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).

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315158 | Period: From 01/01/2023 To 12/31/2024 P : 37 am Date/Time Prepared: 5/13/2024 P : 37 am

			37 13.	2027 /.	J / UIII
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically prepared cost re	oort	Date: 5/13/2024	Time:	9:37 am
use only	2. [ ] Manually prepared cost report				
	3. [ 0 ] If this is an amended report en	ter the number of times the provide	r resubmitted this cos	t report	t
	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 reoper	ned
	(5) Amended	11. Contractor Vendor Code	4	•	
	5. Date Received:	12.[ F ] Medicare Utilization. Ente		r 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 RIDGEWOOD CENTER ( 315158 ) 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	Dia	ne Morris	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	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			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	26, 179	3, 616	0	1. 00
2.00 NURSING FACILITY	0			0	2. 00
3. 00   I CF/I I D				0	3. 00
4. 00 SNF - BASED HHA I	0	0	0		4. 00
5. 00 SNF - BASED RHC I	0		0		5. 00
6.00 SNF - BASED FQHC I	0		0		6. 00
7.00 SNF - BASED CMHC I	0		0		7. 00
7. 10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	26, 179	3, 616	0	100. 00

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

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

Health Financial Systems RI DGEWOOD CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315158 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/13/2024 9:37 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 330 FRANKLIN TURNPIKE 1.00 PO Box: 1.00 2.00 Ci ty: RI DGEWOOD State: NJ Zi p Code: 07450 2.00 3.00 County: BERGEN CBSA Code: 35614 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 RIDGEWOOD CENTER 315158 06/04/1975 N Р Р 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 Ν 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 90, 139 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 90 139 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) Ν 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) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 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 N 30.00 31.00 | ICF/IID Ν 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC Ν 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 1 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: 41 00

Heal th	Financial Systems	RI DGEWOOD CEN	TER		In Lie	u of Form CMS-2	2540-10
SKI LLED	NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3			Worksheet S-2	
COMPLEX	( INDENTIFICATION DATA				1/01/2023	Part I	
				To 1	2/31/2023	Date/Time Pre 5/13/2024 9:3	pared:
						Y/N	/ alli
							-
						1. 00	
	Are malpractice premiums and paid loss					N	42. 00
C	center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing	cost centers	and		
a	amounts.						
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?			Υ	43.00
44. 00 I	If line 43 is yes, enter the home offi	ce chain number and enter	the name and add	dress of the h	nome	HB0067	44. 00
C	office on lines 45, 46 and 47.						
	1. 00	2. 00			3. 00		
I	If this facility is part of a chain or	ganization, enter the nam	e and address of	the home offi	ce on the	lines	
k	pel ow.						
45.00	Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	AS Co	ontractor's Nu	mber: 1200	1	45. 00
46. 00	Street: 101 EAST STATE STREET	PO Box:					46.00
47.00	City: KENNETT SQUARE	State: PA	Zi	ip Code:	1934	8	47. 00
47.00	City: KENNETT SQUARE	State: PA	Zi	ip Code:	1934	8	47. 00

	Financial Systems	RI DGEWOOD CENTER				eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	IY HEALIH CARE P	rovi der	1	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre	epared:
					Y/N	5/13/2024 9:3 Date	3/am
	Constant I make the control of the c		\/	- V UNU 4	1. 00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column i,	"Ү" ТОІ	r yes or "N" i	or No. For all	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Program	? If	1. 00 N	2. 00	3. 00	2.00
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and in	col umn				
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions)	., chain home offices d to the provider or I, or members of the I	drug ts board	Y			3. 00
	refactionships: (see That detrons)			Y/N	Туре	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" for te copy or enter date	r	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 reconciliation.	revenues different fi	rom	N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00		
6. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	ool? (Y/N) Column 2:	Is the	provider the	N	N	6. 00
7. 00 8. 00	Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so	ng the cost reporting		for Nursing	N N		7. 00 8. 00
	(7.1.) e	00 1 110 11 40 11 01101			l .	Y/N 1.00	
	Bad Debts	1 1 1 2 0 0 0 0					
9. 00 10. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				reporting	Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wai v	ed? If "'	Y", see instru	ıcti ons.	N	11. 00
12.00	Have total beds available changed from prior	cost reporting period	d? If "Y			N	12. 00
		Description		Y/N	rt A Date	Part B Y/N	
		0		1.00	2. 00	3. 00	
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			N		N	13. 00
14. 00	4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			Υ	03/09/2024	Y	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			N		N	16. 00
	corrections of other PS&R Report						
17. 00	"			N		N	17. 00

Heal th	Financial Systems RIDGEWOOD	CEN	TER		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE X REIMBURSEMENT QUESTIONNAIRE		Provi der No.: 315158		ri od: om 01/01/2023 12/31/2023		
				10	12/31/2023	Date/Time Pre 5/13/2024 9:3	7 am
			1. 00		2. (	00	
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title/position	JEAN		PF	RICE		19. 00
	held by the cost report preparer in columns 1, 2, and 3, respectively.						
20. 00	Enter the employer/company name of the cost report preparer.	GENE	SIS HEALTHCARE				20. 00
	• • • • • • • • • • • • • • • • • • •	4108	044481	JE	EAN. PRI CE@GENE	ESI SHCC. COM	21. 00

Health Financial Systems RIDGEWOOD CENTER In Lieu of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

RIDGEWOOD CENTER
Provider No.: 315158
Period: Worksheet S-2
From 01/01/2023 Part II

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023	
		Part B			
		<u>Date</u> 4.00			
	PS&R Data	4.00			
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)				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.	03/09/2024			14.00
15. 00	1 '				15. 00
16. 00					16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:				17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18. 00
			3.00		
	Cost Report Preparer Contact Information				
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		REIMBURSEMENT ANALYST		19. 00
20. 00	Enter the employer/company name of the cost r preparer.	report			20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective				21. 00

In Lieu of Form CMS-2540-10 RI DGEWOOD CENTER

 
 Heal th
 Financial
 Systems
 RIDGEWOOD

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

Provi der No.: 315158 

					0 12/31/2023	5/13/2024 9:37	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	90	32, 850			22, 495	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4. 00
5. 00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF	_	_	_	_	_	6. 10
7.00	HOSPI CE	0	0	0		0	7. 00
8. 00	Total (Sum of lines 1-7)	90 Inpatient D	32, 850	0	1, 406 Di scharges	22, 495	8. 00
		Thipatrent b	ays/ vi si ts		Di Schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6. 00	7.00	8. 00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	2, 171	26, 072	0	15	29	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	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF	_	_	_	_	_	6. 10
7. 00	HOSPI CE	0	0	0		0	7. 00
8. 00	Total (Sum of lines 1-7)	2, 171	26, 072			29	8. 00
		Di scha	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	30	74	0.00	93. 73	775. 69	1. 00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0	0				7. 00
8. 00	Total (Sum of lines 1-7)	30 Average Length	74		93. 73 si ons	775. 69	8. 00
		of Stay		Adiii 3	31 0113		
	Component	Total	Title V	Title XVIII	Title XIX	0ther	
		16.00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	352. 32	0		10	34	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2. 00
3.00	ICF/IID	0. 00			0	0	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5.00	Other Long Term Care	0. 00				0	5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF HOSPI CE	0.00	0	0	0		6. 10
7. 00 8. 00	Total (Sum of lines 1-7)	0. 00 352. 32	0				7. 00 8. 00
0.00	Total (Suil of Titles 1-7)	Admi ssi ons	Full Time		10	34	0.00
		· ·					
	Component	Total	Employees on	Nonpai d			
		21. 00	Payrol I 22. 00	Workers 23.00			
1.00	SKILLED NURSING FACILITY	65	58. 90				1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	Ö	0.00				3. 00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	O	0.00				5.00
6.00	SNF-Based CMHC		0.00	0.00			6.00
6. 10	SNF-Based CORF		0.00				6. 10
7.00	HOSPI CE	0	0.00				7. 00
8.00	Total (Sum of lines 1-7)	65	58. 90	0.00			8. 00

				Ť	0 12/31/2023	Date/Time Prep 5/13/2024 9:3	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	Zili
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6		Salary in col.	col . 4)	
				,	3	,	
		1.00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	3, 913, 119	0	3, 913, 119	122, 515. 25	31. 94	1. 00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2. 00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5. 00
6.00	Revised wages (line 1 minus line 5)	3, 913, 119	0	3, 913, 119	122, 515. 25	31. 94	6. 00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00		11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	3, 913, 119	0	3, 913, 119	122, 515. 25	31. 94	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	1, 644, 388	0	1, 644, 388	i i		14. 00
15. 00	Contract Labor: Physician services-Part A	35, 741	0	35, 741			15. 00
16. 00	Home office salaries & wage related costs	229, 245	0	229, 245	4, 641. 00	49. 40	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	617, 854	0	617, 854			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20.00	Physician Part A - WRC	0	0	0			20.00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	617, 854	0	617, 854			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION RI DGEWOOD CENTER

				Т	o 12/31/2023	Date/Time Prep 5/13/2024 9:3	
		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	0	0.00	0.00	1. 00
2.00	Administrative & General	403, 397	0	403, 397	13, 118. 58	30. 75	2. 00
3.00	Plant Operation, Maintenance & Repairs	78, 739	0	78, 739	2, 527. 52	31. 15	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	0	0.00	0.00	5. 00
6.00	Di etary	0	0	0	0.00	0.00	6. 00
7.00	Nursing Administration	293, 272	-56, 355	236, 917	4, 594. 64	51. 56	7. 00
8.00	Central Services and Supply	0	6, 607	6, 607	437. 10	15. 12	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	49, 748	49, 748	2, 124. 90	23. 41	10.00
11.00	Soci al Servi ce	128, 287	0	128, 287	3, 445. 64	37. 23	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	137, 136	0	137, 136	6, 482. 76	21. 15	13.00
14. 00	Total (sum lines 1 thru 13)	1, 040, 831	[	1, 040, 831	32, 731. 14	31.80	14. 00

Health Financial Systems	RI DGEWOOD CENTER	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS		Period: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: 5/13/2024 9:37 am

	To 12/31/2023		
		Amount	
		Reported 1.00	
	PART IV - WAGE RELATED COSTS	1.00	
	Part A - Core List		
	RETIREMENT COST		
1. 00	401K Employer Contributions	28, 703	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	20, 703	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost		3. 00
4.00	Prior Year Pension Service Cost		4. 00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	0	4.00
5. 00	401K/TSA Plan Administration fees	0	5. 00
6. 00	Legal /Accounting/Management Fees-Pension Plan		6. 00
7. 00	Employee Managed Care Program Administration Fees		7. 00
7.00	HEALTH AND INSURANCE COST	<u> </u>	7.00
8. 00	Health Insurance (Purchased or Self Funded)	133, 724	8. 00
9. 00	Prescription Drug Plan	133, 724	9. 00
10.00	Dental, Hearing and Vision Plan		10.00
11. 00	Life Insurance (If employee is owner or beneficiary)		11. 00
	Accident Insurance (If employee is owner or beneficiary)		12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)		13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)		14.00
15. 00 16. 00	Workers' Compensation Insurance	121, 807	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion) TAXES		
17 00	FICA-Employers Portion Only	292, 850	17 00
18. 00	Medicare Taxes - Employers Portion Only	292, 830	
	Unemployment Insurance		19. 00
	State or Federal Unemployment Taxes	40, 770	
20.00	OTHER	40,770	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances		21.00
	Tuition Reimbursement		22.00
	Total Wage Related cost (Sum of lines 1 - 23)	617, 854	
24.00	Total Wage Related Cost (Sum Of FITTES 1 - 23)	617,854 Amount	24.00
		Reported	
		1. 00	
	Part B - Other than Core Related Cost	1.00	
25 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
25.00	TOTHER WASE RELATED GOSTS (SECOTE)	١	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No.: 315158 Peri od: From 01/01/2023 Part V 12/31/2023

107, 990

3, 552

35, 741

1, 614. 00

74.00

420.00

66. 91

48.00

85. 10 26. 00

24.00

25.00

Date/Time Prepared: 5/13/2024 9:37 am Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Sal ari es (col Related to Wage (col. 3 Reported col . 4) 1 + col. 2Salary in col 3.00 5. 00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 538, 440 63, 072 601, 512 10, 070. 57 59. 73 1.00 159, 893 1, 322, 922 27, 733. 99 Licensed Practical Nurses (LPNs) 1, 163, 029 47.70 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 1, 170, 819 253, 464 1, 424, 283 51, 979. 55 27.40 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 2, 872, 288 476, 429 3, 348, 717 89, 784. 11 37.30 4.00 5.00 Physical Therapists 0.00 5.00 0 00 0 Physical Therapy Assistants 0.00 6.00 0 C 0 0.00 6.00 7.00 Physical Therapy Aides 0 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 0.00 8.00 0 0 0 0 0.00 8.00 0 0 0.00 9.00 0.00 9.00 10.00 Occupational Therapy Aides 0 0 0.00 0.00 10.00 Speech Therapists 0 0 0 0.00 11.00 0.00 11.00 Respiratory Therapists 0 12.00 0 00 0 00 12 00 Ω 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 0 00 14 00 0 0 0.00 15.00 Licensed Practical Nurses (LPNs) 0 0 0.00 0.00 15.00 Certified Nursing Assistant/Nursing 1,500 1, 500 60.00 25.00 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 1,500 1,500 60.00 25.00 17.00 18.00 Physical Therapists 147, 347 147, 347 2, 177. 00 67.68 18.00 19.00 Physical Therapy Assistants 27, 918 27, 918 554.00 50.39 19.00 Physical Therapy Aides 20.00 0.00 0.00 20.00 21.00 Occupational Therapists 162, 636 2, 305. 00 70. 56 21.00 162,636 Occupational Therapy Assistants 22.00 0 0 0.00 0.00 22.00 Occupational Therapy Aides 0.00 0.00 23.00 23.00

