Other Long Term Care	0	0. 00	0.00			5. 00
6. 00	SNF-Based CMHC]					6. 00
7. 00	HOSPI CE	0	0.00	0.00			7. 00
8. 00	Total (Sum of lines 1-7)	369	94. 80	0.00			8.00

21.00 Physician Part B - WRC

instructions)

Total Adjusted Wage Related cost (see

22.00

21.00

22.00

SNF WAGE INDEX INFORMATION Provider No.: 315111 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/28/2024 3:15 pm Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 Reported col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 5, 253, 229 5, 253, 229 196, 919. 00 1.00 26.68 Physician salaries-Part A 0.00 0.00 2.00 2.00 0 0 0 3.00 Physician salaries-Part B 0 0.00 0.00 3.00 Home office personnel 0 0 0.00 0.00 4.00 0 4.00 Sum of lines 2 through 4 0.00 5.00 0 0.00 5.00 0 0 0 5, 253, 229 196, 919. 00 6.00 Revised wages (line 1 minus line 5) 5, 253, 229 26.68 6.00 7.00 Other Long Term Care 0.00 0.00 7.00 HOME HEALTH AGENCY COST 8.00 8.00 9.00 CMHC 9.00 10.00 HOSPI CE 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0.00 0.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 5, 253, 229 C 5, 253, 229 196, 919. 00 26.68 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 46. 27 14.00 1, 576, 409 1, 576, 409 34, 069. 00 14.00 15.00 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 2, 247, 227 2, 247, 227 17.00 18.00 Wage-related costs other (See Part IV) 0 18.00 \cap Wage related costs (excluded units) 0 19.00 0 20.00 Physician Part A - WRC 0 0 0 20.00

2, 247, 227

οl

0

0

2, 247, 227

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315111

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | Prepared:

						5/28/2024 3: 1	5 pm
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1.00
2.00	Administrative & General	540, 105	0	540, 105	8, 850. 00	61. 03	2.00
3.00	Plant Operation, Maintenance & Repairs	54, 034	0	54, 034	2, 730. 00	19. 79	3.00
4.00	Laundry & Li nen Servi ce	65, 235	0	65, 235	4, 130. 00	15. 80	4.00
5.00	Housekeepi ng	360, 339	0	360, 339	20, 207. 00	17. 83	5.00
6.00	Di etary	493, 251	0	493, 251	28, 250. 00	17. 46	6.00
7.00	Nursing Administration	554, 444	0	554, 444	16, 634. 00	33. 33	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	22, 108	0	22, 108	1, 039. 00	21. 28	10.00
11.00	Soci al Servi ce	88, 428	0	88, 428	2, 012. 00	43. 95	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	153, 872	0	153, 872	8, 539. 00	18. 02	13.00
14.00	Total (sum lines 1 thru 13)	2, 331, 816	0	2, 331, 816	92, 391. 00	25. 24	14.00
		•	•	•	•		

Health Financial Systems	PREFERRED CARE AT HAMILTON	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315111	Peri od: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:

	To 12/31/2023	Date/Time Prep 5/28/2024 3:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
į.	Part A - Core List		
į.	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
	Qualified and Non-Qualified Pension Plan Cost	786	3. 00
	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
	401K/TSA Plan Administration fees	0	5. 00
	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		7.00
	Health Insurance (Purchased or Self Funded)	197, 573	8.00
	Prescription Drug Plan	177, 373	9.00
	Dental, Hearing and Vision Plan	110, 115	
	Life Insurance (If employee is owner or beneficiary)	110, 113	11.00
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)		13.00
			14.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	-	
	Workers' Compensation Insurance	179, 224	
	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion) TAXES		
	FICA-Employers Portion Only	471, 387	17 00
	Medicare Taxes - Employers Portion Only Unemployment Insurance	1 252 020	
		1, 253, 030	
	State or Federal Unemployment Taxes OTHER	35, 112	20. 00
μ.			21 00
	Executive Deferred Compensation	0	
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	2, 247, 227	24. 00
		Amount	
		Reported	
	Don't D. Other than Comp. Deleted Cont.	1.00	
	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Provi der No.: 315111

					o 12/31/2023	Date/Time Pre 5/28/2024 3:1	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	J piii
	occupational dategory	Reported		Sal ari es (col.		Wage (col. 3 ÷	
		opor tou	5001. 10		Salary in col.	col . 4)	
					3	.,	
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	359, 345	46, 032				1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 323, 979	169, 602		· ·		
3.00	Certified Nursing Assistant/Nursing	1, 238, 090	158, 599	1, 396, 689	62, 364. 00	22. 40	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	2, 921, 414	374, 233	3, 295, 647			4. 00
5.00	Physi cal Therapists	0	0	0	0.00		
6.00	Physical Therapy Assistants	0	0	0	0.00		
7.00	Physi cal Therapy Ai des	0	0	0	0.00		
8.00	Occupational Therapists	0	0	0	0.00		
9.00	Occupational Therapy Assistants	0	0	C	0.00	0. 00	9. 00
10.00	Occupational Therapy Aides	0	0	C	0.00		
11. 00	Speech Therapists	0	0	C	0.00		11. 00
12.00	Respi ratory Therapi sts	0	0	C	0.00	0. 00	12.00
13.00	Other Medical Staff	0	0	C	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00		496		496			14. 00
15. 00		179, 241		179, 241			
16. 00		654, 071		654, 071	17, 508. 00	37. 36	16. 00
47.00	Assistants/Aides	200 000			00 107 00		47.00
17. 00	Total Nursing (sum of lines 14 through 16)	833, 808		833, 808			17. 00
18. 00	Physical Therapists	141, 390		141, 390	1		
19. 00	Physical Therapy Assistants	128, 904		128, 904	· ·		
20. 00	Physical Therapy Aides	46, 707		46, 707	· ·		20. 00
21. 00		131, 513		131, 513			
22. 00		188, 620		188, 620			
23. 00		0		0	0.00		23. 00
24. 00		105, 467		105, 467	· ·		24. 00
25. 00	1 1 3 1	0		C	0.00		25. 00
26. 00	Other Medical Staff	0		[0.00	0.00	26. 00

