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

OMB NO. 0938-0463

Expires: 12/31/2021

			EXPIT 03. 12/01/202
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315377	From 01/01/2022	Worksheet S Parts I, II & III Date/Time Prepared:

			4/	10/2023 10.39 alli
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost re	ort	Date: 4/18/2023	Time: 10:59 an
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report en	er the number of times th	e provider resubmitted this o	ost report
	3.01 [] No Medicare Utilization. Enter '	Y" for yes or leave blank	for no.	
Contractor	4. [1]Cost Report Status	6. Contractor No.		
use only	(1) As Submitted	7. [N] First Cost Report	for this Provider CCN	
	(2) Settled without audit	8. [N] Last Cost Report	for this Provider CCN	
	(3) Settled with audit	9. NPR Date:		
	(4) Reopened	10.[0]If line 4. column	1 1 is "4": Enter number of ti	mes reopened
	(5) Amended	11. Contractor Vendor Code		,
	5. Date Received:	12.[F] Medicare Utilizat	tion. Enter "F" for full, "L"	for low, or "N"
		for no utilization	on.	

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 THE ACTORS FUND NURSING HOME (315377) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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	Jord	dan Strohl	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	Jordan Strohl			2
3	Signatory Title	ADMI NI STRATOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-9, 478	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-9, 478	0	0	100.00
Tho ob	reverse amounts represent "due to" or "due from" the applicable	program for th	o alamant of the	no obovo compl	ov indicated	

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

Health Financial Systems THE ACTORS FUND NURSING HOME In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315377 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 4/18/2023 10:59 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 175 WEST HUDSON AVENUE PO Box: 1.00 2.00 City: ENGLEWOOD State: NJ Zi p Code: 07631 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 THE ACTORS FUND NURSING 315377 12/01/1994 N Р Ν 4.00 HOME 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12 00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related N 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 1, 700, 695 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 1, 700, 695 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0 0

Heal th	Financial Systems	THE ACTORS FUND NURS	SING HOME	In Lieu	u of Form CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315377 Period:			Worksheet S-2		
COMPLE	X INDENTIFICATION DATA			From 01/01/2022	Part I	
				To 12/31/2022		
					4/18/2023 10:	59 am_
				Y/N		
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative	e and General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing co	ost centers and		
	amounts.		_			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addre	ess of the home		44. 00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3.00		
	If this facility is part of a chain or	ganization, enter the name	e and address of t	he home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Cont	tractor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zi p	Code:		47. 00

Health Financial Systems	THE ACTORS FUND NUR	SING HOME		In Lie	eu of Form CMS	-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACI COMPLEX REIMBURSEMENT QUESTIONNAIRE			No.: 315377	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S- Part II Date/Time Pr	2 epared:
				Y/N	4/18/2023 10 Date	. 59 alli
General Instruction: For all column 1 respresponses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites		1, "Y" fo	or Yes or "N"	1.00 for No. For all	the date	
Provider Organization and Operation 1.00 Has the provider changed ownership immedia reporting period? If column 1 is "Y", ente instructions)	tely prior to the beg r the date of the cha	inning of nge in col	umn 2. (see	N		1. 00
			1.00	2. 00	V/I 3. 00	
2.00 Has the provider terminated participation column 1 is yes, enter in column 2 the dat 3, "V" for voluntary or "I" for involuntary	e of termination and		N			2. 00
3.00 Is the provider involved in business trans contracts, with individuals or entities (e or medical supply companies) that are rela officers, medical staff, management person of directors through ownership, control, o relationships? (see instructions)	g., chain home offic ted to the provider o nel, or members of th	es, drug r its e board	N			3. 00
			Y/N 1.00	Type 2. 00	Date 3.00	
Financial Data and Reports 4.00 Column 1: Were the financial statements pr Accountant? (Y/N) Column 2: If yes, enter Compiled, or "R" for Reviewed. Submit comp	"A" for Audited, "C" lete copy or enter da	for te	Υ	C C	3.00	4. 00
available in column 3. (see instructions) 5.00 Are the cost report total expenses and tot those on the filed financial statements? I reconciliation.	al revenues different	from	N			5. 00
				Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities						
6.00 Column 1: Were costs claimed for Nursing S legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Program. 8.00 Were approvals and/or renewals obtained du	ams? (Y/N) see instru	ctions.		N N N	N	6. 00 7. 00 8. 00
School and/or Allied Health Program? (Y/N)					Y/N	
					1.00	
9.00 Is the provider seeking reimbursement for 10.00 If line 9 is "Y", did the provider's bad d period? If "Y", submit copy.				st reporting	Y N	9. 00 10. 00
11.00 If line 9 is "Y", are patient deductibles	and/or coinsurance wa	ived? If "	Y", see instr	ructi ons.	N	11. 00
Bed Complement 12.00 Have total beds available changed from pri	or cost reporting per	iod?lf"Y			N	12. 00
	Descriptio	n	Y/N	art A Date	Part B Y/N	
DC+D Do+o	0		1.00	2. 00	3. 00	
PS&R Data 13.00 Was the cost report prepared using the PS& 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.)	R		Y	03/20/2023	Y	13. 00
14.00 Was the cost report prepared using the PS& 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 us to prepare this cost report in columns 2 a 4.	ed		N		N	14. 00
15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims th have been billed but are not included on t PS&R used to file this cost report? If "Y" see Instructions.	he		N		N	15. 00
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			N		N 	17. 00
18.00 Was the cost report prepared only using th provider's records? If "Y" see Instruction			N		N	18. 00

Health Financial Systems	THE ACTORS FUND	NURSING HOME		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACI	LITY HEALTH CARE	Provi der		Peri od:	Worksheet S-2	!
COMPLEX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022		pared: 59 am
		1.	. 00	2. (00	
Cost Report Preparer Contact Information				_		
19.00 Enter the first name, last name and the ti	tle/position	CHRI S		GUI LBAULT		19. 00
held by the cost report preparer in columns	s 1, 2, and 3,					
respecti vel y.						
20.00 Enter the employer/company name of the cost	t report	HEALTH CARE RE	ESOURCES			20. 00
preparer.						
21.00 Enter the telephone number and email address		609-987-1440		CHRI S. GUI LBAULT	Γ@HCRNJ. NET	21. 00
report preparer in columns 1 and 2, respect	ti vel y.					

Health Financial Systems THE ACTORS FUND SKILLED NURSING FACILITY HEALTH CARE THE ACTORS FUND NURSING HOME Provi der No.: 315377

COMPLEX REIMBURSEMENT QUESTIONNAIRE

OOMI EE	A REFINDORSEMENT GOESTFORWARE			To 12/31/2022	Date/Time Pre 4/18/2023 10:	
		Part B			., .,	
		Date				
		4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	03/20/2023				13. 00
	only? If either col. 1 or 3 is "Y", enter					
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
	4. (see Instructions.)					
14. 00	Was the cost report prepared using the PS&R					14. 00
	for total and the provider's records for					
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
45.00	4.					45.00
15. 00	If line 13 or 14 is "Y", were adjustments					15. 00
	made to PS&R data for additional claims that					
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y",					
1/ 00	see Instructions. If line 13 or 14 is "Y", then were					16. 00
16. 00						16.00
	adjustments made to PS&R data for					
	corrections of other PS&R Report information? If yes, see instructions.					
17 00	If line 13 or 14 is "Y", then were					17. 00
17.00	adjustments made to PS&R data for Other?					17.00
	Describe the other adjustments:					
18. 00	Was the cost report prepared only using the					18. 00
10.00	provider's records? If "Y" see Instructions.					10.00
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title		PREPARER			19. 00
	held by the cost report preparer in columns 1	, 2, and 3,				
00.00	respecti vel y.					00.00
20. 00	Enter the employer/company name of the cost r	report				20. 00
04.00	preparer.					04.00
21.00	Enter the telephone number and email address					21. 00
	report preparer in columns 1 and 2, respective	ei y.				I

Health Financial Systems THE ACTORS FUND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

					7 12/31/2022	4/18/2023 10: 5	
				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	107	39, 055		5, 485	16, 518	1.00
2.00	NURSING FACILITY	0	0			0	2.00
3.00	I CF/II D	0	0		0	0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST	62	22 420	0	0	0	4. 00 5. 00
6.00	Other Long Term Care SNF-Based CMHC	02	22, 630				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	169	61, 685		5, 485	16, 518	8. 00
	1.000. (00 0	Inpatient D			Di scharges	13/313	<u> </u>
	Component	Other (22	Total	Title V	Title XVIII	Title XIX	
1 00	CKILLED MUDCING FACILLEY	6. 00	7. 00 32, 446	8. 00	9. 00 148	10.00	1. 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	10, 443	32, 440		148	0	2. 00
3.00	ICF/IID		0	U			3. 00
4. 00	HOME HEALTH AGENCY COST	0	0				4. 00
5. 00	Other Long Term Care	16, 086	16, 086				5. 00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	26, 529			148	19	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	-	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	36			37. 06	869. 37	1.00
2.00	NURSING FACILITY	0	0			0.00	2.00
3. 00 4. 00	HOME HEALTH AGENCY COST		U			0. 00	3. 00 4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC		0				6. 00
7. 00	HOSPI CE	o	0	0.00	0.00	0.00	7. 00
8.00	Total (Sum of lines 1-7)	36	203	0.00	37.06	869. 37	8.00
		Average Length		Admi s	si ons		
	Companant	of Stay	T: +1 o V	Title XVIII	T: +I o VI V	Othon	
	Component	Total 16. 00	Title V 17.00	18. 00	Title XIX 19.00	0ther 20.00	
1.00	SKILLED NURSING FACILITY	159. 83			19.00	20.00	1. 00
2.00	NURSING FACILITY	0.00	0	107	0	0	2. 00
3. 00	ICF/IID	0.00	J		0	ol ol	3. 00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7. 00	HOSPICE	0.00	0		0	0	7. 00
8. 00	Total (Sum of lines 1-7)	239. 07 Admi ssi ons	Full Time	169 Equi val ent	9	25	8. 00
	Component	Total	Employees on	Nonpai d			
		21. 00	Payrol I 22. 00	Workers 23.00			
1. 00	SKILLED NURSING FACILITY	21.00	117. 50				1. 00
2.00	NURSING FACILITY	0					2. 00
3. 00	ICF/IID	o					3. 00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	0					5.00
6. 00	SNF-Based CMHC		0.00				6. 00
7.00	HOSPI CE	0					7. 00
8. 00	Total (Sum of lines 1-7)	203	164. 40	0.00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315377