107, 990

3, 552

35, 741

24.00

25.00

Speech Therapists

26.00 Other Medical Staff

Respiratory Therapists

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:37 am

	10	) 12/31/2023	5/13/2024 9:3	
		Group	Days	
		1. 00	2. 00	1.00
1.00		RUX		1.00
2. 00 3. 00		RUL RVX		2. 00 3. 00
4.00		RVL		4.00
5.00		RHX		5. 00
6.00		RHL		6. 00
7.00		RMX		7. 00
8.00		RML		8. 00
9.00		RLX		9. 00
10. 00		RUC		10. 00
11.00		RUB		11.00
12.00		RUA		12. 00 13. 00
13. 00 14. 00		RVC RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21.00		RMA		21. 00
22.00		RLB		22. 00
23. 00 24. 00		RLA ES3		23. 00 24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27.00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31. 00
32.00		HC1		32.00
33. 00 34. 00		HB2		33.00
35. 00		HB1 LE2		34. 00 35. 00
36.00		LE1		36.00
37.00		LD2		37. 00
38. 00		LD1		38. 00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41. 00		LB2		41. 00
42.00		LB1		42.00
43. 00 44. 00		CE2 CE1		43. 00 44. 00
45. 00		CD2		45. 00
46.00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00		CB1		50.00
51.00		CA2		51.00
52. 00 53. 00		CA1 SE3		52. 00 53. 00
53.00		SE3 SE2		54.00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		I B2		59. 00
60.00		I B1		60.00
61.00		I A2		61.00
62. 00 63. 00		I A1 BB2		62. 00 63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66.00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69. 00		PD2		69. 00
70. 00		PD1		70.00
71.00		PC2		71.00
72. 00 73. 00		PC1 PB2		72.00
73. 00		PB1		73. 00 74. 00
75. 00		PA2		75. 00
			i	. 3. 30

Health Financial Systems	RI DGEWOOD CENTE	R		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315158	Peri od:	Worksheet S-7	,
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/13/2024 9:3	
				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 Vol payments beginning 10/01/2003. Congress expec- expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" for with direct patient care and related expenses (See instructions)	ted this increase to column 1 the amount each category to to r yes or "N" for no	be used of the otal SNF if the s	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related Iter in Part I, Esociated	
101. 00 Staffi ng						101. 00
102.00 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Line	e 1, column 3)					106.00

Health Financial Systems	RI DGEWOOD CE	ENTER		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	pared.
				10 12/01/2020	5/13/2024 9: 3	
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons	Trial Balance	
				Increase/Decre ase (Fr Wkst	(col. 3 +- col. 4)	
				A-6)	COI. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS			2.22		9.77	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES		949, 283	949, 28	3 0	949, 283	1. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT		26, 331			26, 331	2. 00
3.00 00300 EMPLOYEE BENEFITS	0	618, 339			618, 339	3. 00
4. 00   00400   ADMI NI STRATI VE & GENERAL	403, 397	1, 258, 490			1, 661, 887	4.00
5.00   O0500   PLANT OPERATION, MAINT. & REPAIRS 6.00   O0600   LAUNDRY & LINEN SERVICE	78, 739	292, 581	371, 32		371, 320 146, 384	5. 00 6. 00
6.00   00600   LAUNDRY & LI NEN SERVI CE 7.00   00700   HOUSEKEEPI NG		146, 384 278, 394	146, 38 278, 39		278, 394	7. 00
8. 00   00800 DI ETARY		833, 284			833, 284	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	293, 272	52, 715			289, 632	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	65, 699			72, 306	10.00
11. 00   01100   PHARMACY	0	0		О	0	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0		9, 748		12. 00
13. 00   01300   SOCIAL SERVICE	128, 287	338	128, 62	5 0	128, 625	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	45/ 00	0	0	14.00
15. 00 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	137, 136	19, 101	156, 23	7] 0]	156, 237	15. 00
30. 00 03000 SKI LLED NURSI NG FACILITY	2, 872, 288	78, 515	2, 950, 80	3 0	2, 950, 803	30. 00
31. 00   03100   NURSI NG   FACILITY	2,072,200	70, 313	2, 930, 00		2, 750, 603	31. 00
32. 00   03200   CF/IID	o	0		o o	-	32. 00
33.00 03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	0	8, 488			8, 488	40. 00
41. 00   04100   LABORATORY	0	8, 215			8, 215	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0	1, 749	1		1, 749	42.00
43.00   04300   0XYGEN (INHALATION) THERAPY 44.00   04400   PHYSI CAL THERAPY	0	9, 633 168, 479			9, 633 168, 479	43. 00 44. 00
45. 00   04500   OCCUPATI ONAL THERAPY		107, 412			107, 412	45. 00
46. 00 04600 SPEECH PATHOLOGY	o	136, 779			136, 779	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	,	o	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o c	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	53, 460	53, 46	0 0	53, 460	49. 00
50. 00   05000   DENTAL CARE - TITLE XIX ONLY	0	0	45.00	0	0	50.00
51. 00   05100   SUPPORT SURFACES 52. 00   05200   OTHER ANCILLARY SERVICE COST CENTERS	0	15, 833		0 0	15, 833 0	51. 00 52. 00
OUTPATIENT SERVICE COST CENTERS	l ol	0		J	0	32.00
60. 00 06000 CLINIC	O	0		0	0	60. 00
61.00 06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62.00 06200 FQHC						62. 00
63.00 O6300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	63. 00
OTHER REIMBURSABLE COST CENTERS			1			
70. 00 07000 HOME HEALTH AGENCY COST	0	0		0	0	
71. 00   07100   AMBULANCE 72. 00   07200   CORF	0	0			0	71. 00 72. 00
73. 00 07300 CMHC		0			0	73.00
74. 00 07400 OTHER REIMBURSABLE COST	o	0			Ö	74. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80. 00
81. 00 08100 I NTEREST EXPENSE		0	1	0 0	0	81. 00
82. 00   08200   UTI LI ZATI ON REVI EW	0	0	1	0	0	82.00
83. 00   08300   HOSPI CE 84. 00   08400   OTHER SPECI AL PURPOSE COST CENTERS	0	0			0 0	83. 00 84. 00
89.00   SUBTOTALS (sum of lines 1-84)	3, 913, 119	5, 129, 502	9, 042, 62	1 0	9, 042, 621	89.00
NONREI MBURSABLE COST CENTERS	3, 713, 117	5, 127, 302	7, 042, 02	1 0	7, 042, 021	0 7. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0		0	0	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	7, 586	7, 58	6 0	7, 586	
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0		o	0	92. 00
93. 00 09300 NONPALD WORKERS	0	0		0 0	0	93. 00
94. 00 09400 PATIENTS LAUNDRY	0	0	1	0	0	94.00
95. 00   O9500   OTHER NONREI MBURSABLE COST CENTERS 100. 00   TOTAL	0 3, 913, 119	0 5 127 000	0.050.30	0 7	0 9, 050, 207	95.00
100.00    101AL	] 3,713,119	5, 137, 088	9, 050, 20	, i	7, 000, 207	1100.00

RI DGEWOOD CENTER In Lieu of Form CMS-2540-10

Health Financial Systems RIDG RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315158 | Peri od: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To 1:	2/31/2023 Date/Time Pre 5/13/2024 9:3	
	Cost Center Description	Adjustments to	Net Expenses		5/13/2024 9.3	o / alli
	р		For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
	GENERAL SERVICE COST CENTERS	6. 00	7.00			
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES		949, 283			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	l c	1			2. 00
3.00	00300 EMPLOYEE BENEFITS	-31, 270	1	1		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-474, 416	1	1		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	C	371, 320			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	C	146, 384			6. 00
7.00	00700 HOUSEKEEPI NG	C	278, 394			7. 00
8.00	00800 DI ETARY	C	833, 284	1		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	C		1		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		72, 306	1		10.00
11.00	01100 PHARMACY		0	1		11.00
12.00	01200   MEDI CAL RECORDS & LI BRARY   01300   SOCI AL SERVI CE		49, 748 128, 625	1		12. 00 13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION		0			14. 00
	01500 ACTIVITIES	-12, 939		•		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	127707	110/270			10.00
30.00	03000 SKILLED NURSING FACILITY	96	2, 950, 899			30.00
31.00	03100 NURSING FACILITY	C	0			31. 00
32.00	03200   CF/IID	C	0			32. 00
33.00	03300 OTHER LONG TERM CARE	C	0			33. 00
	ANCILLARY SERVICE COST CENTERS					4
40. 00	04000 RADI OLOGY	C		1		40.00
41. 00	04100 LABORATORY	C		1		41. 00
	04200 I NTRAVENOUS THERAPY	C	.,	1		42.00
	04300   OXYGEN (INHALATION) THERAPY   04400   PHYSI CAL THERAPY		.,	1		43. 00 44. 00
	04500 OCCUPATI ONAL THERAPY		1	1		45. 00
	1 1		136, 779	1		46. 00
	04700 ELECTROCARDI OLOGY	l c	0	1		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	Ó			48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	C	53, 460			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0			50. 00
	05100 SUPPORT SURFACES	C		1		51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	C	0			52. 00
(0.00	OUTPATIENT SERVICE COST CENTERS	Ι .	J	T		
	06000   CLI NI C   06100   RURAL HEALTH CLI NI C	C	ł .	•		60.00
	06200 FQHC		0			61. 00 62. 00
	06300 OTHER OUTPATIENT SERVICE COST CENTER		0			63.00
03.00	OTHER REIMBURSABLE COST CENTERS		,			03.00
70. 00	07000 HOME HEALTH AGENCY COST	C	0			70. 00
71.00	07100 AMBULANCE	C	0			71. 00
	07200 CORF	C	0			72. 00
		C	0			73. 00
74. 00	07400 OTHER REIMBURSABLE COST	C	0			74. 00
0.5 -:	SPECIAL PURPOSE COST CENTERS		ı			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	C	0			80.00
81.00	08100 I NTEREST EXPENSE		0			81.00
82.00	08200   UTI LI ZATI ON REVI EW   08300   HOSPI CE		0			82. 00 83. 00
	08400 OTHER SPECIAL PURPOSE COST CENTERS		_	1		84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-518, 529	_	1		89. 00
200	NONREI MBURSABLE COST CENTERS	3.3,327	2,02.,072			1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0			90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		7, 586	,		91. 00
	09200 PHYSICIANS PRIVATE OFFICES	C	0			92. 00
	09300 NONPAI D WORKERS	C	0			93. 00
	09400 PATIENTS LAUNDRY	C	0			94.00
	09500 OTHER NONREIMBURSABLE COST CENTERS	[ C10 F00	0 501 770			95. 00
100.00	TOTAL	-518, 529	8, 531, 678	I		100. 00

Health Financial Systems	RIDGEWOOD CENTER		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Prov	vi der No.: 315158	Peri od: From 01/01/2023	Worksheet A-6	
				Date/Time Pre 5/13/2024 9:3	pared: 7 am
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2.00	3.00	4. 00	5. 00	
(1) A - DEFAULT					
1. 00	CENTRAL SERVICES & SUPPL	LY 10.	00 6, 607	0	1.00
2. 00	MEDICAL RECORDS & LIBRAR	RY 12.	00 49, 748	0	2.00
TOTALS					
100. 00	Total Reclassifications	(Sum	56, 355	0	100.00
	of columns 4 and 5 must				
	equal sum of columns 8 a	and			
	9)				

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

Health Financial Systems	RI DGEWOOD CENT	ΓER		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 5/13/2024 9:3	pared: 7 am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
(1) A - DEFAULT						
1. 00	NURSING ADMINISTRAT	I ON	9. 0	6, 607	0	1. 00
2. 00	NURSING ADMINISTRAT	I ON	9. 0	49, 748	0	2. 00
TOTALS						
100. 00				56, 355	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RI DGEWOOD CENTER In Lieu of Form CMS-2540-10 | Peri od: | Worksheet A-7 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315158

				10	) 12/31/2023	5/13/2024 9:3	
				Acqui si ti ons		07 107 202 1 71 0	2
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	·	Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	3					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	54, 345	0	0	0	0	2. 00
3.00	Buildings and Fixtures	3, 210, 378	0	0	0	0	3. 00
4.00	Building Improvements	439, 139		0	0	0	4. 00
5.00	Fi xed Equi pment	107, 090	3, 328	0	3, 328	0	5. 00
6.00	Movable Equipment	415, 766	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	4, 226, 718	3, 328	0	3, 328	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	4, 226, 718		0	3, 328	0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
	TANALYSIS OF SURVISES IN SARITAL ASSET BALANCE	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					4 00
1.00	Land	54.045	0				1.00
2.00	Land Improvements	54, 345	0				2. 00
3.00	Buildings and Fixtures	3, 210, 378	0				3. 00
4.00	Building Improvements	439, 139	0				4. 00
5.00	Fi xed Equipment	110, 418	0				5. 00
6.00	Movable Equipment	415, 766	0				6. 00
7.00	Subtotal (sum of lines 1-6)	4, 230, 046	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	4, 230, 046	0				9. 00

