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

			Exp11 001 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315354	From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/29/2024 10:20 am

			3/27	7 2 0 2 4 1 0 . 2 0 a 1 1 1
PART I - COST I	REPORT STATUS	·		
Provi der	1. [X] Electronically prepared cost rep	oort	Date: 5/29/2024	Time: 10:20 am
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report ent	er the number of times the provide	er resubmitted this cos	t report
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor No.		
use only	(1) As Submitted	7.[N] First Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[N] Last Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:		
	(4) Reopened	10.[0]If line 4, column 1 is "4"	: Enter number of time	s reopened
	(5) Amended	11. Contractor Vendor Code	4	'
	5. Date Received:	12.[F] Medicare Utilization. Ento	er "F" for full, "L" fo	or low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SUNNYSIDE MANOR (315354) 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	Mary	rellen Keane	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	Maryellen Keane			2
3	Signatory Title	ADMI NI STRATOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2. 00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	0	0	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 FOHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	0	0	0	100.00
Tho ob	pays amounts represent "due to" or "due from" the applicable	program for th	a alamant of t	he shows comple	ov indicated	

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 SUNNYSI DE MANOR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315354 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/29/2024 10: 20 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 2500 RIDGEWOOD ROAD PO Box: 1.00 2.00 City: WALL State: NJ Zi p Code: 07719 2.00 3.00 County: MONMOUTH CBSA Code: 35154 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 SUNNYSI DE MANOR 315354 05/08/1996 N Р 0 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 922, 501 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 922 501 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38, 00 39.00 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 0 41 00

Heal th	Financial Systems	SUNNYSIDE MAN	IOR	In Lie	u of Form CMS-2	2540-10
SKI LLE						
COMPLE	X INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023	Date/Time Pre	
					5/29/2024 10:	20 am
					Y/N	
					1.00	
42.00	Are mal practice premiums and paid losse	es reported in other than	the Administrativ	ve and General cost	N	42. 00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing d	cost centers and		
	amounts.		3			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?		N	43.00
	If line 43 is yes, enter the home office			ress of the home		44. 00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3. 00		
<u> </u>	If this facility is part of a chain or	ganization, enter the nam	e and address of	the home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Cor	ntractor's Number:		45. 00
46.00	5.00 Street: PO Box:					46. 00
47.00	Ci ty:	State:	Zi p	code:		47. 00

COMPLEX	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Provid		Period: From 01/01/2023 To 12/31/2023		
				Y/N	5/29/2024 10: Date	20 am
	General Instruction: For all column 1 respons	and onton in column 1 "V"	for Voc or "N"	1.00	2.00	
	General Instruction: For all column Frespons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in corumn i, i	TOT YES OF IN	TOT NO. FOT ALL	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter			N		1.00
	instructions)		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
	Has the provider terminated participation in column 1 is yes, enter in column 2 the date		umn N			2. 00
3.00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or	., chain home offices, dru d to the provider or its I, or members of the board	ıg			3.00
	relationships? (see instructions)		Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prep. Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" for	Y	С		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	revenues different from	N			5. 00
	reconciliation.			Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2: Is t	the provider the	N	N	6. 00
7.00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program ${\bf P}$			N		7. 00
	Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s		od for Nursing	N		8. 00
					Y/N 1. 00	
	Bad Debts Is the provider seeking reimbursement for ba	d dahts? (V/N) saa instruc	rti ons		N	9. 00
10. 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection policy change	e during this cos	,	N	10. 00
	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance waived? I	f "Y", see instr	ucti ons.	N	11. 00
	Have total beds available changed from prior	cost reporting period? If			N	12. 00
		Description	Y/N	rt A Date	Part B Y/N	
	DC+D Do+o	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 4. (see Instructions.)		Y	04/17/2024	Y	13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		N		N	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N	15.00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report		N		N	16. 00
	information? If was see instructions			1	1	1
17. 00	information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		N	17. 00

Heal th	Financial Systems SUNNYSI	DE MA	NOR			In Lie	u of Form CMS	-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		E	Provi der	No.: 315354		riod: om 01/01/2023 12/31/2023	Worksheet S- Part II Date/Time Pr 5/29/2024 10	epared:
			1	00		2.0	00	_
	Cost Report Preparer Contact Information	_						
19. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATH	LEEN		M	ESKER		19. 00
20. 00	Enter the employer/company name of the cost report preparer.	HEAL	TH CARE RE	SOURCES				20. 00
21. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-	987-1440		K	ATHLEEN. MESKER	@HCRNJ. NET	21. 00

Heal th Financial Systems

SUNNYSIDE MANOR

In Lieu of Form CMS-2540-10

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEY PELMBURGEMENT QUESTIONNALES

From 01/01/2023 Part II

From 01/01/2023 To 12/31/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Date/Time Prepared: 5/29/2024 10: 20 am 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 04/17/2024 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,

20.00

21.00

respecti vel y.

preparer.

20.00

21.00

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

Enter the telephone number and email address of the cost

SUNNYSI DE MANOR In Lieu of Form CMS-2540-10

 Heal th
 Financial
 Systems
 SUNNYSIDE

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

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/29/2024 10:20 am Provi der No.: 315354

			<u> </u>		5/29/2024 10:	20 am
			I np:	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	60	21, 900	0	1, 511	4, 124	1. 00
2.00 NURSING FACILITY	o	0			0	2.00
3. 00 ICF/IID	0	0			0	3. 00
4.00 HOME HEALTH AGENCY COST		_	0	0	0	4. 00
5.00 Other Long Term Care	92	33, 580	_	_	-	5. 00
6.00 SNF-Based CMHC	1	00,000				6. 00
7. 00 HOSPI CE	0	0	0	0	0	7. 00
8.00 Total (Sum of lines 1-7)	152	55, 480	ľ	1, 511	4, 124	8. 00
o. oo Total (Sam of Trines 17)	Inpatient D		J	Di scharges	1, 121	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	9, 240	14, 875		45	2	1.00
2.00 NURSING FACILITY	0	0	0		0	2.00
3.00 ICF/IID	0	0			0	3.00
4.00 HOME HEALTH AGENCY COST	0	0				4.00
5.00 Other Long Term Care	28, 865	28, 865				5.00
6.00 SNF-Based CMHC						6.00
7. 00 HOSPI CE	0	0	0	0	0	7.00
8.00 Total (Sum of lines 1-7)	38, 105	43, 740	0	45	2	8.00
	Di sch	arges	Aver	age Length of	Stay	
Component	Other	Total	Title V	Title XVIII	Title XIX	
	11.00	12.00	13. 00	14. 00	15. 00	
1.00 SKILLED NURSING FACILITY	33	80		33. 58	2, 062. 00	1. 00
2.00 NURSING FACILITY	0	0			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		Ĭ				6. 00
7. 00 HOSPICE	0	0	0.00	0.00	0.00	7. 00
8.00 Total (Sum of lines 1-7)	33	80				8. 00
creat (cam or rrings r r)	Average Length			si ons	2,002.00	0.00
	of Stay					
Component	Total	Title V	Title XVIII	Title XIX	0ther	
	16. 00	17. 00	18. 00	19. 00	20. 00	
1.00 SKILLED NURSING FACILITY	185. 94	0	60	1	17	1. 00
2.00 NURSING FACILITY	0.00	0		o	0	2.00
3.00 ICF/IID	0.00			o	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	0	7.00
8.00 Total (Sum of lines 1-7)	546. 75	0	60	1	17	8.00
	Admi ssi ons	Full Time	Equi val ent			
Component	Total	Employees on	Nonpai d			
Component	10141	Payrol I	Workers			
	21. 00	22. 00	23. 00			
1.00 SKILLED NURSING FACILITY	78					1. 00
2. 00 NURSING FACILITY	0	0.00				2. 00
3. 00 ICF/IID	0	0.00				3. 00
4.00 HOME HEALTH AGENCY COST		0.00				4. 00
5.00 Other Long Term Care	0	72. 70				5. 00
6. 00 SNF-Based CMHC		0.00				6. 00
7. 00 HOSPI CE	0	0.00				7. 00
8.00 Total (Sum of lines 1-7)	78					8. 00
5. 55 Total (Julii of Tries 1-1)	1 /0	124.70	1 0.00			0.00

					To 12/31/2023		
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from		Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
	DART III DIRECT CALARIES	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES SALARIES						
1 00	Total salaries (See Instructions)	7, 565, 211	1 0	7, 565, 211	263, 681. 00	28. 69	1. 00
1.00	. ,	7, 505, 211	0	7, 505, 21			2.00
2.00	Physician salaries-Part A	0	0		0.00		3.00
3. 00 4. 00	Physician salaries-Part B	0	0		0.00		4. 00
4. 00 5. 00	Home office personnel Sum of lines 2 through 4	0	0		0.00		5.00
6. 00		7 5/5 211	0	7, 565, 211			
	Revised wages (line 1 minus line 5)	7, 565, 211	0		· ·		6.00
7.00	Other Long Term Care	2, 254, 607	0	2, 254, 607	· ·		
8.00	HOME HEALTH AGENCY COST	0	0		0.00		
9.00	CMHC	0	0		0.00		
10.00	HOSPI CE	0	0		0.00		
11. 00	Other excluded areas	0	0	, ,,,,	0.00		
12. 00	Subtotal Excluded salary (Sum of lines 7	2, 254, 607	0	2, 254, 607	80, 301. 00	28. 08	12. 00
12 00	through 11)	F 210 404	0	F 210 (0)	102 200 00	20.04	12.00
13. 00	Total Adjusted Salaries (line 6 minus line 12)	5, 310, 604	0	5, 310, 604	183, 380. 00	28. 90	13. 00
	OTHER WAGES & RELATED COSTS						
14 00	Contract Labor: Patient Related & Mgmt	992, 615		992, 615	19, 847. 00	50. 01	14. 00
15. 00	Contract Labor: Physician services-Part A	772,019		772,010	0.00		
	Home office salaries & wage related costs	0			0.00		16. 00
10.00	WAGE-RELATED COSTS				0.00	0.00	10.00
17. 00	Wage-related costs core (See Part IV)	1, 796, 941	0	1, 796, 941	ı		17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	1,,,,,,,,			18. 00
19. 00	Wage related costs (excluded units)	534, 342	0	534, 342			19. 00
20. 00	Physician Part A - WRC	004, 042		334, 342			20.00
21. 00	Physician Part B - WRC						21.00
22. 00	Total Adjusted Wage Related cost (see	1, 262, 599		1, 262, 599	á		22.00
22.00	instructions)	1, 202, 377	١	1, 202, 37			22.00
	1	1	1	1	1	1	1

In Lieu of Form CMS-2540-10
Period: Worksheet S-3
From 01/01/2023 Part III Health Financial Systems
SNF WAGE INDEX INFORMATION SUNNYSI DE MANOR