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

					0 12/31/2022	4/18/2023 10:	
		Amount	Reclass. of	Adjusted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES		_		1		
1.00	Total salaries (See Instructions)	9, 318, 344	0	9, 318, 344	· ·		1.00
2.00	Physician salaries-Part A	0	0	9	0. 00		2. 00
3.00	Physician salaries-Part B	0	0	9	0.00		3. 00
4.00	Home office personnel	0	0	9	0. 00		4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	9, 318, 344	l e	9, 318, 344	· ·		6. 00
7.00	Other Long Term Care	882, 025	0	882, 025	· ·		7. 00
8.00	HOME HEALTH AGENCY COST	0	0) c	0.00		8. 00
9.00	CMHC	0	0) c	0.00		9. 00
10. 00	HOSPI CE	0	0	C	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	882, 025	0	882, 025	43, 927. 00	20. 08	12.00
	through 11)						
13. 00	Total Adjusted Salaries (line 6 minus line	8, 436, 319	0	8, 436, 319	298, 121. 00	28. 30	13.00
	12)						
4	OTHER WAGES & RELATED COSTS	1 015 700		1 4 045 700		·	
14.00	Contract Labor: Patient Related & Mgmt	1, 815, 739	0	1, 815, 739	·		14.00
15. 00	Contract Labor: Physician services-Part A	0	0	9	0. 00		15. 00
16. 00	Home office salaries & wage related costs	0		<u> </u>	0.00	0.00	16. 00
	WAGE-RELATED COSTS		_				
17. 00	Wage-related costs core (See Part IV)	3, 394, 409	0	3, 394, 409			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	324, 232	0	324, 232			19. 00
20. 00	Physician Part A - WRC	0	0	l c			20. 00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	3, 070, 177	0	3, 070, 177			22. 00
	instructions)			1			

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315377

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared:

						4/18/2023 10:	59 am
		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	1, 616, 399	0	1, 616, 399	39, 481. 00	40. 94	2. 00
3.00	Plant Operation, Maintenance & Repairs	245, 725	0	245, 725	7, 889. 00	31. 15	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	471, 062	0	471, 062	28, 258. 00	16. 67	5. 00
6.00	Di etary	1, 132, 922	0	1, 132, 922	59, 351. 00	19. 09	6. 00
7.00	Nursing Administration	569, 363	0	569, 363	12, 070. 00	47. 17	7. 00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10. 00
11. 00	Soci al Servi ce	0	0	0	0.00	0.00	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	274, 682	0	274, 682	11, 958. 00	22. 97	13.00
14. 00	Total (sum lines 1 thru 13)	4, 310, 153	0	4, 310, 153	159, 007. 00	27. 11	14. 00

Health Financial Systems	THE ACTORS FUND NURSING HOME	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315377	Peri od: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

	To 12/31/202		
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List]
	RETI REMENT COST		1
1.00	401K Employer Contributions	475, 806	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	•	
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 931, 313	8.00
9.00	Prescription Drug Plan	0	
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	
	Disability Insurance (If employee is owner or beneficiary)	15, 434	
14. 00	1 3	0	1
15. 00	Workers' Compensation Insurance	171, 373	
16. 00	· ·	0	
	Non cumul ative portion)		
	TAXES	<u>'</u>	1
17.00	FICA-Employers Portion Only	695, 183	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00		0	19. 00
	State or Federal Unemployment Taxes	105, 300	
	OTHER		
21. 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	o o	
	Tui ti on Rei mbursement	o o	
	Total Wage Related cost (Sum of Lines 1 - 23)	3, 394, 409	
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
		•	•

Provi der No.: 315377

				T	o 12/31/2022		
	Occupational Category	Amount	Fri nge	Adjusted	Pai d Hours	Average Hourly	
	3 3	Reported		Salaries (col.		Wage (col. 3 ÷	
				1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	921, 320	303, 554		·		1.00
2.00	Licensed Practical Nurses (LPNs)	1, 315, 104	433, 297				2.00
3.00	Certified Nursing Assistant/Nursing	1, 831, 730	603, 513	2, 435, 243	80, 976. 00	30. 07	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	4, 068, 154	1, 340, 364	5, 408, 518			4. 00
5.00	Physical Therapists	0	0	0	0. 00		5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		
7. 00	Physical Therapy Aides	58, 012	19, 114	77, 126			7. 00
8.00	Occupational Therapists	0	0	0	0. 00		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0. 00		9. 00
10. 00	Occupational Therapy Aides	0	0	0	0. 00		
11. 00	Speech Therapists	0	0	0	0.00		
12.00	Respi ratory Therapi sts	0	0	_	0. 00		12.00
13. 00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
	Registered Nurses (RNs)	0		0			14.00
	Licensed Practical Nurses (LPNs)	267, 500		267, 500	·		
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	350, 998		350, 998	9, 772. 00	35. 92	16. 00
17.00	Total Nursing (sum of lines 14 through 16)	618, 498		618, 498	14, 684. 00	42. 12	17.00
18.00	Physical Therapists	314, 183		314, 183	3, 380. 00	92. 95	18.00
19. 00	Physical Therapy Assistants	302, 099		302, 099	3, 900. 00	77. 46	19.00
20. 00	Physical Therapy Aides	0		0	0.00		20. 00
21.00	Occupational Therapists	208, 306		208, 306	3, 640. 00	57. 23	21. 00
22. 00	Occupational Therapy Assistants	185, 988		185, 988	·		
23. 00	Occupational Therapy Aides	0		0	0.00		23. 00
24.00	Speech Therapists	186, 666		186, 666	3, 900. 00		
25. 00	Respiratory Therapists	0		0	0.00		
26. 00	Other Medical Staff	O		0	0.00		26.00
	•				•	. '	

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Peri od: Worksheet S-7 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 4/18/2023 10:59 am Provi der No.: 315377

	10 12/31/202	4/18/2023 10:59 am
	Group	Days
	1.00	2.00
1.00	RUX	1.00
2. 00 3. 00	RUL RVX	2.00
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 11. 00	RUC RUB	10.00
12.00	RUA	12. 00
13. 00	RVC	13. 00
14. 00	RVB	14. 00
15. 00	RVA	15. 00
16.00	RHC	16. 00
17. 00	RHB	17. 00
18. 00 19. 00	RHA RMC	18. 00 19. 00
20. 00	RMB	20.00
21. 00	RMA	21. 00
22. 00	RLB	22. 00
23. 00	RLA	23. 00
24.00	ES3	24.00
25. 00 26. 00	ES2 ES1	25. 00 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 33. 00	HC1 HB2	32. 00 33. 00
34. 00	HB1	34.00
35. 00	LE2	35. 00
36. 00	LE1	36.00
37. 00	LD2	37. 00
38.00	LD1	38.00
39. 00 40. 00	LC2 LC1	39. 00 40. 00
41.00	LB2	41. 00
42. 00	LB1	42. 00
43. 00	CE2	43. 00
44.00	CE1	44. 00
45. 00	CD2	45. 00
46. 00 47. 00	CD1 CC2	46. 00 47. 00
48. 00	CC1	48. 00
49. 00	CB2	49. 00
50. 00	CB1	50.00
51. 00	CA2	51. 00
52.00	CA1	52. 00
53. 00 54. 00	SE3 SE2	53. 00 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 61. 00	I B1 I A2	60.00
62. 00	I A1	62.00
63. 00	BB2	63. 00
64. 00	BB1	64. 00
65. 00	BA2	65. 00
66.00	BA1	66.00
67. 00 68. 00	PE2 PE1	67. 00 68. 00
69. 00	PET PD2	69. 00
70.00	PD1	70. 00
71. 00	PC2	71. 00
72. 00	PC1	72.00
73. 00	PB2	73. 00
74.00	PB1	74.00
75. 00	PA2	75. 00

Health Financial Systems	THE ACTORS FUND NURSING HOME		In Lieu of Form CMS-2540-10				
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider			Worksheet S-7	'		
			From 01/01/2022 To 12/31/2022				
			Group	Days			
			1. 00	2. 00			
76. 00			PA1		76. 00		
99. 00			AAA		99. 00		
100. 00 TOTAL					100.00		
		Expenses	Percentage	Y/N			
		1.00	2. 00	3. 00			
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101. 00 Staffi ng 102. 00 Recrui tment					101. 00 102. 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 1, column 3)				106. 00		

Heal th	Financial Systems	THE ACTORS FUND N	NURSING HOME		In Lie	u of Form CMS-2	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2022 Fo 12/31/2022	Date/Time Pre	narod:
					10 12/31/2022	4/18/2023 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
	·			+ col . 2)	ons	Trial Balance	
					I ncrease/Decre	(col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)		
	DENERAL DEPUT DE COOT DENTERO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS	1	2 407 707	2 407 70	,	2 407 707	1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		2, 486, 606	2, 486, 600	1	2, 486, 606	1. 00 2. 00
2.00	00300 EMPLOYEE BENEFITS	0	3, 425, 401	3, 425, 40°	-	2 425 401	3.00
3. 00 4. 00	00400 ADMINISTRATIVE & GENERAL	1, 616, 399	968, 781	2, 585, 180		3, 425, 401 2, 585, 180	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	245, 725	897, 405			1, 143, 130	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	245, 725	81, 209			81, 209	6.00
7. 00	00700 HOUSEKEEPING	471, 062	102, 561	573, 623		573, 623	7. 00
8. 00	00800 DI ETARY	1, 132, 922	913, 165			2, 046, 087	8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	569, 363	713, 103	569, 36		569, 363	
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0	007,000		0	
11. 00	01100 PHARMACY	0	0	ĺ		0	11.00
12. 00	l l	0	0			0	12.00
13. 00	01300 SOCIAL SERVICE	0	0	ĺ		0	13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		ol ol	0	14. 00
	01500 PATIENT ACTIVITIES	274, 682	36, 462	311, 14	4 0	311, 144	
	INPATIENT ROUTINE SERVICE COST CENTERS		227 .22	2,	-,	21.71.11	
30.00	03000 SKILLED NURSING FACILITY	4, 068, 154	1, 162, 034	5, 230, 188	3 0	5, 230, 188	30.00
31.00		0	0		ol	0	31.00
32.00	03200 CF/IID	o	0		ol	0	32. 00
33.00		882, 025	0	882, 02	5 0	882, 025	33. 00
	ANCILLARY SERVICE COST CENTERS					-	
40.00	04000 RADI OLOGY	0	0	(0	0	40. 00
41.00	04100 LABORATORY	0	319, 882	319, 882	0	319, 882	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	(0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	58, 012	645, 446	· ·		703, 458	
45. 00	04500 OCCUPATI ONAL THERAPY	0	394, 294	'		394, 294	
46. 00	04600 SPEECH PATHOLOGY	0	186, 666	186, 666	6 0	186, 666	
47. 00	04700 ELECTROCARDI OLOGY	0	0	(이	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	94, 512	94, 512	0	94, 512	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	9		0	
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	U	0	(0	0	51. 00
40.00	06000 CLINIC		٥	· ,		0	60.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0)		0	
	06200 FQHC		U	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		U	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70 00	07000 HOME HEALTH AGENCY COST	0	0	(0	70. 00
	07100 AMBULANCE	0	0	ì		0	
	07300 CMHC	o o	0	ĺ		0	
70.00	SPECIAL PURPOSE COST CENTERS	J	<u> </u>		<u> </u>	0	70.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(0	0	80. 00
81. 00	1 1		0		o	0	1
82.00	08200 UTILIZATION REVIEW - SNF	o	0		ol	0	
83.00	08300 HOSPI CE	o	0	(o	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	9, 318, 344	11, 714, 424	21, 032, 768	0	21, 032, 768	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00		0	0		0	0	90. 00
	09100 BARBER AND BEAUTY SHOP	0	0	(이	0	
	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	(이	0	
	09300 NONPAI D WORKERS	0	0	(이	0	
	09400 PATIENTS LAUNDRY	0 212 24	0	01 000 7			94. 00
100.00	TOTAL	9, 318, 344	11, 714, 424	21, 032, 768	3 0	21, 032, 768	100.00