100		To 12/31/2023	Date/lime Prepared: 5/28/2024 3:15 pm
1.00			Days
2.00	1.00		
2.00			
Section Sect			
Section Sect			
7.00 RML 8.00 RML 9.00 RML 9.00 RML 9.00 RML 9.00 RML 11.00 RML			1
B. 00			
9.00 SIX			
11.00 Right 11.00 Right 11.00 Right 12.00 Right 12.00 Right 13.00 Right			
12.00 RUA 112.00 RUA 113.00 RUC RU			
13.00 RVC 114.00 RVG RVG 114.00 RVG RVG 114.00 RVG RVG 119.00 RVG			
14.00 RVB			
16.00 RHC 10.00 RHG 17.00 RHG 17.00 RHG 18.00 RHA			
17.00			
18 00			
19,00 RMB			
21.00 RIMA 21.00 RIMA 22.00 RIMA 22.00 RIMA 23.00 RIMA 23.0			
22.00 RIB 22.00 RIA 23.00 24.00 ES3 25.00 ES3 25.00 ES3 24.00 ES3 25.00 ES3 25.00 ES3 25.00 ES3 25.00 ES3 25.00 ES3			
23 00 RIA 23 00 ES3 24 00 ES3 24 00 ES5 25 00 ES5 26			
24.00 ESS 24.00 ESS 25.00 ESS 25			
25.00 ES2 25.00 27.00 ES1 26.00 27.00 HE2 27.00 HE2 27.00 HE2 27.00 HE2 27.00 HE3 28.00 HE3			,
27.00 HE2 27.00 HE1 28.00 29.00 HE1 28.00 HE1 28.00 HE1 28.00 HE1 30.00 HE1 30.00 HE1 30.00 HE1 32.00 HE1 32.00 HE1 32.00 HE2 33.00 HE2 33.00 HE2 34.00 HE3 34	25. 00	ES2	25. 00
28.00 30.00 30.00 31.00 30.00 31.00 32.00 32.00 34.00 34.00 34.00 35.00 36.00			
29.00 HD2			
31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 38.00 39.00 LD2 37.00 39.00 LD2 39.00 LD2 39.00 LC1 49.00 LC2 49.00 41.00 LC2 49.00 41.00 LBB1 42.00 43.00 44.00 CE1 44.00 CE1 44.00 CE1 44.00 CE1 44.00 CC2 43.00 CC3 CC2 47.00 CC3 CC3 CC3 CC3 CC4 CC3 CC5 CC5 CC5 CC5 CC5 CC5 CC6 CC7 CC7 CC7 CC8 CC7 CC8 CC8 CC8 CC8 CC9 CC9 CC9 CC9 CC9 CC9			
32.00 34.00 34.00 35.00 36.00 36.00 36.00 36.00 37.00 38.00 38.00 39.00 LD1 38.00 39.00 LC2 39.00 40.00 LL1 101 38.00 40.00 LL2 41.00 LL2 41.00 42.00 42.00 43.00 44.00 44.00 44.00 44.00 45.00 46.00 46.00 47.00 48.00 49.00 55.00			
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 LE2 37. 00 39. 00 LD2 37. 00 39. 00 LC2 39. 00 LC2 39. 00 LC2 39. 00 LC2 39. 00 LC3 LC2 39. 00 LC4 LC3 40. 00 LC4 LC5 LC6 LC7			
34.00 35.00 36.00 36.00 37.00 38.00 38.00 38.00 38.00 39.00 30.00 40.00 40.00 40.00 40.00 41.00 42.00 42.00 43.00 44.00 44.00 45.00 46.00 47.00 48.00 48.00 48.00 49.00 60.00 48.00 60.00			
Section Sect			
37 00 38 00 1.02 37 00 38 00 1.01 38 00 1.02 39 00 1.02 39 00 1.02 39 00 1.02 39 00 1.02 39 00 1.00			
38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 51. 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 60			
100			
100 100 110 120			
A2 00 A3 00 CE2			
43.00 CE2			
44. 00			
46. 00 47. 00 48. 00 CC2 47. 00 48. 00 CC2 47. 00 48. 00 CC1 48. 00 CC1 48. 00 CC2 47. 00 CC2 47. 00 CC2 48. 00 CC1 48. 00 CC1 48. 00 CC2 CC1 48. 00 CC2 CC2 CC2 CC2 CC2 CC2 CC2 CC2 CC2 C	44. 00		44.00
47.00 CC2 47.00 48.00 CC1 48.00 CC1 48.00 CC1 48.00 CC1 48.00 CC2 49.00 CC2 49.00 CC2 51.00 CC3 CC3 SE3 SE3.00 CC4 SE2 SE3 SE3.00 SE3 SE3 SE3.00 SE2 SE4.00 SE1 SE5.00 SE1 SE5.00 SE1 SE5.00 SE1 SE5.00 SE1 SE5.00 SE1 SE5.00 SE3 SE3.00 SE			
48. 00 49. 00 50. 00 61. 00 62. 00 63. 00 65. 00 6			
49.00 CB2			
50. 00 CB1 50. 00 51. 00 CA2 51. 00 52. 00 CAT 52. 00 53. 00 SE3 53. 00 54. 00 SE2 54. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 PE2 67. 00 68. 00 PE1 68. 00 69. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PC1 72. 00 73. 00 PB1 74. 00			
52. 00 CA1 52. 00 53. 00 SE3 53. 00 54. 00 SE2 54. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA1 66. 00 67. 00 PE2 67. 00 68. 00 PP1 68. 00 69. 00 PD2 69. 00 70. 00 PC2 71. 00 72. 00 PR2 73. 00 74. 00 PP1 74. 00	50. 00	CB1	50.00
53. 00 SE3 53. 00 54. 00 SE1 55. 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 PE2 67. 00 68. 00 PE1 68. 00 69. 00 PD1 70. 00 70. 00 PC2 71. 00 72. 00 PC3 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 BA1 66.00 67.00 BA1 66.00 67.00 PE2 67.00 68.00 PE1 68.00 69.00 PD1 70.00 71.00 PC2 71.00 72.00 PC2 71.00 73.00 PB2 73.00 74.00 PB1 74.00			
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 PP2 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	54.00
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 66. 00 67. 00 66. 00 67. 00 68. 00 69. 00 70. 00 PD1 68. 00 69. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PC1 72. 00 73. 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 64. 00 65. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 0 68. 00 PE1 68. 00 69. 00 PD2 69. 00 70. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PR2 73. 00 74. 00 PB1 74. 00			
59. 00 60. 00 61. 00 62. 00 63. 00 64. 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			
61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 61. 00 61. 00 62. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 6	59. 00	I B2	59.00
62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BA1 62. 00 BB2 63. 00 64. 00 BB1 64. 00 BB4 65. 00 BB4 66. 00 PE2 67. 00 PE1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB2 PC3. 00 PB3 PB1 74. 00			
63. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BB2 BB1 64. 00 BA1 66. 00 BA1 66. 00 PE1 68. 00 PP1 70. 00 PP1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB1 72. 00 PB1 74. 00	61.00		61.00
64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BB1 64. 00 BA2 65. 00 BA1 66. 00 PE2 67. 00 PE1 68. 00 PD2 70. 00 PD1 70. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00			
66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BA1 PE2 67. 00 PE1 68. 00 PP1 70. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 PB1 74. 00	64. 00	BB1	64.00
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PE2 67. 00 PB1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 PC1 72. 00 PB2 73. 00 PB2 74. 00			
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 Ref (68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 PC1 72. 00 PC3 PC1 PC2 PC1 72. 00 PC3 PC1 PC2 PC1 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC4 PC4 PC7			
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PD2 PB1 F0. 00 F0.			
71. 00 72. 00 73. 00 74. 00 PB1 71. 00 72. 00 PB2 PB1 74. 00	69. 00	PD2	69. 00
72. 00 73. 00 74. 00 PB1 72. 00 PB1 74. 00			
73. 00 74. 00 PB1 73. 00 74. 00		PC2	
74.00 PB1 74.00			
75. 00 PA2 75. 00	74. 00	PB1	74.00
	75. 00	PA2	75.00

Health Financial Systems	PREFERRED CARE AT I	HAMI LTON		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315111	Peri od:	Worksheet S-7	7
				From 01/01/2023 To 12/31/2023	Date/Time Pro 5/28/2024 3:	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL			1			100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register' payments beginning 10/01/2003. Congress expexpenses. For lines 101 through 106: Enter column 2 the percentage of total expenses fine 1, column 3. Indicate in column 3 "Y" with direct patient care and related expense (See instructions)	ected this increase in column 1 the amou or each category to for yes or "N" for no	to be used nt of the total SNF o if the s	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related Iter in Part I, Issociated	
101. 00 Staffing						101. 00
102.00 Recrui tment						102.00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)	: 1! 2)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, I	THE I, COLUMN 3)		I	ı l		106. 00

Heal th	Financial Systems	PREFERRED CARE A	T HAMILTON		In Lie	u of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
					rom 01/01/2023 o 12/31/2023	Doto/Timo Dro	oorod.
				'	o 12/31/2023	Date/Time Pre 5/28/2024 3:1	bareu. 5 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col. 4)	
		1.00	2. 00	3. 00	A-6) 4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		3, 637, 802	3, 637, 802	0	3, 637, 802	1. 00
3.00	00300 EMPLOYEE BENEFITS	0	673, 106	673, 106	0	673, 106	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	540, 105	3, 037, 943	3, 578, 048	0	3, 578, 048	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	54, 034	425, 164	479, 198	0	479, 198	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	65, 235	128, 033	193, 268	0	193, 268	6. 00
7.00	00700 HOUSEKEEPI NG	360, 339	53, 687	414, 026	0	414, 026	7. 00
8.00	00800 DI ETARY	493, 251	461, 894	955, 145	0	955, 145	8. 00
9.00	00900 NURSING ADMINISTRATION	554, 444	131, 440	685, 884	0	685, 884	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	202, 126	202, 126	0	202, 126	
12.00	01200 MEDICAL RECORDS & LIBRARY	22, 108	0	22, 108		22, 108	
13. 00 15. 00	01300 SOCIAL SERVICE	88, 428	21 554	88, 428		88, 428	
15.00	01500 PATIENT ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	153, 872	31, 556	185, 428	U	185, 428	15. 00
30. 00	03000 SKILLED NURSING FACILITY	2, 921, 413	922, 676	3, 844, 089	O	3, 844, 089	30. 00
31. 00	03100 NURSING FACILITY	2, 721, 413	722, 070	3, 044, 007	0	0, 044, 007	31. 00
32. 00	03200 CF/IID		0	0	0	0	32. 00
	03300 OTHER LONG TERM CARE		Ö	0	o	0	33. 00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			- 1		
40.00	04000 RADI OLOGY	0	23, 561	23, 561	0	23, 561	40. 00
41.00	04100 LABORATORY	0	81, 062	81, 062	0	81, 062	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	1, 028	1, 028	0	1, 028	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	354, 457	354, 457	0	354, 457	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	412, 785	412, 785	0	412, 785	
46. 00 47. 00	04600 SPEECH PATHOLOGY		105, 467 0	105, 467	0	105, 467	46. 00
47.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	315, 776	315, 776	ا م ا	315, 776	
51.00	05100 SUPPORT SURFACES		313, 770	313,770	0	0	51.00
01.00	OTHER REIMBURSABLE COST CENTERS	٩	<u> </u>		<u> </u>	J	01.00
71. 00	07100 AMBULANCE	0	101, 804	101, 804	0	101, 804	71. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			- 1	,	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80. 00
81.00	08100 I NTEREST EXPENSE		0	0	0	0	81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0	0	0	0	82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	5, 253, 229	11, 101, 367	16, 354, 596	0	16, 354, 596	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	0	0	0	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES		0	0	0	0	92.00
93. 00 94. 00	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY		0	0		0	93. 00 94. 00
100.00		5, 253, 229	11, 101, 367	16, 354, 596	0	ŭ	
100.00	I I I I I I I I I I I I I I I I I I I	0,200,221	11, 101, 307	10, 334, 370	ı o	10, 334, 370	100.00

 Heal th Financial
 Systems
 PREFERRED

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315111 Peri od: Worksheet A From 01/01/2023 | Worksneet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				То	12/31/2023	Date/Time Prepared: 5/28/2024 3:15 pm
	Cost Center Description	Adjustments to	Net Expenses			37 207 2024 3. 13 piii
	'	Expenses (Fr	For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES	-1, 496, 535	1	•		1. 00
3.00	00300 EMPLOYEE BENEFITS	0	673, 106			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-847, 381	2, 730, 667	•		4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	479, 198	1		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	193, 268	•		6. 00
7.00	00700 HOUSEKEEPI NG	0	414, 026	•		7. 00
8.00	00800 DI ETARY	0	955, 145	•		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	685, 884	1		9.00
10.00	01000 CENTRAL SERVI CES & SUPPLY	0	202, 126	•		10.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	22, 108	•		12. 00 13. 00
	01500 PATIENT ACTIVITIES	0	88, 428	•		15. 00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	185, 428			15.00
30. 00	03000 SKILLED NURSING FACILITY	-1, 200	3, 842, 889			30.00
31. 00	03100 NURSING FACILITY	-1, 200	1			31.00
32. 00	03200 CF/IID	0	1			32.00
	03300 OTHER LONG TERM CARE	0	0			33.00
33.00	ANCI LLARY SERVI CE COST CENTERS	0	0			33.00
40. 00	04000 RADI OLOGY	0	23, 561			40. 00
	04100 LABORATORY	0	81, 062			41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0 1,7 552			42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	1, 028			43.00
44. 00	04400 PHYSI CAL THERAPY	0	354, 457	1		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	412, 785	1		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	105, 467	•		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	315, 776			49. 00
51.00	05100 SUPPORT SURFACES	0	0			51. 00
	OTHER REIMBURSABLE COST CENTERS					
71. 00	07100 AMBULANCE	0	101, 804			71. 00
	SPECIAL PURPOSE COST CENTERS					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0			80.00
81. 00	08100 I NTEREST EXPENSE	0	0			81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	0	0			82. 00
83.00	08300 H0SPI CE	0	0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-2, 345, 116	14, 009, 480			89. 00
	NONREI MBURSABLE COST CENTERS			T		_
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	•		90.00
	09100 BARBER AND BEAUTY SHOP	0	0			91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0			92.00
93. 00	09300 NONPAI D WORKERS	0	0			93.00
94. 00	09400 PATIENTS LAUNDRY	0	14 000 400			94.00
100.00	TOTAL	-2, 345, 116	14, 009, 480			100.00