Provi der No.: 315354

					o 12/31/2023	Date/Time Prep 5/29/2024 10:	
	·	Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0) C	0.00	0.00	1. 00
2.00	Administrative & General	1, 061, 789	0	1, 061, 789	22, 973. 00	46. 22	2. 00
3.00	Plant Operation, Maintenance & Repairs	287, 051	0	287, 051	13, 327. 00	21. 54	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	38, 315	0	38, 315	1, 641. 00	23. 35	5. 00
6.00	Di etary	1, 055, 281	0	1, 055, 281	46, 656. 00	22. 62	6. 00
7.00	Nursing Administration	342, 000	0	342, 000	5, 253. 00	65. 11	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	0	0	C	0.00	0.00	10.00
11. 00	Soci al Servi ce	201, 041	0	201, 041	2, 080. 00	96. 65	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	330, 420	0	330, 420	15, 519. 00	21. 29	13.00
14. 00	Total (sum lines 1 thru 13)	3, 315, 897	o	3, 315, 897	107, 449. 00	30. 86	14. 00

Health Financial Systems	SUNNYSI DE MANOR	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315354	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 5/29/2024 10:	pared:
			Amount Reported 1.00	

	10 12/01/2020	5/29/2024 10:	20 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	203, 412	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	765, 165	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9, 441	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	160, 096	15. 00
16.00	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	440, 133	17. 00
	Medicare Taxes - Employers Portion Only	105, 244	18. 00
	Unempl oyment I nsurance	0	19. 00
20.00	State or Federal Unemployment Taxes	113, 450	20. 00
	OTHER		
	Executive Deferred Compensation	0	
	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	1, 796, 941	24. 00
		Amount	
		Reported	
		1. 00	
0= 0-	Part B - Other than Core Related Cost	_	
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

					rom 01/01/2023	Part V	
				1	o 12/31/2023	Date/Time Prep 5/29/2024 10:2	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	20 aiii
	occupational category	Reported		Sal ari es (col.		Wage (col. 3 ÷	
		Reported	Delie I I I S		Salary in col.	col. 4)	
				1 + COI. 2)	3	(01. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	Direct Salaries	1.00	2.00	0.00	1. 00	0.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	363, 245	86, 089	449, 334	8, 282. 00	54, 25	1. 00
2. 00	Licensed Practical Nurses (LPNs)	497, 259	117, 850				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 134, 203	268, 806		· ·		3. 00
	Assi stants/Ai des	1, 101, 200		1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	,		
4.00	Total Nursing (sum of lines 1 through 3)	1, 994, 707	472, 745	2, 467, 452	71, 771. 00	34. 38	4.00
5.00	Physical Therapists	0	0	C	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	l c	0.00	0.00	6. 00
7.00	Physical Therapy Aides	0	0	l c	0.00	0.00	7. 00
8.00	Occupational Therapists	o	0		0.00	0.00	8. 00
9.00	Occupational Therapy Assistants	o	0		0.00	0.00	9. 00
10.00	Occupational Therapy Aides	0	0	l c	0.00	0.00	10.00
11. 00	Speech Therapists	O	0	l c	0.00	0.00	11.00
12.00	Respi ratory Therapi sts	o	0	l c	0.00	0.00	12.00
13.00	Other Medical Staff	o	0	l c	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	689		689	9. 00	76. 56	14.00
15.00	Licensed Practical Nurses (LPNs)	54, 801		54, 801	605.00	90. 58	15.00
16.00	Certified Nursing Assistant/Nursing	32, 410		32, 410	805.00	40. 26	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	87, 900		87, 900			
18. 00	Physical Therapists	208, 479		208, 479			18. 00
19. 00	Physical Therapy Assistants	36, 603		36, 603	· ·		19.00
20. 00	Physical Therapy Aides	0		[C	0.00		20.00
21. 00	Occupational Therapists	152, 703		152, 703			21.00
22. 00	Occupational Therapy Assistants	0		0			22.00
23. 00	Occupational Therapy Aides	11, 349		11, 349			23.00
24.00	Speech Therapists	45, 223		45, 223			24.00
25. 00	Respiratory Therapists	452, 357		452, 357			
26. 00	Other Medical Staff	0		[C	0.00	0.00	26. 00

Peri od: Worksheet S-7
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/29/2024 10:20 am Provi der No.: 315354

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Health Financial Systems SUNN	NYSIDE MANOR		In Lie	u of Form CMS-	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315354	Peri od:	Worksheet S-	7
			From 01/01/2023 To 12/31/2023	Date/Time Pro 5/29/2024 10:	
			Group	Days	
			1. 00	2. 00	
76. 00			PA1		76. 00
99. 00			AAA		99. 00
100. 00 TOTAL					100. 00
		Expenses	Percentage	Y/N	
		1.00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column 1 column 2 the percentage of total expenses for each cat line 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each (See instructions)	increase to be used the amount of the egory to total SNF "N" for no if the s	for direct perpense for expense for expense from spending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101. 00 Staffing					101.00
102.00 Recrui tment					102.00
103.00 Retention of employees					103. 00 104. 00
104. 00 Trai ni ng					
105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, colu	mn 3)				105. 00 106. 00

Heal th	Financial Systems	SUNNYSI DE N	MANOR		In Lie	u of Form CMS-2	2540-10
	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					rom 01/01/2023 o 12/31/2023	Date/Time Prep 5/29/2024 10::	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	20 4
				+ col . 2)	ons	Trial Balance	
					Increase/Decre	`	
					ase (Fr Wkst	col . 4)	
		1.00	0.00	0.00	A-6)	F 00	
	CENEDAL CEDULCE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		1, 848, 488	1, 848, 488	22, 914	1, 871, 402	1. 00
2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES		1, 040, 400	1, 040, 400	22, 914	1, 671, 402	2. 00
3.00	00300 EMPLOYEE BENEFITS		1, 793, 114	1, 793, 114	0	1, 793, 114	3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	1, 061, 789	2, 132, 887	3, 194, 676		3, 171, 762	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	287, 051	932, 751	1, 219, 802		1, 219, 802	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	166, 155	166, 155		166, 155	6. 00
7. 00	00700 HOUSEKEEPI NG	38, 315	441, 926	480, 241		480, 241	7. 00
8. 00	00800 DI ETARY	1, 055, 281	963, 352	2, 018, 633		2, 018, 633	8. 00
9.00	00900 NURSING ADMINISTRATION	342,000	37, 042	379, 042	0	379, 042	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	(0	0	10.00
11. 00	01100 PHARMACY	0	10, 218	10, 218	0	10, 218	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	(0	0	12.00
13. 00	01300 SOCI AL SERVI CE	201, 041	0	201, 041	0	201, 041	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	14. 00
15.00	01500 RECREATION	330, 420	239, 484	569, 904	0	569, 904	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	1, 994, 707	431, 604	2, 426, 311	0	2, 426, 311	30. 00
31. 00	03100 NURSING FACILITY	0	0	(0	0	31. 00
32.00	03200 CF/ I D	0	10.010	0 0 4 4 6	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	2, 254, 607	10, 013	2, 264, 620)	2, 264, 620	33. 00
40. 00	04000 RADI OLOGY	O	4, 174	4, 174	0	4, 174	40. 00
41. 00	04100 LABORATORY	0	9, 596	9, 596		9, 596	41. 00
42. 00	04200 I NTRAVENOUS THERAPY		7, 370 O	7, 370		9, 390	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	o o	0		o o	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	229, 823	229, 823	o	229, 823	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	O	153, 879	153, 879		153, 879	45. 00
46.00	04600 SPEECH PATHOLOGY	o	48, 974	48, 974		48, 974	46. 00
47.00	04700 ELECTROCARDI OLOGY	o	0	(0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	90, 719	90, 719	0	90, 719	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	(0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS			_	ا		
60.00	06000 CLINIC	0	0	(0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	U	(0	61.00
02.00	OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	O	0	(ol	0	70. 00
71.00			0			0	71.00
	07300 CMHC	0	0			0	73. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		,	0	70.00
80.00			0	(0	0	80. 00
81.00			0		o	0	81. 00
82.00	08200 UTILIZATION REVIEW - SNF	o	0	(o	0	82. 00
83.00	08300 H0SPI CE	0	0	(0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	7, 565, 211	9, 544, 199	17, 109, 410	0	17, 109, 410	89. 00
	NONRE MBURSABLE COST CENTERS						
90.00		0	0		0	0	90.00
91. 00		0	0	(0	0	91. 00
92.00		0	0	(0	0	92.00
	09300 NONPALD WORKERS	0	0)	9	0	93. 00
	O9400 PATIENTS LAUNDRY TOTAL	7 545 211	0 544 100	17 100 416		0 17, 109, 410	94.00
100.00	J TUTAL	7, 565, 211	9, 544, 199	17, 109, 410	y U	17, 109, 410	100.00

SUNNYSI DE MANOR In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 SUNN

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315354 | Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				То	12/31/2023	Date/Time Prepa	
	Cost Center Description	Adjustments to	Net Expenses			5/29/2024 10: 20	alli
	Social Person		For Allocation				
		Wkst A-8)	(col. 5 +-				
			col . 6)				
		6. 00	7. 00				
4 00	GENERAL SERVICE COST CENTERS	2 000	4 0/7 470				4 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-3, 932	1, 867, 470				1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	0 1, 793, 114				2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	-1, 224, 800	1, 946, 962				4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 224, 000	1, 219, 802				5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE		166, 155				6. 00
7. 00	00700 HOUSEKEEPI NG	o	480, 241				7. 00
8.00	00800 DI ETARY	0	2, 018, 633				8. 00
9.00	00900 NURSING ADMINISTRATION	O	379, 042				9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0			1	10. 00
11. 00	01100 PHARMACY	0	10, 218				11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0				12. 00
13. 00	01300 SOCIAL SERVICE	0	201, 041				13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	5 (0 0 0 4				14.00
15. 00	01500 RECREATION	0	569, 904				15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	O	2 426 211				30. 00
31. 00	03100 NURSING FACILITY	0	2, 426, 311				31. 00
32. 00	03200 CF/11D		0				32. 00
	03300 OTHER LONG TERM CARE	0	2, 264, 620				33. 00
	ANCILLARY SERVICE COST CENTERS	-1					
40.00	04000 RADI OLOGY	0	4, 174				40. 00
41.00	04100 LABORATORY	0	9, 596			4	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0			4	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0				43. 00
44. 00	04400 PHYSI CAL THERAPY	0	229, 823				44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	153, 879			•	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	48, 974				46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0				47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	90, 719				48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	90, 719				50.00
51. 00	05100 SUPPORT SURFACES		o				51. 00
	OUTPATIENT SERVICE COST CENTERS	-1	-1				
60.00	06000 CLI NI C	0	0				50. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0			ϵ	51. 00
62.00	06200 FQHC					6	52. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00		0	0				70. 00
	07100 AMBULANCE 07300 CMHC	0	0				71. 00
73.00	SPECIAL PURPOSE COST CENTERS	l ol	0				73. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	O	0				30. 00
	08100 INTEREST EXPENSE	0	o			I .	31. 00
	08200 UTILIZATION REVIEW - SNF	o	o				32. 00
83.00	08300 HOSPI CE	0	0				33. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 228, 732	15, 880, 678				39. 00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			•	90.00
	09100 BARBER AND BEAUTY SHOP	0	0				91. 00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0			•	92.00
93.00	09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY	0	0				93.00
94. 00 100. 00	l l	-1, 228, 732	0 15, 880, 678				94. 00 00. 00
100.00) ITOTAL	-1,220,732	13, 000, 070			ļ ic	50.00