Provi der No.: 315158

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

				10 12/31/2023	5/13/2024 9:3	
				Expense Classification on		, diii
				To/From Which the Amount is		
					,	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1.00	2. 00	3. 00	4. 00	
1.00	Investment income on restricted funds		C	O TOTAL CONTRACTOR OF THE PROPERTY OF THE PROP	0.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		C		0.00	2. 00
0.00	8)				0.00	0.00
3.00	Refunds and rebates of expenses (chapter 8)		C		0.00	3. 00
4.00	Rental of provider space by suppliers		C		0.00	4. 00
F 00	(chapter 8)				0.00	F 00
5. 00	Tel ephone services (pay stations excluded)		C	)	0.00	5. 00
	(chapter 21)		40.000	A O T L VII T L F C	45.00	
6.00	Television and radio service (chapter 21)	A	- 12, 939	ACTI VI TI ES	15.00	6. 00
7.00	Parking lot (chapter 21)	4.0.0	C		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	C	)		8. 00
0.00	physician adjustment				0.00	0.00
9.00	Home office cost (chapter 21)		C		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	10.00
11. 00	Nonallowable costs related to certain		C	)	0.00	11. 00
12.00	Capital expenditures (chapter 24)	A-8-1	(2 5/1			12 00
12. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	63, 561			12. 00
13. 00			C		0.00	13. 00
14. 00	Laundry and linen service		C	1		14. 00
	Revenue - Employee meals		C			
15. 00	Cost of meals - Guests		C	1	0. 00 0. 00	
16. 00	Sale of medical supplies to other than patients		C	1	0.00	16.00
17. 00	Sale of drugs to other than patients		C		0.00	17. 00
18. 00	Sale of medical records and abstracts				0.00	18.00
19. 00	Vendi ng machi nes					19. 00
20. 00					0.00	20.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		C	1	0.00	20.00
21. 00	Interest expense on Medicare overpayments	1	_		0.00	21. 00
21.00	and borrowings to repay Medicare		C		0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation	1	(	DUTILIZATION REVIEW	82.00	22. 00
22.00	(chapter 21)		C	DOTTETZATION REVIEW	02.00	22.00
23. 00	Depreciationbuildings and fixtures		(	CAP REL COSTS - BLDGS &	1.00	23. 00
20.00	bepreer at ron barrarings and rextares			FIXTURES	1.00	20.00
24. 00	Depreciationmovable equipment		(	CAP REL COSTS - MOVABLE	2.00	24. 00
21.00	Bepreser at ron movabre equipment			EQUI PMENT	2.00	21.00
25. 00	MISC INCOME	В	-4 771	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	UNALLOWED A & G	A		ADMINISTRATIVE & GENERAL	4.00	
25. 01		A		EMPLOYEE BENEFITS	3.00	25. 02
	HEP/SALINE	A		SKILLED NURSING FACILITY	30.00	25. 02
	Total (sum of lines 1 through 99) (Transfer	''	-518, 529			100. 00
. 55. 56	to Worksheet A, col. 6, line 100)		010,027			. 55. 55
(1) Do	scription - all chapter references in this co	ı Lumn nertain to	CMS Pub 15_1	' 1	'	1

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

RIDGEWOOD CENTER

Health Financial Systems RIDGEWOOD OF STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS 

OFFICE	COSTS				Tom 01/01/2023	Date/Time Pr	
		Line No.	Cost	L Center	Expense	5/13/2024 9: tems	3/ am
		1. 00	2.		3. (		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	4. 00 44. 00 45. 00 46. 00 30. 00 43. 00	ADMI NI STRATI VE ADMI NI STRATI VE PHYSI CAL THERA OCCUPATI ONAL T SPEECH PATHOLO SKI LLED NURSI N OXYGEN (I NHALA ADMI NI STRATI VE	& GENERAL PY HERAPY GY G FACILITY TION) THERAPY	HOME OFFICE A&G HOME OFFICE CAF PT OT ST NURSING PURCHAS RT MEDICAL DIRECTO	PITAL SED SERVICES	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
	12.	Amount Allowable In Cost	Amount Included in Wkst. A, col.	Adjustments (col. 4 minus col. 5)			
		4. 00	5. 00	6, 00	-		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICAL MED HOME OFFICE COSTS:				D ORGANI ZATI ONS	OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column	412, 597 21, 455 167, 773 107, 239 136, 779 1, 500 3, 552 35, 741 0	0 167, 773 107, 239 136, 779 1, 500 3, 552 35, 741	21, 455 C C C C C C			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
	6, line 100 to Worksheet A-8, column 3, line 12.	330, 330	320, 373	30,50.			

 			5/13/2024 9:3	<u>/ am</u>
Symbol (1)	Name	Percentage of		
		Ownershi p		
1.00	2. 00	3. 00		

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

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

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

1.00	В	0.	00 1.00
2.00	В	0.	00 2.00
3.00	В	0.	00 3.00
4.00	В	0.	00 4.00
5. 00	В	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.

Rel ated Organi	Related Organization(s) and/or Home Office					
Name	Percentage of	Type of Business				
11	Ownershi p	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
4.00	5.00	6. 00	1			

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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	GENESIS HEALTHCARE	100.00 MANAGEMENT COMPANY	1.00
2.00	GRS	100.00 PT 0T ST	2.00
3. 00	CSU	100.00 NURSING PURCHASED SERVICES	3. 00
4. 00	RHS	100. 00 RT	4.00
5. 00	GPS	100.00 MEDICAL DIRECTOR	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.

 FER
 In Lieu of Form CMS-2540-10

 Provider No.: 315158
 Period: From 01/01/2023 Part I To 12/31/2023 Pate/Time Prepared:

			То	12/31/2023	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/13/2024 9: 3	/ alli
	<u>-</u>					
Cost Center Description	Net Expenses for Cost	BLDGS & FLXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TIATURES	LQUIFWLINI	DENETTIS		
	(from Wkst A					
	col . 7)	1.00	0.00			
GENERAL SERVICE COST CENTERS	0	1. 00	2.00	3. 00	3A	
1. 00 O0100 CAP REL COSTS - BLDGS & FLXTURES	949, 283	949, 283				1. 00
2. 00   00200 CAP REL COSTS - MOVABLE EQUI PMENT	26, 331	,	26, 331			2. 00
3.00 00300 EMPLOYEE BENEFITS	587, 069	6, 905	192	594, 166		3. 00
4. 00   00400   ADMI NI STRATI VE & GENERAL	1, 187, 471	23, 981	665	61, 251	1, 273, 368	4. 00
5.00   00500   PLANT OPERATION, MAINT. & REPAIRS 6.00   00600   LAUNDRY & LINEN SERVICE	371, 320 146, 384	37, 619 39, 367	1, 043 1, 092	11, 956	421, 938 186, 843	5. 00 6. 00
7. 00   00700   HOUSEKEEPI NG	278, 394	48, 822	1, 354	0	328, 570	7. 00
8. 00   00800 DI ETARY	833, 284	58, 392	1, 620	o	893, 296	8. 00
9.00 00900 NURSING ADMINISTRATION	289, 632	O	0	35, 973	325, 605	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	72, 306	34, 697	962	1, 003	108, 968	10.00
11. 00   01100   PHARMACY 12. 00   01200   MEDI CAL RECORDS & LI BRARY	49, 748	0 5, 759	160	7, 554	0 63, 221	11. 00 12. 00
13. 00 01300 SOCIAL SERVICE	128, 625	2, 407	67	19, 479	150, 578	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	O	0	0	14. 00
15. 00 01500 ACTI VI TI ES	143, 298	18, 423	511	20, 823	183, 055	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.050.000	, o	47.00			
30. 00   03000   SKILLED NURSING FACILITY 31. 00   03100   NURSING FACILITY	2, 950, 899	635, 492	17, 628	436, 127	4, 040, 146 0	30. 00 31. 00
32. 00   03200   1CF/11D		0		0	0	32.00
33. 00 03300 OTHER LONG TERM CARE	Ö	Ö	Ö	o	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	8, 488	0	0	0	8, 488	40.00
41. 00   04100   LABORATORY 42. 00   04200   I NTRAVENOUS THERAPY	8, 215	0	0	O	8, 215	41. 00 42. 00
43.00   04200   TNTRAVENOUS THERAPY 43.00   04300   0XYGEN (INHALATION) THERAPY	1, 749 9, 633	0	0	0	1, 749 9, 633	42.00
44. 00 04400 PHYSI CAL THERAPY	168, 479	11, 547	320	Ö	180, 346	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	107, 412	9, 799	272	0	117, 483	45. 00
46. 00   04600   SPEECH PATHOLOGY	136, 779	6, 131	170	0	143, 080	46. 00
47. 00 04700 ELECTROCARDIOLOGY 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 3, 581	0 99	O	0 3, 680	47. 00 48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	53, 460	6, 361	176	0	59, 997	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	o	0	50. 00
51. 00   05100   SUPPORT SURFACES	15, 833	O	0	0	15, 833	51.00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
60.00 OCTO CLINIC	O	O	O	0	0	60. 00
61. 00   06100 RURAL HEALTH CLINIC		o		ol	0	61. 00
62. 00 06200 FQHC				-	_	62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS	O	ما	O	ol	0	70.00
70.00   07000   HOME HEALTH AGENCY COST 71.00   07100   AMBULANCE		0		0	0	70. 00 71. 00
72. 00 07200 CORF	o	o	Ö	o	0	72. 00
73. 00 07300 CMHC	0	O	0	0	0	73. 00
74. 00 O7400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS  80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		1				80. 00
81. 00   08100   NTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW						82. 00
83. 00   08300   HOSPI CE	0	0	0	O	0	83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	8, 524, 092	949, 283	26, 331	594, 166	8, 524, 092	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	ol	O	o	0	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	7, 586	O	0	0	7, 586	91.00
92. 00 09200 PHYSI CLANS PRI VATE 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 95. 00   09500   OTHER NONREI MBURSABLE COST CENTERS		0		0	0	94. 00 95. 00
98.00 Cross Foot Adjustments		ol Ol		0	0	98. 00
99. 00 Negative Cost Centers		o	0	o	0	99. 00
100. 00 TOTAL	8, 531, 678	949, 283	26, 331	594, 166	8, 531, 678	100. 00

Provi der No.: 315158

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

				T	0 12/31/2023	Date/Time Prep 5/13/2024 9:3	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	/ alli
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT					  -	2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 273, 368				  -	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	74, 023	495, 961			  -	5. 00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	32, 779 57, 643	22, 167 27, 492		l	  -	6. 00 7. 00
8. 00	00800 DI ETARY	156, 716	32, 880	1	30, 479	1, 113, 371	8.00
9. 00	00900 NURSING ADMINISTRATION	57, 123	32, 660		0	1, 113, 3, 1	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	19, 117	19, 538	0	18, 111	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	11, 091	3, 243		3, 006	0	12. 00
13. 00	01300 SOCIAL SERVICE	26, 417	1, 355	0	1, 256	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	10.274	0	0 (1)	0	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	32, 114	10, 374	. 0	9, 616	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	708, 786	357, 840	241, 789	331, 706	1, 113, 371	30. 00
31. 00	03100 NURSING FACILITY	0	007,010	0	0	0	31. 00
32. 00	03200   CF/IID	o	0	o	Ö	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	1, 489	0	0	0	0	40.00
41.00	04100 LABORATORY	1, 441	0	0	0	0	41.00
42. 00 43. 00	04200   NTRAVENOUS THERAPY 04300   OXYGEN (INHALATION) THERAPY	307 1, 690	0		0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	31, 639	6, 502		6, 027	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	20, 611	5, 518		l ' '	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	25, 101	3, 453		3, 200	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	o	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	646	2, 017		1, 869	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	10, 526	3, 582	0	3, 320	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 2, 778	0	0	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	2,778	0			0	52.00
02.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,	٥	0	02.00
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	O	0	61. 00
62.00	06200 FQHC						62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	) 0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST			1 0	O		70.00
70. 00 71. 00	07100 AMBULANCE	0	0	0		0	70. 00 71. 00
72. 00	07200 CORF	0	0		0	Ö	72.00
73. 00	07300 CMHC	o	0	o	Ö	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES					  -	80. 00
81. 00	08100   INTEREST EXPENSE					  -	81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE		0		0	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS		0			0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 272, 037	495, 961	241, 789	413, 705		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	1, 331	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00 94. 00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0	0	0	0	0	93.00
94. 00 95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0			0	94. 00 95. 00
98. 00	Cross Foot Adjustments		0			0	98.00
99. 00	Negative Cost Centers		0	ol ő	o	0	99. 00
100.00	1 1 9	1, 273, 368	495, 961	241, 789	413, 705	1, 113, 371	ł
		•		•	·	·	