 Heal th Financial
 Systems
 THE ACTORS

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315377

				То	12/31/2022	Date/Time Prepa 4/18/2023 10:59	
	Cost Center Description	Adjustments to	Net Expenses			1 47 107 2023 10. 5.	/ dill
			For Allocation				
		Wkst A-8)	(col. 5 +-				
			col . 6)				
	I	6.00	7. 00				
4 00	GENERAL SERVICE COST CENTERS	054 000	0.405.044				1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-351, 292	1	1			1. 00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	0	ł			2.00
4. 00	OO300 EMPLOYEE BENEFITS OO400 ADMINISTRATIVE & GENERAL	-395, 142	3, 425, 401 2, 190, 038	•			3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	-373, 142	1, 143, 130	1			5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	81, 209	•			6. 00
7. 00	00700 HOUSEKEEPI NG	0	573, 623	•			7. 00
8. 00	00800 DI ETARY	-4, 053	1				8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	0	569, 363	•			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	1			10. 00
11.00	01100 PHARMACY	0	0				11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00	01300 SOCIAL SERVICE	0	0				13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0				14.00
15. 00	01500 PATIENT ACTIVITIES	0	311, 144				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	5, 230, 188				30.00
	03100 NURSING FACILITY	0	0	•			31. 00
32. 00	03200 CF/IID	0	0	l .			32. 00
33. 00	03300 OTHER LONG TERM CARE	0	882, 025				33. 00
	ANCILLARY SERVICE COST CENTERS	_	_	I			
40.00	04000 RADI OLOGY	0	0	1			40.00
41. 00	04100 LABORATORY	0	319, 882	1			41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0			•	42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	-20, 406	683, 052				43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	-20, 400	394, 294	1			45.00
46. 00	04600 SPEECH PATHOLOGY	0	186, 666	•			46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0 100,000	1		•	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ł			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	94, 512	1			49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1			50. 00
51. 00	05100 SUPPORT SURFACES	0	0	1			51. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0				60.00
61.00	06100 RURAL HEALTH CLINIC	0	0				61. 00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0		•			70. 00
71. 00	07100 AMBULANCE	0	1				71. 00
73. 00	07300 CMHC	0	0				73. 00
	SPECIAL PURPOSE COST CENTERS		_	T			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0	•			80.00
	08100 I NTEREST EXPENSE	0	0	•			81. 00
	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0	l .			82.00
89. 00	1 1	_	_	1		I	83. 00 89. 00
07.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	-770, 893	20, 261, 875			_	υ 9 . UU
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0				90. 00
	09100 BARBER AND BEAUTY SHOP		0	ł			91.00
	09200 PHYSI CLANS PRI VATE OFFICES					•	92. 00
	09300 NONPALD WORKERS	0	ا م			•	93. 00
	09400 PATIENTS LAUNDRY	0	ا م			•	94. 00
100.00		-770, 893	20, 261, 875				00.00
	•		•	•			

Health Financial Systems	THE ACTORS FUND NURSII	NG HOME	In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	P	Provider No.: 315377	Peri od: From 01/01/2022 To 12/31/2022		pared:
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2.00	3. 00	4. 00	5. 00	
TOTALS					
100. 00	Total Reclassification	Total Reclassifications (Sum			100.00
	of columns 4 and 5 mu	ust			
	equal sum of columns	8 and			
	9)				

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

Health Financial Systems	THE ACTORS FUND NURS	ING HOME		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315377	Peri od:	Worksheet A-6)
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	pared:
					4/18/2023 10:	59 am
	Decreases					
	Cost Center	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS THE ACTORS FUND NURSING HOME In Lieu of Form CMS-2540-10 Provi der No.: 315377 | Peri od: | Worksheet A-7 | From 01/01/2022 | To | 12/31/2022 | Date/Time Preparation

				T	o 12/31/2022	Date/Time Prep 4/18/2023 10:	pared: 59 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100, 000	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	52, 423, 661	152, 934	0	152, 934	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	3, 694, 607	122, 382		122, 382	0	6. 00
7.00	Subtotal (sum of lines 1-6)	56, 218, 268	275, 316	0	275, 316	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	56, 218, 268	275, 316	0	275, 316	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100, 000	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	52, 576, 595	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	3, 816, 989	0				6. 00
7.00	Subtotal (sum of lines 1-6)	56, 493, 584	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	56, 493, 584	0				9. 00

Provi der No.: 315377

Peri od: Worksheet A-8

From 01/01/2022 | Worksneet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				lo 12/31/2022	Date/lime Pre 4/18/2023 10:	
				Expense Classification on		39 alli
				To/From Which the Amount is		
				TO/TTOIL WITCH THE AMOUNT TS	to be Aujusteu	
	D (4)	(0) D : E			I N	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adj ustment				
	<u>, </u>	1. 00	2. 00	3. 00	4. 00	
1. 00	Investment income on restricted funds	В	-351, 214	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)	В	-12, 080	ADMINISTRATIVE & GENERAL	4.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7.00	Parking Lot (chapter 21)		l o		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	l o			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		l o		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	1
11. 00	Nonallowable costs related to certain		0		0.00	
	Capi tal expendi tures (chapter 24)				0.00	
12. 00	Adjustment resulting from transactions with	A-8-1	1			12. 00
12.00	related organizations (chapter 10)	7. 0 1	Ĭ			12.00
13. 00	Laundry and Linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0		0.00	
15. 00	Cost of meals - Guests	В	_4 053	DI ETARY	8.00	
16. 00	Sale of medical supplies to other than		-4, 033		0.00	
10.00	pati ents		٥		0.00	10.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts			1	0.00	
19. 00	Vending machines		ا	1	0.00	
20. 00	Income from imposition of interest, finance				1	1
20.00	or penalty charges (chapter 21)		0		0.00	20.00
21. 00					0.00	21. 00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0		0.00	21.00
	overpayments					
22.00		4		UTILIZATION DEVIEW CNE	02.00	22.00
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
22.00	(chapter 21)			CAD DEL COSTS DI DOS «	1 00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
24.00	Demonstration and the second			FI XTURES	2.00	24.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
25 02	MADIZETI NO. CUDACUTE UNUT		2 227	EQUI PMENT		25 00
25. 00	MARKETING - SUBACUTE UNIT	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 01	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	4.00	
25. 02	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 03	FUND RAISING EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	REBRANDI NG EXPENSE	Α		ADMINISTRATIVE & GENERAL	4. 00	1
25. 05	INTEREST INCOME	В	-78	CAP REL COSTS - BLDGS &	1.00	25. 05
				FI XTURES	1	
25. 06	MISC INCOME - THERAPY REIMB	В		PHYSI CAL THERAPY	44.00	25. 06
100.00	Total (sum of lines 1 through 99) (Transfer		-770, 893	3		100. 00
	to Worksheet A, col. 6, line 100)				1	
			0110 0 1 45 4	•		

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

| Peri od: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315377

					То	12/31/2022	Date/Time Pre 4/18/2023 10:	pared:
			CAPI TAL REL	ATED COSTS			4/16/2023 10.	39 alli
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE		EMPLOYEE	Subtotal	
	oust defiter bescription	for Cost	FIXTURES	EQUI PMENT		BENEFITS	Subtotal	
		Allocation						
		(from Wkst A col. 7)						
		0	1. 00	2. 00		3. 00	3A	
1 00	GENERAL SERVICE COST CENTERS	2 125 214	2 125 214					1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	2, 135, 314	2, 135, 314		0			1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS	3, 425, 401	0		0	3, 425, 401		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 190, 038	220, 893		0	594, 185	3, 005, 116	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 143, 130	101, 143	1	0	90, 328	1, 334, 601	5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	81, 209 573, 623	25, 194 11, 650	1	0	0 173, 161	106, 403 758, 434	6. 00 7. 00
8. 00	00800 DI ETARY	2, 042, 034	216, 545	1	0	416, 460	2, 675, 039	7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	569, 363	0		0	209, 297	778, 660	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	O	3, 536		0	0	3, 536	10.00
11. 00	01100 PHARMACY	0	0		0	0	0	11. 00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY	0	1, 352		0	0	1, 352	12.00
14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION		0		0	0	0	13. 00 14. 00
15. 00	01500 PATIENT ACTIVITIES	311, 144	129, 873		0	100, 973	541, 990	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		, , ,				,	
30. 00	03000 SKILLED NURSING FACILITY	5, 230, 188	890, 778		0	1, 495, 441	7, 616, 407	30. 00
31.00	03100 NURSING FACILITY	0	0		0	0	0	31. 00
32. 00 33. 00	03300 OTHER LONG TERM CARE	882, 025	419, 779		0	324, 231	1, 626, 035	32. 00 33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS	002, 025	417,777		<u> </u>	324, 231	1, 020, 033	33.00
40.00	04000 RADI OLOGY	0	0		0	0	0	40. 00
41.00	04100 LABORATORY	319, 882	0		0	0	319, 882	41. 00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	683, 052	98, 728		0	21, 325	803, 105	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	394, 294	0		0	0	394, 294	45. 00
46. 00	04600 SPEECH PATHOLOGY	186, 666	0		0	О	186, 666	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0			0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	04 513	4, 347		0	0	4, 347	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	94, 512	3, 652 0	1	0	0	98, 164 0	50.00
51. 00	05100 SUPPORT SURFACES	0	Ö		0	o	0	51. 00
	OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0	0		0	0	0	60.00
61. 00 62. 00	O6100 RURAL HEALTH CLINIC O6200 FQHC	0	0		0	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS							02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	0	71. 00
73. 00	07300 CMHC	0	0		0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES				Т			80. 00
81. 00	08100 NTEREST EXPENSE							81. 00
82. 00	08200 UTILIZATION REVIEW - SNF							82. 00
83. 00	08300 HOSPI CE	0	0		0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	20, 261, 875	2, 127, 470		0	3, 425, 401	20, 254, 031	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		0	ol	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		7, 844		0	0	7, 844	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0		0	ō	0	92. 00
93. 00	09300 NONPAID WORKERS	0	0		0	o	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0		0	0	0	98. 00 99. 00
100.00		20, 261, 875	2, 135, 314		0	3, 425, 401	20, 261, 875	
. 55. 50	1.0	20,201,070	2, 100, 014	ı	٦,	5, .25, 101	20, 201, 070	. 55. 55