Health Financial Systems	SUNNYSIDE MAN	OR		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Prep 5/29/2024 10:	
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
(1) A - PROPERTY INSURANCE IN A/C 61400						
1. 00	CAP REL COSTS - BLD	GS &	1. (0 0	22, 914	1. 00
	FI XTURES					
TOTALS						
100. 00	Total Reclassificat	ions (Sum		0	22, 914	100. 00
	of columns 4 and 5	must				
	equal sum of column	ns 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	SUNNYSI DE MANO	OR		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 5/29/2024 10:	
			Decreases			
	Cost Center	•	Li ne #	Sal ary	Non Salary	
	6.00		7.00	8. 00	9. 00	
(1) A - PROPERTY INSURANCE IN A/C 61400						
1. 00	ADMINISTRATIVE & GE	NERAL	4. 0	0 0	22, 914	1. 00
TOTALS						
100. 00				0	22, 914	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.

| Period: | Worksheet A-7 | To | 12/31/2023 | To Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS SUNNYSI DE MANOR Provi der No.: 315354

						Date/Time Prep 5/29/2024 10:2	oared: 20 am
			Acqui si ti ons				
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
Description Beginning Balances Purchases Donation Total Disposals and Retirements							
						_	
			0		0 0	۱ ۲	1. 00
			7, 150		7, 150	0	2. 00
			0		0	0	3. 00
						0	4. 00
		3, 586, 846	68, 652		0 68, 652	0	5. 00
		0	0		0	0	6. 00
		26, 908, 125	198, 092		0 198, 092	0	7. 00
		0	0		0	0	8. 00
9. 00			· · · · · · · · · · · · · · · · · · ·		0 198, 092	0	9. 00
	Description	Endi ng Bal ance					
9.00 Total (line 7 minus line 8) 26,908,125 198,092 0 198,092 0 Description Ending Balance Fully Depreciated Assets 6.00 7.00							
			0				1. 00
	· ·		0				2. 00
			0				3.00
		1, 133, 097	0				4.00
		3, 655, 498	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	Subtotal (sum of lines 1-6)	27, 106, 217	0				7.00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	27, 106, 217	0				9. 00

Provi der No.: 315354

Peri od:

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

				10 12/31/2023	5/29/2024 10:	
				Expense Classification on		20 4111
				To/From Which the Amount is		
				TOTTO WITH CIT THE AMOUNT 13	to be haj usted	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
	bescription (1)	Adjustment	Alliourt	Cost center	LITTE NO.	
		1.00	2.00	3.00	4. 00	
1.00	Investment income on restricted funds	B		CAP REL COSTS - BLDGS &	1.00	1. 00
1.00	(chapter 2)	D	-1, 700	FIXTURES	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter		C	•	0.00	2. 00
2.00	8)			1	0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		C		0.00	3. 00
4. 00	Rental of provider space by suppliers			1	0.00	4. 00
4.00	(chapter 8)			1	0.00	4.00
5.00	Tel ephone services (pay stations excluded)		c		0.00	5. 00
5.00	(chapter 21)			1	0.00	3.00
6.00	Television and radio service (chapter 21)		c		0.00	6. 00
7. 00	Parking lot (chapter 21)			1	0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2		1	0.00	8. 00
0.00	physician adjustment	A-0-2		1		0.00
9.00	Home office cost (chapter 21)		C		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)			7	0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	C			12. 00
12.00	related organizations (chapter 10)	A-0-1				12.00
13. 00	Laundry and linen service		c		0.00	13. 00
14. 00	Revenue - Employee meals			1	0.00	
15. 00	Cost of meals - Guests		C	1	0.00	
16. 00	Sale of medical supplies to other than			•	0.00	
10.00	pati ents			1	0.00	10.00
17. 00	Sale of drugs to other than patients		c		0.00	17. 00
18. 00	Sale of medical records and abstracts				0.00	
19. 00	Vending machines			1	0.00	
20. 00	Income from imposition of interest, finance				0.00	
20.00	or penalty charges (chapter 21)			7	0.00	20.00
21. 00	Interest expense on Medicare overpayments		C		0.00	21. 00
21.00	and borrowings to repay Medicare				0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation		۲	DUTILIZATION REVIEW - SNF	82 00	22. 00
22.00	(chapter 21)			SOTTETE ATTOM REVIEW - SIN	02.00	22.00
23. 00	Depreciationbuildings and fixtures		ر	CAP REL COSTS - BLDGS &	1 00	23. 00
23.00	bepreciationbarraings and frattales			FIXTURES	1.00	23.00
24. 00	Depreciationmovable equipment		ر ا	CAP REL COSTS - MOVABLE	2 00	24. 00
24.00	beprecrationmovabre equipment			EQUI PMENT	2.00	24.00
25. 00	CONTRI BUTI ONS	Α	1 255	SADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	SALARY MARKETING	A		I ADMI NI STRATI VE & GENERAL	4.00	
25. 02	INTEREST EXPENSE OTHER	A	· ·	SCAP REL COSTS - BLDGS &	1.00	
25.03	THILKEST EXILINGE OTHER	_ ^	- 1, 700	FIXTURES	1.00	20.00
25. 04	MARKETI NG	Α	_25/ 707	ADMINISTRATIVE & GENERAL	4 00	25. 04
25. 04	CORPORATE TAX	A		BADMINISTRATIVE & GENERAL	4.00	
	MANAGEMENT FEE	A		ADMINISTRATIVE & GENERAL	4.00	
	NANAGEMENT FEE Total (sum of lines 1 through 99) (Transfer	A	-805, 294 -1, 228, 732	•	4.00	25. 06 100. 00
100.00	to Worksheet A, col. 6, line 100)		-1,220,732	-		100.00
(1) D-	scription all chapter references in this co	 	ONC DUE 15 1	 	1	

⁽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.

SUNNYSI DE MANOR

Heal th Financial Systems SUNNYSIDE STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provi der No.: 315354

OFFICE COSTS				o 12/31/2023		
	Li ne	No. Cos	t Center	Expense		20 alli
	1.0	0	2.00	3. (00	
PART I. COSTS INCURRED AND CLAIMED HOME OFFICE COSTS:	ADJUSTMENTS REQUIRED AS A	RESULT OF TRANSACT	IONS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		1.00 CAP REL COST FIXTURES	S - BLDGS &	FACILITY RENT		1.00
2. 00		4. 00 ADMI NI STRATI	VE & GENERAL	ADMI NI STRATI VE		2.00
3.00		0. 00				3.00
4. 00		0. 00			ŀ	4.00
5. 00		0. 00				5. 00
6. 00		0. 00			1	6. 00
7. 00		0. 00			1	7. 00
8. 00		0. 00				8. 00
9. 00		0. 00				9. 00
10.00 TOTALS (sum of lines 1-9). 6, line 100 to Worksheet A						10.00
	Amou	nt Amount	Adjustments			
	Allowab	le In Included i	n (col. 4 minus			
	Cos	t Wkst. A, co	col. 5)			
	4.0	5.00	6. 00			
PART I. COSTS INCURRED AND CLAIMED HOME OFFICE COSTS:				D ORGANI ZATI ONS	OR	
1. 00	1, 7	39, 673 1, 739, <i>6</i>	.73 C)		1. 00
2.00	3	17, 990 317, 9	90 0)		2. 00
3. 00		0	0 0)		3. 00
4.00		0	0 0)		4. 00
5. 00		0	0 0			5. 00
6. 00		0	0 0)		6. 00
7. 00		0	0 0)		7. 00
8. 00		0	0)		8. 00
9.00		. 0	0)		9. 00
10.00 TOTALS (sum of lines 1-9). 6, line 100 to Worksheet A 12.		57, 663 2, 057, 6	663 C	0		10.00

Provider No.: 315354

Worksheet A-8-1 From 01/01/2023 Parts I-II Date/Time Prepared: 12/31/2023

Symbol (1) Name Percentage of Ownershi p 2.00

3.00

5/29/2024 10:20 am

1.00 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	С	SUNNYSIDE MANOR	100.00	1.00
2.00			0.00	2. 00
3.00			0.00	3. 00
4.00			0.00	4. 00
5. 00			0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			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 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	1	
		Ownershi p			
	4.00	5. 00	6. 00	1	
DART II INTERRELATIONOMER TO BELATER ORGANI	TATLONICON AND COD HOME OFFI OF				

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	SUNNYSIDE REALTY LLC	0. 00 REALTY	1.00
2.00		0.00	2.00
3. 00		0.00	3.00
4. 00		0.00	4.00
5. 00		0.00	5.00
6. 00		0.00	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10. 00		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 related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315354
Period: Worksheet B From 01/01/2023 To 12/31/2023
Part I Date/Time Prepared: 5/29/2024 10: 20 am