				1	0 12/31/2023	5/13/2024 9:3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	, Giii
			SUPPLY	11.00	LI BRARY	10.00	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11.00	12.00	13.00	
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 00600 LAUNDRY & LINEN SERVICE						5. 00
6. 00 7. 00	00700 HOUSEKEEPING						6. 00 7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	382, 728					9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	0	165, 734	_			10.00
11. 00	1	0	0	0	00 5/1		11.00
12. 00 13. 00		0	0		80, 561 0	179, 606	12. 00 13. 00
14. 00		0	0	Ö	o o	0	14. 00
15.00	1	0	0	0	0	0	15. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T		Г			
30.00	1	382, 728			72, 502	179, 606	30.00
31. 00 32. 00		0	0   0		0	0	31. 00 32. 00
33. 00	1	0	0		o o	Ö	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00		0	0	0	72	0	40.00
41. 00 42. 00		0	0	0	34 11	0	41. 00 42. 00
43. 00		0	0		1		42.00
44. 00	,	0	Ö	Ö	3, 079	o o	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	2, 136	0	45. 00
46. 00		0	0	0	2, 278	l	46. 00
47. 00		0	0	0	0	0	47. 00
48. 00 49. 00		0	0	0	0 447	0	48. 00 49. 00
50.00		0	Ö		0	Ö	50.00
51.00		0	0	0	1	0	51. 00
52. 00		0	0	0	0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	0	0	0	60. 00
61.00		0			0	0	61. 00
62.00			•				62. 00
63. 00		0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST				_		70.00
70. 00 71. 00		0	0		0	0	70. 00 71. 00
72. 00		0	Ö	Ö	Ö	ő	72. 00
73. 00		0	0	· -	0	0	73. 00
74. 00		0	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00							81. 00
82.00							82. 00
83. 00		0	0		0	0	
84. 00		0	1/5 724	·	0 5(1	170 (0)	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)   NONREIMBURSABLE COST CENTERS	382, 728	165, 734	0	80, 561	179, 606	89. 00
90. 00		0	0	0	0	0	90. 00
91. 00		0	0	0	0	0	91. 00
92.00		0	0	0	0	0	92.00
93. 00 94. 00		0	0	0	0	0	93. 00 94. 00
94.00			0		0		95.00
98. 00		0	Ö	]			98. 00
99. 00	Negative Cost Centers	0	0	·	0	0	
100.00	0   TOTAL	382, 728	165, 734	0	80, 561	179, 606	100. 00

 FER
 In Lieu of Form CMS-2540-10

 Provider No.: 315158
 Period: From 01/01/2023 Part I To 12/31/2023 Pate/Time Prepared:

				-	To 12/31/2023	Date/Time Pre 5/13/2024 9:3	
			OTHER GENERAL			37 137 2024 9.3	/ aiii
	Cost Center Description	NURSI NG AND	SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown	Total	
	cost center bescription	ALLI ED HEALTH	ACTIVITIES	Subtotal	Adjustments	iotai	
		EDUCATION 14.00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY						11. 00 12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTIVITIES	0	235, 159				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		·				
30. 00	03000 SKILLED NURSING FACILITY	0		7, 829, 36		7, 829, 367	30. 00
31. 00	03100 NURSING FACILITY	0		1	0	0	31. 00
32.00	03200   CF/IID	0	l e	1	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0		)	0 0	0	33. 00
40. 00	04000 RADI OLOGY	0		10, 04	9 0	10, 049	40.00
41. 00	04100 LABORATORY	0	ł	9, 69		9, 690	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	d	2, 06		2, 067	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	11, 32	4 0	11, 324	43. 00
44.00	04400 PHYSI CAL THERAPY	0	C	227, 59		227, 593	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	C	150, 86		150, 863	1
46. 00	04600 SPEECH PATHOLOGY	0	C	177, 11	2 0	177, 112	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		8, 21	2 0	0 8, 212	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS			77, 87		77, 872	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	Ö	Ö	1	o o	0	50.00
51.00	05100 SUPPORT SURFACES	0	c	18, 61	2 0	18, 612	51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0 0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	l .	1	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	C	'	0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS			1	<u> </u>		00.00
70.00	07000 HOME HEALTH AGENCY COST	0	C		0 0	0	70. 00
71. 00	07100 AMBULANCE	0			0	0	71. 00
72. 00	07200 CORF	0	C		0	0	72. 00
	07300 CMHC	0			0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0		ار	0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100   NTEREST EXPENSE						81. 00
82.00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	0	C		0 0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	<b>l</b>		0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	235, 159	8, 522, 76	1 0	8, 522, 761	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0				0	90. 00
90.00	09100 BARBER AND BEAUTY SHOP			8, 91	7 0	8, 917	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		0, 71	0 0	0, 717	92.00
93. 00	09300 NONPALD WORKERS	0	[ c		o o	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	[ c		0 0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	C		0 0	0	95. 00
98.00	Cross Foot Adjustments	0	C		0	0	98. 00
99. 00 100. 00	Negative Cost Centers   TOTAL	0	235, 159	8, 531, 67	0 8 0	0 8, 531, 678	99.00
100.00	) ITOTAL	1	1 235, 159	7 0,551,67	0	0, 551, 076	1100.00

Provi der No.: 315158 Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Ti me Prepared: 5/13/2024 0:37 am

					12/31/2023	5/13/2024 9:3	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	cost conten bescriptron	Assigned New	FIXTURES	EQUI PMENT	Subtotal	BENEFITS	
		Capi tal					
		Related Costs 0	1.00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS	0 1	1.00	2.00	ZA	3.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	6, 905	192	7, 097	7, 097	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	23, 981 37, 619	665 1, 043	24, 646 38, 662	732 143	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	39, 367	1, 043	40, 459	0	6.00
7. 00	00700 HOUSEKEEPI NG	0	48, 822	1, 354	50, 176	0	7. 00
8. 00	00800 DI ETARY	0	58, 392	1, 620	60, 012	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	430	1
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	34, 697	962 0	35, 659 0	12 0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		5, 759	160	5, 919	90	•
13. 00	01300 SOCIAL SERVICE	0	2, 407	67	2, 474	233	•
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITIES	0	18, 423	511	18, 934	249	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	635, 492	17, 628	653, 120	5, 208	30.00
31. 00	03100 NURSING FACILITY	0	033, 472	0	033, 120	0, 200	31.00
32. 00	03200   CF/IID	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		0	0	ol	0	1 40 00
40. 00 41. 00	04100 LABORATORY	0	0	0	0	0	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	o o	Ö	0	o	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	11, 547	320	11, 867	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	0	9, 799	272	10, 071	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	6, 131 0	170 0	6, 301 0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 581	99	3, 680	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	6, 361	176	6, 537	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52. 00
60. 00	06000 CLINIC	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71. 00	07100 AMBULANCE	Ö	0	Ö	o	0	
72.00	07200 CORF	0	0	0	0	0	72. 00
73. 00	07300 CMHC	0	0	0	0	0	1
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100   NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0	0 949, 283	26, 331	975, 614	0 7, 097	84. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	747, 203	20, 331	775, 014	7,097	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	o	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	o	0	
93. 00 94. 00	09300 NONPALD WORKERS 09400 PATIENTS LAUNDRY		0	0	0	0	
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	0	1
98. 00	Cross Foot Adjustments	1			ō	_	98. 00
99. 00	Negative Cost Centers		0	0	0	0	
100.00	D   TOTAL	0	949, 283	26, 331	975, 614	7, 097	100. 00

Provi der No.: 315158

			T	0 12/31/2023	Date/Time Pre 5/13/2024 9:3	
Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	/ aiii
	& GENERAL	OPERATION,	LINEN SERVICE			
		MAINT. & REPAIRS				
	4.00	5. 00	6. 00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00   00200   CAP REL COSTS - MOVABLE EQUIPMENT 3.00   00300   EMPLOYEE BENEFITS						2. 00 3. 00
4. 00   00400 ADMINISTRATIVE & GENERAL	25, 378					4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 475	40, 280				5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	653	1, 800				6. 00
7. 00   00700   HOUSEKEEPI NG	1, 149	2, 233	0	53, 558		7. 00
8. 00   00800   DI ETARY	3, 123	2, 670	0	3, 946	69, 751	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	1, 138	1 507	0	0	0	9.00
10. 00   01000   CENTRAL SERVI CES & SUPPLY   11. 00   01100   PHARMACY	381	1, 587 0	0	2, 345	0	10. 00 11. 00
12. 00   01200 MEDICAL RECORDS & LI BRARY	221	263	_	389	0	12. 00
13. 00   01300   SOCI AL   SERVI CE	526	110		163	0	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	О	0	14. 00
15. 00 01500 ACTI VI TI ES	640	843	0	1, 245	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	14 407	00.040	10.040	40.040	/0.754	00.00
30.00   03000   SKILLED NURSING FACILITY 31.00   03100   NURSING FACILITY	14, 127	29, 063 0	42, 912 0	42, 942	69, 751 0	30. 00 31. 00
32. 00   03200   CF/IID	0	0	_	0	0	32.00
33. 00   03300   OTHER LONG TERM CARE	l o	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS		-		-1		
40. 00   04000   RADI OLOGY	30	0	0	0	0	40. 00
41. 00   04100   LABORATORY	29	0	0	0	0	41. 00
42. 00   04200   I NTRAVENOUS THERAPY	6	0	0	0	0	42.00
43. 00   04300   0XYGEN (I NHALATI ON) THERAPY 44. 00   04400   PHYSI CAL THERAPY	34 630	() E20	0	780	0	43. 00 44. 00
45. 00   04400   PHYSICAL THERAPY 45. 00   04500   OCCUPATIONAL THERAPY	411	528 448		662	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	500	280		414	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0		О	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	13	164	0	242	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	210	291	0	430	0	49. 00
50. 00   05000   DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00   05100   SUPPORT SURFACES 52. 00   05200   OTHER ANCILLARY SERVICE COST CENTERS	55 0	0	0	0	0	51. 00 52. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	U <sub>I</sub>	0	32.00
60. 00   06000   CLINIC	0	0	0	0	0	60. 00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	О	0	61. 00
62. 00   06200   FQHC						62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS  70.00 O7000 HOME HEALTH AGENCY COST	0	0	0	O	0	70. 00
71. 00   07100  AMBULANCE		0	0	0	0	71.00
72. 00   07200   CORF	o	0	o o	o	0	72. 00
73. 00 07300 CMHC	0	0	0	О	0	73. 00
74.00 O7400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS			I			
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00   08200   UTI LI ZATI ON REVI EW						82.00
83. 00   08300   HOSPI CE	0	0	0	0	0	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	О	0	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	25, 351	40, 280	42, 912	53, 558	69, 751	89. 00
NONREI MBURSABLE COST CENTERS	1		_	ام		
90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00   09100   BARBER AND BEAUTY SHOP	0 27	0	0	0	0	90. 00 91. 00
92. 00   09200   PHYSI CLANS PRI VATE OFFICES	27	0	0	0	0	91.00
93. 00 09300 NONPALD WORKERS		0	0	0	0	93. 00
94. 00 09400 PATIENTS LAUNDRY		0	0	o	0	94. 00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	О	0	95. 00
98.00 Cross Foot Adjustments			0	0	0	98. 00
99.00   Negative Cost Centers	0	40.300	0	0	0 40.751	99.00
100. 00   TOTAL	25, 378	40, 280	42, 912	53, 558	69, 751	100.00

Provi der No.: 315158

				'	0 12/31/2023	5/13/2024 9: 3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
		0.00	SUPPLY	11.00	LI BRARY	10.00	
	CENEDAL SEDVICE COST CENTERS	9. 00	10. 00	11.00	12.00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 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	1, 568					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	o	39, 984				10.00
11. 00	01100 PHARMACY	0	0	0			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	6, 882		12. 00
13. 00	+ + +	0	0	0	0	3, 506	13. 00
14. 00	+ I	0	0	0	0	0	14. 00
15. 00		0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	22.22.4			1 0.50/	
30.00	+ I	1, 568	39, 984	0			30.00
31.00	I I	0	0	0		0	31.00
32.00	I I	0	0	0		0	32. 00 33. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	l d	U		0	0	33.00
40. 00		0	0	0	6	0	40. 00
41. 00	1		0		-	Ö	41. 00
42. 00		o	0	l o	1	l o	42. 00
43.00	1	O	0	0	0	0	43.00
44.00		0	0	0	263	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	o	0	0	183	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	195	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	1 1	0	0	0	0	0	48. 00
49. 00		0	0	0	38		49. 00
50. 00	I I	0	0	0	0	0	50. 00
51.00	1 1	0	0	0	0	0	51.00
52. 00		0	U		0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0	0	0	0	60.00
61. 00	+ I		0	1 0	0	0	61. 00
62. 00	1 1		J	Ĭ		· ·	62.00
63. 00	1 1	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS	-1	-	<u>-</u>			
70.00		0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	o	0	0	0	0	71. 00
72. 00		0	0	0	0	0	72. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
74. 00		0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS			T	T	T	
80.00							80.00
81. 00 82. 00	I I						81. 00 82. 00
83. 00			0	0	0	0	82.00
84. 00			0			0	84. 00
89. 00		1, 568	39, 984				89. 00
07.00	NONREI MBURSABLE COST CENTERS	1,7000	377 701		3, 552	0,000	07.00
90.00		0	0	0	0	0	90. 00
91.00	The state of the s	0	0	0	0		91.00
92.00		0	0	0	0	0	92. 00
93.00	I I	O	0	0	0	0	93. 00
94. 00	I I	0	0	0	_	0	94. 00
95. 00		0	0	0	_	0	95. 00
98. 00		0	0	0	_	_	98. 00
99.00	1 1 3	1.5(0)	30,004		0	0	99.00
100.00	D   TOTAL	1, 568	39, 984	0	6, 882	3, 506	100. 00

 FER
 In Lieu of Form CMS-2540-10

 Provider No.: 315158
 Period: From 01/01/2023 Part II To 12/31/2023 Pate/Time Prepared:

				1	To 12/31/2023	Date/Time Pre 5/13/2024 9:3	
			OTHER GENERAL			07 107 202 1 7. 0	, diii
	Cost Center Description	NURSI NG AND	SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down	Total	
	cost center bescription	ALLI ED HEALTH	ACTIVITIES	Subtotal	Adj ustments	Total	
		EDUCATI ON					
	GENERAL SERVICE COST CENTERS	14.00	15. 00	16. 00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00 4. 00	OO300						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10. 00
11. 00 12. 00	O1100   PHARMACY   O1200   MEDI CAL RECORDS & LI BRARY						11. 00 12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTIVITIES	0	21, 911				15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000 SKILLED NURSING FACILITY	0	21, 911	930, 285	5 0	930, 285	30.00
31.00	03100 NURSING FACILITY	Ö	0			0	31. 00
	03200   CF/IID	0	0			0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	(	0	0	33.00
40. 00	04000 RADI OLOGY	0	0	36	j 0	36	40. 00
41.00	04100 LABORATORY	0	0			32	1
42. 00 43. 00	04200   INTRAVENOUS THERAPY   04300   OXYGEN (INHALATION) THERAPY	0	0	34		7 34	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	ő	14, 068		14, 068	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	11, 775		11, 775	1
46. 00 47. 00	04600  SPEECH PATHOLOGY   04700  ELECTROCARDI OLOGY	0	0	7, 690		7, 690 0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4, 099		4, 099	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	7, 506		7, 506	1
50. 00 51. 00	05000   DENTAL CARE - TITLE XIX ONLY   05100   SUPPORT SURFACES	0	0	55		0 55	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	o o			0	1
	OUTPATIENT SERVICE COST CENTERS	_	_		_	_	
60. 00 61. 00	O6000   CLINIC   O6100   RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62. 00	06200 FQHC					0	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(	0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71. 00	07100 AMBULANCE	0	ő		o o	0	1
72. 00	07200 CORF	0	0	(	0	0	
73.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0	(	0	0	
74.00	SPECIAL PURPOSE COST CENTERS				,	<u> </u>	74.00
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	08100   I NTEREST EXPENSE   08200   UTI LI ZATI ON REVI EW						81. 00 82. 00
83. 00	08300 HOSPI CE	0	0	(	0	0	1
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	(		0	
89. 00	SUBTOTALS (sum of lines 1-84)   NONREIMBURSABLE COST CENTERS	0	21, 911	975, 587	7 0	975, 587	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	27		27	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	(		0	ı
94. 00	09400 PATIENTS LAUNDRY	Ö	0		-	0	1
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	(	0	0	98. 00 99. 00
100.00		0	21, 911	975, 614			

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315158 | Peri od: From 01/01/2023

Worksheet B-1

12/31/2023 Date/Time Prepared: 5/13/2024 9:37 am CAPITAL RELATED COSTS BLDGS & MOVABLE **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description **FLXTURES FOUL PMENT** BENEFITS & GENERAL (SQUARE FEET) (SQUARE FEET) (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 4A 4.00 3.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 33, 132 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 33, 132 2.00 3.00 00300 EMPLOYEE BENEFITS 241 241 3, 913, 119 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 837 837 403, 397 -1, 273, 368 7, 258, 310 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 1, 313 78, 739 421 938 5 00 1.313 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 1, 374 1, 374 C 186, 843 7.00 00700 HOUSEKEEPI NG 1,704 1, 704 0 328, 570 7.00 00800 DI ETARY 2.038 2,038 0 893, 296 8 00 0 8 00 00900 NURSING ADMINISTRATION 0 9.00 236, 917 325, 605 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 1, 211 1, 211 6,607 108, 968 10.00 01100 PHARMACY 0 11.00 11.00 0 01200 MEDICAL RECORDS & LIBRARY 49. 748 63, 221 201 12 00 201 12 00 13.00 01300 SOCIAL SERVICE 84 84 128, 287 150, 578 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 0 14.00 01500 ACTIVITIES 15.00 643 643 137, 136 0 183, 055 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 22, 180 22, 180 2, 872, 288 0 4, 040, 146 30.00 03100 NURSING FACILITY 0 31.00 31.00 03200 | CF/IID 0 0 0 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 8,488 40.00 0 41.00 04100 LABORATORY 0 0 0 8, 215 41.00 04200 I NTRAVENOUS THERAPY 0 0 42.00 C 1, 749 42 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 43.00 0 0 0 9,633 04400 PHYSI CAL THERAPY 44.00 403 403 180, 346 44.00 04500 OCCUPATIONAL THERAPY 0 117, 483 45.00 342 45.00 342 46.00 04600 SPEECH PATHOLOGY 214 214 0 143,080 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 125 125 0 3, 680 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49 00 49 00 222 222 59, 997 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05100 SUPPORT SURFACES 51.00 0 C 0 0 15, 833 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 C 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 Ω 0 o 0 61.00 06200 FOHC 62.00 62.00 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 70.00 07100 AMBULANCE 0 0 0 71.00 C 0 71.00 72.00 07200 CORF 0 C 0 0 0 72.00 0 0 73.00 07300 CMHC 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 74 00 0 74 00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW 82 00 82 00 83.00 08300 HOSPI CE 0 83.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 84.00 84.00 SUBTOTALS (sum of lines 1-84)
NONREIMBURSABLE COST CENTERS 89.00 33, 132 33, 132 3, 913, 119 -1, 273, 368 7, 250, 724 89.00 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 Λ 09100 BARBER AND BEAUTY SHOP 0 0 0 91.00 0 7,586 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 92.00 0 0 0 0 09300 NONPALD WORKERS 0 93.00 C 0 93.00 09400 PATIENTS LAUNDRY 0 0 94.00 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 95.00 98.00 Cross Foot Adjustments 98 00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, 949, 283 26, 331 594, 166 1, 273, 368 102. 00 Part I) 0. 175436 103. 00 103.00 Unit cost multiplier (Wkst. B. Part I) 28. 651545 0.794730 0.151839 7, 097 104.00 Cost to be allocated (per Wkst. B, 25, 378 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.001814 0.003496 105.00 II)

Provi der No.: 315158

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:37 am Worksheet B-1

				'	0 12/31/2023	5/13/2024 9: 3	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(TOTAL PATIENT			CTOTAL DATE OUT	
		REPAIRS (SQUARE FEET)	DAYS)			(TOTAL PATIENT DAYS)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	30, 741					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 374	26, 072				6. 00
7.00	00700 HOUSEKEEPI NG	1, 704	0	27, 663			7. 00
8.00	00800 DI ETARY	2, 038	0	2, 038	78, 216		8. 00
9.00	00900 NURSING ADMINISTRATION	C	0	0	0	26, 072	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	1, 211	0	1, 211	0	0	10. 00
11. 00	01100 PHARMACY	C	1	0	0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	201	1	201	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	84	<b> </b>	84	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	1	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	643	8 0	643	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 SKILLED NURSING FACILITY	22, 180	1	22, 180	78, 216		30.00
31.00	03100 NURSING FACILITY		1	0	0	0	31.00
32. 00	03200 I CF/II D	C	1	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		)[	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		) 0	0	0	0	40.00
41. 00	04100 LABORATORY		1	· -	_	•	41.00
42. 00	04200 I NTRAVENOUS THERAPY		1	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		1	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	403	1	403	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	342	l control of the cont	342		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	214	l e	214		Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY		l l	0	0	l o	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	125		125	0	l o	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	222	l control of the cont	222	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		1	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	C	0	0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	C	0	0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	C	1	0		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61. 00
62. 00	06200 FQHC						62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER		) 0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS		) 0		0	0	70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE			0	0	0	70. 00 71. 00
	07200 CORF				0	0	71.00
	07300 CMHC				0	0	73.00
	07400 OTHER REIMBURSABLE COST				0		74.00
7 1. 00	SPECIAL PURPOSE COST CENTERS		,				, 1. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100   NTEREST EXPENSE						81. 00
82.00	08200 UTI LI ZATI ON REVI EW						82. 00
83.00	08300 HOSPI CE	C	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	84. 00
89.00	SUBTOTALS (sum of lines 1-84)	30, 741	26, 072	27, 663	78, 216	26, 072	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	0	0	0	
91.00	09100 BARBER AND BEAUTY SHOP	C	0	0	0	-	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	C	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	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		) 0	0	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99.00	Negative Cost Centers	40E 0/1	241 700	412 7OF	1 110 071	202 720	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	495, 961	241, 789	413, 705	1, 113, 371	382, 728	102.00
103.00		16. 133535	9. 273895	14. 955175	14. 234568	14. 679656	103.00
104.00		40, 280	I .				104. 00
. 5 1. 50	Part II)	10, 200	12, /12	33, 330	07,731	1,500	
105.00		1. 310302	1. 645904	1. 936088	0. 891774	0. 060141	105.00

In Lieu of Form CMS-2540-10 Health Financial Systems RI DGEWOOD CENTER COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315158 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/13/2024 9:37 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & SERVICES & (COSTED ALLI ED HEALTH SUPPLY REQUIS.) LI BRARY (TOTAL PATIENT **EDUCATION** (COSTED (GROSS DAYS) (ASSI GNED REQUIS.) CHARGES) TIME) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 2.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 7.00 00700 HOUSEKEEPI NG 8.00 00800 DI ETARY 00900 NURSING ADMINISTRATION 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 22, 362 11.00 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 12.00 0 12, 890, 314 01300 SOCIAL SERVICE 26, 072 13 00 0 Ω C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C 0 0 01500 ACTI VI TI ES 15.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 22, 362 0 11, 600, 471 26, 072 0 03100 NURSING FACILITY 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 0 03300 OTHER LONG TERM CARE 0 Ω O 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 11, 596 0 41.00 04100 LABORATORY 0 5, 519 0 0 0000000000 04200 INTRAVENOUS THERAPY 1, 809 42 00 Ω 0 43.00 04300 OXYGEN (INHALATION) THERAPY 235 0 492, 603 04400 PHYSI CAL THERAPY 44.00 0 0 0 0 0 04500 OCCUPATIONAL THERAPY 45.00 341.767 0 04600 SPEECH PATHOLOGY 46.00 Ω 364, 559 0 47.00 04700 ELECTROCARDI OLOGY 0 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 71, 574 0 50.00 C  $\cap$ Λ 05100 SUPPORT SURFACES 0 0 0 51.00 181 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 O 0 Λ 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 63.00 0 C 0 Λ OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST C 07100 AMBULANCE 71.00 0 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 73.00 07300 CMHC 0 0 0 0 07400 OTHER REIMBURSABLE COST 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPLCE 0 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 89.00 SUBTOTALS (sum of lines 1-84) 22, 362 12, 890, 314 26, 072 0 0 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 0 0 0 93 00 09300 NONPALD WORKERS 0 Ω 0 09400 PATIENTS LAUNDRY 94.00 0 0 0 0

RI DGEWOOD CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315158

		10 12/31/2023	5/13/2024 9:37 am
	OTHER GENERAL		
	SERVI CE		
Cost Center Description	ACTI VI TI ES		
	(TOTAL PATIENT		
	DAYS)		
	15. 00		
GENERAL SERVICE COST CENTERS			
1.00   00100   CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00   00200   CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00 00300 EMPLOYEE BENEFITS			3.00
4.00 00400 ADMINISTRATIVE & GENERAL			4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00 00600 LAUNDRY & LINEN SERVICE			6.00
7. 00 00700 HOUSEKEEPI NG			7.00
8. 00   00800 DI ETARY			8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON			9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00   01100   PHARMACY			11.00
			· ·
12. 00 01200 MEDI CAL RECORDS & LI BRARY			12.00
13. 00 01300 SOCI AL SERVI CE			13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0, 070		14. 00
15. 00 01500 ACTIVITIES	26, 072		15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			
30.00 03000 SKILLED NURSING FACILITY	26, 072		30.00
31.00 03100 NURSING FACILITY	0		31.00
32. 00  03200 1CF/IID	0		32. 00
33.00 03300 OTHER LONG TERM CARE	0		33. 00
ANCILLARY SERVICE COST CENTERS			
40. 00   04000   RADI OLOGY	0		40.00
41. 00   04100   LABORATORY	O		41.00
42. 00 04200 I NTRAVENOUS THERAPY	0		42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	o		43.00
44. 00   04400 PHYSI CAL THERAPY	O		44.00
45. 00 04500 OCCUPATI ONAL THERAPY	O		45. 00
46. 00 04600 SPEECH PATHOLOGY	O		46. 00
47. 00   04700   ELECTROCARDI OLOGY	0		47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY			50.00
	o o		
51. 00 05100 SUPPORT SURFACES			51.00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0		52. 00
OUTPATIENT SERVICE COST CENTERS			/0.00
60. 00   06000   CLI NI C 61. 00   06100   RURAL HEALTH CLI NI C	0		60.00
	0		62. 00
62. 00   06200   FOHC			
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
OTHER REIMBURSABLE COST CENTERS			70.00
70. 00 07000 HOME HEALTH AGENCY COST	0		70.00
71. 00   07100   AMBULANCE	0		71. 00
72. 00   07200   CORF	0		72. 00
73. 00   07300   CMHC	0		73.00
74. 00 O7400 OTHER REIMBURSABLE COST	0		74.00
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 UTILIZATION REVIEW			82.00
83. 00   08300   HOSPI CE	0		83.00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0		84. 00
89.00 SUBTOTALS (sum of lines 1-84)	26, 072		89. 00
NONREI MBURSABLE COST CENTERS			
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	·	90.00
91.00 09100 BARBER AND BEAUTY SHOP	O		91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00 09300 NONPALD WORKERS	0		93. 00
94.00 09400 PATIENTS LAUNDRY	0		94. 00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS	O		95. 00
98.00 Cross Foot Adjustments	]		98. 00
99.00   Negative Cost Centers			99.00
102.00 Cost to be allocated (per Wkst. B,	235, 159		102. 00
Part 1)	200, 107		1,02.00
103.00 Unit cost multiplier (Wkst. B, Part I)	9. 019600		103. 00
104.00 Cost to be allocated (per Wkst. B,	21, 911		104. 00
Part II)	21,711		104.00
105.00 Unit cost multiplier (Wkst. B, Part	0. 840403		105. 00
II)	0. 040403		103.00
'''/	ı I		I