Health Financial Systems	PREFERRED CARE AT HA	AMI LTON		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 3:1	
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3.00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassificati	ons (Sum		0	0	100. 00
	of columns 4 and 5 m	ust				
	equal sum of columns	8 and				
	9)					

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

Health Financial Systems	PREFERRED CARE AT H.	AMI LTON		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/28/2024 3:1	
			Decreases			
	Cost Center	-	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS PREFERRED CARE AT HAMILTON In Lieu of Form CMS-2540-10 Provi der No.: 315111

| Peri od: | Worksheet A-7 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					0 12/31/2023	Date/lime Prep 5/28/2024 3:15	
				Acqui si ti ons		3/20/2024 3. 13) DIII
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	203011 P 11 011	Bal ances	i di chases	Donati on	Total	Retirements	
		1.00	2. 00	3, 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0	C	0	0	1.00
2.00	Land Improvements	o	0	(0	0	2.00
3.00	Buildings and Fixtures	o	0	(0	j o	3.00
4.00	Building Improvements	2, 389, 522	230, 266	C	230, 266	0	4.00
5.00	Fi xed Equipment	0	0	C	0	0	5.00
6.00	Movable Equipment	391, 276	0	C	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	2, 780, 798	230, 266	C	230, 266	0	7.00
8.00	Reconciling Items	o	0	C	0	0	8.00
9.00	Total (line 7 minus line 8)	2, 780, 798	230, 266	C	230, 266	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	\$					
1. 00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	2, 619, 788	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	391, 276	0				6. 00
7.00	Subtotal (sum of lines 1-6)	3, 011, 064	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	3, 011, 064	0				9. 00

Provi der No.: 315111

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

				10 12/31/2023	5/28/2024 3:1	
				Expense Classification on		J pili
				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.	
	203011 pt 1 011 (1)	Adjustment	7 unodire		Erric No.	
		1.00	2.00	3.00	4. 00	
1.00	Investment income on restricted funds	В		CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)		02, . , ,	FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2.00
2.00	8)		ا		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		l o		0.00	4.00
1. 00	(chapter 8)		Ĭ		0.00	1.00
5. 00	Telephone services (pay stations excluded)		0		0.00	5.00
0.00	(chapter 21)		Ĭ		0.00	0.00
6. 00	Television and radio service (chapter 21)		1		0.00	6. 00
7. 00	Parking Lot (chapter 21)		٥		0.00	7.00
8. 00	Remuneration applicable to provider-based	A-8-2			0.00	8.00
0.00	physician adjustment	A-0-2	١	1		0.00
9. 00	Home office cost (chapter 21)		_		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)				0.00	
11. 00	Nonallowable costs related to certain			1	0.00	
11.00	Capital expenditures (chapter 24)		٦	1	0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	-1, 434, 338	,		12.00
12.00	related organizations (chapter 10)	A-0-1	-1,434,330			12.00
13. 00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals			1	0.00	
15. 00	Cost of meals - Guests				0.00	
16. 00	Sale of medical supplies to other than				0.00	
16.00	patients		١	1	0.00	16.00
17. 00			0		0.00	17. 00
18. 00	Sale of medical records and abstracts			1	0.00	
19. 00					0.00	
	Vending machines				1	
20. 00	Income from imposition of interest, finance or penalty charges (chapter 21)			1	0.00	20. 00
21. 00			,		0.00	21. 00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare		U	1	0.00	21.00
22. 00	overpayments		,	NUTLL I ZATLONI DEVLEW CNE	82.00	22. 00
22.00			U	UTILIZATION REVIEW - SNF	82.00	22.00
23. 00	(chapter 21) Depreciationbuildings and fixtures		,	CAD DEL COSTS DIDOS 8	1.00	23. 00
23.00	Depirecrationburidings and frixtures		·	CAP REL COSTS - BLDGS &	1.00	23.00
24.00	Denreciation moved a equipment		,	FIXTURES *** Cost Center Deleted ***	2.00	24. 00
24. 00	, .	D.			2.00	
25. 00	GAIN/LOSS ON INVESTMENT	В		ADMINISTRATIVE & GENERAL	4.00	
25. 01	MARKETI NG	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02		A	ł	ADMINISTRATIVE & GENERAL	4.00	
25. 04	PSYCHIATRIC EVAL/NON-REIM	A		SKILLED NURSING FACILITY	30.00	
25. 05	BAD DEBTS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 06		A	1	ADMINISTRATIVE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-2, 345, 116			100. 00
	to Worksheet A, col. 6, line 100)				l	l

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

PREFERRED CARE AT HAMILTON

Heal th Financial Systems PREFERRED CARE A STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provi der No.: 315111

OFFICE COSTS				To 12/31/2023 Parts 1-1 Date/Time 5/28/2024	Prepared:
	Line No.	Cost (Center	Expense I tems	3. 13 piii
	1. 00	2.	00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRE CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1. 00 2. 00	1. 00	ADMINISTRATIVE CAP REL COSTS		MANAGEMENT RENT	1. 00 2. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column	9. 00	FIXTURES NURSING ADMINI: ADMINISTRATIVE		CLINICALCONSULTING ADMIN ASSISTANCE	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
6, line 100 to Worksheet A-8, column 3, line 12.	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRE CLAIMED HOME OFFICE COSTS:	4.00 ED AS A RESULT	5.00 OF TRANSACTIO	6.00 NS WITH RELATE	D ORGANIZATIONS OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	777, 282 1, 739, 662 131, 440 116, 560 0 0 0 0 0 2, 764, 944	777, 282 3, 174, 000 131, 440 116, 560 0 0 0 0 4, 199, 282	-1, 434, 338 C C C C C C C		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

Worksheet A-8-1 From 01/01/2023

12/31/2023

Parts I-II Date/Time Prepared: 5/28/2024 3:15 pm

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1.00	Α	0.00	1.00
2.00	A	0.00	2. 00
3.00	Α	0.00	3.00
4.00	Α	0.00	4. 00
5. 00	Α	0.00	5. 00
6.00	Α	0.00	6.00
7. 00	Α	0.00	7. 00
8.00	Α	0.00	8. 00
9. 00	A	0.00	9. 00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
specify:			
		 •	•

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

	Related Organization(s) and/or Home Office					
	Name	Percentage of	Type of Business			
		Ownershi p				
	4. 00	5. 00	6. 00			
BART II INTERRE ATLANGUER TO BELATER ORGANIE	74TLON(0) AND (0D HOME OFFICE					

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

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

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

1.00	PCH MANAGEMENT LLC	20.00 MANAGEMENT COMPANY	1.00
2. 00	PCH MANAGMENT LLC	35.00 MANAGEMENT COMPANY	2. 00
3. 00	PCH MANAGEMENT LLC	45.00 MANAGEMENT COMPANY	3.00
4.00	PREFERRED CARE AT HAMILTON	23. 00 REALTY	4. 00
	REALTY		
5. 00	PREFERRED CARE AT HAMILTON	36. 00 REALTY	5. 00
	REALTY		
6. 00	PREFERRED CARE AT HAMILTON	38. 00 REALTY	6. 00
	REALTY		
7. 00	PREFERRED CARE AT HAMILTON	1. 00 REALTY	7.00
	REALTY		
8. 00	PREFERRED CARE AT HAMILTON	2. 00 REALTY	8. 00
	REALTY		
9. 00	PC CONSULTING	O. OO CLINICAL AND ADMIN	9. 00
		ASSI STANCE	l l
10. 00		0. 00	10.00
100.00 G. Other (financial or non-financial)		0. 00	100. 00
speci fy:			

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

In Lieu of Form CMS-2540-10
Period: Worksheet B
From 01/01/2023 Part I
To 1/01/3033 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315111

				To	12/31/2023		
			CAPI TAL			3/20/2024 3. 1	5 pili
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FIXTURES	BENEFITS		& GENERAL	
		Allocation					
		(from Wkst A					
		col . 7)					
		0	1. 00	3. 00	3A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	2, 141, 267	2, 141, 267				1. 00
3.00	00300 EMPLOYEE BENEFITS	673, 106	0	673, 106			3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	2, 730, 667	59, 976		2, 859, 848		4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	479, 198	115, 434	6, 923	601, 555		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	193, 268	40, 033	8, 359	241, 660		6. 00
7. 00	00700 HOUSEKEEPI NG	414, 026	14, 441	46, 171	474, 638		7. 00
8. 00	00800 DI ETARY	955, 145	187, 051	63, 201	1, 205, 397	309, 181	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	685, 884	18, 420	71, 042	775, 346		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	202, 126	0	0	202, 126		10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	22, 108	0	2, 833	24, 941	6, 397	12.00
13.00	01300 SOCIAL SERVICE	88, 428	3, 930		103, 688		13.00
15. 00	01500 PATIENT ACTIVITIES	185, 428	60, 860	19, 716	266, 004	68, 229	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	2 042 000	1 5/2 225	274 224	E 770 4E0	1 400 410	30. 00
31. 00	03100 NURSING FACILITY	3, 842, 889	1, 562, 235	374, 326 0	5, 779, 450 0	1, 482, 413 0	30.00
32. 00	03200 CF/IID		0		0		32.00
33. 00	03300 OTHER LONG TERM CARE		0		0		33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	l ol	<u> </u>	U	0	0	33.00
40. 00	04000 RADI OLOGY	23, 561	O	0	23, 561	6, 043	40. 00
41. 00	04100 LABORATORY	81, 062	Ö	_	81, 062	20, 792	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	01,002	Ö	0	01,002	20, 7, 2	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	1, 028	o	0	1, 028	264	43. 00
44. 00	04400 PHYSI CAL THERAPY	354, 457	49, 759	0	404, 216	103, 680	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	412, 785	16, 750	0	429, 535		45.00
46.00	04600 SPEECH PATHOLOGY	105, 467	5, 403	0	110, 870	28, 438	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	315, 776	6, 975	0	322, 751	82, 785	49.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	101, 804	0	0	101, 804	26, 112	71. 00
	SPECIAL PURPOSE COST CENTERS	,					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	14, 009, 480	2, 141, 267	673, 106	14, 009, 480	2, 859, 848	89. 00
	NONREI MBURSABLE COST CENTERS	1 6	al				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	_	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0	0	0	0	93. 00 94. 00
98.00	1		O O	0	0		94. 00 98. 00
98.00	Cross Foot Adjustments Negative Cost Centers		U A	0	0	0	98. 00 99. 00
100.00		14, 009, 480	2, 141, 267	_	14, 009, 480	-	
100.00	TIOTAL	17,007,400	2, 141, 207	373, 100	17, 007, 400	2,007,040	100.00

Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part II
To 1/21/

				To	12/31/2023	Date/Time Pre 5/28/2024 3:1	
	Cost Center Description	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	5 piii
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7. 00	
1. 00 3. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS						1. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	755, 852					5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	15, 392	ł .	·			6. 00
7. 00	00700 HOUSEKEEPING	5, 553					7.00
8. 00	00800 DI ETARY	71, 919		58, 906	1, 645, 403		8.00
9. 00	00900 NURSING ADMINISTRATION	7, 082		5, 801	1, 043, 403	987, 103	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	7,082		3, 801	0	987, 103	10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0			0	0	12.00
13. 00	01300 SOCIAL SERVICE	1, 511		1, 238	0	0	13.00
15. 00	01500 PATIENT ACTIVITIES	23, 400			0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	23, 400		17, 100		0	13.00
30. 00	03000 SKILLED NURSING FACILITY	600, 663	319, 037	491, 979	1, 645, 403	987, 103	30.00
31. 00	03100 NURSING FACILITY	000,003	317,037	471, 777	1, 043, 403	0	31.00
32. 00	03200 CF/11D	0		0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0			0	0	33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	0		<u> </u>		0	33.00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	1		0		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	1		0	Ö	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0			0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	19, 132		15, 670	0	Ö	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	6, 440		5, 275	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	2, 078		1, 702	0	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	2,070		1, 702	0	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	2, 682	0	2, 197	0	Ö	49.00
51. 00	05100 SUPPORT SURFACES	0	0	2,177	0	o o	51.00
011.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>			0 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
	SPECIAL PURPOSE COST CENTERS	<u>-</u>		-1	-		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 H0SPI CE	0	0	o	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	755, 852	319, 037	601, 934	1, 645, 403	987, 103	89. 00
	NONREI MBURSABLE COST CENTERS	<u> </u>				<u> </u>	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	o	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	o	0	0	94. 00
98. 00	Cross Foot Adjustments	0	0	o	0	0	98. 00
99. 00	Negative Cost Centers	0	0	o	0	0	99. 00
100.00	TOTAL	755, 852	319, 037	601, 934	1, 645, 403	987, 103	100. 00

| 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.: 315111

				T	0 12/31/2023	Date/Time Pre	
					OTHER GENERAL	5/28/2024 3: 1	3 piii
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE		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 NURSING ADMINISTRATION						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	253, 971					10. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	31, 338				12. 00
13.00	01300 SOCI AL SERVI CE	0	C	133, 033			13. 00
15. 00	01500 PATIENT ACTIVITIES	0	C	0	376, 799		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	99, 119	31, 338	133, 033	376, 799	11, 946, 337	30. 00
31. 00	03100 NURSING FACILITY	0	C	0	0	0	31. 00
32.00	03200 CF/IID	0	C	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	C	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	C	1	0	29, 604	40. 00
41. 00	04100 LABORATORY	0	C	1	0	101, 854	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	C	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	0	0	1, 292	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	C	0	0	542, 698	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	C	0	0	551, 424	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	C	0	0	143, 088	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	C	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	154, 852	C	0	0	565, 267	49. 00
51. 00	05100 SUPPORT SURFACES	0	C	0	0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	C	0	0	127, 916	71. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	0	C	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	253, 971	31, 338	133, 033	376, 799	14, 009, 480	89. 00
	NONREI MBURSABLE COST CENTERS				اه		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	0	0	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	C	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	C	J 0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	C	0 ال	0	0	94.00
98. 00	Cross Foot Adjustments	0	_		0	0	98. 00
99. 00	Negative Cost Centers	0 0	24 222	122 222	0 77. 700	14 000 400	99.00
100.00	D TOTAL	253, 971	31, 338	133, 033	376, 799	14, 009, 480	100.00

Provi der No.: 315111

			5/28/2024 3:1	
Cost Center Description	Post Stepdown	Total		
· ·	Adjustments			
	17. 00	18. 00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES				1. 00
3.00 00300 EMPLOYEE BENEFITS				3.00
4.00 00400 ADMINISTRATIVE & GENERAL				4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS				5. 00
6.00 00600 LAUNDRY & LINEN SERVICE				6. 00
7. 00 00700 HOUSEKEEPI NG				7. 00
8. 00 00800 DI ETARY				8. 00
9.00 00900 NURSING ADMINISTRATION				9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY				10.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY				12. 00
13. 00 01300 SOCI AL SERVI CE				13. 00
15. 00 01500 PATIENT ACTIVITIES				15. 00
INPATIENT ROUTINE SERVICE COST CENTERS				10.00
30. 00 03000 SKILLED NURSING FACILITY	0	11, 946, 337		30.00
31. 00 03100 NURSING FACILITY	o	0		31. 00
32. 00 03200 CF/IID	o	0		32. 00
33. 00 03300 OTHER LONG TERM CARE	o o	0		33. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		33.00
40. 00 04000 RADI OLOGY	0	29, 604		40.00
41. 00 04100 LABORATORY	o	101, 854		41. 00
42. 00 04200 I NTRAVENOUS THERAPY	o	0		42. 00
43. 00 04300 0XYGEN (INHALATION) THERAPY	o	1, 292		43. 00
44. 00 04400 PHYSI CAL THERAPY		542, 698		44. 00
45. 00 04500 OCCUPATI ONAL THERAPY		551, 424		45. 00
46. 00 04600 SPEECH PATHOLOGY		143, 088		46. 00
47. 00 04700 ELECTROCARDI OLOGY	l ol	0		47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	l ol	565, 267		49. 00
51. 00 05100 SUPPORT SURFACES	o	0		51.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	O ₁		31.00
71. 00 07100 AMBULANCE	0	127, 916		71. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	127,710		1 7 11 00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				80. 00
81. 00 08100 I NTEREST EXPENSE				81. 00
82.00 08200 UTILIZATION REVIEW - SNF				82. 00
83. 00 08300 HOSPI CE	0	0		83. 00
89.00 SUBTOTALS (sum of lines 1-84)	o o	14, 009, 480		89. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	14, 007, 400		1 07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91. 00 09100 BARBER AND BEAUTY SHOP	o	0		91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	o o	0		92. 00
93. 00 09300 NONPALD WORKERS		0		93. 00
94. 00 09400 PATI ENTS LAUNDRY		0		94.00
98.00 Cross Foot Adjustments		0		98. 00
99.00 Negative Cost Centers	0	0		99.00
100. 00 TOTAL		14, 009, 480		100.00
100.00 1011/12	١	11,007,400		1.00.00

ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315111 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/28/2024 3:15 pm CAPI TAL RELATED COSTS Directly ADMI NI STRATI VE Cost Center Description BLDGS & Subtotal EMPLOYEE Assigned New **FIXTURES** 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 00300 EMPLOYEE BENEFITS 3.00 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 0 59, 976 59, 976 0 59, 976 4.00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 0 0 0 115, 434 115, 434 0 3, 236 5.00 00600 LAUNDRY & LINEN SERVICE 40. 033 40, 033 1, 300 6.00 6 00 7.00 00700 HOUSEKEEPI NG 14, 441 14, 441 2, 553 7.00 0 6, 484 8.00 00800 DI ETARY 187, 051 187, 051 8.00 18, 420 00900 NURSING ADMINISTRATION 0 0 18.420 0 4.171 9.00 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 C 1,087 10.00 12.00 01200 MEDICAL RECORDS & LIBRARY 134 12.00 01300 SOCIAL SERVICE 0 0 13.00 3, 930 3, 930 558 13.00 01500 PATIENT ACTIVITIES 0 15.00 60,860 60,860 0 1, 431 15 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 1, 562, 235 1, 562, 235 0 31, 089 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 C 0 0 o 32.00 03200 | CF/IID O Ω 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 0 40.00 04000 RADI OLOGY 0 40.00 0000000000 127 04100 LABORATORY 0 41.00 0 436 41 00 0 42.00 04200 I NTRAVENOUS THERAPY 0 0 42.00 04300 OXYGEN (INHALATION) THERAPY 43.00 0 0 6 43.00 04400 PHYSI CAL THERAPY 49, 759 44.00 49.759 2.174 44.00 04500 OCCUPATIONAL THERAPY 2, 310 45.00 16, 750 16, 750 45 00 5, 403 46.00 04600 SPEECH PATHOLOGY 5, 403 596 46.00 0 04700 ELECTROCARDI OLOGY 47.00 47.00 C 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 48.00 0 04900 DRUGS CHARGED TO PATIENTS 0 49 00 6, 975 6, 975 0 1,736 49.00 05100 SUPPORT SURFACES 51.00 0 51.00 OTHER REIMBURSABLE COST CENTERS 07100 AMBULANCE 0 0 0 0 548 71.00 71.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 83.00 89.00 SUBTOTALS (sum of lines 1-84) 0 2, 141, 267 2, 141, 267 0 59, 976 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 92.00 0