					То	12/31/2023	Date/Time Prep 5/29/2024 10:	pared:
			CAPI TAL REL	ATED COSTS			3/24/2024 10	20 aiii
			DI DOC A	HOVARIE		EMBL OVEE		
	Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT		EMPLOYEE BENEFITS	Subtotal	
		Allocation	TTATORES	EQUIT MENT		DENETTIS		
		(from Wkst A						
		col . 7)	1.00	2.00		2.00	2.4	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00		3. 00	3A	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1, 867, 470	1, 867, 470					1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0			0			2. 00
3.00	00300 EMPLOYEE BENEFITS	1, 793, 114	0		0	1, 793, 114	0 000 750	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 946, 962 1, 219, 802	141, 125 131, 523		0	251, 666 68, 037	2, 339, 753 1, 419, 362	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	166, 155	17, 699		0	00, 037	183, 854	6. 00
7.00	00700 HOUSEKEEPI NG	480, 241	4, 558	1	0	9, 081	493, 880	7. 00
8.00	00800 DI ETARY	2, 018, 633	88, 300		О	250, 124	2, 357, 057	8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	379, 042	0		0	81, 061 0	460, 103 0	9. 00 10. 00
11. 00	01100 PHARMACY	10, 218	0		0	0	10, 218	
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	O	0	12. 00
13. 00	01300 SOCI AL SERVI CE	201, 041	5, 014		0	47, 651	253, 706	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	70 21/	707.274	14. 00
15. 00	O1500 RECREATION INPATIENT ROUTINE SERVICE COST CENTERS	569, 904	59, 054		0	78, 316	707, 274	15. 00
30. 00	03000 SKILLED NURSING FACILITY	2, 426, 311	382, 218		0	472, 787	3, 281, 316	30. 00
31.00	03100 NURSING FACILITY	0	0		0	0	0	31. 00
32. 00	03200 CF/ D	0	0		0	0	0	32. 00
33. 00	O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	2, 264, 620	1, 018, 609		0	534, 391	3, 817, 620	33. 00
40. 00	04000 RADI OLOGY	4, 174	0		0	O	4, 174	40. 00
41.00	04100 LABORATORY	9, 596	0		0	0	9, 596	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	220 822	14 029		0	0	245 951	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	229, 823 153, 879	16, 028 0		0	0	245, 851 153, 879	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	48, 974	0		0	o	48, 974	
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	00.710	0		0	0	00.710	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	90, 719	0		0	0	90, 719 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	o	0		0	Ö	0	51. 00
	OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0	0		0	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>						02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	0	71.00
73. 00	O7300 CMHC SPECIAL PURPOSE COST CENTERS	l ol	U		U	U _I	0	73. 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 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	15, 880, 678	0 1, 864, 128		0	1, 793, 114	0 15, 877, 336	83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	13,000,010	1,004,120		0	1, 775, 114	13, 077, 330	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	3, 342		0	0	3, 342	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0		0	0	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		ol		0	ol	0	94. 00
98. 00	Cross Foot Adjustments	o	o		0	o	0	98. 00
99. 00	Negative Cost Centers	0	0		0	0	0	99. 00
100.00) TOTAL	15, 880, 678	1, 867, 470	I	0	1, 793, 114	15, 880, 678	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315354

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

				T	01/01/2023	Date/Time Pre 5/29/2024 10:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	20 diii
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	2, 339, 753					1. 00 2. 00 3. 00 4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	245, 253 31, 768	1, 664, 615				5. 00 6. 00
7. 00	00700 HOUSEKEEPING	85, 338	18, 474 4, 757		583, 975		7. 00
8.00	00800 DI ETARY	407, 278	92, 164		32, 790	2, 889, 289	8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	79, 502	72, 104 0		32, 790	2, 869, 269	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	74, 302	0		0	0	10.00
11. 00	01100 PHARMACY	1, 766	0		0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	1, 700	0		0	0	12.00
13. 00	01300 SOCIAL SERVICE	43, 838	5, 233		1, 862	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	43, 636	5, 233		1, 002	0	14. 00
15. 00	1	122 211	41 420	0	21, 930	0	15. 00
15.00	01500 RECREATION INPATIENT ROUTINE SERVICE COST CENTERS	122, 211	61, 638	<u> </u>	21, 930	0	15.00
20.00	03000 SKILLED NURSING FACILITY	F// 000	200.044	70 /11	141 027	002 502	20.00
30.00		566, 982	398, 944 0	1	141, 937	982, 583	30.00
31. 00	03100 NURSING FACILITY	0	0	0	U	0	31.00
32. 00	03200 I CF/II D	0	1 0/2 10/	154 405	270 272	1 007 707	32.00
33. 00	03300 OTHER LONG TERM CARE	659, 654	1, 063, 186	154, 485	378, 263	1, 906, 706	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	704			ما	0	40.00
40.00	04000 RADI OLOGY	721	0	0	U	0	40.00
41. 00	04100 LABORATORY	1, 658	0		U	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		U	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	42 401	1/ 720		- OF 3	0	43.00
44. 00	04400 PHYSI CAL THERAPY	42, 481	16, 730	1	5, 952	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	26, 589	0		U	-	45. 00
46.00	04600 SPEECH PATHOLOGY	8, 462	0		U	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0		0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	15, 675	0		0	0	49. 00
		1	0		U		
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00 51. 00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	U U	U	<u> </u>	U	U	31.00
60. 00	06000 CLINIC	0	0	0	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0	1	0	0	61.00
62. 00	06200 FQHC		0	,	U U	Ü	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	O	0	70. 00
71. 00	07100 AMBULANCE		0		0	0	71.00
73. 00	07300 CMHC	0	0		0	0	73. 00
73.00	SPECIAL PURPOSE COST CENTERS	1 9		,	<u> </u>		75.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 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)	2, 339, 176	1, 661, 126	234, 096	582, 734	2, 889, 289	89. 00
07.00	NONREI MBURSABLE COST CENTERS	2, 337, 170	1,001,120	234, 070	302, 734	2,007,207	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	٥	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	577	3, 489		1, 241	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	377	J, 409 ∩		1, 241	0	92.00
93. 00	09300 NONPALD WORKERS		0		0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		0		0	0	98. 00
99. 00	Negative Cost Centers		0		0	0	99. 00
100.00		2, 339, 753	1, 664, 615	234, 096	583, 975		
	The state of the s		, 3 . 0		, . , 9	,, -0,	

Provi der No.: 315354 Peri od: Worksheet B From 01/01/2023 Part I Date/Ti me Prepared: 5/29/2024 10:20 am

					12/31/2023	5/29/2024 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	·	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	539, 605					9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0				10. 00
	01100 PHARMACY	0	0	11, 984	_		11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0		12. 00
	01300 SOCIAL SERVICE	0	0	0	0	304, 639	1
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	
15. 00	01500 RECREATION	0	0	0	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0/4 400				400 (04	00.00
30.00	03000 SKILLED NURSING FACILITY	264, 422	0	6, 165	0	103, 601	30.00
	03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00	03200 1 CF/1 D	275 102	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	275, 183	0	0	0	201, 038	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	l ol	0	O	0	0	40.00
40. 00 41. 00	04100 LABORATORY	0	0		0	0	40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY		0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY		0	0	0	0	44. 00
	04500 OCCUPATI ONAL THERAPY		0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
	04700 ELECTROCARDI OLOGY		0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		0	5, 819	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		0	3, 017	0	0	50.00
51. 00	05100 SUPPORT SURFACES		0	0	0	0	1
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>			01.00
60.00	06000 CLINIC	0	0	0	0	0	60. 00
	06100 RURAL HEALTH CLINIC	0	0		0	0	61. 00
	06200 FQHC		J	Ĭ	J	Ŭ	62.00
	OTHER REIMBURSABLE COST CENTERS	L L					
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	o	0		0	0	71. 00
	07300 CMHC	o	0		0	0	ı
	SPECIAL PURPOSE COST CENTERS	<u>'</u>					
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 HOSPI CE	o	0	0	0	0	83. 00
89.00	SUBTOTALS (sum of lines 1-84)	539, 605	0	11, 984	0	304, 639	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 PHYSICIANS PRIVATE OFFICES	o	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98.00	Cross Foot Adjustments	0	0				98. 00
99. 00	Negative Cost Centers	0	0		0	0	
100.00	TOTAL	539, 605	0	11, 984	0	304, 639	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315354

						To 12/31/2023	Date/Time Pre 5/29/2024 10:	
				OTHER GENERAL			3/2//2024 10.	20 4111
				SERVI CE				
		Cost Center Description	NURSI NG AND	RECREATI ON	Subtotal	Post Stepdown	Total	
			ALLI ED HEALTH			Adjustments		
			EDUCATI ON	15.00	1/ 00	17.00	10.00	
	CENED	AL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	1	EMPLOYEE BENEFITS						3. 00
4.00		ADMINISTRATIVE & GENERAL						4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600	LAUNDRY & LINEN SERVICE						6. 00
7.00	00700	HOUSEKEEPING						7. 00
8.00	00800	DI ETARY						8. 00
9.00		NURSING ADMINISTRATION						9. 00
10. 00		CENTRAL SERVICES & SUPPLY						10. 00
11.00		PHARMACY						11.00
12.00		MEDICAL RECORDS & LIBRARY						12.00
13.00		SOCIAL SERVICE	0					13.00
14.00		NURSING AND ALLIED HEALTH EDUCATION RECREATION	0	012 052				14. 00 15. 00
15. 00		ENT ROUTINE SERVICE COST CENTERS	0	913, 053				15.00
30. 00		SKILLED NURSING FACILITY	0	310, 509	6, 136, 07	0 0	6, 136, 070	30.00
31. 00		NURSING FACILITY	0	0 0			0, 100, 070	1
32. 00		ICF/IID	0	o		o o		1
33. 00	1	OTHER LONG TERM CARE	0	602, 544	9, 058, 67		l	1
	ANCI L	_ARY SERVICE COST CENTERS						
40.00	04000	RADI OLOGY	0	0	4, 89	5 0	4, 895	40. 00
41. 00	1	LABORATORY	0	0	11, 25	4 0	11, 254	
42. 00		INTRAVENOUS THERAPY	0	0		0	0	42. 00
43.00	1	OXYGEN (INHALATION) THERAPY	0	0		0	0	43. 00
44. 00		PHYSI CAL THERAPY	0	0	311, 01		311, 014	1
45. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0			180, 468	
46. 00 47. 00	1	ELECTROCARDI OLOGY	0	0	57, 43	0 0	57, 436 0	1
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	48.00
49. 00		DRUGS CHARGED TO PATIENTS	0	Ö	112, 21	3 0	112, 213	1
50. 00	1	DENTAL CARE - TITLE XIX ONLY	o o	Ö	1	o o	0	1
51.00	1	SUPPORT SURFACES	0	0		0	0	1
	OUTPA	TIENT SERVICE COST CENTERS						
60.00		CLINIC	0			0	l	
61. 00		RURAL HEALTH CLINIC	0	0		0	0	
62. 00	06200							62. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST		0		0 0	0	70. 00
71.00		AMBULANCE	0	0		0 0		
73.00	07300		0	0		0 0	l	
70.00		AL PURPOSE COST CENTERS				<u> </u>		70.00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	08100	INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF						82. 00
83.00	08300	HOSPI CE	0			0	l	
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	0	913, 053	15, 872, 02	9 0	15, 872, 029	89. 00
90. 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN				0 0	0	90. 00
91.00		BARBER AND BEAUTY SHOP	0	0	8, 64		8, 649	
92. 00		PHYSICIANS PRIVATE OFFICES	0	0	0,04		0,047	1
93. 00		NONPALD WORKERS	0				0	
94. 00		PATIENTS LAUNDRY	0	l ő		ol o	Ö	
98. 00	1	Cross Foot Adjustments	0	o		o o	Ō	ı
99. 00		Negative Cost Centers	0	0		0	0	99. 00
100.00		TOTAL	0	913, 053	15, 880, 67	8 0	15, 880, 678	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