Health Financial Systems	RI DGEWOOD CENTER	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCIL	ARY AND OUTPATIENT COST CENTERS Provider N	o.: 315158   Peri od:   Worksheet C   From 01/01/2023

		F	rom 01/01/2023		
		l T		Date/Time Pre	pared:
				5/13/2024 9:3	
	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 0L0GY	10, 049	11, 596	0. 866592	40. 00
41.00	04100 LABORATORY	9, 690	5, 519	1. 755753	41.00
42.00	04200 I NTRAVENOUS THERAPY	2, 067	1, 809	1. 142620	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	11, 324	235	48. 187234	43.00
44.00	04400 PHYSI CAL THERAPY	227, 593	492, 603	0. 462021	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	150, 863	341, 767	0. 441421	45. 00
46.00	04600 SPEECH PATHOLOGY	177, 112	364, 559	0. 485825	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0.000000	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 212	0	0.000000	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	77, 872	71, 574	1. 087993	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	05100 SUPPORT SURFACES	18, 612	181	102. 828729	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	52.00
	OUTPATIENT SERVICE COST CENTERS				
60.00	06000 CLI NI C	0	0	0. 000000	60.00
61.00	06100 RURAL HEALTH CLINIC				61.00
62.00	06200 FQHC				62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0. 000000	63. 00
71.00	07100 AMBULANCE	0	0	0.000000	71. 00
100.00	Total	693, 394	1, 289, 843		100.00
	'	•		'	•

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315158	Peri od:	Worksheet D	
ALLOCATION WILLIAM OF ANCIELANT AND COTTAILENT COSTS		Trovidei		From 01/01/2023	Part I	
				To 12/31/2023	Date/Time Pre	pared:
					5/13/2024 9:3	7 am
		Title	XVIII (1)	Skilled Nursing	PPS	
		II	01	<u>Facility</u>	D 0 1	1
		Health Care Pr	rogram Charge	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col 1	
	to Charges	Tur CA	Tare B	x col. 2)	x col. 3)	
	(Fr. Wkst. C			/ OO!! 2)	λ σσ σγ	
	Col umn 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPATI	ENT COST					
ANCILLARY SERVICE COST CENTERS						1
40. 00   04000   RADI OLOGY	0. 866592	950		0 823	0	40.00
41. 00   04100   LABORATORY	1. 755753	1, 885		0 3, 310	0	41.00
42. 00   04200   I NTRAVENOUS THERAPY	1. 142620	378		0 432	0	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY	48. 187234	0		0	0	43.00
44. 00 O4400 PHYSI CAL THERAPY	0. 462021	104, 000		0 48, 050	0	
45. 00   04500   OCCUPATI ONAL THERAPY	0. 441421	70, 554		0 31, 144	0	
46. 00 04600 SPEECH PATHOLOGY	0. 485825	92, 624		0 44, 999	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 087993	14, 652		0 15, 941	0	1
50.00 O5000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00   05100   SUPPORT SURFACES	102. 828729	0		0	0	
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS		_			_	
60. 00   06000   CLI NI C	0. 000000	0		0	0	
61. 00   06100   RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC		_			_	62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	
71.00   07100   AMBULANCE (2) 100.00   Total (Sum of Lines 40 - 71)	0. 000000	005 040		0	0	
	i l	285, 043	1	0 144, 699		100.00

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

From 01/01/2023 P. To 12/31/2023 D.	Worksheet D Parts II-III	
Cost Center Description Facility	Date/Time Pre 5/13/2024 9:3	
	PPS	
PART II - APPORTIONMENT OF VACCINE COST	1. 00	
	1.00	
1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1. 087993	1.00
2.00 Program vaccine charges (From your records, or the PS&R)	6, 710	
3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	7, 300	3. 00
Cost Center Description Total Cost Nursing & Ratio of Program Part A Par		
(From Wkst. B,   Allied Health   Nursing &   Cost (From	& Allied	
	Heal th Costs	
	for Pass	1
	hrough (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   10, 049   0   0. 000000   823	0	
41. 00   04100   LABORATORY 9, 690 0 0. 000000 3, 310	0	
42. 00   04200   I NTRAVENOUS THERAPY 2, 067 0 0. 000000 432	0	1 .2.00
43. 00   04300   0XYGEN (I NHALATI ON) THERAPY 11, 324 0 0.000000 0	0	1 .0.00
44. 00   04400   PHYSI CAL THERAPY   227, 593   0   0. 000000   48, 050	0	1
45. 00   04500   0CCUPATI ONAL THERAPY   150, 863   0   0. 000000   31, 144	0	1 .0.00
46. 00   04600   SPEECH PATHOLOGY   177, 112   0   0. 000000   44, 999	0	1 .0.00
47. 00   04700  ELECTROCARDI OLOGY   0   0. 000000   0	0	1
48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   8, 212   0   0.000000   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   77, 872   0   0.000000   15, 941	0	
49. 00   04900   DRUGS CHARGED TO PATIENTS   77, 872   0   0.000000   15, 941   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0.000000   0	0	
51. 00   05100  SUPPORT SURFACES   18, 612   0   0. 000000   0	0	ı
52. 00   05200  OTHER ANCI LLARY SERVI CE COST CENTERS   0   0.000000  0   0   0   0   0   0	0	
100.00 Total (Sum of lines 40 - 52) 693,394 0 144,699	- 1	100.00