0

0

0

0

0

2, 141, 267

0

0

C

C

2, 141, 267

93.00

98.00

0

0 94.00

0 99.00

59, 976 100. 00

09300 NONPALD WORKERS

TOTAL

09400 PATIENTS LAUNDRY

Cross Foot Adjustments

Negative Cost Centers

93.00

94.00

98.00

99 00

100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315111 | Period: From 01/01/2023

d: Worksheet B 01/01/2023 Part II 12/31/2023 Date/Time Prepared:

5/28/2024 3:15 pm Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATI ON, LINEN SERVICE ADMI NI STRATI ON MAINT. & REPAI RS 6.00 9. 00 7.00 8.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4 00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 118,670 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 2, 417 43, 750 6.00 00700 HOUSEKEEPI NG 7.00 872 17,866 7.00 00800 DI ETARY 8.00 11, 291 C 1,748 206, 574 8.00 9.00 00900 NURSING ADMINISTRATION 1, 112 0 172 23, 875 9.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 0 0 0 0 01200 MEDICAL RECORDS & LIBRARY 12.00 0 0 Λ 0 Λ 12.00 13.00 01300 SOCIAL SERVICE 237 C 37 0 0 13.00 15.00 01500 PATIENT ACTIVITIES 3,674 569 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 23, 875 30.00 03000 SKILLED NURSING FACILITY 94, 305 43, 750 206, 574 30.00 14, 602 31.00 03100 NURSING FACILITY 0 31.00 03200 | CF/IID 0 0 0 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 33 00 0 0 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42.00 0 42 00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 43.00 04400 PHYSI CAL THERAPY 44.00 3,004 465 0 0 44.00 04500 OCCUPATIONAL THERAPY 45 00 1 011 0 45.00 157 0 04600 SPEECH PATHOLOGY 46.00 326 C 51 0 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 0 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 0 0 0 0 48.00 o 04900 DRUGS CHARGED TO PATIENTS 49 00 421 Ω 65 0 49 00 05100 SUPPORT SURFACES 51.00 0 0 51.00 OTHER REIMBURSABLE COST CENTERS 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CF 83.00 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 118,670 43, 750 17, 866 206, 574 23, 875 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 09100 BARBER AND BEAUTY SHOP 0 0 0 91.00 C Λ 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 o 0 93.00 09400 PATIENTS LAUNDRY 94.00 0 94.00 0 0 0 0 98.00 Cross Foot Adjustments C 0 0 0 98.00 99.00 Negative Cost Centers 99.00 100.00 118, 670 43, 750 17, 866 206, 574 23, 875 100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315111

				10	5 12/31/2023	Date/IIme Prep 5/28/2024 3:1	
					OTHER GENERAL	0,20,2021 011	<u> </u>
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	PATI ENT	Subtotal	
		SERVICES &	RECORDS &		ACTIVITIES		
		SUPPLY	LI BRARY				
	OFNEDAL CERVI OF COCT CENTERS	10.00	12. 00	13.00	15. 00	16. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 3. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00300 EMPLOYEE BENEFITS						1. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
4. 00 5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPING						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	1, 087					10.00
12. 00	01200 MEDICAL RECORDS & LI BRARY	1,007	134				12. 00
13. 00	01300 SOCIAL SERVICE	0	134	l			13. 00
15. 00	01500 PATIENT ACTIVITIES	0	C		66, 534		15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	٩		ή σ	00, 334		13.00
30. 00	03000 SKILLED NURSING FACILITY	424	134	4, 762	66, 534	2, 048, 284	30. 00
31. 00	03100 NURSING FACILITY	0	C		00,001	0	31. 00
32. 00	03200 CF/11D	0	C		o	Ö	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	C		Ö	Ö	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		γ <u>ι</u>		Ü	00.00
40.00	04000 RADI OLOGY	0	C	ol	0	127	40. 00
41. 00	04100 LABORATORY	0	C	1	ol	436	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	C	1	ol	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	ol	o	6	43.00
44. 00	04400 PHYSI CAL THERAPY	0	C	o	0	55, 402	44.00
45.00	04500 OCCUPATI ONAL THERAPY	o	C	ol	o	20, 228	45. 00
46.00	04600 SPEECH PATHOLOGY	0	C	o	0	6, 376	46. 00
47.00	04700 ELECTROCARDI OLOGY	O	C	o	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	C	o	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	663	C	o	0	9, 860	49. 00
51.00	05100 SUPPORT SURFACES	o	C	o	0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	C	0	0	548	71. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 HOSPI CE	0	C	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 087	134	4, 762	66, 534	2, 141, 267	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	1	0	0	91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	C	ή "Ι	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	C	1	0	0	93. 00
94.00	09400 PATI ENTS LAUNDRY	0	C	0	0	0	94.00
98. 00	Cross Foot Adjustments	0	_		0	0	98. 00
99. 00	Negative Cost Centers	0	C] 0	0	0	99. 00
100.00	TOTAL	1, 087	134	4, 762	66, 534	2, 141, 267	100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315111 Per

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

5/28/2024 3:15 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 2, 048, 284 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 127 41.00 04100 LABORATORY 00000000 436 41.00 04200 I NTRAVENOUS THERAPY 42.00 0 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 6 44. 00 04400 PHYSI CAL THERAPY 55, 402 44.00 45.00 04500 OCCUPATIONAL THERAPY 20, 228 45.00 04600 SPEECH PATHOLOGY 46.00 6, 376 46.00 04700 ELECTROCARDI OLOGY 47.00 Ω 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49.00 9,860 05100 SUPPORT SURFACES 51.00 51.00 OTHER REIMBURSABLE COST CENTERS 71.00 07100 AMBULANCE 0 548 71.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 00 80 00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84)
NONREIMBURSABLE COST CENTERS 2, 141, 267 0 89.00 89.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 90.00 91 00 09100 BARBER AND BEAUTY SHOP 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 92.00 93.00 09300 NONPALD WORKERS 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 94.00 98 00 Cross Foot Adjustments 98.00 0 99.00 Negative Cost Centers 99.00 100.00 TOTAL 2, 141, 267 100.00

	Trianciai Systems	TIKET EKKED CAKE					
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2023 o 12/31/2023		narod:
					0 12/31/2023	5/28/2024 3:1	
		CAPI TAL				37 207 2024 3. 1	J piii
		RELATED COSTS					
	Cost Contor Dossription	BLDGS &	EMPLOYEE	Doconci Li ati or	ADMINICTDATIVE	PLANT	
	Cost Center Description			Reconciliation	ADMI NI STRATI VE		
		FI XTURES	BENEFITS		& GENERAL	OPERATI ON,	
		(SQUARE FEET)	(GROSS		(ACCUM COST)	MAINT. &	
			SALARI ES)			REPAI RS	
						(SQUARE FEET)	
		1.00	3. 00	4A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	43, 592					1.00
3.00	00300 EMPLOYEE BENEFITS	o	5, 253, 229				3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 221	540, 105		11, 149, 632		4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 350	54, 034		601, 555	l	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	815	65, 235	1	241, 660		1
7. 00	00700 HOUSEKEEPI NG	294	360, 339	1		l e	•
		1		1		l e	•
8.00	00800 DI ETARY	3, 808	493, 251	1	., 200, 0,,	3, 808	
9.00	00900 NURSING ADMINISTRATION	375	554, 444		775, 346	l	1
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0	1	202, 126	0	
12.00	01200 MEDICAL RECORDS & LIBRARY	0	22, 108	3	24, 941	0	12. 00
13.00	01300 SOCIAL SERVICE	80	88, 428	3	103, 688	80	13. 00
15.00	01500 PATIENT ACTIVITIES	1, 239	153, 872	2	266, 004	1, 239	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·	•	•			İ
30.00	03000 SKILLED NURSING FACILITY	31, 804	2, 921, 413	(5, 779, 450	31, 804	30.00
31. 00	03100 NURSING FACILITY	01,001	2, 721, 110	1		0 1, 00 1	
	03200 CF/11D		0	1	_	0	1
32.00		0		1	_	1	
33. 00	03300 OTHER LONG TERM CARE	l ol	0) (0	0	33. 00
	ANCILLARY SERVICE COST CENTERS					_	
	04000 RADI OLOGY	0	0		,	0	
41. 00	04100 LABORATORY	0	0)	81, 062	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0)	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0) (1, 028	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 013	0		404, 216	1, 013	44.00
45.00	04500 OCCUPATI ONAL THERAPY	341	0) (429, 535	341	45. 00
46.00	04600 SPEECH PATHOLOGY	110	0		110, 870		•
	04700 ELECTROCARDI OLOGY	0	0		1.0,0,0	0	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			o o	
		140	0	1	_		•
49. 00	04900 DRUGS CHARGED TO PATIENTS	142	U		022,701	142	•
51.00	05100 SUPPORT SURFACES	0	0) (0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,				ı	
71. 00	07100 AMBULANCE	0	0) (101, 804	0	71. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF	1					82. 00
83.00	08300 H0SPI CE	0	0		0	0	ı
89. 00	SUBTOTALS (sum of lines 1-84)	43, 592	5, 253, 229	-2, 859, 848	11, 149, 632		1
07.00	NONREI MBURSABLE COST CENTERS	43, 372	5, 255, 227	-2,037,040	11, 147, 032	40,021	09.00
00 00					\ \ \	0	00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				
	09100 BARBER AND BEAUTY SHOP	0	0	ή	ار ا	0	1
	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0)	0	0	
93.00	09300 NONPALD WORKERS	0	0)	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0) (0	0	94.00
98.00	Cross Foot Adjustments	1					98. 00
99.00	Negative Cost Centers	1					99. 00
102.00	3	2, 141, 267	673, 106	,	2, 859, 848	755, 852	1
102.00	Part I)	2, 111, 20,	070, 100	1	2,007,010	700,002	102.00
103.00	1 1 '	49. 120641	0. 128132	,	0. 256497	18. 886385	103 00
		49. 120041	0. 120132				
104.00			Ü	ή	59, 976	118, 670	104.00
405 55	Part II)		0 0005		0 0050-	0.0/5455	405 00
105.00			0. 000000	ין	0. 005379	2. 965193	105.00
		1		1			