						То	12/31/2023	Date/Time Pre 5/29/2024 10:	pared:
				CAPI TAL REI	ATED COSTS			3/24/2024 10.	20 aiii
		Cost Center Description	Directly	BLDGS &	MOVABLE		Subtotal	EMPLOYEE	
		·	Assigned New	FIXTURES	EQUI PMENT			BENEFI TS	
			Capital Related Costs						
	CENED	AL CERVICE COCT CENTERS	0	1. 00	2. 00		2A	3. 00	
1. 00	00100	AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES				Т			1. 00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT							2. 00
3.00	1	EMPLOYEE BENEFITS	0	0		0	0	0	3. 00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	0	141, 125 131, 523		0	141, 125 131, 523	0	4. 00 5. 00
6. 00		LAUNDRY & LINEN SERVICE	o	17, 699		0	17, 699	0	6. 00
7. 00	4	HOUSEKEEPI NG	0	4, 558		0	4, 558	0	7. 00
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON	0	88, 300 0	1	0	88, 300	0	8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	0		0	o	0	10. 00
11. 00	4	PHARMACY	o	0		0	0	0	11. 00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	0 E 014		0	0 5, 014	0	12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION		5, 014 0		0	5, 014	0	14. 00
15. 00	01500	RECREATI ON	0	59, 054		0	59, 054	0	15. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	1 0	202 210			202 210		20.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY		382, 218 0	l	0	382, 218 0	0	30. 00 31. 00
32. 00	03200	ICF/IID	o	0	•	0	0	0	32. 00
33. 00		OTHER LONG TERM CARE	0	1, 018, 609		0	1, 018, 609	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY		0		0	0	0	40. 00
41. 00		LABORATORY	o	0	•	0	0	0	41. 00
42.00	1	I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43. 00 44. 00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0	0 16, 028		0	16, 028	0	43. 00 44. 00
45. 00		OCCUPATIONAL THERAPY	O	0 0	ı	0	10, 020	0	45. 00
46. 00		SPEECH PATHOLOGY	0	0		0	0	0	46. 00
47. 00 48. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	47. 00 48. 00
49. 00		DRUGS CHARGED TO PATIENTS		0		0	0	0	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50. 00
51. 00		SUPPORT SURFACES	0	0		0	0	0	51. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	l ol	0		0	0	0	60. 00
61. 00	06100	RURAL HEALTH CLINIC	0	0		0	0	0	61. 00
62. 00	06200	FQHC REIMBURSABLE COST CENTERS							62. 00
70. 00		HOME HEALTH AGENCY COST	O	0		0	o	0	70. 00
71. 00		AMBULANCE	o	0		0	0	0	71. 00
73. 00	07300		0	0		0	0	0	73. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES							80. 00
81. 00	08100	INTEREST EXPENSE							81. 00
82. 00		UTILIZATION REVIEW - SNF							82. 00
83. 00 89. 00	08300	HOSPICE SUBTOTALS (sum of lines 1-84)	0	0 1, 864, 128		0	1, 864, 128	0	83. 00 89. 00
07.00	NONRE	IMBURSABLE COST CENTERS	<u> </u>	1,004,120		O _I	1,004,120		07.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0	3, 342 0		0	3, 342	0	91. 00 92. 00
93. 00		NONPAID WORKERS		0		o	Ö	0	
94.00		PATIENTS LAUNDRY	0	0		0	0	0	94. 00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers		^		0	0	0	98. 00 99. 00
100.00	o	TOTAL	О	1, 867, 470		0	1, 867, 470		100.00
		•	. '			,	'		•

In Lieu of Form CMS-2540-10
Period: Worksheet B
From 01/01/2023 Part II
To 12/21/2022 Part II
To 12/21/2022 Part II
To 12/21/2022 Part III
To 12/21/2022 Part III Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315354

					T	0 12/31/2023	Date/Time Pre 5/29/2024 10:	pared:
		Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	zo alli
			4.00	5. 00	6.00	7. 00	8. 00	
	GENERA	AL SERVICE COST CENTERS				,,,,,,		
1. 00 2. 00 3. 00	00200	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS						1. 00 2. 00 3. 00
4. 00	1	ADMINISTRATIVE & GENERAL	141, 125					4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	14, 793	146, 316				5. 00
6.00	1	LAUNDRY & LINEN SERVICE	1, 916	1, 624	21, 239	l .		6. 00
7.00	1	HOUSEKEEPI NG	5, 147	418	1	10, 123		7. 00
8.00		DI ETARY	24, 565	8, 101		568	121, 534	8. 00
9. 00 10. 00	1	NURSI NG ADMINISTRATION CENTRAL SERVICES & SUPPLY	4, 795 0	0	1	0	0	9. 00 10. 00
11. 00	1	PHARMACY	106	0	0	0	0	11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY	0	0	ő	o	0	12. 00
13.00		SOCIAL SERVICE	2, 644	460	0	32	0	13. 00
14. 00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00		RECREATI ON	7, 371	5, 418	0	380	0	15. 00
20.00		ENT ROUTINE SERVICE COST CENTERS	24 100	25.077	7 222	2.440	41 221	20.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	34, 198	35, 066 0	1	2, 460 0	41, 331 0	30. 00 31. 00
32.00		ICF/IID	0	0		0	0	32.00
33. 00		OTHER LONG TERM CARE	39, 790	93, 451	_	6, 558	80, 203	33. 00
		_ARY SERVICE COST CENTERS	, ,					
40.00		RADI OLOGY	44	0	0	0	0	40. 00
41. 00		LABORATORY	100	0	0	0	0	41. 00
42.00	1	INTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	2 5(2)	1 471	0	103	0	43.00
44. 00 45. 00		OCCUPATIONAL THERAPY	2, 562 1, 604	1, 471 0	1	103	0	44. 00 45. 00
46. 00	1	SPEECH PATHOLOGY	510	0		0	0	46. 00
47. 00		ELECTROCARDI OLOGY	0	0	ő	o	0	47. 00
48.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	О	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	945	0	0	0	0	49. 00
50. 00	1	DENTAL CARE - TITLE XIX ONLY	0	0	_	0	0	50. 00
51. 00		SUPPORT SURFACES	0	0	0	0	0	51. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	l ol	0	0	ol	0	60. 00
61.00	1	RURAL HEALTH CLINIC	0	0	1		0	61. 00
62. 00	06200			O			O.	62. 00
	OTHER	REIMBURSABLE COST CENTERS						
70. 00	1	HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00		AMBULANCE	0	0	1	0	0	71. 00
73. 00	07300		0	0	0	0	0	73. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES			1			80. 00
	1	INTEREST EXPENSE						81. 00
82. 00	1	UTILIZATION REVIEW - SNF						82. 00
83.00		HOSPI CE	0	0	0	О	0	83. 00
89. 00		SUBTOTALS (sum of lines 1-84)	141, 090	146, 009	21, 239	10, 101	121, 534	89. 00
		MBURSABLE COST CENTERS						
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91. 00 92. 00		BARBER AND BEAUTY SHOP	35	307		22	0	91. 00 92. 00
92.00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS		0		0	0	92. 00 93. 00
94. 00		PATIENTS LAUNDRY		0			0	94. 00
98. 00		Cross Foot Adjustments		Ö	o o	o	0	98. 00
99. 00	1	Negative Cost Centers	0	0	0	o	0	99. 00
100.00)	TOTAL	141, 125	146, 316	21, 239	10, 123	121, 534	100. 00

Provi der No.: 315354

					12/31/2023	5/29/2024 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						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 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	4, 795					8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	4, 775	0				10. 00
11. 00	01100 PHARMACY		0	106			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0	0	0		12. 00
13. 00	01300 SOCIAL SERVICE		0	o o	0	8, 150	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	o o	0	0, 100	
15. 00	01500 RECREATION	0	0		0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		
30.00	03000 SKILLED NURSING FACILITY	2, 350	0	55	0	2, 772	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	31.00
32.00	03200 CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	2, 445	0	0	0	5, 378	33.00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	0		0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	51	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		0		0	0	50. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>	0	31.00
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
00 00	SPECIAL PURPOSE COST CENTERS						00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00 81. 00
82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	4, 795	0		0		
07.00	NONREI MBURSABLE COST CENTERS	1, 7, 7, 0		100	J	0, 100	07.00
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	0	0	0	93. 00
94. 00	09400 PATI ENTS LAUNDRY	0	0		0	0	94.00
98. 00	Cross Foot Adjustments	0	0				98. 00
99.00	Negative Cost Centers	0	0		0	0	
100.00	TOTAL	4, 795	0	106	0	8, 150	100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315354

					-	Γο 12/31/2023	Date/Time Pre 5/29/2024 10:	
				OTHER GENERAL			372772024 10.	20 am
				SERVI CE				
		Cost Center Description	NURSING AND	RECREATI ON	Subtotal	Post Step-Down	Total	
			ALLI ED HEALTH EDUCATI ON			Adjustments		
			14.00	15. 00	16. 00	17.00	18. 00	
	GENER.	AL SERVICE COST CENTERS	1					
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	1	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00	1	PLANT OPERATION, MAINT. & REPAIRS						5.00
6. 00	1	LAUNDRY & LINEN SERVICE						6. 00
7.00	1	HOUSEKEEPI NG						7. 00
8.00	1	DI ETARY						8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						9. 00 10. 00
11. 00		PHARMACY						11.00
12. 00		MEDICAL RECORDS & LIBRARY						12.00
13.00	01300	SOCIAL SERVICE						13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		RECREATION	0	72, 223				15. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	0	24, 561	532, 23	4 0	532, 234	30. 00
31. 00		NURSING FACILITY	0	24, 301	1		0 0	31.00
32.00		ICF/IID	0	0		o o	0	•
33. 00		OTHER LONG TERM CARE	0	47, 662	1, 308, 11	2 0	1, 308, 112	33. 00
10.00		LARY SERVICE COST CENTERS				4	4.4	40.00
40. 00 41. 00	1	RADI OLOGY LABORATORY	0	0			44 100	•
42. 00	1	INTRAVENOUS THERAPY	0	0			0	ı
43. 00		OXYGEN (INHALATION) THERAPY	0	0	•	o o	0	43. 00
44. 00		PHYSI CAL THERAPY	0	0			20, 164	1
45. 00		OCCUPATIONAL THERAPY	0	0	1, 60		1, 604	1
46. 00 47. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	51		510 0	46. 00 47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l		0	ł
49. 00	1	DRUGS CHARGED TO PATIENTS	0	Ö		-	996	
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		o o	0	50. 00
51. 00		SUPPORT SURFACES	0	0		0	0	51.00
40.00		TIENT SERVICE COST CENTERS CLINIC	0	0			0	40.00
60. 00 61. 00		RURAL HEALTH CLINIC	0	0			0	60. 00 61. 00
62. 00	06200						ŭ	62. 00
	OTHER	REIMBURSABLE COST CENTERS						
70. 00	1	HOME HEALTH AGENCY COST	0	_		0	0	
71.00		AMBULANCE	0	0			0	
73. 00	07300 SPECI	AL PURPOSE COST CENTERS	0	U		<u> </u>	0	73. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00	1	UTILIZATION REVIEW - SNF						82. 00
83.00	08300	HOSPI CE	0			0 4 0	0	
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS] 0	72, 223	1, 863, 76	4 0	1, 863, 764	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		ol o	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	3, 70	6 0	3, 706	1
92. 00		PHYSICIANS PRIVATE OFFICES	0	0		0	0	1
93.00		NONPALD WORKERS	0	0			0	
94. 00 98. 00	09400	PATIENTS LAUNDRY Cross Foot Adjustments	0	0			0	
99. 00		Negative Cost Centers		0			0	ł
100.00	o	TOTAL	0	72, 223	1, 867, 47		1, 867, 470	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