Private room days Inpatient days including private room days applicable to the Program 1, 406 Medically necessary private room days applicable to the Program 7, 829, 367 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service cost 6,00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Ceneral inpatient routine service cost/charge ratio (Line 5 divided by line 6) Ceneral inpatient routine service cost/charge ratio (Line 5 divided by private room days, line 2) Ceneral inpatient routine service cost/charge ratio (Line 5 divided by private room days, line 2) Ceneral inpatient routine service cost/charge ratio (Line 5 divided by private room days, line 2) Ceneral inpatient routine service cost/charge ratio (Line 9 divided by private room days, line 2) Ceneral inpatient room charges from your records Average private room charges from your records Average semi-private room charges from your records Average semi-private room days Ceneral inpatient room charge differential (Line 9 minus line 10, divided by semi-private room days) Ceneral inpatient room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Ceneral inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 divided by line 1) PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 17 plus line 18) Ceneral inpatient routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Condition of Service does discount of the cost (Line 17 plus line 18) Condition of Service does (Line 20 divided by line 1) Cost of diem capital related cost (Line 20 divided by line 1) Cost of diem capital related cost (Line 20 divided by line 1) Cost of diem capital related cost (Line 20 divided by line 1) Cost of diem capital related cost (Line 20 d	Heal th	lealth Financial Systems RIDGEWOOD CENTER In Lieu					
PART I CALCULATION OF INPATIENT ROUTINE COSTS    NPATIENT DAYS	COMPUT	From 01/01/2023 Part To 12/31/2023 Date					
PART I CALCILATION OF INPATIENT ROUTINE COSTS  INPATIENT DAYS  1.00 Inpatient days including private room days 26,072 27 20 Private room days 28 3.00 Inpatient days including private room days applicable to the Program 39 4.00 Medically necessary private room days applicable to the Program 40 Medically necessary private room days applicable to the Program 50 7,829,367 50 Total general inpatient routine service cost 50 Total general inpatient routine service cost charges 50 General inpatient routine service cost / Charge ratio (Line 5 divided by line 6) 50 General inpatient routine service cost / Charge ratio (Line 5 divided by line 6) 60 General inpatient routine service cost / Charge ratio (Line 5 divided by line 6) 60 General inpatient routine service cost / Charge ratio (Line 5 divided by private room days, line 2) 60 Center private room charges from your records 60 Center semi-private room per diem charge (Private room charges line 8 divided by private room days, line 2) 61 Center semi-private room charges from your records 62 Center semi-private room charges from your records 73 Average per diem private room charge differential (Line 9 minus line 10, divided by 444.00 semi-private room days) 74 Average per diem private room charge differential (Line 9 minus line 11) 75 Center semi-private room cost differential (Line 7 times line 12) 76 Average per diem private room cost differential (Line 7 times line 12) 77 Average per diem private room cost differential (Line 7 times line 13) 78 Average per diem private room cost not of private room cost differential (Line 5 minus line 14) 78 Average per diem private room cost not of private room cost differential (Line 5 minus line 14) 79 Average per diem private room cost not of private room cost differential (Line 5 minus line 14) 79 Average per diem private room cost not of private room cost differential (Line 5 minus line 12) 70 Center line service cost (Line 3 times line 15 divided by line 1) 70 Program routine service cost (Line 3 times line 15 divided by line 1)			Title XVIII				
PART I CALCIJATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS  1.00 Inpatient days including private room days 26,072 27.00 Private room days 28,000 Inpatient days including private room days applicable to the Program 29,000 Medically necessary private room days applicable to the Program 30,00 Inpatient days including private room days applicable to the Program 30,00 Medically necessary private room days applicable to the Program 30,00 Medically necessary private room days applicable to the Program 30,00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 30,00 General inpatient routine service cost // Charge ratio (Line 5 divided by line 6) 30,00 Enter private room charges from your records 30,00 Enter private room per diem charge (Private room charges line 8 divided by private room days, line 2) 31,00 Average private room per diem charge (Semi-private room charges line 10, divided by semi-private room days, line 2) 31,00 Average per diem private room charge differential (Line 9 minus line 11) 31,00 Average per diem private room charge differential (Line 9 minus line 12) 31,00 Average per diem private room cost differential (Line 7 times line 12) 31,00 Average per diem private room cost differential (Line 7 times line 12) 31,00 Average per diem private room cost differential (Line 7 times line 13) 31,00 Average per diem private room cost differential (Line 7 times line 13) 32,00 Average per diem private room cost differential (Line 7 times line 13) 33,00 Average per diem private room cost differential (Line 7 times line 13) 34,00 Private room cost differential adjustment (Line 2 times line 13) 35,00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 36,00 Average per diem private room cost private room cost differential (Line 5 minus line 14) 36,00 Average per diem private room cost private room cost differential (Line 5 minus line 14) 36,00 Average per diem private room cost private room cost differential (Line 5 minus line 12) 36,00 Average per diem private room cost private					1 00		
Inpatient days including private room days   26,072   24   30   1   1   1   1   1   1   1   1   1		PART I CALCULATION OF INPATIENT ROUTINE COSTS					
Private room days Inpatient days including private room days applicable to the Program 1, 406 4.00 Medically necessary private room days applicable to the Program 0 7, 829, 367 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service cost 7, 829, 367 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service charges 6.00 Enter private room charges from your records 7, 829, 367 8.00 Enter private room per diem charge (Private room charges line 8 divided by line 6) 8.00 Enter semi-private room per diem charge (Private room charges line 8 divided by private room days, line 2) 9, 00 Enter semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 11, 665, 312 11, 00 Enter semi-private room charges from your records 11, 655, 312 11, 00 Enter semi-private room charge differential (Line 9 minus line 10, divided by semi-private room days) 12, 00 Average per diem private room charge differential (Line 9 minus line 11) 12, 00 Average per diem private room charge differential (Line 7 times line 12) 13, 00 Average per diem private room cost differential (Line 2 times line 12) 14, 00 Private room cost differential adjustment (Line 2 times line 13) 15, 00 Private room cost differential adjustment (Line 2 times line 13) 16, 00 Private room cost differential adjustment (Line 2 times line 13) 17, 00 Program routine service cost per diem (Line 15 divided by line 1) 18, 00 Average per diem private room cost applicable to program (line 4 times line 13) 19, 00 Average per diem charge (Private room cost (Line 17 plus line 18) 10, 01 Average per diem charge (Private room cost (Line 17 plus line 18) 10, 01 Average per diem charge (Private room cost (Line 17 plus line 18) 11, 00 Program routine service cost (Line 20 divided by line 1) 11, 00 Program routine service cost (Line 20 divided by line 1) 12, 00 Program routine service cost (Line 20 divided by line 1) 13, 00 Average per diem limitation (1) 14, 00 Program routine service cost (Line 20 divided by l							
Inpatient days including private room days applicable to the Program   1,406						1. 00	
4.00 Medically necessary private room days applicable to the Program  7, 829, 367  Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  6.00 General inpatient routine service charges  6.00 Enter private room charges from your records  8.00 Enter private room charges from your records  11, 640  Average private room charges from your records  10.00 Enter semi-private room charges from your records  11, 655, 312  10.00 Enter semi-private room charges from your records  11, 640  12, 00 Enter semi-private room charges from your records  12, 00 Enter semi-private room charges from your records  13, 655, 312  14, 00 Semi-private room days)  Average per diem private room charge (Semi-private room charges line 10, divided by semi-private room days)  Average per diem private room charge differential (Line 9 minus line 11)  Average per diem private room cost differential (Line 7 times line 12)  14, 00 Private room cost differential adjustment (Line 2 times line 13)  15, 00 Feneral inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  16, 00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  17, 00 Program routine service cost per diem (Line 15 divided by line 1)  18, 00 Medically necessary private room cost applicable to program (line 4 times line 13)  10 Total program general inpatient routine service cost (Line 17 plus line 18)  10 Total program general inpatient routine service cost (Line 17 plus line 18)  10 Total program general inpatient routine service cost (Line 17 plus line 18)  10 Program capital related cost (Line 3 times line 21)  11 Jour program capital related cost (Line 19 minus line 22)  12 Jour Program capital related cost (Line 19 minus line 22)  13 Jour Program capital related cost (Line 3 times line 21)  14 Jour Program capital related cost (Line 19 minus line 22)  15 Jour Program capital related cost (Line 20 minus line 22)  16 Jour Program capital related cost (Line 20 minus line 22)  17 Jour Program capit						2. 00	
Total general inpatient routine service cost  Rough FRIVATE ROOM DIFFERENTIAL ADJUSTMENT  6.00 General inpatient routine service charges  General inpatient routine service cost/charge ratio (Line 5 divided by line 6)  Ceneral inpatient routine service cost/charge ratio (Line 5 divided by line 6)  Enter private room charges from your records  Neverage private room per diem charge (Private room charges line 8 divided by private room days, line 2)  Enter semi-private room charges from your records  11, 565, 312  11, 00  Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)  Average semi-private room charge differential (Line 9 minus line 11)  Average per diem private room cost differential (Line 9 minus line 11)  Average per diem private room cost differential (Line 7 times line 12)  Average per diem private room cost differential (Line 2 times line 12)  Average per diem private room cost differential (Line 2 times line 13)  General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  Average and Inpatient routine service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Oral program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, 1930, 285  Line 30 for SNF; line 31 for NF, or line 32 for ICF/11D)  Program capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 3 times line 21)  Average per diem program routine service costs (From provider records)  Oral program routine service cost (Line 19 minus line 22)  Application representation of the cost limitation (Line 23 minus line 24)  Application representation of the cost limitation (Line 25 minus line 26) (1)  Reimburg representation of the cost limitation (							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service cost/charges 7. 00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 8. 00 Enter private room charges from your records 9. 00 Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) Captage semi-private room per diem charge (Semi-private room charges line 10, divided by 8. 00 Enter semi-private room per diem charge (Semi-private room charges line 10, divided by 8. 01 Semi-private room days) 10. 00 Enter semi-private room per diem charge (Semi-private room charges line 10, divided by 9. 01 Semi-private room days) 11. 00 Average semi-private room charge differential (Line 9 minus line 11) 12. 01 Average per diem private room cost differential (Line 7 times line 12) 13. 02 Average per diem private room cost differential (Line 7 times line 12) 14. 00 Private room cost differential adjustment (Line 2 times line 13) 15. 00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 17. 00 Program routine service cost per diem (Line 15 divided by line 1) 17. 00 Program routine service cost (Line 3 times line 16) 18. 00 Medically necessary private room cost applicable to program (line 4 times line 13) 19. 00 Total program general inpatient routine service cost (Line 17 plus line 18) 20. 00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF: line 31 for NF, or line 32 for ICF/IID) 21. 00 Program capital related costs (Line 20 divided by line 1) 22. 00 Program capital related costs (Line 20 divided by line 1) 23. 00 Inpatient routine service cost (Line 18 times line 21) 24. 00 Aggregate charges to beneficiaries for excess costs (From provider records) 25. 00 Inpatient routine service costs (Line 20 divided by line 1) 27. 00 Inpatient routine service cost (Line 3 times line 21) 28. 00 Inpatient routine service cost (Line 3 times line 21) 29. 00 Inpatient routine service cos					_	4. 00 5. 00	
General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Center private room charges from your records Center private room charges from your records Center semi-private room charges from your recor	5.00	9 1			1,829,301	5.00	
General inpatient routine service cost charge ratio (Line 5 divided by line 6)  Enter private room charges from your records  Neverage private room per diem charge (Private room charges line 8 divided by private room days, line  Average private room charges from your records  11, 565, 312  11. 00  Enter semi-private room charges from your records  Average semi-private room days)  Average per diem private room charge (Semi-private room charges line 10, divided by semi-private room days)  Average per diem private room cost differential (Line 9 minus line 11)  Average per diem private room cost differential (Line 7 times line 12)  Private room cost differential adjustment (Line 2 times line 13)  General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Redically necessary private room cost applicable to program (line 4 times line 13)  O Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF: line 31 for NF, or line 32 for ICF/IID)  Program capital related cost (Line 20 divided by line 1)  Program capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 19 minus line 21)  Jone Program capital related costs (Line 19 minus line 22)  Aggregate charges to benefic aries for excess costs (From provider records)  Total program routine service cost (Line 3 times line 21)  Total program routine service cost (Line 3 times line 21)  Total program routine service cost (Line 22 plus the lesser of line 25 or line 27)  Transfer to Worksheet E, Part II, line 4) (See instructions)	6 00				11 576 952	6.00	
Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 485.00 2) 10.00 Enter semi-private room charges from your records 11,565,312 1 11.00 Average semi-private room charges from your records 11,565,312 1 11.00 Average semi-private room charge differential (Line 9 minus line 11) 20.00 Average per diem private room charge differential (Line 7 times line 12) 27.73 28.00 Average per diem private room cost differential (Line 7 times line 12) 27.73 29.00 Average per diem private room cost differential (Line 7 times line 12) 20.00 Average per diem private room cost differential (Line 7 times line 12) 20.00 Average per diem private room cost differential (Line 5 minus line 14) 20.00 Average per diem private room cost differential (Line 5 minus line 14) 20.00 Average per diem private room cost differential (Line 5 minus line 14) 20.00 Average per diem private room cost differential (Line 5 minus line 14) 20.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 20.00 Program routine service cost (Line 3 times line 16) 20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, 11 on 20 for SNF; line 31 for NF, or line 32 for ICF/IID) 21.00 Per diem capital related costs (Line 20 divided by line 1) 22.00 Per diem capital related cost (Line 3 times line 21) 23.00 Inpatient routine service cost (Line 19 minus line 22) 24.00 Aggregate charges to beneficiaries for excess costs (From provider records) 25.00 Total program routine service cost for comparison to the cost limitation (Line 23 minus line 24) 26.00 Enter the per diem limitation (1) 27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 27) 29.00 Total program routine service cost limitation (Line 3 times the per diem limitation line 27) 20.01 Reimbursable inpatient routine service			vided by line 6)				
2) Enter semi-private room charges from your records 11. 00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12. 00 Average per diem private room charge differential (Line 9 minus line 11) 13. 00 Average per diem private room cost differential (Line 7 times line 12) 14. 00 Private room cost differential adjustment (Line 2 times line 12) 15. 00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 16. 00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17. 00 Program routine service cost (Line 3 times line 16) 18. 00 Medically necessary private room cost applicable to program (line 4 times line 13) 19. 00 Total program general inpatient routine service cost (Line 17 plus line 18) 20. 00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) 21. 00 Per diem capital related costs (Line 20 divided by line 1) 22. 00 Program capital related costs (Line 20 divided by line 1) 23. 00 Inpatient routine service cost (Line 19 minus line 22) 24. 00 Aggregate charges to beneficiaries for excess costs (From provider records) 25. 00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) 26. 00 Enter the per diem limitation (1) 27. 00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 28. 00 Rombursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 28. 00 (Transfer to Worksheet E, Part II, line 4) (See instructions)		,				ł	
10.00 Enter semi-private room charges from your records 11.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 12) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) 18.00 Medically necessary private room cost applicable to program (line 4 times line 13) 10.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF: line 31 for NF, or line 32 for ICF/IID) 19.00 Aggregate charges to beneficiaries for excess costs (From provider records) 19.00 Aggregate charges to beneficiaries for excess costs (From provider records) 19.00 Contail program routine service cost (Line 19 minus line 22) 20.00 Inpatient routine service cost (Line 19 minus line 22) 21.00 Inpatient routine service cost (Line 3 times line 21) 22.00 Inpatient routine service cost (Line 19 minus line 22) 23.00 Inpatient routine service cost (Line 19 minus line 22) 24.00 Aggregate charges to beneficiaries for excess costs (From provider records) 25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) 26.00 Inpatient routine service cost (Line 3 times the per diem limitation line 26) 27.01 Inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 28.00 Remarks for the cost limitation (Line 3 times the per diem limitation line 26) 29.00 Inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 29.00 Remarks for the cost limitation (Line 3 times the per diem limitation line 26) 29.00 Remarks for the cost limitation (Line 3 times the per	9.00	Average private room per diem charge (Private room charges line	8 divided by private	room days, line	485. 00	9. 00	
11. 00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)  12. 00 Average per diem private room charge differential (Line 9 minus line 11)  13. 00 Average per diem private room cost differential (Line 7 times line 12)  14. 00 Private room cost differential adjustment (Line 2 times line 13)  15. 00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  16. 00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  17. 00 Program routine service cost (Line 3 times line 16)  18. 00 Medically necessary private room cost applicable to program (line 4 times line 13)  19. 00 Total program general inpatient routine service cost (Line 17 plus line 18)  20. 00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21. 00 Per diem capital related costs (Line 20 divided by line 1)  22. 00 Program capital related costs (Line 20 divided by line 1)  23. 00 Inpatient routine service cost (Line 19 minus line 22)  24. 00 Aggregate charges to beneficiaries for excess costs (From provider records)  25. 00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  26. 00 Enter the per diem limitation (1)  27. 01 Inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)		2)					
semi-private room days)  12.00 Average per diem private room charge differential (Line 9 minus line 11)  Average per diem private room cost differential (Line 7 times line 12)  Private room cost differential adjustment (Line 2 times line 13)  General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  8.00 Medically necessary private room cost applicable to program (line 4 times line 13)  9.01 Total program general inpatient routine service cost (Line 17 plus line 18)  19.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 3 times line 21)  10.01 Inpatient routine service costs for excess costs (From provider records)  23.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)  Capital related cost (Line 19 minus line 22)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Capital related cost (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)							
12.00 Average per diem private room charge differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 27.73 1 14.00 Private room cost differential adjustment (Line 2 times line 13) 27.73 1 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 27.828,701 1 27.73 1 27.70 1 27.7	11. 00						
13. 00 Average per diem private room cost differential (Line 7 times line 12)  14. 00 Private room cost differential adjustment (Line 2 times line 13)  15. 00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  15. 00 PROGRAM INPATIENT ROUTINE SERVICE COSTS  16. 00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  17. 00 Program routine service cost (Line 3 times line 16)  18. 00 Medically necessary private room cost applicable to program (line 4 times line 13)  19. 00 Total program general inpatient routine service cost (Line 17 plus line 18)  20. 00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21. 00 Per diem capital related costs (Line 20 divided by line 1)  22. 00 Program capital related cost (Line 3 times line 21)  23. 00 Inpatient routine service cost (Line 19 minus line 22)  24. 00 Aggregate charges to beneficiaries for excess costs (From provider records)  25. 00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  26. 00 Enter the per diem limitation (1)  27. 73 1  28. 00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  27. 10 (Transfer to Worksheet E, Part II, line 4) (See instructions)	12 00		line 11)		41 00	12 00	
14.00 Private room cost differential adjustment (Line 2 times line 13)  General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  18.00 Medically necessary private room cost applicable to program (line 4 times line 13)  19.00 Total program general inpatient routine service cost (Line 17 plus line 18)  20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Program capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  35.68 Zero Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Total program routine service costs (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)							
15.00   General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)   7,828,701   7,						1	
16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  17.00 Program routine service cost (Line 3 times line 16)  18.00 Medically necessary private room cost applicable to program (line 4 times line 13)  19.00 Total program general inpatient routine service cost (Line 17 plus line 18)  20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 20 divided by line 1)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  27.00 Enter the per diem limitation (1)  10.00 Inpatient routine service cost (Line 22 plus the lesser of line 25 or line 27)  28.00 (Transfer to Worksheet E, Part II, line 4) (See instructions)				minus line 14)		1	
17.00 Program routine service cost (Line 3 times line 16)  18.00 Medically necessary private room cost applicable to program (line 4 times line 13)  19.00 Total program general inpatient routine service cost (Line 17 plus line 18)  20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 20 divided by line 1)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  27.00 Enter the per diem limitation (1)  17.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)			,	, ,			
18.00 Medically necessary private room cost applicable to program (line 4 times line 13)  19.00 Total program general inpatient routine service cost (Line 17 plus line 18)  20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 3 times line 21)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  29.00 (Transfer to Worksheet E, Part II, line 4) (See instructions)			ded by line 1)				
19.00 Total program general inpatient routine service cost (Line 17 plus line 18)  20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 3 times line 21)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  25.00 Enter the per diem limitation (1)  27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)							
20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 3 times line 21)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  26.00 Enter the per diem limitation (1)  27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)					_	18.00	
line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 3 times line 21)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  26.00 Enter the per diem limitation (1)  27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)				+ II column 10			
21.00 Per diem capital related costs (Line 20 divided by line 1)  22.00 Program capital related cost (Line 3 times line 21)  23.00 Inpatient routine service cost (Line 19 minus line 22)  24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  26.00 Enter the per diem limitation (1)  27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)	20.00		IS (FIONEWRS). B, Par	t II Corumn 18,	930, 285	20.00	
22.00 Program capital related cost (Line 3 times line 21)  33.00 Inpatient routine service cost (Line 19 minus line 22)  44.00 Aggregate charges to beneficiaries for excess costs (From provider records)  50, 166 2  372, 014 2  28.00 Enter the per diem limitation (1)  1 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)	21. 00				35. 68	21. 00	
23.00 Inpatient routine service cost (Line 19 minus line 22) 24.00 Aggregate charges to beneficiaries for excess costs (From provider records) 25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) 26.00 Enter the per diem limitation (1) 27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)							
24.00 Aggregate charges to beneficiaries for excess costs (From provider records)  25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  26.00 Enter the per diem limitation (1)  27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)							
26.00 Enter the per diem limitation (1) 27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			ider records)			24. 00	
27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		' '	limitation (Line 23 mi	nus line 24)	372, 014		
28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		) Enter the per diem limitation (1)					
(Transfer to Worksheet E, Part II, line 4) (See instructions)							
	28. 00		Tesser of line 25 or	line 27)		28. 00	
(1) Lines 20 and 27 are not appricable for title AVIII, but may be used for title V and or title AIA	(1) !:		d for title V and or t	itla YIY	I	I	
	(1)	nes 20 and 27 are not appricable for title AVIII, but may be use		THE MIN			
1.00					1 00		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		i
1.00	Total SNF inpatient days	26, 072	1.00
2.00	Program inpatient days (see instructions)	1, 406	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. 053928	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	RI DGEWOOD CEN	TER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE	XVIII	Provi der No.: 315158	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/13/2024 9:37 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			1, 076, 852	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)	,		1, 076, 852	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			190, 600	5. 00
6.00	Allowable bad debts (From your records)			161, 954	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		154, 174	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			105, 270	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)			991, 522	11. 00
12.00	Interim payments (See instructions)			945, 513	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)		2, 105	14. 75	
14. 99	Sequestration amount (see instructions)		17, 725	14. 99	
15. 00	Balance due provider/program (see Instructions)	26, 179	15. 00		
16. 00	Protested amounts (Nonallowable cost report items in accordance		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	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)				18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)		1	7, 300	
20. 00	Medicare Part B ancillary charges (See instructions)			6, 710	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			6, 710	
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	
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)		6, 710		
26. 00	Interim payments (See instructions)		2, 960		
27. 00	Tentative adjustment	0			
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			134	
29.00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	a with CMS Dub 15 2	section 115 2	3, 616 0	
30.00	processed amounts (nonarrowable cost report realis) ill accordance	c with ows rub. 15-2,	36611011 113. 2	O <sub>1</sub>	30.00

