Health Financial Systems

BARTLEY NURSING AND REHAB

In Lieu of Form CMS-2540-10

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 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315288 Worksheet S Parts I, II & III Peri od. From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: То 5/30/2024 12:47 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2024 Time: 12:47 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 3.01 [] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[0]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11.Contractor Vendor Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BARTLEY NURSING AND REHAB (315288) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Yo	sef Lewin	ř	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Yosef Lewin			2
3	Signatory Title	CFO			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	1, 063, 168	946	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	1, 063, 168	946	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete and review the information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the 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.

(I LLED	Financial Systems BARTLEY D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH (INDENTIFICATION DATA	<u>NURSING AN</u> H CARE	Provider No	. : 315288	Period: From 01/01/ To 12/31/	/2023	u of For Workshe Part I Date/Ti 5/30/20	et S-2 me Pre	parec
	1.00	2.00		3.00			07 307 20	27 12.	
	Skilled Nursing Facility and Skilled Nursing Facility	/ Complex Ac	ddress:						
	Street: 175 BARTLEY ROAD PO Box:								1.0
	City: JACKSON State: N		Zip Code: 08						2.0
1	County: OCEAN CBSA Cod		Urban/Rural	: U					3.
01	CBSA Cod				_				3.
		Compor	nent Name	Provi der		Payme	ent Syst		
				CCN	Certified		0, or N	í	-
			1 00	2.00	2.00	V	XVIII	XIX	
6	CNE and CNE Deced Component I dentification.		1.00	2.00	3.00	4.00	5.00	6.00	
-	SNF and SNF-Based Component Identification:	BARTLEY NU		315288	03/01/1990	N	Р	N	4.0
00	SNF	REHAB	KSTING AND	315200	03/01/1990	IN			4.
00	Nursing Facility	KEIKO							5.0
	ICF/IID								6.
	SNF-Based HHA								7.0
	SNF-Based RHC								8.
	SNF-Based FQHC								9.1
	SNF-Based CMHC								10.
	SNF-Based OLTC				1				11.
	SNF-Based HOSPICE				1				12.
	SNF-Based CORF								13.
. [*					From:		To		
					1.00		2.0		1
00 0	Cost Reporting Period (mm/dd/yyyy)				01/01/2		12/31/		14.
	Type of Control (See Instructions)					6			15.
							Y/I	N	
							1. C	0	1
1	Type of Freestanding Skilled Nursing Facility								
	Is this a distinct part skilled nursing facility that	meets the	requi rements	s set forth	in 42 CFR		Y		16.
5	section 483.5?								
	Is this a composite distinct part skilled nursing fac	ility that	meets the re	equirements	set forth	in	N		17.
4	42 CFR section 483.5?								1
	Are there any costs included in Worksheet A that resu						Y		18.
	organizations as defined in CMS Pub. 15-1, chapter 10)? If yes,	complete Wor	rksheet A-8	8-1.				4
Ν	Miscellaneous Cost Reporting Information								
	If this is a low Medicare utilization cost report, in						N		19.0
	If line 19 is yes, does this cost report meet your co			filing a	low Medicar	э	N		19.
	utilization cost report, indicate with a "Y", for yes						00 00		-
	Depreciation - Enter the amount of depreciation repor	ted in this	S SINF FOR TH	e metnoa ir	ndicated on	LI nes			200
	Straight Line						5	562, 638	
	Declining Balance							(21.
	Sum of the Year's Digits								22.
	Sum of line 20 through 22						5	562, 638	
	If depreciation is funded, enter the balance as of t								24.
	Nere there any disposal of capital assets during the						N		25.
	Was accelerated depreciation claimed on any assets in	i the currer	it or any pri	or cost re	porting per	00?	N		26.
	(Y/N)	at and of t	he needed to	which thi	a aget range		N		07
	Did you cease to participate in the Medicare program applies? (Y/N)	at end of t	ine period to	o which thi	s cost repo	i L	N		27.
	Nas there a substantial decrease in health insurance	proportion	of allowable	o cost from	prior cost		N		28.
	reports? (Y/N)			5 0031 1100	i pi i di cost		IN IN		20.
						Part	APart B	Other	
						1.00		3.00	1
I	If this facility contains a public or non-public prov	/ider that d	qualifies fo	r an exempt	tion from th				
	of the lower of the costs or charges enter "Y" for ea								L
	exemption.								
00	Skilled Nursing Facility					N	N		29.
00	Nursing Facility							N	30.
	ICF/IID								31.
	SNF-Based HHA					N	N		32.
	SNF-Based RHC								33.
	SNF-Based FQHC								34.
00	SNF-Based CMHC						N		35.
	SNF-Based OLTC								36.
00					Y/N				
00					1.00		2.0	00	
	المستحمين والمستحد والمتعالية فالمستحد والمستحد وال			der as a SN	IF Y				37.
00	Is the skilled nursing facility located in a state th	XIX nationt	ts? (Y/N)						0-
l 00	regardless of the level of care given for Titles V &				I N		1		
00 1 4 00	regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran	nce? (Y/N)			N				
00 I 1 00 A 00 I	regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran Is the malpractice a "claims-made" or "occurrence" po	nce?(Y/N) blicy?lfth	ne policy is						38. 39.
00 I r 00 A 00 I	regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran	nce?(Y/N) blicy?lfth	ne policy is	Deart					39.
00 I r 00 A 00 I	regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insuran Is the malpractice a "claims-made" or "occurrence" po	nce?(Y/N) blicy?lfth	ne policy is	Premiums 1.00	Paid Los 2.00	ses S	SelfIns 3.0		39.