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315377 Per

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

4/18/2023 10:59 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 3,005,116 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 232, 409 1, 567, 010 5.00 00600 LAUNDRY & LINEN SERVICE 146, 704 18.529 21.772 6.00 6.00 00700 HOUSEKEEPI NG 7.00 132,074 10,068 C 900.576 7.00 8.00 00800 DI ETARY 465, 834 187, 136 0 109, 779 3, 437, 788 8.00 9.00 00900 NURSING ADMINISTRATION 135, 597 9.00 0 3, 055 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 616 1, 792 Ω 11.00 01100 PHARMACY 0 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 235 1, 169 686 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 0 0 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 Ω 0 14.00 15.00 01500 PATIENT ACTIVITIES 94, 383 112, 235 65, 840 0 15.00 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 769, 796 2, 298, 328 30.00 1, 326, 335 98 079 451, 586 03100 NURSING FACILITY 31.00 0 31.00 32.00 03200 | CF/IID 32.00 0 0 33.00 03300 OTHER LONG TERM CARE 283, 159 362, 767 48, 625 212, 810 1, 139, 460 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 40.00 41.00 04100 LABORATORY 55, 705 0 0 41.00 0 0 42 00 04200 I NTRAVENOUS THERAPY Ω ol 42 00 0 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY Ω 0 0 43.00 04400 PHYSI CAL THERAPY 139, 854 85, 320 50, 051 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 68,663 0 45.00 C 0 0 04600 SPEECH PATHOLOGY 46 00 32, 506 0 46 00 C 0 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 757 3, 757 0 2, 204 48.00 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 17.094 3. 156 0 1.851 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 50.00 0 C 0 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 0 07100 AMBULANCE O 71.00 0 r 0 Λ 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 3, 437, 788 3,003,750 1, 560, 231 146, 704 896, 599 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 3, 977 91.00 1,366 6,779 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 0 C 0 98.00 Cross Foot Adjustments 0 0 0 Λ 98 00 99.00 Negative Cost Centers 0 0 99.00 100.00 TOTAL 3, 005, 116 1, 567, 010 146, 704 900, 576 3, 437, 788 100. 00

Provi der No.: 315377

In Lieu of Form CMS-2540-10

| Period: | Worksheet B |
| From 01/01/2022 | Part |
| To 12/31/2022 | Date/Time Prepared: 4/18/2023 10:59 am

				, ,	12/31/2022	4/18/2023 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	'	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE 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	914, 257					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	714, 257	8, 999				10.00
11. 00	01100 PHARMACY	0	0, 777	0			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0	0	3, 442		12.00
13. 00	01300 SOCIAL SERVICE		0	0	3, 442	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	0	0	14.00
			0	0	0	0	1
15. 00	01500 PATIENT ACTIVITIES	l d	Ч	0	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	700 075	7 004		0.004	1 0	00.00
30.00	03000 SKILLED NURSING FACILITY	708, 275	7, 391	0	2, 301	0	30.00
31.00		0	0	0	0	0	31.00
32. 00	03200 CF/ I D	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	205, 982	0	0	1, 141	0	33. 00
	ANCILLARY SERVICE COST CENTERS			_		T	
40. 00	04000 RADI OLOGY	0	0	0	0	-	40. 00
41. 00	04100 LABORATORY	0	0	0	0	1	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	1, 608	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	o	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	o	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>	'			<u> </u>	
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	1	o	o	0	0	0	61.00
62. 00	1		1				62.00
	OTHER REIMBURSABLE COST CENTERS		L				
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	o	o	0	0	-	71. 00
73. 00	1	0	0	0	0	l o	73. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	٩	J			70.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	1 1						82. 00
83. 00	1	0	0	0	0	0	
89. 00	1	914, 257	8, 999		3, 442		•
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	914, 237	0, 999	U	3, 442	0	09.00
00.00			ما	0		0	00 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	_	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	O	0	0	94.00
98.00		0	0		-	_	98. 00
99. 00		0	0	0	0	0	99.00
100.00	D TOTAL	914, 257	8, 999	0	3, 442	J 0	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315377

Cast Center Description					Т	o 12/31/2022	Date/Time Pre 4/18/2023 10:	
CENTRAL SERVICE COST CENTERS		Cost Center Description	ALLI ED HEALTH	SERVI CE PATI ENT	Subtotal			9 7 diii
CEMBRAL SERVICE COST CENTERS				15 00	16.00	17 00	18 00	
1.00		GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	10.00	
30.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	1	814, 448				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
31.00 03100 NURSI NG FACILITY 0 0 0 0 0 0 0 31.00 32.00 03200 1CF/II D 0 0 0 0 0 0 0 0 32.00 33.00 03300 07FR LONG TERM CARE 0 269,950 4,149,929 0 4,149,929 33.00 40.00 04000 RADIOLOY 0 0 0 0 0 0 0 0 0		INPATIENT ROUTINE SERVICE COST CENTERS						
40.00 04000 RADI OLOGY	31. 00 32. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0	0	0	0	31. 00 32. 00
41. 00 04100 LABORATORY 0 0 0 375, 587 0 375, 587 1 00 42. 00 42. 00 04. 200 01 NTRANDUS THERAPY 0 0 0 0 0 0 0 0 0	40 00		0	0	0	0	0	40 00
45. 00 04500 OCCUPATI ONAL THERAPY 0 0 0 462, 957 0 462, 957 45. 00 46. 00 04600 SPECCH PATHOLOGY 0 0 0 0 219, 172 0 219, 172 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 11, 065 0 11, 065 48. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 121, 873 0 121, 873 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 SUPPORT SURFACES 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 61. 00 06000 CLINI C 0 0 0 0 0 0 61. 00 06000 CLINI C 0 0 0 0 0 0 61. 00 06200 FOHC 0 0 0 0 0 0 61. 00 06200 FOHC 0 0 0 0 0 0 61. 00 05200 FOHC 0 0 0 0 0 0 61. 00 07100 AMBULANCE 0 0 0 0 0 0 0 61. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 61. 00 05000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 61. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 61. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 61. 00 08000 SUBUTOTALS (sum of lines 1-84) 0 814, 448 20, 241, 909 0 20, 241, 909 61. 00 09100 INTEREST EXPENSE 82. 00 0 0 0 0 0 0 61. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 0 61. 00 09100 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 61. 00 00 00 0 0 0 0 0 0	41. 00 42. 00 43. 00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY		0 0	_	0 0	375, 587 0	41. 00 42. 00 43. 00
46. 00 04600 SPEECH PATHOLOGY			0	0		0		
47. 00 44700 ELECTROCARDI OLOGY			0	0		0		
48,00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 11,065 0 11,065 48,00 49,00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 121,873 0 121,873 49,00 50,00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51,00 05100 SUPPORT SURFACES 0 0 0 0 0 0 60,00 05100 SUPPORT SURFACES 0 0 0 0 0 0 61,00 06000 CLINIC 0 0 0 0 0 0 62,00 06000 CLINIC 0 0 0 0 0 0 62,00 06000 CLINIC 0 0 0 0 0 0 62,00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71,00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71,00 07100 AMBULANCE 0 0 0 0 0 0 0 71,00 07100 AMBULANCE 0 0 0 0 0 0 71,00 07100 AMBULANCE 0 0 0 0 0 0 71,00 08000 MALPRACTICE PREMI UMS & PAI D LOSSES 81,00 08100 INTEREST EXPENSE 82,00 82,00 08200 UTILIZATION REVIEW - SNF 82,00 83,00 08300 HOMEN COST CENTERS 0 0 0 0 0 80,00 08300 HOMEN COST CENTERS 0 0 0 0 0 814,448 20,241,909 0 20,241,909 99,00 89,00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 0 91,00 09000 GLIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 92,00 09000 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 93,00 09300 NORPAID WORKERS 0 0 0 0 0 0 94,00 09400 PATIENTS LAUNDRY 0 0 0 0 0 96,00 Nogetive Cost Centers 0 0 0 0 0 97,00 Nogetive Cost Centers 0 0 0 0 0 98,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers 0 0 0 0 0 99,00 Nogetive Cost Centers			0	0	219, 1/2	0	•	
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 121,873 0 121,873 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 50. 00 0UTPATI ENT SERVICE COST CENTERS 60. 00 06000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 61. 00 62. 00 06200 FOHC 0THER REI MBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	11 065	0	-	
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50.00			0	0		0		
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0			0	0		l		
OUTPATIENT SERVICE COST CENTERS O		1			1	١	-	
61. 00						-1		
62.00	60.00	06000 CLI NI C	0	0	0	0	0	60.00
OTHER REIMBURSABLE COST CENTERS O			0	0	0	0	0	
70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 70. 00 71. 00 71. 00 07100 AMBULANCE 0 0 0 0 0 0 0 0 0	62. 00							62. 00
71. 00 07100 AMBULANCE 0 0 0 0 0 0 0 71. 00 73. 00 73. 00 073.00 CMHC 0 0 0 0 0 0 0 0 0	70.00						0	70.00
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 0			1					
SPECIAL PURPOSE COST CENTERS 80.00 81.00 80.00 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 82.00 82.00 82.00 82.00 83.00		1				1	-	
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 00 81. 00 81. 00 82. 00 82. 00 82. 00 82. 00 83. 00	73.00			J		9		73.00
81. 00	80.00							80. 00
82. 00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 0 83. 00 83. 00 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 814, 448 20, 241, 909 0 20, 241, 909 89. 00 NONREI MBURSABLE COST CENTERS								•
SUBTOTALS (sum of lines 1-84) 0 814,448 20,241,909 0 20,241,909 89.00	82.00	08200 UTILIZATION REVIEW - SNF						82. 00
NONREI MBURSABLE COST CENTERS 90. 00 00 00 00 00 00 00			1	1	0		-	
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 9200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 92. 00 93. 00 93. 00 93. 00 094. 00 0	89. 00		0	814, 448	20, 241, 909	0	20, 241, 909	89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 0 19, 966 91. 00 92. 00 92. 00 93. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 96. 00	00.00		1 -		1 -	-		00.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 98. 00 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 0 0 99. 00 0 0 0 0 0 0 0 0 0			0	0	10.044	0		
93. 00 09300 NONPALD WORKERS 0 0 0 0 93. 00 94. 00 94. 00 94. 00 98. 00 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 0 0 99. 00 0 0 0 0 0 0 0 0 0			0	0	19, 900	0		•
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 94. 00 98. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00			0				-	
98.00 Cross Foot Adjustments			0	ا	ا م		-	•
99.00 Negative Cost Centers 0 0 0 99.00			0	Ö	Ö	ol	-	
100. 00 TOTAL 0 814, 448 20, 261, 875 0 20, 261, 875 100. 00	99. 00	Negative Cost Centers	0	0	0	o	_	99. 00
	100.00	TOTAL	0	814, 448	20, 261, 875	0	20, 261, 875	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315377