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS PREFERRED CARE AT HAMILTON In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315111

					T	o 12/31/2023	Date/Time Pre 5/28/2024 3:1	
		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	5 pili
			LINEN SERVICE		(MEALS SERVED)		SERVICES &	
			(PATI ENT				SUPPLY	
			CENSUS)			(DI RECT	(COSTED	
						NURSI NG)	REQUIS.)	
	CENED	AL CEDIUSE COCT SENTEDS	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES			I			1.00
3. 00		EMPLOYEE BENEFITS			•			3.00
4. 00	1	ADMINISTRATIVE & GENERAL						4.00
5. 00		PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	1	LAUNDRY & LINEN SERVICE	39, 729					6. 00
7.00	00700	HOUSEKEEPI NG	0	38, 912				7. 00
8.00		DI ETARY	0	3, 808	119, 187			8. 00
9.00		NURSING ADMINISTRATION	0	375	1	124, 966		9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	0	_	0	517, 902	1
12.00		MEDICAL RECORDS & LIBRARY	0	0	_	0	0	12.00
13. 00 15. 00	1	SOCIAL SERVICE PATIENT ACTIVITIES	0	80 1, 239	1		0	
15.00		IENT ROUTINE SERVICE COST CENTERS	0	1, 239	1 0	<u> </u>	0	15.00
30. 00		SKILLED NURSING FACILITY	39, 729	31, 804	119, 187	124, 966	202, 126	30.00
31. 00	1	NURSING FACILITY	0,7,127	0.,001		0	0	1
32. 00		ICF/IID	0	Ö		o	0	1
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCI L	LARY SERVICE COST CENTERS						
40.00	1	RADI OLOGY	0	0		0	0	
41. 00	1	LABORATORY	0	0	1	0	0	41. 00
42.00		I NTRAVENOUS THERAPY	0	0	1	0	0	
43. 00 44. 00		OXYGEN (INHALATION) THERAPY	0	0	_	0	0	
45. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	1, 013 341	1	0	0	
46. 00		SPEECH PATHOLOGY	0	110	1		0	46.00
47. 00		ELECTROCARDI OLOGY	0	0		o	0	47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö		o	0	48. 00
49.00		DRUGS CHARGED TO PATIENTS	0	142	0	o	315, 776	49. 00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
		REIMBURSABLE COST CENTERS						
71. 00		AMBULANCE	0	0	0	0	0	71. 00
00.00		AL PURPOSE COST CENTERS						00.00
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00	1	UTILIZATION REVIEW - SNF						82.00
83. 00	1	HOSPI CE	0	0	0	0	0	1
89. 00		SUBTOTALS (sum of lines 1-84)	39, 729	38, 912	119, 187	124, 966	517, 902	
	NONRE	IMBURSABLE COST CENTERS			, -	.,	<u> </u>	
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92.00	1	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93. 00		NONPAI D WORKERS	0	0	0	0	0	93. 00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
98. 00 99. 00		Cross Foot Adjustments						98. 00 99. 00
102.00		Negative Cost Centers Cost to be allocated (per Wkst. B,	319, 037	601, 934	1, 645, 403	987, 103	253, 971	
102.00	Ί	Part I)	317,037	001, 334	1, 043, 403	707, 103	233, 7/1	102.00
103.00)	Unit cost multiplier (Wkst. B, Part I)	8. 030330	15. 469110	13. 805222	7. 898973	0. 490384	103.00
104.00		Cost to be allocated (per Wkst. B,	43, 750		1	23, 875	1, 087	104. 00
		Part II)						
105.00		Unit cost multiplier (Wkst. B, Part	1. 101211	0. 459139	1. 733192	0. 191052	0. 002099	105. 00
	1	11)	I	l	I	ı I		I

Provi der No.: 315111

Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Time Prepared: 5/28/2024 3:15 pm

						5/28/2024 3:	15 pm
					OTHER GENERAL		
					SERVI CE		
		Cost Center Description	MEDI CAL	SOCIAL SERVICE			
			RECORDS &	·	ACTI VI TI ES		
			LI BRARY	(PATI ENT	(PATI ENT		
			(PATI ENT	CENSUS)	CENSUS)		
			CENSUS)	10.00	15.00		
	lo EN ED	AL OFFICE OF STATES	12. 00	13. 00	15. 00		
4 00		AL SERVICE COST CENTERS					4
1.00	1	CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00		EMPLOYEE BENEFITS					3. 00
4.00	1	ADMINISTRATIVE & GENERAL					4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS					5. 00
6.00		LAUNDRY & LINEN SERVICE					6. 00
7.00		HOUSEKEEPI NG					7. 00
8.00	1	DI ETARY					8. 00
9.00	1	NURSING ADMINISTRATION			•		9. 00
10.00		CENTRAL SERVICES & SUPPLY	20 720				10.00
12.00		MEDICAL RECORDS & LIBRARY	39, 729	l .			12.00
13.00		SOCIAL SERVICE	0	39, 729	1		13.00
15. 00	LNDAT	PATIENT ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	U	0	39, 729		15. 00
30. 00		SKILLED NURSING FACILITY	39, 729	39, 729	39, 729		30.00
31. 00		NURSING FACILITY	39, 129	39, 129	39, 729		31. 00
32.00		ICF/IID	0	0	0		32.00
33. 00		OTHER LONG TERM CARE	0	0			33. 00
33.00		LARY SERVICE COST CENTERS	U	0	ıj U		33.00
40. 00		RADI OLOGY	0	0	0		40.00
41. 00	1	LABORATORY	0	0			41. 00
42. 00		INTRAVENOUS THERAPY	0	0			42. 00
43. 00		OXYGEN (INHALATION) THERAPY	0		0		43. 00
44. 00		PHYSI CAL THERAPY	0				44. 00
45. 00	1	OCCUPATIONAL THERAPY	0				45. 00
46. 00	1	SPEECH PATHOLOGY	0	0	Ö		46. 00
47. 00		ELECTROCARDI OLOGY	0	0	Ö		47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö			48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	Ö			49. 00
51. 00		SUPPORT SURFACES	0	Ö	1		51. 00
01.00		REIMBURSABLE COST CENTERS			<u> </u>		-
71. 00		AMBULANCE	0	0	0		71. 00
		AL PURPOSE COST CENTERS		-	-		
80.00		MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	1	INTEREST EXPENSE					81. 00
82.00	08200	UTILIZATION REVIEW - SNF					82. 00
83.00	08300	HOSPI CE	0	0	0		83. 00
89.00		SUBTOTALS (sum of lines 1-84)	39, 729	39, 729	39, 729		89. 00
	NONRE	IMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90. 00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0		91. 00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0		92. 00
93.00	09300	NONPALD WORKERS	0	0	0		93. 00
94.00	09400	PATIENTS LAUNDRY	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,	31, 338	133, 033	376, 799		102. 00
		Part I)					
103.00		Unit cost multiplier (Wkst. B, Part I)	0. 788794	l .	1		103. 00
104.00)	Cost to be allocated (per Wkst. B,	134	4, 762	66, 534		104. 00
105 00		Part II)	0 000070	0.440010	4 /74/01		105 00
105.00	'	Unit cost multiplier (Wkst. B, Part	0. 003373	0. 119862	1. 674696		105. 00
	1	[11)		I	I I		I

Heal th	Financial Systems	PREFERRED CARE AT	HAMI LTON		In Lie	eu of Form CMS-2	2540-10
	OF COST TO CHARGES FOR ANCILLARY AND OUTPATI	ENT COST CENTERS	Provi der	No.: 315111 F	Peri od:	Worksheet C	
					rom 01/01/2023		
				1	o 12/31/2023		
	Cost Contor Description			Total (from	Total Charges	5/28/2024 3: 15	5 pm
	Cost Center Description			Total (from	Total Charges		
				Wkst. B, Pt I,		di vi ded by	
				col . 18)	0.00	col. 2	
				1. 00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY			29, 604	1 0	0.000000	40. 00
41.00	04100 LABORATORY			101, 854	81, 062	1. 256495	41.00
42.00	04200 I NTRAVENOUS THERAPY			(0	0.000000	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY			1, 292	0	0. 000000	43.00
44.00	04400 PHYSI CAL THERAPY			542, 698	589, 688	0. 920314	44.00
45.00	04500 OCCUPATI ONAL THERAPY			551, 424	682, 140	0. 808374	45. 00
46.00	04600 SPEECH PATHOLOGY			143, 088			46. 00
47.00	04700 ELECTROCARDI OLOGY			(0	0. 000000	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0. 000000	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS			565, 267	315, 776	1. 790089	49. 00
51. 00	05100 SUPPORT SURFACES			(0.000000	51. 00
2 20	OUTPATIENT SERVICE COST CENTERS					21.222000	
71. 00	07100 AMBULANCE			127, 916	0	0.000000	71. 00
100.00				2, 063, 143			100. 00
100.00	1 1.0.00			2,000,140	1, 751, 760	<i>i</i> 1	1.50.55

Health Financial Systems	PREFERRED CARE	AT HAMILTON		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/28/2024 3:1	
		Title	XVIII (1)	Skilled Nursing		o piii
			()	Facility		
		Health 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	l ruit n	l lare B	x col. 2)	x col. 3)	
	(Fr. Wkst. C			,	,	
	Column 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS		T	T			
40. 00 04000 RADI OLOGY	0. 000000			0 0	0	1 .0.00
41. 00 04100 LABORATORY	1. 256495			0 1, 066	0	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0. 920314			0 261, 704	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 808374			0 237, 117		10.00
46. 00 04600 SPEECH PATHOLOGY	0. 543850			0 70, 206	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 790089			0	0	1 . ,
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51. 00
OUTPATIENT SERVICE COST CENTERS	0.000000	I				71 00
71.00 07100 AMBULANCE (2) 100.00 Total (Sum of Lines 40 - 71)	0. 000000			0 0 570, 093		71.00
,	1	707, 629	I	0 570, 093	1 0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 or	ı y.					