Heal th	Financial Systems	BARTLEY NURSING AN	ID REHAB		In Lie	u of Form CN	IS-2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3		Period:	Worksheet S	5-2
COMPLE	X INDENTIFICATION DATA				From 01/01/2023 To 12/31/2023	Part I Date/Time I	Pronarod
					10 12/31/2023	5/30/2024	
						Y/N	
	00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost						42.00
	center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and						
	amounts.						10.00
	Are there any home office costs as defi				C 11 1	Ν	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and ac	ddress o	t 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 org	ganization, enter the nam	e and address of	f the ho	me office on the	lines	
	bel ow.						
45.00	Name:	Contractor's Name:	C	Contracto	or's Number:		45.00
46.00	Street:	PO Box:					46.00
47.00	Ci ty:	State:	Z	Zip Code:			47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Provi	der No.: 315288	Period: From 01/01/2023 To 12/31/2023		repared
				Y/N	Date	<u></u>
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1, "Y'	for Yes or "N"	1.00 for No. For all	2.00 the date	_
00	Provider Organization and Operation Has the provider changed ownership immediated reporting period? If column 1 is "Y", enter instructions)	ly prior to the beginning the date of the change in	column 2. (see	N		1. (
			Y/N 1.00	Date 2.00	V/I 3.00	_
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact	of termination and in colu tions, including managemen	umn nt Y			2. 3.
	contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or t relationships? (see instructions)	d to the provider or its L, or members of the board	0			
			Y/N 1.00	Туре 2. 00	Date 3.00	
	Financial Data and Reports			2.00	3.00	
00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	" for Audited, "C" for te copy or enter date no, see instructions.		С		4.
00	Are the cost report total expenses and total those on the filed financial statements? If a reconciliation.		N			5.
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2: Is ⁻	the provider the	e N	N	6.
00 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	ng the cost reporting peri		N N		7. 8.
					Y/N 1.00	
00 00				ost reporting	Y N	9. 10.
	IDEFLOOPENT Y. SUDMEL CODV.		f"Y", see inst	ructions.	N	111.
00		d/or coinsurance waived? I				
			[≈] "Y", see instr	uctions.	N	
	If line 9 is "Y", are patient deductibles and Bed Complement	cost reporting period? In	F	Part A	Part B	
	If line 9 is "Y", are patient deductibles and Bed Complement					
00	If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to	cost reporting period? If Description	F Y/N	Part A Date	Part B Y/N	12.
00	If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used	cost reporting period? I1 Description 0	F Y/N 1.00	Part A Date 2.00	Part B Y/N 3.00	12.
00	If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the	cost reporting period? I1 Description 0	F Y/N 1.00 Y	Part A Date 2.00	Part B Y/N 3.00 Y	12.
00	If line 9 is "Y", are patient deductibles and Bed ComplementHave total beds available changed from priorWas the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.If line 13 or 14 is "Y", then were adjustments made to PS&R Report	cost reporting period? I1 Description 0	F Y/N 1.00 Y N	Part A Date 2.00	Part B Y/N 3.00 Y	11. 12. 13. 14. 15. 16.
. 00 . 00 . 00 . 00 . 00	If line 9 is "Y", are patient deductibles and Bed ComplementHave total beds available changed from priorWas the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	cost reporting period? I1 Description 0	F Y/N 1.00 Y N N	Part A Date 2.00	Part B Y/N 3.00 Y N	12. 13. 14. 15.