					То	12/31/2022	Date/Time Pre 4/18/2023 10:	pared:
			CAPI TAL REI	_ATED COSTS			47 107 2023 10.	37 4111
	Cost Center Description	Directly	BLDGS &	MOVABLE		Subtotal	EMPLOYEE	
	oost denter bescription	Assigned New	FIXTURES	EQUI PMENT		Subtotal	BENEFITS	
		Capital Related Costs						
		0	1.00	2.00		2A	3. 00	
4 00	GENERAL SERVICE COST CENTERS			Г		T		4 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT							1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	O	0		0	О	0	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	220, 893		0	220, 893	0	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	101, 143 25, 194		0	101, 143 25, 194	0	5. 00 6. 00
7. 00	00700 HOUSEKEEPING		11, 650		0	11, 650	0	7. 00
8.00	00800 DI ETARY	0	216, 545		0	216, 545	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	2 524		0	0	0	9.00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY		3, 536 0		0	3, 536 0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	O	1, 352		0	1, 352	0	12. 00
13.00	01300 SOCIAL SERVICE	0	0		0	0	0	13. 00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	0	0 129, 873		0	0 129, 873	0	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	127,073		O _I	127, 075		13.00
30. 00	03000 SKILLED NURSING FACILITY	0	890, 778	ı	0	890, 778	0	30. 00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0	•	0	0 0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		419, 779		0	419, 779	0	33. 00
	ANCILLARY SERVICE COST CENTERS							
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0		0	0	0	40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY		0		0	ol	0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	o	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	98, 728	ı	0	98, 728	0	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY		0		0	0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	o	0		0	ō	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 347		0	4, 347	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY		3, 652 0		0	3, 652 0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	0		0	o	0	51. 00
	OUTPATIENT SERVICE COST CENTERS					_1		
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0	0	0	60. 00 61. 00
62. 00	06200 FQHC		O		J	J	O	62. 00
	OTHER REIMBURSABLE COST CENTERS			ı		_1		
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0	0	0	70. 00 71. 00
73. 00	07300 CMHC		0		0	o	0	73.00
	SPECIAL PURPOSE COST CENTERS							
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF							82.00
83. 00	08300 H0SPI CE	0	0		0	О	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	2, 127, 470		0	2, 127, 470	0	89. 00
90. 00		O	0		0	ol	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	7, 844		0	7, 844	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	o	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0		0	0	0	93. 00 94. 00
98. 00	Cross Foot Adjustments		0			ő	Ü	98. 00
99. 00	Negative Cost Centers	_	0 435 311		0	0	0	
100.00) TOTAL	0	2, 135, 314		0	2, 135, 314	0	100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315377

Period: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

4/18/2023 10:59 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 220, 893 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 17,083 118, 226 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 1.362 28, 199 6.00 1, 643 00700 HOUSEKEEPI NG 7.00 9, 708 760 C 22, 118 7.00 8.00 00800 DI ETARY 34, 240 14, 119 0 2, 696 267, 600 8.00 9.00 00900 NURSING ADMINISTRATION 9,967 0 9.00 01000 CENTRAL SERVICES & SUPPLY 45 10.00 0 10.00 231 44 Ω 11.00 01100 PHARMACY 0 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 17 88 0 17 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 0 C 0 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 Ω 0 0 14.00 15.00 01500 PATIENT ACTIVITIES 6,937 8,468 1,617 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 58, 078 11, 091 178. 904 30.00 97 499 18 852 03100 NURSING FACILITY 31.00 0 31.00 32.00 03200 | CF/IID 0 32.00 0 03300 OTHER LONG TERM CARE 33.00 20, 813 27, 370 9, 347 5, 227 88, 696 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 40.00 04100 LABORATORY 41.00 4,094 0 0 41.00 0 42 00 04200 I NTRAVENOUS THERAPY Ω 0 0 42 00 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 C 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 10, 280 6, 437 1, 229 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 5,047 0 o 0 45.00 C 04600 SPEECH PATHOLOGY 46 00 2.389 0 0 46 00 Ω 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 56 283 0 54 48.00 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 1.256 238 0 45 0 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 C 05100 SUPPORT SURFACES 51.00 0 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C О 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 61.00 0 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 0 07100 AMBULANCE 0 0 71.00 r 0 0 71.00 73.00 07300 CMHC 0 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 220, 793 117, 715 267, 600 28, 199 22, 020 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 100 511 98 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 C 0 98.00 Cross Foot Adjustments 0 0 Λ 98.00 99.00 Negative Cost Centers 0 0 99.00 100.00 TOTAL 220, 893 118, 226 28, 199 22, 118 267, 600 100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315377 | Period: From 01/01/202

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 4/18/2023 | 10: 59 am

						4/18/2023 10:	59 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMINI STRATI ON	9, 967					9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	9, 967	2 054				10.00
		0	3, 856				
11.00	01100 PHARMACY	0	0	0	1 474		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	1, 474		12.00
13.00	01300 SOCIAL SERVICE	0	0	0	0	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00		0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 [_	
30.00	03000 SKILLED NURSING FACILITY	7, 721	3, 167	0	985	0	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	2, 246	0	0	489	0	33. 00
	ANCILLARY SERVICE COST CENTERS					ı	
40. 00	04000 RADI OLOGY	0	0	0	0		40. 00
41. 00	1	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	689	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00		0	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS	,					
60.00	06000 CLI NI C	0	0	0	0	l e	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00							62.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00		0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0		71. 00
73.00		0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00							80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	9, 967	3, 856	0	1, 474	0	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	_	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98.00	Cross Foot Adjustments	0	0	0			98. 00
99. 00		O	0	0	0	0	99. 00
100.00	D TOTAL	9, 967	3, 856	0	1, 474	0	100. 00
		•		·			

| Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315377

				Т	o 12/31/2022	Date/Time Pre 4/18/2023 10:	pared:
			OTHER GENERAL			47 107 2023 10.	Ja alli
			SERVI CE				
	Cost Center Description	NURSI NG AND	PATI ENT	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH	ACTI VI TI ES		Adjustments		
		EDUCATI ON	15.00	1/ 00	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	I					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8.00
9. 00 10. 00	O0900 NURSI NG ADMI NI STRATI ON O1000 CENTRAL SERVI CES & SUPPLY						9. 00 10. 00
11. 00	01100 PHARMACY						11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15.00	01500 PATIENT ACTIVITIES	0	146, 895				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0		1	0	1, 365, 281	30.00
31.00	03100 NURSING FACILITY	0	0			0	31.00
32. 00 33. 00	03200 1 CF/I I D	0	0	1		(22, 454	
33.00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	48, 689	622, 656	l 0	622, 656	33. 00
40. 00	04000 RADI OLOGY	0	0	0	ol	0	40. 00
41. 00	04100 LABORATORY	0	0			4, 094	
42. 00	04200 I NTRAVENOUS THERAPY	0	o	0		0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	O	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	116, 674	0	116, 674	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	5, 047		5, 047	
46. 00	04600 SPEECH PATHOLOGY	0	0	2, 389		2, 389	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	0		0	
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	4, 740 5, 880	I	4, 740 5, 880	1
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			3, 880 0	1
	05100 SUPPORT SURFACES	0	Ö			0	1
	OUTPATIENT SERVICE COST CENTERS			-	-1	-	1
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	_			0	
73.00	07300 CMHC	0	0			0	1
73.00	SPECIAL PURPOSE COST CENTERS				٩		73.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0		0	0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	146, 895	2, 126, 761	0	2, 126, 761	89. 00
00.00	NONREI MBURSABLE COST CENTERS					^	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	0 8, 553		0 8, 553	
91.00	09200 PHYSI CLANS PRI VATE OFFI CES			[8, 553 [0		8, 553	1
93. 00	09300 NONPAID WORKERS	0				0	
94. 00	09400 PATIENTS LAUNDRY	0	Ö	Ö	o	0	
98.00	Cross Foot Adjustments	0	o	0	o	0	1
99. 00	Negative Cost Centers	0	0	0	o	0	
100.00	TOTAL	0	146, 895	2, 135, 314	0	2, 135, 314	100.00