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

Health Finar	ncial Systems	PREFERRED CARE	AT HAMILTON		In lie	eu of Form CMS-:	2540-10
	NT OF ANCILLARY AND OUTPATIENT COSTS	THE EINES OF THE		No.: 315111	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III	pared:
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
PΔRT	II - APPORTIONMENT OF VACCINE COST					1.00	
1. 00 2. 00 3. 00	Drugs charged to patients - ratio of co Program vaccine charges (From your reco Program costs (Line 1 x line 2) (Title E, Part I, line 18)	rds, or the PS	&R)		,	1. 790089 4, 577 8, 193	1. 00 2. 00 3. 00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Dart A Nurcina	
	Cost Center Description	(From Wkst. B,			Cost (From	& Allied	
			(From Wkst. B,			Heal th Costs	
		18	Part I, Col.	Costs to Total		for Pass	
		10	14)	Costs - Part		Through (Col.	
			17)	(Col. 2 / Col		3 x Col . 4)	
				1)	•	0 X 001. 1)	
		1, 00	2.00	3.00	4, 00	5. 00	
PART	III - CALCULATION OF PASS THROUGH COSTS			0.00	11.00	0.00	
	LARY SERVICE COST CENTERS		71227 20 112712111				
	RADI OLOGY	29, 604	(0.0000	00	0	40.00
	LABORATORY	101, 854		0.0000		0	41. 00
	INTRAVENOUS THERAPY	0		0.0000		0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	1, 292		0. 00000		0	43.00
	PHYSI CAL THERAPY	542, 698		0.0000		0	44. 00
45. 00 04500	OCCUPATIONAL THERAPY	551, 424		0.0000			45. 00
	SPEECH PATHOLOGY	143, 088	ł .	0. 00000		l .	46, 00
	ELECTROCARDI OLOGY	0		0.0000		0	47. 00
48. 00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0. 00000	00 0	0	48. 00
	DRUGS CHARGED TO PATIENTS	565, 267		0.0000		0	49.00
	SUPPORT SURFACES	0		0.0000		Ō	51.00
100.00	Total (Sum of lines 40 - 52)	1, 935, 227			570, 093	0	100. 00

	Financial Systems PREFERRED CARE AT I ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315111	Peri od:	u of Form CMS-2 Worksheet D-1	
COMPO	ATION OF INFAITENT ROUTINE COSTS	Frovider No 313111	From 01/01/2023 To 12/31/2023	Parts I-II Date/Time Prep 5/28/2024 3:1	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
			raciiity		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS				1
1. 00	Inpatient days including private room days			39, 729	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicable to the Pr	3		7, 711	
4.00	Medically necessary private room days applicable to the Program			0	4.00
5. 00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			11, 946, 337	5.00
6. 00	General inpatient routine service charges			15, 242, 625	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 783745	
8. 00	Enter private room charges from your records			0	8.00
9. 00	Average private room per diem charge (Private room charges line	8 divided by private	room days, line	0. 00	9.00
10. 00	2) Enter semi-private room charges from your records			0	10.00
11. 00	Average semi-private room per diem charge (Semi-private room c	harges line 10, divide	d by	0. 00	
	semi-private room days)				
12. 00	Average per diem private room charge differential (Line 9 minus			0. 00	
13. 00 14. 00	Average per diem private room cost differential (Line 7 times I Private room cost differential adjustment (Line 2 times line 13			0. 00 0	l l
15. 00					
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	4111010111141 (21110-0		11, 946, 337	10.00
16. 00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		300. 70	
17. 00	Program routine service cost (Line 3 times line 16)			2, 318, 698	
18. 00 19. 00	Medically necessary private room cost applicable to program (I Total program general inpatient routine service cost (Line 17			0 2, 318, 698	
20. 00	Capital related cost allocated to inpatient routine service cost		t II column 18.	2, 048, 284	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			, ,	
21. 00	Per diem capital related costs (Line 20 divided by line 1)			51. 56	
22. 00 23. 00	Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22)			397, 579 1, 921, 119	
24. 00	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		1, 921, 119	1
	Total program routine service costs for comparison to the cost		nus line 24)	1, 921, 119	
26. 00	Enter the per diem limitation (1)		,		26.00
27. 00	Inpatient routine service cost limitation (Line 3 times the per		, · · /		27. 00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	Tesser of line 25 or	line 27)		28. 00
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		ı
(.,	The 25 and 27 and not appropal to the Avilly 24 may 25 and		1 1 0 7.17		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH			
1. 00	Total SNF inpatient days			39, 729	
2.00	Program inpatient days (see instructions)		VIV	7, 711	
3. 00 4. 00	Total nursing & allied health costs. (see instructions)(Do not Nursing & allied health ratio. (line 2 divided by line 1)	complete for titles V	OF XLX)	0 0. 194090	
5. 00	Program nursing & allied health costs for pass-through. (line 3	times line 4)		0. 194090	5.00

Health Financial Systems	PREFERRED CARE AT H	HAMI LTON	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	FOR TITLE XVIII	Provi der No.: 315111	From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/28/2024 3:15 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS		
			Facility			
	-	1. 00				
		1.00				
1.00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 1.00 Inpatient PPS amount (See Instructions)					
2.00	Nursing and Allied Health Education Activities (pass through pa		5, 785, 167 0	1. 00 2. 00		
3.00	Subtotal (Sum of lines 1 and 2)		5, 785, 167	3. 00		
4.00	Primary payor amounts			3, 308	4. 00	
5.00	Coinsurance			1, 092, 200	5. 00	
6.00	Allowable bad debts (From your records)			1, 063, 996	6. 00	
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		141, 324	7. 00	
8.00	Adjusted reimbursable bad debts. (See instructions)			691, 597	8. 00	
9.00	Recovery of bad debts - for statistical records only			0	9. 00	
10.00	Utilization review			0	10.00	
11.00	Subtotal (See instructions)			5, 381, 256	11. 00	
12.00	Interim payments (See instructions)			5, 023, 041	12.00	
13.00	Tentati ve adjustment			0	13.00	
14.00	OTHER adjustment (See instructions)			0	14.00	
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50	
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55	
14. 75	Sequestration for non-claims based amounts (see instructions)			13, 832	14. 75	
14. 99	Sequestration amount (see instructions)		93, 793			
15.00					15. 00	
16.00					16. 00	
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (OF COST OR CHARGES - T	TITLE XVIII ONLY			
17. 00	Ancillary services Part B			0		
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			8, 193		
19. 00	Total reasonable costs (Sum of lines 17 and 18)			8, 193		
20. 00	Medicare Part B ancillary charges (See instructions)			4, 577		
21. 00	Cost of covered services (Lesser of line 19 or line 20)			4, 577		
22. 00	Pri mary payor amounts			0		
23. 00	Coinsurance and deductibles			0		
24. 00	· · · · · · · · · · · · · · · · · · ·				24. 00	
24. 01					24. 01	
24. 02	· · · · · · · · · · · · · · · · · · ·				24. 02	
25. 00					25. 00	
26. 00	Interim payments (See instructions)		4, 036			
27. 00	Tentative adjustment		0			
28. 00	Other Adjustments (See instructions) Specify		0	28. 00		
28. 50	Demonstration payment adjustment amount before sequestration		0	28. 50		
28. 55	Demonstration payment adjustment amount after sequestration		0 92			
28. 99						
29. 00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 1E 2	oction 115 2	449 0		
30.00	Triotested amounts (Monarrowable cost report reals) in accordance	e with two Pub. 13-2, S	SECTION 113. Z	υĮ	30.00	

From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/28/2024 3:15 pm

Title XVIII Skilled Nursing

PPS

Facility Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3. 00 2.00 4, 952, 316 1.00 Total interim payments paid to provider 4,036 1.00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 06/20/2023 70, 725 0 3. 01 3.02 0 3.02 C 0 0 3 03 3.03 0 3.04 0 3.04 3.05 0 0 3.05 Provider to Program 3 50 ADJUSTMENTS TO PROGRAM 3.50 0 0 3.51 0 0 3.51 0 0 3. 52 3.52 3.53 0 0 3.53 3.54 0 0 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 70, 725 0 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 5, 023, 041 4,036 4.00 (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVIDER 0 0 5.01 0 5.02 0 5.02 5.03 5.03 0 0 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5.51 0 5 52 0 5 52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 PROGRAM TO PROVIDER 250, 590 449 6.01 PROVIDER TO PROGRAM 6.02 \cap Λ 6.02 Total Medicare program liability (see instructions) 5, 273, 631 4, 485 7.00 Contractor Name Contractor Number 1.00 2 00 8.00 Name of Contractor 8.00