Health Financial Sy	ystems	BARTLEY NURSIN	NG AND	REHAB			In Lieu	u of Form CMS	2540-10
	CILITY AND SKILLED NURSING FACIL	ITY HEALTH CARE		Provi der	No.: 315288		i od:	Worksheet S-	2
COMPLEX REIMBURSEM	ENT QUESTI ONNAI RE					To	m 01/01/2023 12/31/2023		epared:
								5/30/2024 12	47 pm
				1.	00		2. (00	
Cost Report	Preparer Contact Information								
	rst name, last name and the titl		ΚΙ ΤΤΥ			BL	I SSI T		19.00
held by the	cost report preparer in columns	1, 2, and 3,							
respecti vel v	y.								
20.00 Enter the er	nployer/company name of the cost	report	HEALT	H CARE RE	SOURCES				20.00
preparer.									
21.00 Enter the te	elephone number and email address	s of the cost	609-9	87-1440		KI	TTY. BLI SSI T@H	ICRNJ. NET	21.00
report prepa	arer in columns 1 and 2, respecti	vel y.							

Heal th	Financial Systems	BARTLEY NURSIN	G AND REHAB		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 12:	pared:
		Part B					
		Date 4.00					
	PS&R Data	4.00					
	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	02/01/2024					13.00
14.00	4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and						14.00
15. 00	4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",						15.00
16. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.						16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:						17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.						18.00
		-	3. (00	_		
	Cost Report Preparer Contact Information		011				
19. 00	Enter the first name, last name and the titl held by the cost report preparer in columns respectively.		PREPARER				19.00
20.00	Enter the employer/company name of the cost	report					20.00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respecti						21.00