						o 12/31/2023	Date/Time Pre 5/29/2024 10:	
			CAPITAL REL	ATED COSTS			372472024 10.	20 alli
		Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		·	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM COST)	
			1.00	2. 00	3.00	4A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	122, 919		I			1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT	122,717	O				2. 00
3.00		EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	0 290	0	,		13, 540, 925	3.00
4. 00 5. 00	1	PLANT OPERATION, MAINT. & REPAIRS	9, 289 8, 657) O	1, 061, 789 287, 051		13, 540, 925	4. 00 5. 00
6.00	00600	LAUNDRY & LINEN SERVICE	1, 165	0	(0	183, 854	6. 00
7. 00 8. 00		HOUSEKEEPI NG DI ETARY	300 5, 812	0	38, 315 1, 055, 281		493, 880 2, 357, 057	7. 00 8. 00
9. 00		NURSING ADMINISTRATION	0,612	0	342, 000		460, 103	9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	O	(0	0	10. 00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	0		0	10, 218	11. 00 12. 00
13. 00		SOCIAL SERVICE	330	0	201, 041	, o	253, 706	
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0	1	0	0	14.00
15. 00		RECREATION ENT ROUTINE SERVICE COST CENTERS	3, 887	0	330, 420	0	707, 274	15. 00
30. 00	03000	SKILLED NURSING FACILITY	25, 158	O	1, 994, 707	0	3, 281, 316	30. 00
31. 00 32. 00		NURSING FACILITY	0	0		0	0 0	31.00
32.00		OTHER LONG TERM CARE	67, 046				l e	32. 00 33. 00
	ANCI L	LARY SERVICE COST CENTERS						
40. 00 41. 00		RADI OLOGY LABORATORY	0	0			4, 174 9, 596	
42. 00		INTRAVENOUS THERAPY	0	0			9, 390	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	O	(0	0	43.00
44. 00 45. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 055	0		0	245, 851 153, 879	
46. 00	1	SPEECH PATHOLOGY	0	Ö		o o	48, 974	
47. 00		ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0				90, 719	48. 00 49. 00
50. 00	1	DENTAL CARE - TITLE XIX ONLY	0	O		Ö	0	50. 00
51. 00		SUPPORT SURFACES	0	0		0	0	51. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	0		0	0	60. 00
61. 00		RURAL HEALTH CLINIC	0	O	(61. 00
62. 00	06200 OTHER	FQHC REI MBURSABLE COST CENTERS						62. 00
70. 00		HOME HEALTH AGENCY COST	0	O	(0	0	70. 00
71.00		AMBULANCE	0	0	1		0	71.00
73. 00	07300 SPECI	AL PURPOSE COST CENTERS	0	0	() 0	0	73. 00
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 82. 00	1	INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00		HOSPICE	0	О		0	0	
89. 00		SUBTOTALS (sum of lines 1-84)	122, 699	O	7, 565, 211	-2, 339, 753	13, 537, 583	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0) 0	0	90. 00
91. 00	09100	BARBER AND BEAUTY SHOP	220				3, 342	
92.00	1	PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0	0	1	0	0	
93. 00 94. 00		PATIENTS LAUNDRY	0				0	94.00
98. 00		Cross Foot Adjustments						98. 00
99. 00 102. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 867, 470	O	1, 793, 114		2, 339, 753	99.00
102.00		Part I)	1,007,470		1, 7, 73, 112	1	2, 337, 733	102.00
103.00	1	Unit cost multiplier (Wkst. B, Part I)	15. 192688	0. 000000	0. 237021		0. 172791	
104.00	1	Cost to be allocated (per Wkst. B, Part II)				,	141, 125	104.00
105.00		Unit cost multiplier (Wkst. B, Part			0. 000000)	0. 010422	105. 00
	I	11)			I		I	I

Provi der No.: 315354

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

			Т	o 12/31/2023	Date/Time Pre 5/29/2024 10:	
Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	OPERATION,	LI NEN SERVI CE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
	MAINT. & REPAIRS	(POUNDS OF LAUNDRY)			(DI RECT	
	(SQUARE FEET)	LAUNDRT)			NURSI NG)	
	5.00	6.00	7.00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS	1	T	T	T T		
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00 00300 EMPLOYEE BENEFITS						3. 00
4. 00 00400 ADMINISTRATIVE & GENERAL						4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	104, 973				•	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	1, 165	43, 740				6. 00
7. 00 00700 HOUSEKEEPI NG	300		103, 508			7. 00
8. 00 00800 DI ETARY	5, 812	0	5, 812	131, 220	157 4/0	8. 00
9.00 00900 NURSI NG ADMI NI STRATI ON 10.00 01000 CENTRAL SERVI CES & SUPPLY	0	0	0	0	157, 462 0	9. 00 10. 00
11. 00 01100 PHARMACY	0			0	0	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	Ö	Ö	o	Ö	12. 00
13.00 01300 SOCIAL SERVICE	330	0	330	0	0	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00 01500 RECREATION	3, 887	0	3, 887	0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 SKILLED NURSING FACILITY	25 150	14 075	25 150	44.425	77 1/1	20.00
30.00 03000 SKILLED NURSING FACILITY 31.00 03100 NURSING FACILITY	25, 158 0	14, 875	25, 158	44, 625	77, 161 0	30. 00 31. 00
32. 00 03200 CF/IID	0			0	0	32.00
33. 00 03300 OTHER LONG TERM CARE	67, 046	1	67, 046	86, 595		33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00 04100 LABORATORY	0	0	0	0	0	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	0	0	0 0	42.00
43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 44. 00 04400 PHYSI CAL THERAPY	1, 055	0	1, 055	0	0	43. 00 44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	1,039	ĺ	1,033	Ö	Ö	45. 00
46.00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
OUTPATIENT SERVICE COST CENTERS			0	<u> </u>		31.00
60. 00 06000 CLI NI C	0	0	0		0	60. 00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71. 00 07100 AMBULANCE	0	•		-		71.00
73. 00 07300 CMHC	0		0		0	73. 00
SPECIAL PURPOSE COST CENTERS						
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 08100 I NTEREST EXPENSE						81.00
82.00 08200 UTI LI ZATI ON REVI EW - SNF 83.00 08300 HOSPI CE	0	0	0	0	0	82. 00 83. 00
89.00 SUBTOTALS (sum of lines 1-84)	104, 753	43, 740	103, 288	131, 220		89. 00
NONREI MBURSABLE COST CENTERS					, , , , ,	
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0				0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	220	l .	220	0	0	91.00
92. 00 O9200 PHYSICIANS PRIVATE OFFICES 93. 00 O9300 NONPAID WORKERS	0 0	1	0	0	0	92. 00 93. 00
94. 00 09400 PATI ENTS LAUNDRY	0	0		0	0	94.00
98.00 Cross Foot Adjustments			١			98. 00
99.00 Negative Cost Centers						99. 00
102.00 Cost to be allocated (per Wkst. B,	1, 664, 615	234, 096	583, 975	2, 889, 289	539, 605	102. 00
Part I)	15 057554	E 254000	E / 4100 4	22.040442	2 42/000	102 00
103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B,	15. 857554 146, 316				3. 426890 4. 705	
Part II)	140, 316	21, 239	10, 123	121, 534	4, 195	104. 00
105.00 Unit cost multiplier (Wkst. B, Part	1. 393844	0. 485574	0. 097799	0. 926185	0. 030452	105. 00
		l	l			

2 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT 3.00 00300 CMPLOYER BETRETIS 3.00 00300 CMPLOYER BETRETIS 3.00 00300 CMPLOYER SERVICE 5.00 00500 CMPLOYER SERVICE 5.00 5.	Heal th	Financial Systems	SUNNYSI DE	MANOR		In Lie	u of Form CMS-	2540-10
COST CONTOUR DISCRIPTION CENTRAL SERVICE COST COST	COST A	LLOCATION - STATISTICAL BASIS		Provi der	No.: 315354	Period:	Worksheet B-1	
CENTRAL STANCES & CONTENT CONT								pared:
NAME SERVICE COST CENTERS 10.00 11.00 12.00 13.00 14.00 1.00		Cost Center Description	SERVICES & SUPPLY (COSTED	(COSTED	RECORDS & LI BRARY		NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED	20 am
0.000 0.000 CAP REL COSTS - BLOGS & FIXTURES				11. 00	12.00	13. 00		
2.00								
30.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 RECREATION	0 0 0 0 0	0 0 0) (0	0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
31.00 33100 NURSING FACILITY	30 00			04 114		14 075	0	20.00
40.00 04000 RADIOLOGY	31. 00 32. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0	0) (0 0	0	31. 00 32. 00
41.00 04100 LABORATORY 0 0 0 0 0 0 42.00 42.00 04200 NITRAVENOUS THERAPY 0 0 0 0 0 0 0 42.00 43.00 04300 OXYGEN (I NHALATION) THERAPY 0 0 0 0 0 0 0 0 44.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 0 45.00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 46.00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 46.00 04500 DELECTROCARDIOLOGY 0 0 0 0 0 0 0 48.00 04500 RELECTROCARDIOLOGY 0 0 0 0 0 0 0 48.00 04500 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 48.00 04500 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 61.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 61.00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 61.00 05000 CLINIC CLINIC	40 00		0	0			0	40 00
OUTPATIENT SERVICE COST CENTERS O	41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 90, 719			0 0 0 0 0 0 0 0	41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00
60.00	51.00		0	0) (0	0	51.00
70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0	61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	0				61. 00
71. 00 07100 AMBULANCE 0 0 0 0 0 0 0 71. 00 73. 00 73. 00 0 0 0 0 0 0 0 0 0	70. 00		O	0		0 (0	70. 00
80. 00	71. 00	07100 AMBULANCE 07300 CMHC	0	0	III			
90. 00	81. 00 82. 00 83. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0		1	-		81. 00 82. 00 83. 00
91. 00	90. 00		٥١	0			0	90.00
103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.064142 0.000000 6.964769 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 0 106 0 8,150 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000567 0.000000 0.186328 0.000000 105.00	91. 00 92. 00 93. 00 94. 00 98. 00 99. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPALD WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0	0 0 0 0		0 0 0 0 0	0 0 0 0	91. 00 92. 00 93. 00 94. 00 98. 00 99. 00
105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000567 0.000000 0.186328 0.000000 105.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 000000		1			
	105.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000567	0. 000000	0. 186328	0. 000000	105. 00