Provider No.: 315377 | Period: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

						o 12/31/2022	Date/Time Pre 4/18/2023 10:	
			CAPITAL REI	LATED COSTS			47 107 2023 10.	37 dili
		Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation		
			FIXTURES (SQUARE FEET)	EQUI PMENT (SQUARE FEET)	BENEFITS (GROSS		& GENERAL (ACCUM COST)	
			1.00	2.00	SALARI ES) 3. 00	4A	4. 00	
		AL SERVICE COST CENTERS	1.00	2.00	3.00	48	4.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES	110, 520					1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	0	110, 520 0				2. 00 3. 00
4. 00	00400	ADMINISTRATIVE & GENERAL	11, 433		1, 616, 399	-3, 005, 116	17, 256, 759	4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	5, 235 1, 304			_	1, 334, 601 106, 403	5. 00 6. 00
7. 00		HOUSEKEEPING	603				758, 434	7. 00
8.00		DI ETARY	11, 208				2, 675, 039	
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0 183	0 183		0	778, 660 3, 536	1
11. 00		PHARMACY	0	0	1	Ö	0,530	1
12.00		MEDICAL RECORDS & LIBRARY	70	70		0	1, 352	
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0 0	13. 00 14. 00
15. 00	01500	PATIENT ACTIVITIES	6, 722	1	1	0	541, 990	
20.00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	46, 105	4/ 105	4 0/0 15/	0	7 (1(407	20.00
30. 00 31. 00		NURSING FACILITY	46, 103	46, 105 0			7, 616, 407 0	30. 00 31. 00
32.00	03200	I CF/IID	0	0		0	0	32. 00
33. 00	_	OTHER LONG TERM CARE LARY SERVICE COST CENTERS	21, 727	21, 727	882, 025	0	1, 626, 035	33. 00
40. 00		RADI OLOGY	0	0	С	0	0	40. 00
41.00		LABORATORY	0	0	C	0	319, 882	
42. 00 43. 00	1	INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0] (0	0 0	42. 00 43. 00
44.00	04400	PHYSI CAL THERAPY	5, 110	5, 110	58, 012	0	803, 105	44. 00
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	·	0	394, 294 186, 666	
47. 00		ELECTROCARDI OLOGY	0		· ·	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	225	225		0	4, 347	48. 00
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	189	•		0	98, 164 0	49. 00 50. 00
51. 00	1	SUPPORT SURFACES	0	1			0	
40.00		TIENT SERVICE COST CENTERS CLINIC	1 0			0	0	40.00
60. 00 61. 00	1	RURAL HEALTH CLINIC		0			0	60. 00 61. 00
62. 00	06200	FQHC						62. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	1 0	0		0	0	70. 00
71. 00		AMBULANCE	Ö	Ö			0	71. 00
73. 00	07300	CMHC AL PURPOSE COST CENTERS	0	0	C	0	0	73. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100	I NTEREST EXPENSE						81. 00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0		0	0	82. 00 83. 00
89. 00	00300	SUBTOTALS (sum of lines 1-84)	110, 114			-3, 005, 116		
00.00		I MBURSABLE COST CENTERS		1 0	Γ			00.00
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0 406				0 7, 844	
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0			0	92. 00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0	0		0	0	93. 00 94. 00
98. 00	0 7400	Cross Foot Adjustments		Ĭ		,		98. 00
99. 00		Negative Cost Centers	0.405.044				0 005 447	99. 00
102.00)	Cost to be allocated (per Wkst. B, Part I)	2, 135, 314	0	3, 425, 401		3, 005, 116	102.00
103.00	1	Unit cost multiplier (Wkst. B, Part I)	19. 320612	0. 000000	0. 367598		0. 174141	
104.00		Cost to be allocated (per Wkst. B, Part II)			C		220, 893	104. 00
105.00		Unit cost multiplier (Wkst. B, Part			0. 000000		0. 012800	105. 00
	1	11)		l				

Provi der No.: 315377

Peri od: From 01/01/2022 To 12/31/2022 Worksheet B-1 Date/Time Prepared: 4/18/2023 10:59 am

						4/18/2023 10:	59 am
	Cost Center Description	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON	
		REPAI RS	(TATTENT DATS)			(DI RECT	
		(SQUARE FEET)				NURSI NG)	
	CENEDAL CEDALCE COCT CENTEDO	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	93, 852	l .				5.00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	1, 304	1	91, 945			6. 00 7. 00
8. 00	00800 DI ETARY	11, 208	l .	11, 208			8.00
9. 00	00900 NURSING ADMINISTRATION	C	1	0	0	194, 971	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	183	0	183	0	0	10.00
11. 00	01100 PHARMACY	C	1	0	_	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	70	0	70	0	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION			0	0	0	13. 00 14. 00
15. 00	01500 PATIENT ACTIVITIES	6, 722	0	6, 722	0	0	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	57.22		0,722			10.00
30.00	03000 SKILLED NURSING FACILITY	46, 105	32, 446	46, 105	97, 338	151, 044	30. 00
31.00	03100 NURSING FACILITY	C	0	0	0	0	31.00
32.00	03200 CF/IID	04 707	0	04 707	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	21, 727	16, 086	21, 727	48, 258	43, 927	33. 00
40. 00	04000 RADI OLOGY		0	0	0	0	40.00
41. 00	04100 LABORATORY		1	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	C	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	5, 110	0	5, 110	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	C	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	225		225	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	189	•	189		0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		l .	0		0	50.00
51.00	05100 SUPPORT SURFACES	C	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	,	,	,	,		
60.00	06000 CLINIC	C	l .			0	60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	C	0	0	0	0	61.00
62. 00	OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST		0	0	0	0	70.00
71. 00	07100 AMBULANCE		Ö	0	0		71. 00
73.00	07300 CMHC	C	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS	1	1	1	T		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF		•				81. 00 82. 00
83. 00	08300 HOSPI CE	C		0	0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	93, 446		91, 539	145, 596		89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	406	l				91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	C	1	· -	0	0	92.00
93. 00	09300 NONPALD WORKERS	C	1	0	0	0	93.00
94. 00 98. 00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	C	ή	0			94. 00 98. 00
99. 00	Negative Cost Centers						99.00
102.00		1, 567, 010	146, 704	900, 576	3, 437, 788	914, 257	1
	Part I)						
103.00		16. 696607				4. 689195	•
104.00		118, 226	28, 199	22, 118	267, 600	9, 967	104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	1. 259707	0. 581039	0. 240557	1. 837963	0. 051120	105 00
103.00		1. 239/0/	0. 301039	0. 240357	1.03/903	0.031120	103.00
	1	I	I .	ı	I	1	1

In Lieu of Form CMS-2540-10 Health Financial Systems THE ACTORS FUND NURSING HOME COST ALLOCATION - STATISTICAL BASIS Provider No.: 315377 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 4/18/2023 10:59 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND SERVICES & RECORDS & ALLI ED HEALTH (COSTED SUPPLY REQUIS) LI BRARY (PATIENT DAYS) **EDUCATION** (ASSI GNED (COSTED (TIME SPENT) REQUIS) TIME) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 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 529, 081 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 12.00 0 48, 532 01300 SOCIAL SERVICE 13 00 0 C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 01500 PATIENT ACTIVITIES 15.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 434, 569 0 32, 446 0 0 03100 NURSING FACILITY 0 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 03300 OTHER LONG TERM CARE 0 0 33.00 Ω 16, 086 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 41.00 04100 LABORATORY 0 0 0 0 0 0 0 0 0 0 00000 04200 I NTRAVENOUS THERAPY 0 0 42 00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 04400 PHYSI CAL THERAPY 0 44.00 0 04500 OCCUPATIONAL THERAPY 45.00 0 0 04600 SPEECH PATHOLOGY 0 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 94, 512 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 r 0 05100 SUPPORT SURFACES 0 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 06100 RURAL HEALTH CLINIC C 0 61.00 0 0 Ω 62.00 06200 FQHC OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 73.00 07300 CMHC 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 82.00 08200 UTILIZATION REVIEW - SNF 08300 H0SPI CE 83.00 0 Λ 89.00 SUBTOTALS (sum of lines 1-84) 529, 081 48, 532 0 NONREIMBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP C 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 93.00 09300 NONPALD WORKERS 0 0

THE ACTORS FUND NURSING HOME In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315377

			To 12/31/2022 Date/Time Pr 4/18/2023 10	
		OTHER GENERAL	17 107 2020 10	. 07 dili
		SERVI CE		
	Cost Center Description	PATI ENT		
		ACTIVITIES (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 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 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY			10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY			12. 00
13. 00	01300 SOCIAL SERVICE			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	01500 PATIENT ACTIVITIES	48, 532		15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	22 444		20.00
30. 00 31. 00	03100 NURSING FACILITY	32, 446 0		30. 00 31. 00
32. 00	03200 CF/IID	O		32. 00
33.00	03300 OTHER LONG TERM CARE	16, 086		33. 00
	ANCILLARY SERVICE COST CENTERS			-
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0		40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY	0		42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	O		43. 00
44.00	04400 PHYSI CAL THERAPY	0		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0		51. 00
60. 00		0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FQHC			62. 00
70.00	OTHER REIMBURSABLE COST CENTERS	0		70.00
		0		70. 00 71. 00
		0		73.00
	SPECIAL PURPOSE COST CENTERS			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
	08100 INTEREST EXPENSE			81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0		82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	48, 532		89. 00
	NONREI MBURSABLE COST CENTERS			
90.00		0		90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0		91. 00 92. 00
93. 00	09300 NONPALD WORKERS	0		93.00
94. 00	09400 PATIENTS LAUNDRY	o		94. 00
98. 00	Cross Foot Adjustments			98. 00
99.00	Negative Cost Centers	014 440		99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	814, 448		102. 00
103.00		16. 781670		103. 00
104.00	Cost to be allocated (per Wkst. B,	146, 895		104. 00
405.55	Part II)	0.001711		405.00
105.00	Unit cost multiplier (Wkst. B, Part	3. 026766		105. 00
	1 1117	ı I		1

Health Financial Systems	THE ACTORS FUND NUR	SING HOME	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANC	CILLARY AND OUTPATIENT COST CENTERS	Provider No.: 315377	From 01/01/2022	Worksheet C Date/Time Prepared:

			o 12/31/2022	Date/Time Pre 4/18/2023 10:	
	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	1			
	04000 RADI OLOGY	0	14, 244		
1	04100 LABORATORY	375, 587	50, 326		41. 00
1	04200 I NTRAVENOUS THERAPY	0	0	0. 000000	
	04300 OXYGEN (INHALATION) THERAPY	0	0	0. 000000	
1	04400 PHYSI CAL THERAPY	1, 078, 330			44. 00
	04500 OCCUPATI ONAL THERAPY	462, 957		0. 759156	
1	04600 SPEECH PATHOLOGY	219, 172	326, 295		
	04700 ELECTROCARDI OLOGY	0	0	0. 000000	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 065	0	0. 000000	
1	04900 DRUGS CHARGED TO PATIENTS	121, 873	228, 614	0. 533095	
1	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0. 000000	50.00
-	05100 SUPPORT SURFACES	0	0	0.000000	51.00
	OUTPATIENT SERVICE COST CENTERS				
60.00	06000 CLI NI C	0	0	0.000000	60.00
61.00	06100 RURAL HEALTH CLINIC				61.00
62.00	06200 FQHC				62.00
71.00	07100 AMBULANCE	0	0	0.000000	71.00
100.00	Total	2, 268, 984	1, 982, 060		100.00

Health Financial Systems	THE ACTORS FUND	NURSING HOME		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 01/01/2022	Worksheet D Part I	
				To 12/31/2022		epared: 59 am
		Title	XVIII (1)	Skilled Nursing		<u> </u>
				Facility		
		Heal th Care Pr	rogram Charges	Heal th Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENI COSI					-
ANCILLARY SERVICE COST CENTERS	0.00000	44.044				40.00
40. 00 04000 RADI OLOGY	0. 000000	14, 244		0 275 507	0	
41. 00 04100 LABORATORY 42. 00 04200 NTRAVENOUS THERAPY	7. 463081 0. 000000	50, 326		0 375, 587	0	
43. 00 04300 0XYGEN (I NHALATION) THERAPY	0. 000000	0		0		
44. 00 04400 PHYSI CAL THERAPY	1. 432521	374, 370		0 536, 293		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 759156	367, 746		0 279, 177		
46. 00 04600 SPEECH PATHOLOGY	0. 734130	211, 688		0 142, 191		
47. 00 04700 ELECTROCARDI OLOGY	0.000000	211,000		0 142, 171		
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 533095	228, 614		0 121, 873		
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS				-	_	1
60. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	71. 00
100.00 Total (Sum of lines 40 - 71)		1, 246, 988		0 1, 455, 121	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.					