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

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

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/28/2024 3:15 pm |

					5/28/2024 3:1	5 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	Assets					
	CURRENT ASSETS	707.000	T a	I al		
1.00	Cash on hand and in banks	787, 039			0	
2.00	Temporary investments Notes receivable		0		0	
4. 00	Accounts receivable	3, 371, 839	-	0	0	
5. 00	Other receivables	414, 399		o	0	
6.00	Less: allowances for uncollectible notes and accounts	-390, 000	0	0	0	6.00
	recei vabl e					
7.00	Inventory	0	0	0	0	
8.00	Prepaid expenses Other current assets	331, 353		0	0	
9. 00 10. 00	Due from other funds	171, 525		0	0	
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4, 686, 155	1	-	0	
	FIXED ASSETS	1,000,100		1 9		1
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14. 00	Less: Accumulated depreciation	0	0	-	0	
15.00	Buildings	0	0	0	0	
16.00	Less Accumulated depreciation	2 (10 700	0	0	0	
17. 00 18. 00	Leasehold improvements Less: Accumulated Amortization	2, 619, 788 -572, 967		-	0	
19. 00	Fi xed equi pment	-572, 707		-	0	
20.00	Less: Accumulated depreciation	0	٥	-	0	
21. 00	Automobiles and trucks	0	0	o	0	
22. 00	Less: Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	391, 276	0	0	0	23. 00
24. 00	Less: Accumulated depreciation	0	0	0	0	1
25. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	
26. 00	Mi nor equipment nondepreciable	0	0	-	0	1
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 438, 097	0	-	0	
20.00	OTHER ASSETS	2, 430, 077		ή σ	0	20.00
29. 00	Investments	0	0	0	0	29. 00
30.00	Deposits on Leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	
32. 00	Other assets	0	0	٦	0	1
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	7 124 252	0	-	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	7, 124, 252		vj Uj	0	34.00
	CURRENT LIABILITIES					1
35.00	Accounts payable	460, 488	0	0	0	35.00
36.00	Salaries, wages, and fees payable	318, 494	0	0	0	36.00
37. 00	Payroll taxes payable	27, 064	0	0	0	
38. 00	Notes & Loans payable (Short term)	57, 571	0	0	0	
39. 00	Deferred income	1, 219, 051	0	0	0	
40. 00 41. 00	Accel erated payments Due to other funds		0		0	40.00
42. 00	Other current liabilities	3, 447, 278	· -	-		1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 529, 946			0	
.0. 00	LONG TERM LIABILITIES	0,02,,,10		<u> </u>		1 .0.00
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured Loans	0	0	-	0	
47. 00	Loans from owners:	0	0	-	0	
48. 00	Other long term liabilities	0	0	-	0	
49. 00 50. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0		0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	5, 529, 946			0	
31.00	CAPITAL ACCOUNTS	3, 327, 740	0	ή <u>σ</u>	0	31.00
52.00	General fund balance	1, 594, 306				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			o		54.00
	Donor created - endowment fund balance - unrestricted			0		55. 00
55. 00	Governing body created - endowment fund balance			0		56. 00
56.00			I .		0	57.00
56. 00 57. 00	Plant fund balance - invested in plant					F 0 -
56.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	58. 00
56. 00 57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	1 504 204		0		
56. 00 57. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	1, 594, 306 7, 124, 252		0	0	59. 00

Provi der No.: 315111

| Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

General Fund Special Purpose Fund Endowment Fund						To 12/31/2023	Date/Time Prep 5/28/2024 3:1	
1.00			General	Fund	Special P	Purpose Fund		5 piii
1.00			1 00	2.00	3 00	4.00	5.00	
2.00	1. 00	Fund balances at beginning of period	1.00		3.00		3.00	1.00
4.00								2.00
5.00 ROUNDING 37,000 0 0 0 0 0 0 0 0 0	3.00	Total (sum of line 1 and line 2)		1, 557, 305		0		3.00
ADDITIONS	4.00	Additions (credit adjustments)						4.00
7.00	5.00	ROUNDI NG	1			0	0	5. 00
8.00 9.00 10.00	6.00	ADDI TI ONS	37, 000			0		6. 00
9.00 Total additions (sum of line 5 - 9) 37,001 0 10.00 11.00 12.00 Deductions (debit adjustments) 0 0 0 0 12.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.	7.00		0			0		7. 00
10.00 Total additions (sum of line 5 - 9) 37,001 0 10.00 11.00 12.00 12.00 12.00 12.00 12.00 13.00 14.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 19.00 19.00 19.00 10.			0			0		8. 00
11. 00 Deductions (debit adjustments)			0			0	0	
12.00				37, 001		0		
13.00 13.00 14.00 14.00 15.00 15.00 15.00 16.00 16.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 19.0				1, 594, 306		0		
14. 00 15. 00 0 0 0 0 0 0 15. 00 0 0 15. 00 0 0 15. 00 0 0 0 0 15. 00 0 0 0 0 0 0 0 0 0		Deductions (debit adjustments)						
15.00 16.00 16.00 16.00 17.00 18.00 18.0			0			-		
16.00 17.00 18.00 17.00 18.00 18.00 18.00 19.00 19.00 10.00 19.0			0			0		
17. 00 18. 00 Total deductions (sum of lines 13 - 17) 19. 00 Fund balance at end of period per balance 1,594,306 0 17. 00 18. 00 19. 00			0			0		
18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance sheet (Line 11 - line 18) Endowment Fund Plant Fund Pla			0			0		
19.00 Fund balance at end of period per balance 1,594,306 0 19.00			0	_		0	0	
Sheet (Line 11 - line 18)				0		0		
Endowment Fund	19.00			1, 594, 306		0		19.00
1.00		Sheet (Line II - Iine 18)	Endowment Fund	Plant	Fund			
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 ROUNDING 0 6.00 7.00 8.00 9.00 0 0 0 0 0 0 0 0 0								
2.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 3.00 4.00 Additions (credit adjustments) 5.00 ROUNDING 0 6.00 7.00 8.00 9.00 10.00 11.00 12.00 12.00 14.00 13.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 19.00 1				7. 00				
3.00 Total (sum of line 1 and line 2) 0 0 0 0 0 0 0 0 0			0			0		
4.00 Additions (credit adjustments) 5.00 ROUNDING 6.00 ADDITIONS 0 ADDITIONS 0 ADDITIONS 0 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Peductions (debit adjustments) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 18.00 Total deductions (sum of lines 13 - 17) 19.00 Total deductions (sum of lines 13 - 17)								
5.00 ROUNDING			0			0		
6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance 0 0 0 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 0 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 0 7.00 8.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
8.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 Subtotal (line 3 plus line 10) 0 Deductions (debit adjustments) 0 0 0 11.00 12.00 13.00 14.00 15.00 0 15.00 16.00 0 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance		ADDI TI ONS		0				
9.00 10.00 Total additions (sum of line 5 - 9) 0 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 0 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 0 9.00 0 10.00 0 11.00 0 12.00 0 13.00 14.00 0 15.00 0 16.00 0 17.00				0				
10.00 Total additions (sum of line 5 - 9)				0				
11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 13.00 13.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 Fund balance at end of period per balance 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 19.00 19.00 19.00 19.00 10.00 19.		T		O				
12.00 Deductions (debit adjustments) 12.00 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 Fund balance at end of period per balance 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 19.00			-1					
13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 0 13.00 14.00 0 15.00 0 17.00 0 18.00 19.00			0			U		
14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 14.00 0 15.00 16.00 17.00 18.00 19.00		Deductions (debit adjustments)						
15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance				0				
16.00				0				
17.00 18.00 Total deductions (sum of lines 13 - 17) 0 19.00 Fund balance at end of period per balance 0 19.00 0				0				
18.00 Total deductions (sum of lines 13 - 17) 0 0 18.00 19.00 Fund balance at end of period per balance 0 0 19.00				0				
19.00 Fund balance at end of period per balance 0 0 19.00		T-+-1		O				
			-					
Silect (Line ii - iiile io)	19.00	· · ·				U		19.00
		SHEET (LINE II - IIIIE 10)	ı I	I		Ţ	ļ	I

Heal th	Financial Systems	PREFERRED CARE AT H	IAMI LTON		In Lie	eu of Form CMS-2	2540-10
	MENT OF PATIENT REVENUES AND OPERATING EXPENS				Peri od: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II	pared:
	Cost Center Description			Inpati ent	Outpati ent	Total	
				1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY			15, 242, 62	5	15, 242, 625	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 o	of lines 1 - 4)		15, 242, 62	5	15, 242, 625	5. 00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES			1, 931, 76	7 0	1, 931, 767	6. 00
7.00	CLINIC				0	0	7. 00
8.00	HOME HEALTH AGENCY COST				0	0	8. 00
9.00	AMBULANCE				0	0	9. 00
10.00	RURAL HEALTH CLINIC				0	0	10.00
10. 10	FQHC				0	0	10. 10
11. 00	CMHC				0	0	11. 00
12.00	HOSPI CE				0	0	12. 00
13.00	ROUTINE CHARGES / BED HOLD			37, 76	3 0	37, 763	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13)) (Transfer column 3	to	17, 212, 15	5 0	17, 212, 155	14. 00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES					T	
1.00	Operating Expenses (Per Worksheet A, Col. 3,	Li ne 100)				16, 354, 596	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	7				0		7. 00

8.00

9. 00 10. 00

11.00

12.00

13. 00 0 14. 00 16, 354, 596 15. 00

8. 00 9. 00

10. 00 11. 00

12.00

Total Additions (Sum of lines 2 - 7)

13.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

Deduct (Specify)

		REFERRED CARE AT H			u of Form CMS-2	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.: 315111	Peri od: From 01/01/2023	Worksheet G-3	
					Date/Time Pre	pared:
					5/28/2024 3:1	
4 00	/F W + 0.0 P + 1		<u></u>		1. 00	4 00
1.00	Total patient revenues (From Wkst. G-2, Part I)		17, 212, 155	
2.00	Less: contractual allowances and discounts on p	patients accounts			1, 502, 731	
3.00	Net patient revenues (Line 1 minus line 2)		4.53		15, 709, 424	
4.00	Less: total operating expenses (From Worksheet		e 15)		16, 354, 596	
5.00	Net income from service to patients (Line 3 mir	nus 4)			-645, 172	5. 00
	Other income:			1		
6. 00	Contributions, donations, bequests, etc				0	6. 00
7.00	Income from investments				129, 693 0	7. 00
8.00	Revenues from communications (Telephone and Internet service)					8. 00
9.00						9. 00
10.00						10. 00
	Rebates and refunds of expenses				0	
	Parking Lot receipts				0	12. 00
	Revenue from Laundry and Linen service				0	
14.00	Revenue from meals sold to employees and guests	S			0	14. 00
15. 00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical suppl	lies to other thar	pati ents		0	16. 00
17.00	Revenue from sale of drugs to other than patier	nts			0	17. 00
18.00	Revenue from sale of medical records and abstra	acts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, cante	een			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
	PRIOR YEAR				771	24. 00
24. 01	NON PATIENT REVENUE				-91, 288	24. 01
	COVI D-19 PHE Funding				0	24. 50
	Total other income (Sum of lines 6 - 24)				39, 176	
	Total (Line 5 plus line 25)				-605, 996	
27. 00	Other expenses (specify)				0	27. 00
28. 00					0	•

26. 00 27. 00 28. 00

0 0 29.00 0 30.00

-605, 996 31.00

28. 00

29. 00

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)