SUNNYSI DE MANOR

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315354

			To 12/31/2023	Date/Time Prepared: 5/29/2024 10:20 am
		OTHER GENERAL		372772024 TO. 20 alli
		SERVI CE		
	Cost Center Description	RECREATION (CENCUS)		
		(CENSUS) 15.00		
	GENERAL SERVICE COST CENTERS	15.00		
	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
	00300 EMPLOYEE BENEFITS			3. 00
	00400 ADMI NI STRATI VE & GENERAL			4.00
	OO500 PLANT OPERATION, MAINT. & REPAIRS OO600 LAUNDRY & LINEN SERVICE			5. 00 6. 00
	00700 HOUSEKEEPING			7. 00
	00800 DI ETARY			8. 00
	00900 NURSING ADMINISTRATION			9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY			10.00
	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY			11. 00
	01300 SOCIAL SERVICE			13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
	01500 RECREATION	43, 740		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
	03000 SKILLED NURSING FACILITY	14, 875		30.00
	03100 NURSING FACILITY	0		31.00
	03200 CF/IID 03300 OTHER LONG TERM CARE	0 28, 865		32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	20, 003		33.00
40.00	04000 RADI OLOGY	0		40. 00
	04100 LABORATORY	0		41.00
	04200 NTRAVENOUS THERAPY	0		42.00
	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0		43. 00 44. 00
	04500 OCCUPATI ONAL THERAPY			45. 00
	04600 SPEECH PATHOLOGY	Ö		46. 00
47.00	04700 ELECTROCARDI OLOGY	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0		49. 00 50. 00
	05100 SUPPORT SURFACES			51. 00
	OUTPATIENT SERVICE COST CENTERS	-1		
	06000 CLI NI C	0		60.00
	06100 RURAL HEALTH CLINIC	0		61.00
62. 00	O6200 FOHC OTHER REIMBURSABLE COST CENTERS			62. 00
70. 00	07000 HOME HEALTH AGENCY COST	O		70.00
	07100 AMBULANCE	Ö		71. 00
73. 00	07300 CMHC	0		73. 00
00.00	SPECIAL PURPOSE COST CENTERS			00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 NTEREST EXPENSE			80. 00 81. 00
	08200 UTILIZATION REVIEW - SNF			82. 00
	08300 H0SPI CE	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	43, 740		89. 00
00.00	NONREI MBURSABLE COST CENTERS			00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0		90.00
	09200 PHYSICIANS PRIVATE OFFICES			92. 00
93. 00	09300 NONPAI D WORKERS	o o		93. 00
94.00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00	Cross Foot Adjustments			98. 00
99.00	Negative Cost Centers	012 052		99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	913, 053		102. 00
103.00	1 1 '	20. 874554		103. 00
104.00	Cost to be allocated (per Wkst. B,	72, 223		104. 00
105 00	Part II)	1 (51100		105.00
105. 00	Unit cost multiplier (Wkst. B, Part	1. 651189		105. 00
	1 1., 1	1		ı

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315354 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 10: 20 am Cost Center Description Total (from Wkst. B, Pt I, col. 18) Col. 18 Col. 2	Health Financial Systems	SUNNYSI DE MAN	IOR		In lie	u of Form CMS-2	2540-10
To 12/31/2023 Date/Time Prepared: 5/29/2024 10: 20 am					Peri od:	Worksheet C	
Wkst. B, Pt I, divided by col. 18) col. 2						Date/Time Pre	pared: 20 am
col. 18) col. 2	Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
				Wkst. B, Pt I	,	di vi ded by	
1.00 2.00 3.00				col . 18)		col. 2	
1.00 2.00 3.00				1. 00	2. 00	3. 00	

			3/2//2024 10.2	20 am
Cost Center Description	Total (from	Total Charges	Ratio (col. 1	
	Wkst. B, Pt I,		di vi ded by	
	col . 18)		col. 2	
	1. 00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS				
40. 00 04000 RADI OLOGY	4, 895	4, 174	1. 172736	40.00
41. 00 04100 LABORATORY	11, 254	9, 596	1. 172780	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44. 00 O4400 PHYSI CAL THERAPY	311, 014	370, 613	0. 839188	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	180, 468	263, 710	0. 684343	45.00
46. 00 04600 SPEECH PATHOLOGY	57, 436	94, 897	0. 605246	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0.000000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	112, 213	90, 719	1. 236929	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51. 00 05100 SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS	·			
60. 00 06000 CLI NI C	0	0	0.000000	60.00
61.00 O6100 RURAL HEALTH CLINIC				61.00
62. 00 06200 FQHC				62.00
71. 00 07100 AMBULANCE	0	0	0.000000	71.00
100.00 Total	677, 280	833, 709		100. 00
·	•			

Health Financial Systems	SUNNYSI DE	E MANOR		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315354	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/29/2024 10:	epared: 20 am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pr			Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	1. 172736			0	0	
41. 00 04100 LABORATORY	1. 172780			0	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 839188			0 137, 744		1
45. 00 04500 OCCUPATI ONAL THERAPY	0. 684343			0 91, 202	l .	
46. 00 04600 SPEECH PATHOLOGY	0. 605246			0 40, 506	l .	
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000	1		0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 000000 1. 236929	1		0	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000				U	50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	1			0	
OUTPATIENT SERVICE COST CENTERS	0.00000	U U		0 0	0	31.00
60. 00 06000 CLINIC	0.000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0.00000	Ĭ				61.00
62. 00 06200 FQHC						62. 00
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	1
100.00 Total (Sum of Lines 40 - 71)		364, 335		0 269, 452		100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.	,	1	,		

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

Heal th	Financial Systems	SUNNYSI DE	E MANOR		In Lie	eu of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315354	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 10:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					11.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	1. 236929	1.00
2.00	Program vaccine charges (From your reco				,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title 1	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health		Cost (From	& Allied	
			(From Wkst. B,			Heal th Costs	
		18		Costs to Tota Costs - Part		for Pass Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		3 X COI . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	4, 895		1 0.0000		0	40. 00
41.00	04100 LABORATORY	11, 254	0	0. 00000		0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0.00000		0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0. 00000		0	43. 00
44. 00	04400 PHYSI CAL THERAPY	311, 014	l e	0.00000		0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	180, 468	ł	0.00000		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	57, 436	0	0.00000		1	46. 00 47. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0. 00000 0. 00000		0	47.00
49. 00	04900 DRUGS CHARGED TO PATTENTS	112, 213		0.00000		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	112, 213 N		0.00000		0	50.00
	05100 SUPPORT SURFACES	0		0.00000		0	
100.00		677, 280	Ö	1	269, 452	_	100.00
			•	•	i	•	•

	NPATIENT ROUTINE COSTS	Pro	ovider No.: 315354	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre	
			Title XVIII		5/29/2024 10:	
				Skilled Nursing Facility	PPS	
				-	1. 00	
I NPATI ENT	LCULATION OF INPATIENT ROUTINE COSTS				1.00	
	days including private room days				14, 875	1.0
00 Pri vate					0	
	days including private room days appl		ım		1, 511	
	necessary private room days applicable	e to the Program			0	1
	eral inpatient routine service cost OOM DIFFERENTIAL ADJUSTMENT				6, 136, 070	5.0
	npatient routine service charges				7, 024, 227	6.0
	npatient routine service cost/charge r	ratio (Line 5 divide	ed by line 6)		0. 873558	
	vate room charges from your records	,	,		0	1
	Average private room per diem charge (Private room charges line 8 divided by private room days, line					9. (
,	1 /					
1.00 Average	emi-private room per diem charge (Sem ate room days)		jes line 10, divide	d by	0.00	11. (
	er diem private room charge differenti	al (Line 9 minus lin	ne 11)		0.00	12. (
3.00 Average	er diem private room cost differential	(Line 7 times line	12)		0.00	13. 0
4.00 Private	oom cost differential adjustment (Line	e 2 times line 13)			0	14. (
	npatient routine service cost net of p NPATIENT ROUTINE SERVICE COSTS	orivate room cost dif	ferential (Line 5	minus line 14)	6, 136, 070	15. (
	general inpatient service cost per die	em (Line 15 divided	by line 1)		412. 51	16. (
	outine service cost (Line 3 times lin				623, 303	17. (
	necessary private room cost applicable				0	
	gram general inpatient routine service	` '	,		623, 303	1
	elated cost allocated to inpatient rou for SNF; line 31 for NF, or line 32 for		(From Wkst. B, Par	t II column 18,	532, 234	20.0
	capital related costs (Line 20 divide	,			35. 78	1
, ,	apital related cost (Line 3 times lin				54, 064	1
	routine service cost (Line 19 minus		1.3		569, 239	1
	charges to beneficiaries for excess c			1: 24)	0	1
	gram routine service costs for comparie per diem limitation (1)	Son to the cost IIMI	tation (Line 23 Mi	nus iine 24)	569, 239	25. 26.
	routine service cost limitation (Line	a 3 times the ner die	m limitation line	26) (1)		27.
3.00 Reimburs	ble inpatient routine service costs (L to Worksheet E, Part II, line 4) (See	ine 22 plus the les		, , ,		28.
1 .	27 are not applicable for title XVIII	,	or title V and or t	itle XIX		I

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	14, 875	1. 00
2.00	Program inpatient days (see instructions)	1, 511	2. 00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3. 00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 101580	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Hea	Ith Financial Systems	SUNNYSIDE MAN	NOR	In Lie	u of Form CMS-2540-10
CAL	CULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVII	I	Provider No.: 315354	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/29/2024 10: 20 am
			Ti +Lo V\/LLL	Skilled Nursing	DDC

		Title XVIII	Skilled Nursing Facility	PPS	
			Taciffty		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			972, 192	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			972, 192	3.00
4.00	Pri mary payor amounts			0	4.00
5.00	Coinsurance			125, 400	5. 00
6.00	Allowable bad debts (From your records)			0	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			0	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)			846, 792	11.00
12.00	Interim payments (See instructions)			829, 856	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)			0	14. 75
14. 99	Sequestration amount (see instructions)			16, 936	14. 99
15.00	Balance due provider/program (see Instructions)			0	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentati ve adj ustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)		445.0	0	29. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	section 115.2	0	30. 00