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

Heal th	Financial Systems T	THE ACTORS FUND	NURSING HOME		In Lie	eu of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2022 To 12/31/2022		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1. 00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C. column 3	line 49)	0. 533095	1.00
2.00	Program vaccine charges (From your reco					0	2.00
3.00	Program costs (Line 1 x line 2) (Title 1			er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		•	(From Wkst. B,			Heal th Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col . 2 / Col 1)	•	3 x Col . 4)	
		1. 00	2.00	3, 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0.00000	0 0	0	40. 00
41.00	04100 LABORATORY	375, 587	0	0.00000	0 375, 587	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0.00000		0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.00000		0	1 .0.00
44. 00	04400 PHYSI CAL THERAPY	1, 078, 330		0. 00000			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	462, 957	l e	0.00000		l	45. 00
46. 00	04600 SPEECH PATHOLOGY	219, 172	0	0.00000		l	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0.00000		0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 065	l e	0.00000		0	1 .0.00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	121, 873		0.00000 0.00000		0 1	
	1 1	0		0.00000		0	
100.00		2, 268, 984		•	1, 455, 121		100.00
100.00		2, 200, 704	1	1	1,400,121	, 0	1100.00

alth Financial Systems MPUTATION OF INPATIENT ROUTINE		Provider No.: 315377	Peri od: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 4/18/2023 10:	pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
PART I CALCULATION OF INPA	TIENT ROUTINE COSTS			1.00	
I NPATI ENT DAYS					İ
OO Inpatient days including	private room days			32, 446	1.
00 Private room days				0	2.
O Inpatient days including	orivate room days applicable to	the Program		5, 485	3.
Medically necessary priva	e room days applicable to the F	Program		0	4.
O Total general inpatient re	outine service cost	-		13, 822, 996	5
PRIVATE ROOM DIFFERENTIAL	ADJUSTMENT				1
O General inpatient routine	servi ce charges			13, 709, 853	6
O General inpatient routine	service cost/charge ratio (Lir	ne 5 divided by line 6)		1. 008253	7
0 Enter private room charge:	from your records			0	8
1 9 1	liem charge (Private room charge	es line 8 divided by private	room days, line	0.00	9
2)				_	
00 Enter semi-private room c	3			0	10
	per diem charge (Semi-private	room charges line 10, divide	d by	0. 00	11
semi-private room days) 00 Average per diem private	room charge differential (Line 9	minus lino 11)		0. 00	12
, , ,	coom cost differential (Line 7 t			0.00	
	ntial adjustment (Line 2 times I			0.00	14
	service cost net of private roo	,	minus line 14)	13, 822, 996	
PROGRAM INPATIENT ROUTINE		5 666 t di 1161 611 (21116 t	ride Trine Tri	10/022/770	
	service cost per diem (Line 15	divided by line 1)		426. 03	16
	ost (Line 3 times line 16)	,		2, 336, 775	17
	e room cost applicable to progr	ram (line 4 times line 13)		0	18
00 Total program general inp	itient routine service cost (Li	ne 17 plus line 18)		2, 336, 775	19
00 Capital related cost allo	ated to inpatient routine servi	ce costs (From Wkst. B, Par	t II column 18,	1, 365, 281	20
1	for NF, or line 32 for ICF/IID)				
	costs (Line 20 divided by line	1)		42. 08	
	ost (Line 3 times line 21)			230, 809	
	cost (Line 19 minus line 22)			2, 105, 966	
	ciciaries for excess costs (Fro			0	24
	vice costs for comparison to the	e cost limitation (Line 23 mi	nus line 24)	2, 105, 966	25
00 Enter the per diem limita	. ,		2/) /1)		26
	cost limitation (Line 3 times t itine service costs (Line 22 plu				27 28
	Part II, line 4) (See instructi		11 ne 27)		28
1.7	cable for title XVIII, but may	•	itle XIX		1
DADT II CALCULATION OF LM	ATIENT NURSING & ALLIED HEALTH	COSTS FOR DRS DASS TUDOUCU		1. 00	
O Total SNF inpatient days	ATTENT NUNSTING & ALLIED REALTH	COUTS FOR FES PASS-THROUGH		32, 446	1
O Program inputiont days (c.				52, 440	'

5, 485

0

2. 00 3. 00 4. 00

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)
Program nursing & allied health costs for pass-through. (line 3 times line 4)

2.00

4. 00 5. 00

Health Financial Systems	THE ACTORS FUND NURSI	ING HOME	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SET	FLEMENT FOR TITLE XVIII	Provider No.: 315377	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 4/18/2023 10:59 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		1.00	
1.00	Inpatient PPS amount (See Instructions)			4, 238, 983	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,		4, 238, 983	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			475, 358	5. 00
6.00	Allowable bad debts (From your records)			138, 658	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		71, 902	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			90, 128	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)			3, 853, 753	11. 00
12.00	Interim payments (See instructions)			3, 806, 861	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	50 Demonstration payment adjustment amount before sequestration				14. 50
14. 55	55 Demonstration payment adjustment amount after sequestration				14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 135	
14. 99	Sequestration amount (see instructions)			55, 235	
15. 00	Balance due provider/program (see Instructions)			-9, 478	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		4 - 00
17. 00	Ancillary services Part B				17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	23. 00 24. 00
24. 00 24. 01	Allowable bad debts (From your records) Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
24. 01	Adjusted reimbursable bad debts (see instructions)	Ctions)		0	
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	
27. 00	Tentati ve adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	
29. 00	Balance due provider/program (see instructions)			0	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	0	
55. 66	1. Stasta dimodrita (Hondri andali e dost i oport i tollis) i il docordalio	5 til 5m5 l ub. 15 2,	110.2	٥١	1 00.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315377 | Period: From 01/01/2022 | To 12/31/2022 | Period: From 01/01/2022 |

Total interim payments paid to provider 1.00					Facility		
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A		t B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payments payable on Individual Bills, either substited or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero 3.00 1.00 3.00			1.00	2.00	3. 00	4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero				3, 806, 861		-	
Services rendered in the cost reporting period. If none, enter zero Services rendered in the cost reporting period. If none, enter zero Services rendered in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Services reporting period. Also show date of each payment. If none, write "None" or enter a zero. (1) Services report reports reported by the cost report reports report reports report reports report reports report	2.00			0		0	2. 00
Online Contractor Online							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each pawment, If none, write "NONE" or enter a zero. (1)	0.00						0.00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 0 0 0 3.03 3.04 3.05 3.	3 01			0		0	3 01
3. 0.4 3. 0.4 3. 0.4 3. 0.5 3. 0.4 3. 0.6 3. 0.6 3. 0.6 3. 0.6 3. 0.7 3.		A SOUTH AND THE THOUSEN		-			
3.04 0				o o		Ö	1
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3. 50				0		0	1
3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 -3.98 0 0 3.59 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,806,861 0 4.00 Total interim payments (sum of lines 2, 0 0 0 5.01 Total interim payments (sum of lines 2, 0 0 0 5.01 Total interim payments (sum of lines 2, 0 0 0 5.51 Total interim payments (sum of lines 3.50 0 0 5.50 Total interim payments (sum of lines 4, 0 0 0 5.51 Total interim payments (sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.52 Total interim payments (sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.59 Total interim payments (sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.59 Total interim payments (sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.59 Total interim payments (sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.59 Total interim payments (sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.59 Total interim payments (sum of lines 5.50 - 5.99 0 0 5.59 Total interim payments (sum of lines 5.50 - 5.99 0 0 5.59 Total interim payments (sum of lines 5.50 - 5.49 minus sum of lines 5.50 0 0 0 5.59 Total interim payment	3.05			0		0	3. 05
3.51 3.52 3.53 3.54 0 0 0 3.52 3.53 3.54 0 0 0 3.53 3.54 3.54 0 0 0 3.53 3.54 3.59 3.59 3.59 3.59 3.50 0 0 0 3.54 3.59 3.50 0 0 0 3.54 3.59 3.50 0 0 0 3.54 3.59 3.50 0 0 0 3.54 3.59 3.50 0 0 0 3.54 3.59 3.59 3.50 0 0 0 3.54 3.59 3.59 3.50 0 0 0 3.59 3.59 3.59 3.59 3.59 3.59 3.59 3.50 3.59		Provider to Program					
3.52 3.53 3.53 3.53 3.53 3.53 3.53 3.53 3.53 3.53 3.53 3.53 3.54 3.99 5.30 3.54 3.99 5.30 3.53 3.53 3.59 5.30	3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.53 3.54 0	3. 51			0		0	3. 51
3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.54	3. 52			0		0	3. 52
3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 -3.98 0 0 0 3.99				0		_	
-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR				-			
A	3. 99			0		0	3. 99
Ciransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR				0.007.074			
26 for Part B) TO BE COMPLETED BY CONTRACTOR	4.00			3, 806, 861		0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5.00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATI VE TO PROVI DER O	0.00						0.00
S. 01 TENTATIVE TO PROVIDER							
Determined net settlement amount (balance due) based on the cost report. (1) PROGRAM PROVIDER TO PROGRAM PROGRAM PROVIDER TO PROGRAM PROGRAM PROVIDER TO PROGRAM PROGRAM PROVIDER TO		Program to Provider					
Description	5.01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program							
TENTATI VE TO PROGRAM	5. 03			0		0	5. 03
5.51 0				_			
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATIVE TO PROGRAM				-	
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99							1
- 5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 5.98) 0		Subtatal (Sum of Lines F O1 F 40 minus sum of Lines F FO		0			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 70 PROGRAM 9, 478 0 6.02 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor	5. 99			U		U	5. 99
the cost report. (1) PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1. 00 2. 00 8. 00 Name of Contractor 8. 00	6 00						6.00
6. 01 PROGRAM TO PROVIDER O	0.00	` '					0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 Name of Contractor	6, 01			n		n	6, 01
7.00 Total Medicare program liability (see instructions) 3,797,383 0 7.00 Contractor Name Contractor Number Number 1.00 2.00 8.00 Name of Contractor 8.00 8.00				9. 478			
Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 8.00		1					1
8.00 Name of Contractor 8.00 8.00				Contract	tor Name	Contractor	
8.00 Name of Contractor 8.00							
ļ ļ				1.	00	2. 00	
		!					8.00