Health Financial Systems	RI DGEWOOD CEN	TER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315158	From 01/01/2023	Worksheet E Part II Date/Time Prepared: 5/13/2024 9:37 am
		Title XIX	Skilled Nursing	PPS

		II tie xix	Facility	PPS	
		1	raciiity		
				1.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		<u> </u>		
1.00	Inpatient ancillary services (see Instructions)			0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	3. 00
4.00	Inpatient routine services (see instructions)			0	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			0	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			0	8. 00
9.00	Primary payor amounts			0	9. 00
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	
14. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services o	n 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	
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
20. 00	Cost of covered services (see Instructions)			0	
21.00	Deductibles			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)		6	0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl cost limit	y collected based on co	orrection of	0	27. 00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	orogram	0	28. 00
20.00	utilization	tron or a decrease in	or ogram	0	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	eciable assets (	0	
	if minus, enter amount in parentheses)				
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32.00	1	•		0	32. 00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	neses) (see	0	33. 00
	Instructions)				

VALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315158
Period:
From 01/01/2023
To 12/31/2023
Date/Time Prepared:
5/13/2024 9: 37 am

Title XVIII
Skilled Nursing
PPS

		liti	e XVIII S	Killed Nursing	PPS	
		I npati en	t Dort A	Facility	t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		941, 349		2, 960	1
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	enter zero					0.00
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	05/26/2023	4, 164		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER	03/20/2023	4, 104			
3. 02			0		0	
3.03			0			
3. 04			0			
3.03	Provider to Program		U		0	3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51	ADSOSTMENTS TO TROOKAM		0		0	
3. 52			0		ا م	
3. 53			0		ا	
3. 54			0		ام	
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		4, 164		ا م	
	- 3. 98)		.,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		945, 513		2, 960	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)					
E 04	Program to Provider		0			- 04
5. 01	TENTATIVE TO PROVIDER		0		0	
5. 02 5. 03			0			
5.03	Provider to Program		U		U	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROOMANI		0		0	
5. 52			0		ا	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		ا	
0. ,,	- 5. 98)		ŭ			0.77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		26, 179		3, 616	6. 01
6.02	PROVI DER TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		971, 692		6, 576	7. 00
			Contract	tor Name	Contractor	
					Number	
			1.	00	2.00	
	Name of Contractor					8. 00

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

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

Provider No.: 315158 Period: From 01/0

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

onl y)	•			lo 12/31/2023	Date/lime Pre 5/13/2024 9:3	
		General Fund	Speci fi c	Endowment Fund	•	T GIII
		1.00	Purpose Fund 2.00	3.00	4. 00	
	Assets	1.00	2.00	0.00	1. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	10, 186		0	0	
2.00	Temporary investments	0		0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	1, 248, 656			0	
5.00	Other receivables	-67, 833			0	
6. 00	Less: allowances for uncollectible notes and accounts	-217, 327	•	ol ol	0	
	recei vabl e	, ,				
7.00	Inventory	45, 709	) (	0	0	
8.00	Prepai d expenses	-31, 036	)	0	0	1
9.00	Other current assets	0		0	0	
10. 00 11. 00	Due from other funds	988, 355		0 0	0	
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10) FIXED ASSETS	988, 333		<u>)</u>	U	11.00
12. 00	Land	1 0		ol lo	0	12. 00
13. 00	Land improvements	54, 345	1		0	
14.00	Less: Accumulated depreciation	-20, 923		o o	0	
15.00	Bui I di ngs	3, 210, 378	3	o	0	15. 00
16.00	Less Accumulated depreciation	-970, 043	3	o	0	16. 00
17.00	Leasehold improvements	439, 139		0	0	17. 00
18.00	Less: Accumulated Amortization	-231, 610	)	0	0	18. 00
19. 00	Fi xed equipment	110, 418		0	0	
20. 00	Less: Accumulated depreciation	-78, 587	'	0	0	
21. 00	Automobiles and trucks	0	)	0	0	
22. 00	Less: Accumulated depreciation	0		0	0	
23. 00	Major movable equipment	415, 766	1	0	0	
24. 00	Less: Accumulated depreciation	-349, 693	1	0	0	
25. 00	Mi nor equipment - Depreciable	0			0	1
26. 00	Mi nor equi pment nondepreci abl e	0			0	
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 579, 190	1		0	
26.00	OTHER ASSETS (Suil of Titles 12 - 27)	2, 379, 190	1	<u> </u>	U	20.00
29. 00	Investments			0	0	29. 00
30.00	Deposits on Leases	0	1		0	
31. 00	Due from owners/officers	-7, 660, 696			0	
32.00	Other assets	0		o	0	
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-7, 660, 696		o	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	-4, 093, 151	(	0	0	34.00
	Liabilities and Fund Balances					
	CURRENT LI ABI LI TI ES					٠
35. 00	Accounts payable	1, 053, 600		0	0	
36.00	Salaries, wages, and fees payable	0			0	
37. 00	Payroll taxes payable (Shart tarm)	0			0	
38. 00 39. 00	Notes & loans payable (Short term) Deferred income				0	
40.00	Accel erated payments				U	40.00
41.00		65	,		0	
42. 00	Other current liabilities	1, 504, 651	1	o o	0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 558, 316		0	0	
	LONG TERM LIABILITIES			-,		1
44.00	Mortgage payable	3, 956, 107	'	0 0	0	44. 00
45.00	Notes payable	0		o	0	45. 00
46.00	Unsecured Loans	0	)	0	0	46. 00
47.00	Loans from owners:	0	)	0	0	47. 00
48.00	Other long term liabilities	0	)	0	0	
49. 00	APIC DISTRIBUTIONS; R/E EARNINGS	-10, 066, 532	1	0	0	
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-6, 110, 425		0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-3, 552, 109	) (	0	0	51.00
E2 00	CAPITAL ACCOUNTS	E41 042	,			00
52. 00 53. 00	General fund balance Specific purpose fund	-541, 042	1			52.00
54.00	Donor created - endowment fund balance - restricted			ر ا		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
58.00		1			_	1
58. 00	replacement, and expansion					
58. 00 59. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-541, 042	2	o	0	59.00
		-541, 042 -4, 093, 151	1	0 0	0	

 
 Feet
 In Lieu of Form CMS-2540-10

 Provider No.: 315158
 Period: From 01/01/2023 To 12/31/2023
 Worksheet G-1

 Date/Time Prepared:
 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES RI DGEWOOD CENTER

					То	12/31/2023	Date/Time Prep 5/13/2024 9:3	
		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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		0 -541, 042 -541, 042			0		1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	Additions (credit adjustments)	0			0		0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00		0			0		0	7. 00 8. 00 9. 00
10. 00 11. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	U	0 -541, 042			0		10. 00 11. 00
12. 00 13. 00 14. 00	Deductions (debit adjustments)	0			0		0	14. 00
15. 00 16. 00 17. 00		0 0 0			0 0 0		0 0	15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)		0 -541, 042			0		18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	0			0			1. 00 2. 00
3. 00 4. 00 5. 00 6. 00	Total (sum of line 1 and line 2) Additions (credit adjustments)	0	0		0			3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00			0					7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	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	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0	0		0			17. 00 18. 00 19. 00

Health Financial Systems	RI DGEWOOD CENTER		In Lieu of Form CMS-2540-10			
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No. : :	315158	Peri od:	Worksheet G-2		
			From 01/01/2023			
				D 1 /T' D 1		

	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		11, 600, 47	1	11, 600, 471	1.00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		11, 600, 47	1	11, 600, 471	5. 00
	All Other Care Services		•	*		1
6.00	ANCI LLARY SERVI CES		1, 303, 01	4 0	1, 303, 014	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
	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11.00
11. 10	CORF			0	Ō	11. 10
	HOSPI CE			0 0	Ō	12. 00
	OTHER (SPECIFY)			0 0	Ō	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	12, 903, 48			
00	Worksheet G-3, Line 1)		12,700,10		12,700,100	
	Cost Center Description		•			
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				9, 050, 207	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	Ĭ	9.00
10. 00	bedder (Speerry)			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	
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				9, 050, 207	
15.00	Trotal operating Expenses (Sum of Times Fand 6, IIII has Title 14)			I	7, 000, 207	1 13.00

Heal th	Financial Systems RIDGEWOOD	RI DGEWOOD CENTER			In Lieu of Form CMS-2540-10			
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Prov	i der No.: 315158	Peri o		Worksheet G	3	
					01/01/2023	D-+- /T: D-		
				То	12/31/2023	Date/Time Pr 5/13/2024 9:		
						1. 00		
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, li	i ne 14)		•		12, 903, 48	5 1.00	
2.00 Less: contractual allowances and discounts on patients accounts				4, 421, 75	6 2.00			
3.00	Net patient revenues (Line 1 minus line 2)					8, 481, 72	9 3.00	
4.00	Less: total operating expenses (From Worksheet G-2, Part II	I, line 15)	)			9, 050, 20	7 4.00	
5.00	Net income from service to patients (Line 3 minus 4)					-568, 47	8 5.00	

		5/13/2024 9:3	<u>/ am</u>			
		1. 00				
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	12, 903, 485	1. 00			
2.00	Less: contractual allowances and discounts on patients accounts	4, 421, 756	2. 00			
3.00	Net patient revenues (Line 1 minus line 2)	8, 481, 729	3. 00			
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	9, 050, 207	4. 00			
5.00	Net income from service to patients (Line 3 minus 4)	-568, 478	5. 00			
	Other income:					
6.00	Contributions, donations, bequests, etc	0	6. 00			
7.00	Income from investments	0	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 discounts	0	10. 00			
11. 00	Rebates and refunds of expenses	0	11. 00			
12. 00	Parking lot receipts	0	12. 00			
13. 00	Revenue from laundry and linen service	0	13. 00			
14. 00	Revenue from meals sold to employees and guests	0	14. 00			
15. 00	Revenue from rental of living quarters	0	15. 00			
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00			
17. 00	Revenue from sale of drugs to other than patients	0	17. 00			
18. 00	Revenue from sale of medical records and abstracts	0	18. 00			
19. 00		0	19. 00			
20. 00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00			
21. 00	Rental of vending machines	0	21. 00			
22. 00	Rental of skilled nursing space	0	22. 00			
23. 00	Governmental appropriations	0	23. 00			
24. 00	MISC INCOME	27, 436				
24. 50	COVI D-19 PHE Fundi ng	0	24. 50			
25. 00	Total other income (Sum of lines 6 - 24)	27, 436				
26. 00	Total (Line 5 plus line 25)	-541, 042				
27. 00	Other expenses (specify)	0	27. 00			
28. 00		0	28. 00			
29. 00		0	29. 00			
30.00		0	30. 00			
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	-541, 042	31.00			