Health Financial Systems	SUNNYSI DE MAN	IOR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEN	MENT TITLE V and TITLE XIX ONLY	Provi der No.: 315354	From 01/01/2023	Worksheet E Part II Date/Time Prepared: 5/29/2024 10:20 am
		Title XIX	Skilled Nursing	Cost

			Facility	0001	
	I			1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	
4.00	Inpatient routine services (see instructions)			0	
5. 00	Utilization reviewphysicians' compensation (from provider reco	rds)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			0	
7. 00	Differential in charges between semiprivate accommodations and I	ess than semiprivate a	ccommodati ons	0	
8.00	SUBTOTAL (Line 6 minus line 7)			0	
9.00	Primary payor amounts			0	
10.00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges			0	11. 00
12.00	Outpati ent servi ce charges			0	
13.00	Inpatient routine service charges			0	13. 00
14.00	Differential in charges between semiprivate accommodations and I	ess than semiprivate a	ccommodati ons	0	14. 00
15.00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for pay	ment for services on a	charge basis	0	16. 00
17.00	Amounts that would have been realized from patients liable for p	ayment for services on	a charge basis	0	17. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.000000	18. 00
19.00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20.00	Cost of covered services (see Instructions)			0	20. 00
21.00	Deducti bl es			0	21.00
22.00	Subtotal (Line 20 minus line 21)			0	22. 00
23.00	Coinsurance			0	23. 00
24.00	Subtotal (Line 22 minus line 23)			0	24. 00
25.00	Allowable bad debts (from your records)			0	25. 00
26.00	Subtotal (sum of lines 24 and 25)			0	26. 00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously	collected based on co	rrection of	0	27. 00
	cost limit				
28.00	Recovery of excess depreciation resulting from provider terminat	ion or a decrease in p	rogram	0	28. 00
	utilization				
29.00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fro	m disposition of depre	ciable assets (0	30.00
	if minus, enter amount in parentheses)	•			
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 2	7 and 28)		0	31. 00
32.00	Interim payments			0	32. 00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate o	verpayments in parenth	eses) (see	0	33. 00
	Instructions)	•			

From 01/01/2023 12/31/2023

Date/Time Prepared: 5/29/2024 10: 20 am

8.00

Title XVIII Skilled Nursing

PPS Facility Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3. 00 829, 856 1.00 Total interim payments paid to provider 1.00 2.00 Interim payments payable on individual bills, either 2.00 0 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 0 0 3. 01 0 3.02 0 3.02 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 0 3.50 0 0 3.51 0 3.51 0 0 3. 52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 829, 856 0 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 Determined net settlement amount (balance due) based on 6.00 6.00 the cost report. (1) 6.01 PROGRAM TO PROVIDER 0 0 6.01 PROVIDER TO PROGRAM 6.02 0 0 6.02 Total Medicare program liability (see instructions) 829, 856 0 7.00 Contractor Name Contractor Number 1.00 2 00

8.00 Name of Contractor

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

Health Financial Systems

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

Provi der No.: 315354 | Peri od: From 01/01/20

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 10: 20 am

ni y)		General Fund	Specific E	Endowment Fund	5/29/2024 10: Plant Fund	20 am
			Purpose Fund			
	Assets	1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS			_		
. 00	Cash on hand and in banks	3, 483, 591	0	0	0	
. 00	Temporary investments Notes receivable	0	0	0	0	
. 00	Accounts receivable	849, 868	_	0	0	
. 00	Other recei vables	047,000	Ö	o	0	
. 00	Less: allowances for uncollectible notes and accounts	-413, 545	O	O	0	
	recei vabl e					
. 00	Inventory	0	0	0	0	
. 00	Prepai d expenses	151, 612	0	0	0	
. 00	Other current assets Due from other funds	0		0	0	
1. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4, 071, 526		0	0	
1. 00	FIXED ASSETS	1,071,020	J	J.	Ü	1
2. 00	Land	1, 667, 327	0	0	0	12.
3. 00	Land improvements	14, 950	0	0	0	13.
4. 00	Less: Accumulated depreciation	0	0	0	0	
5. 00	Bui I di ngs	21, 768, 442	1	0	0	
6. 00	Less Accumulated depreciation	-7, 489, 992	1	0	0	
7. 00 8. 00	Leasehold improvements Less: Accumulated Amortization	0	0	0	0	1
9. 00	Fixed equipment	3, 655, 497	_	0	0	
0.00	Less: Accumulated depreciation	3,033,477		0	0	
1. 00	Automobiles and trucks	0	o o	0	0	
2. 00	Less: Accumulated depreciation	0	J o	o	0	
3. 00	Major movable equipment	0	O	0	0	1
4. 00	Less: Accumulated depreciation	0	0	0	0	24.
5. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	25.
5. 00	Mi nor equipment nondepreciable	0	0	0	0	
7. 00	Other fixed assets	0	0	0	0	
3. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	19, 616, 224	0	0	0	28.
9. 00	OTHER ASSETS Investments	1 0	0	0	0	29.
9. 00 D. 00	Deposits on Leases		0	0	0	
1. 00	Due from owners/officers	2, 368, 681		0	0	
2. 00	Other assets	646, 172	1	0	0	
3. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	3, 014, 853	1	o	0	
4. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	26, 702, 603	0	0	0	34.
	Liabilities and Fund Balances					
	CURRENT LIABILITIES	17.005				
5.00	Accounts payable	17, 805	1	0	0	
5.00	Salaries, wages, and fees payable	1, 754, 441	1	0	0	
7. 00 3. 00	Payroll taxes payable Notes & Loans payable (Short term)	-20, 379		0	0	
9. 00	Deferred income	0		0	0	
0.00	Accel erated payments	0	j j	Ĭ	ū	40.
1. 00	Due to other funds	0	О	0	0	
2. 00	Other current liabilities	569, 668	0	0	0	42.
3. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 321, 535	0	0	0	43.
	LONG TERM LIABILITIES					
4. 00	Mortgage payable	23, 014, 300	1	0	0	
5. 00	Notes payable	0	0	0	0	
5. 00	Unsecured Loans	0	0	0	0	
7. 00	Loans from owners:	25, 000	0	0	0	
3. 00 9. 00	Other long term liabilities OTHER (SPECIFY)	0		0	0	
). 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	23, 039, 300	T .	0	0	
. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	25, 360, 835	1	0	0	
	CAPITAL ACCOUNTS					
. 00	General fund balance	1, 341, 768				52
. 00	Specific purpose fund		0			53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			O		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	1 2/1 7/0			0	l EO
00	LIVIAL FUND BALANCES COUNTOL LINES 57 INCU 581	1, 341, 768	0	이	0	
9. 00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	26, 702, 603	ا ما	ما	0	60

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES SUNNYSI DE MANOR

					То	12/31/2023	Date/Time Prep 5/29/2024 10:2	oared: 20 am
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
		1.00	2.00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	462, 227 3 0 0 0 0	1, 361, 817 -482, 279 879, 538 462, 230 1, 341, 768		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund				
4 00	TE	6. 00	7. 00	8. 00				1 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ADDITIONS ROUNDING	0	0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0	0 0 0 0		0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems	SUNNYSI DE MANOR		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315354	From 01/01/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/29/2024 10:2	pared:
Cost Center Description		I npati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
PART I - PATIENT REVENUES					

			From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
	Cost Center Description	Inpatient	Outpati ent	5/29/2024 10: Total	20 am
	Cost Center Description	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	3.00	
	General Inpatient Routine Care Services				
1. 00	SKILLED NURSING FACILITY	7, 024, 22	7	7, 024, 227	1. 00
2.00	NURSING FACILITY		ó	0	2. 00
3. 00	ICF/IID		0	0	3. 00
4. 00	OTHER LONG TERM CARE	9, 587, 42	6	9, 587, 426	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	16, 611, 65		16, 611, 653	5. 00
3.00	All Other Care Services	10,011,03	<u>J</u>	10, 011, 033	3.00
6.00	ANCI LLARY SERVI CES	833, 70	9 0	833, 709	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	26, 42	4 0	26, 424	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3			17, 471, 786	14. 00
	Worksheet G-3, Line 1)				
	Cost Center Description	·			
			1. 00	2. 00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			17, 109, 410	1.00
2.00	Add (Specify)		0		2. 00
3.00			0		3. 00
4.00			0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7.00			0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)			0	8. 00
9.00	Deduct (Specify)		0		9. 00
10. 00			0		10. 00
11. 00			0		11. 00
12. 00			0		12. 00
13. 00			0		13. 00
14. 00	Total Deductions (Sum of lines 9 - 13)			0	
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			17, 109, 410	15. 00

ealth Fir	nancial Systems SUNNYSIDE MA	SUNNYSI DE MANOR		In Lieu of Form CMS-2		
TATEMENT	OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315354	Peri od: From 01/01/2023	Worksheet G-3		
			To 12/31/2023	Date/Time Prep 5/29/2024 10:2	oared: 20 am	
				1.00		
1.00 To	0 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			17, 471, 786	1. 00	
2.00 Le	0 Less: contractual allowances and discounts on patients accounts			1, 361, 703	2.00	
3.00 Ne	00 Net patient revenues (Line 1 minus line 2)			16, 110, 083	3.00	
1.00 Le:	ss: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		17, 109, 410	4. 00	
	t income from service to patients (Line 3 minus 4)		1	-999, 327	5. 00	

		5/29/2024 10: 2	<u> 20 am </u>
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17, 471, 786	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	1, 361, 703	2.00
3.00	Net patient revenues (Line 1 minus line 2)	16, 110, 083	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17, 109, 410	4. 00
5.00	Net income from service to patients (Line 3 minus 4)	-999, 327	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6. 00
7.00	Income from investments	124, 263	7. 00
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase di scounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00	Parking lot receipts	0	12. 00
13.00	Revenue from laundry and linen service	0	13. 00
14.00	Revenue from meals sold to employees and guests	0	14. 00
15. 00	Revenue from rental of living quarters		15. 00
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00
21. 00	Rental of vending machines	0	21. 00
22.00	Rental of skilled nursing space	0	22. 00
23.00	Governmental appropriations	0	23. 00
	MISC - ERC CREDIT	392, 785	24. 00
	COVI D-19 PHE Fundi ng	0	24. 50
25.00	Total other income (Sum of lines 6 - 24)	517, 048	25. 00
26.00	Total (Line 5 plus line 25)	-482, 279	26. 00
27. 00	Other expenses (specify)	0	27. 00
28. 00		0	28. 00
29. 00		0	
	Total other expenses (Sum of lines 27 - 29)	0	00.00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	-482, 279	31.00