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

Health Financial Systems

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

Provi der No.: 315377 | Peri od: From 01/01/2022 To 12/31/2022

Period: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared: 4/18/2023 10:59 am

1. 00	Assets	General Fund	Speci fi c Er Purpose Fund 2.00	ndowment Fund	Plant Fund	
	Appata	1 00	2 00			
		1.00	2.00	3. 00	4. 00	
. 00	CURRENT ASSETS					
	Cash on hand and in banks	1, 075, 433	0	0	0	1.0
2.00	Temporary investments	0	0	0	0	2.0
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	1 241 400	0	0	0	3. 0 4. 0
+. 00 5. 00	Other receivables	1, 361, 600 9, 639	0	0	0	5.0
5. 00	Less: allowances for uncollectible notes and accounts	-320, 798	Ö	ő	0	6.0
	recei vabl e				_	
7. 00	Inventory	0	0	0	0	7.0
3. 00	Prepai d expenses	241, 923	0	0	0	8.0
9. 00 10. 00	Other current assets Due from other funds	780, 737 41, 520, 708	0	0	0	9. 0 10. 0
11. 00	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	44, 669, 242	0	0	0	11.0
1. 00	FIXED ASSETS	14,007,242	o o	<u> </u>		1 11.0
12.00	Land	100, 000	0	0	0	12.0
13.00	Land improvements	0	0	0	0	13.0
14.00	Less: Accumulated depreciation	0	0	0	0	14.0
15.00	Bui I di ngs	52, 576, 595	0	0	0	15.0
16.00	Less Accumulated depreciation	-18, 944, 777	0	0	0	16.0
17. 00 18. 00	Leasehold improvements Less: Accumulated Amortization	0	0	0	0	17. C
19. 00	Fixed equipment	0	o o	Ö	0	19.0
20. 00	Less: Accumulated depreciation	Ö	o	o	0	20.0
21. 00	Automobiles and trucks	О	0	О	0	21. C
22. 00	Less: Accumulated depreciation	0	0	0	0	22.0
23. 00	Major movable equipment	3, 816, 989	0	0	0	23.0
24. 00	Less: Accumulated depreciation	-2, 926, 484	0	0	0	24.0
	Mi nor equipment - Depreciable	0	0	0	0	25.0
26. 00 27. 00	Minor equipment nondepreciable Other fixed assets	0	0	0	0	26. C
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	34, 622, 323	0	0	0	28.0
.0. 00	OTHER ASSETS	0 17 0227 020	<u> </u>	<u> </u>		
29. 00	Investments	0	0	0	0	29.0
30. 00	Deposits on Leases	0	0	0	0	30.0
31. 00	Due from owners/officers	0	0	0	0	31.0
32. 00	Other assets	257, 345	0	0	0	32.0
33. 00 34. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)	257, 345 79, 548, 910	0	0	0	33. 0 34. 0
14. 00	Liabilities and Fund Balances	77, 340, 710	<u> </u>	<u> </u>	0	34.0
	CURRENT LI ABI LI TI ES					İ
35. 00	Accounts payable	1, 132, 028	0	0	0	35. C
36. 00	Salaries, wages, and fees payable	956, 673	0	0	0	36.0
37. 00	Payroll taxes payable	0	0	0	0	37.0
38. 00 39. 00	Notes & Loans payable (Short term) Deferred income	0	0	0	0	38. 0 39. 0
10.00	Accel erated payments	0	٥	۷	U	40.0
11.00	Due to other funds	58, 745, 602	0	0	0	41.0
12.00	Other current liabilities	1, 589, 449		Ö	0	42.0
13. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	62, 423, 752	0	0	0	43. C
	LONG TERM LIABILITIES					
14. 00	Mortgage payable	22, 037, 630	0	0	0	44.0
15.00	Notes payable	0	0	0	0	45.0
16. 00 17. 00	Unsecured Loans Loans from owners:	0	0	0	0	46. C
47. 00 48. 00	Other long term liabilities	0	0	0	0	48.0
19. 00	OTHER (SPECIFY)	0	Ö	Ö	0	49.0
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	22, 037, 630		o	0	50.0
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	84, 461, 382	0	0	0	51.0
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	-4, 912, 472				52.0
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0			53. 0 54. 0
55. 00	Donor created - endowment fund balance - restricted			0		55. (
56. 00	Governing body created - endowment fund balance			Ö		56. (
57. 00	Plant fund balance - invested in plant			Ĭ	0	57. (
58. 00	Plant fund balance - reserve for plant improvement,			İ	0	58. 0
	repl acement, and expansi on					
.0 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-4, 912, 472		0	0	59. (
59. 00 50. 00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	79, 548, 910				60.0

Provi der No.: 315377

						4/18/2023 10:	pared: 59 am
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-3, 844, 680			0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-1, 067, 790				2. 00
3.00	Total (sum of line 1 and line 2)		-4, 912, 470		(0	3. 00
4.00	Additions (credit adjustments)						4. 00
5.00		0			0	0	
6.00		0			0	0	
7.00		0			0	0	
8. 00 9. 00		0			0	0	
9. 00 10. 00	Total additions (sum of line 5 - 9)	١			0		9.00
11. 00	Subtotal (line 3 plus line 10)		-4, 912, 470				11.00
12.00	Deductions (debit adjustments)		-4, 912, 470		'	٩	12.00
13. 00	ROUNDI NG	2			0	0	
14. 00	ROUNDING	0			0	0	
15. 00		0			0	o o	
16. 00		o			0	0	
17.00		O			0	0	17. 00
18.00	Total deductions (sum of lines 13 - 17)		2			0	18. 00
19. 00	Fund balance at end of period per balance		-4, 912, 472		(0	19. 00
	sheet (Line 11 - line 18)						
		Endowment Fund	PI ant	Fund			
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0		1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	6.00			0		1. 00 2. 00
		6.00			0		
2.00	Net income (loss) (from Wkst. G-3, line 31)	6.00					2. 00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00			0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Net income (Ioss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00 0			0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING Total deductions (sum of lines 13 - 17)	6.00 0 0			0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

Health Financial Systems	THE ACTORS FUND N	NURSING HOME		In Lie	u of Form CMS-:	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENS	ES	Provi der	No.: 315377	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-2 Parts I-II Date/Time Pre 4/18/2023 10:	pared:
Cost Center Description			Inpatient	Outpati ent	Total	
			1. 00	2. 00	3. 00	

STATEM	ENI OF PATTENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2022 To 12/31/2022		narod:
				10 12/31/2022	4/18/2023 10:	
	Cost Center Description		Inpatient	Outpati ent	Total	
	'		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			•		
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		13, 709, 85	3	13, 709, 853	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	ICF/IID			0	0	3.00
4.00	OTHER LONG TERM CARE		3, 039, 02	3	3, 039, 023	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		16, 748, 87	6	16, 748, 876	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		1, 982, 06	1 0	1, 982, 061	6. 00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10. 00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
12. 00	HOSPI CE			0	0	12.00
13. 00	ROUTINE CHARGES / BED HOLD		59, 08		59, 087	13.00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	18, 790, 02	4 0	18, 790, 024	14.00
	Worksheet G-3, Line 1)					
	Cost Center Description					
	DADT 11 ODEDATING EVERYORS			1. 00	2. 00	
4 00	PART II - OPERATING EXPENSES			T	04 000 7/0	4 00
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				21, 032, 768	1.00
2.00	Add (Specify)			0		2.00
3.00				0		3. 00
4.00				0		4. 00 5. 00
5.00				0		
6. 00 7. 00				0		6. 00 7. 00
8. 00	Total Additions (Sum of lines 2 - 7)			0	0	7. 00 8. 00
9. 00	Deduct (Specify)			0	U	9. 00
10.00	Specify)			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)				21, 032, 768	
13.00	Trotal operating Expenses (Sum of Times Fand o, millias Time 14)			1	21,032,700	13.00

	Financial Systems THE ACTORS FUND NUR	 		u of Form CMS-2	
STATE	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315377	Peri od: From 01/01/2022	Worksheet G-3	
			To 12/31/2022		
				4/18/2023 10:	59 am
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1	14)		18, 790, 024	1. 00
2. 00	Less: contractual allowances and discounts on patients accounts			1, 715, 131	
3. 00	Net patient revenues (Line 1 minus line 2)			17, 074, 893	
4. 00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		21, 032, 768	
5. 00	Net income from service to patients (Line 3 minus 4)	,		-3, 957, 875	
	Other income:				
6.00	Contributions, donations, bequests, etc			2, 462, 095	6. 00
7.00	Income from investments			351, 292	7. 00
8.00	Revenues from communications (Telephone and Internet service)			12, 080	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	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 that	an patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21. 00	Rental of vending machines			0	
22. 00	Rental of skilled nursing space			0	22. 00
23. 00	Governmental appropriations			0	
24.00	Other miscellaneous revenue (specify)			0	24. 00
24. 01	PRI OR YEAR			-7, 443	24. 01
24. 02	NON PATIENT REVENUE			4, 198	24. 02
24. 03	BARBER BEAUTY			0	24. 03
24. 04	MI SC			14, 500	
	COVI D-19 PHE Fundi ng			53, 363	
	Total other income (Sum of lines 6 - 24)			2, 890, 085	
26 00	Total (line 5 plus line 25)			_1 067 700	26 00

26.00

27.00

28. 00 29. 00

0 0

0 30.00

-1, 067, 790 31. 00

-1, 067, 790

24.50 COVID-19 PHE Funding
25.00 Total other income (Sum of lines 6 - 24)
26.00 Total (Line 5 plus line 25)

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

27.00 Other expenses (specify)

28. 00 29. 00