	ED NURSING FACILITY AND SKILLED NURSI EX STATISTICAL DATA	NG FACILITY HEALTH CARE	Provi der	F	Period: From 01/01/2023 To 12/31/2023		pared
				l np	oatient Days/Vis		
	Component	Number of Beds	Bed Days Avai LabLe	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	234	85, 410	C		41, 111	1.0
00 00	NURSING FACILITY	0	0	C)	0	2.0
00	HOME HEALTH AGENCY COST	0	0			U	3. 0 4. 0
00	Other Long Term Care	0	0				5.0
00	SNF-Based CMHC						6. (
00	HOSPICE	0	0	C		0	7.0
00	Total (Sum of lines 1-7)	234 Inpatient D	85, 410	C	Di scharges	41, 111	8. (
			ays/ vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
0.0		6.00	7.00	8.00	9.00	10.00	
00 00	SKILLED NURSING FACILITY	10, 883	68, 978 0		338	104 0	1. 2.
00	ICF/IID	0	0		,	0	3.
00	HOME HEALTH AGENCY COST						4.
00	Other Long Term Care	0	0				5.
00	SNF-Based CMHC		0			0	6.
00 00	HOSPICE Total (Sum of lines 1-7)	10, 883	0 68, 978		0 0 338	0 104	7. 8.
00		Di scha			rage Length of		0.
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	component	11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	290	732	0.00		395.30	1. (
00	NURSING FACILITY	0	0	0.00)	0.00	2.
00 00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3. 4.
00	Other Long Term Care	0	0				5.
00	SNF-Based CMHC						6.
00	HOSPICE	0	0	0.00		0.00	
00	Total (Sum of lines 1-7)	290 Average Length	732	0.00	50.25 ssi ons	395.30	8.
		of Stay		Adimis			
	Component	Total	Title V	Title XVIII	Title XIX	Other	
00		16.00	17.00	18.00	19.00	20.00	1
00 00	SKILLED NURSING FACILITY NURSING FACILITY	94. 23 0. 00	0	381	58	316 0	1. 2.
00	ICF/IID	0.00	0		0	0	3.
00	HOME HEALTH AGENCY COST						4.
00	Other Long Term Care	0.00				0	5.
00 00	SNF-Based CMHC HOSPI CE	0.00	0	C	0	0	6. 7.
00	Total (Sum of lines 1-7)	94.23	0			316	
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d	-		
		21.00	Payrol I	Workers	-		
00	SKILLED NURSING FACILITY	21.00	<u>22.00</u> 161.50	23.00 0.00)		1.
00	NURSING FACILITY	0	0.00				2.
00	ICF/IID	0	0.00				3.
00	HOME HEALTH AGENCY COST	_					4.
00	Other Long Term Care SNF-Based CMHC	0	0.00	0.00) I		5.
00	HOSPI CE		0.00	0.00			6. 7.
00		UI ()	0.00	0.00	/	1	

	Financial Systems	BARTLEY NURSI				u of Form CMS-2	
SNF WA	IGE INDEX INFORMATION				Period: From 01/01/2023 To 12/31/2023		pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES	1					
1.00	Total salaries (See Instructions)	9, 310, 849	0	9, 310, 84			
2.00	Physician salaries-Part A	0	C		0 0.00		
3.00	Physician salaries-Part B	0	0		0 0.00		
4.00	Home office personnel	0	C		0 0.00		
5.00	Sum of lines 2 through 4	0	0		0 0.00		
6.00	Revised wages (line 1 minus line 5)	9, 310, 849	0	9, 310, 84			
7.00	Other Long Term Care	0	0		0 0.00	0.00	
8.00	HOME HEALTH AGENCY COST						8.0
9.00	CMHC					0.00	9.0
10.00	HOSPI CE	0	0		0 0.00		
11.00	Other excluded areas	0			0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0			0 0.00		12.0
13.00	Total Adjusted Salaries (line 6 minus line 12)	9, 310, 849	C	9, 310, 84	335, 821. 00	27.73	13.0
	OTHER WAGES & RELATED COSTS						1
14.00	Contract Labor: Patient Related & Mgmt	4, 623, 801	C	4, 623, 80			
15.00	Contract Labor: Physician services-Part A	0	0		0 0.00		
16.00	Home office salaries & wage related costs	0	0		0 0.00	0.00	16.0
	WAGE-RELATED COSTS		1	-			
17.00	Wage-related costs core (See Part IV)	1, 511, 045	0	1, 511, 04	15		17.0
18.00	Wage-related costs other (See Part IV)	0	0		0		18.0
19.00	Wage related costs (excluded units)	0	0		0		19.0
20.00	Physician Part A - WRC	0	0		0		20.0
21.00	Physician Part B - WRC	0	0		0		21.0
22.00	Total Adjusted Wage Related cost (see instructions)	1, 511, 045	0	1, 511, 04	15		22. 0

Heal th	Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023		nored.
					10 12/31/2023	5/30/2024 12:4	
		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		0.00	0.00	1.00
2.00	Administrative & General	658, 189	0	658, 18	9 15, 661. 00	42.03	2.00
3.00	Plant Operation, Maintenance & Repairs	194, 108	0	194, 10	8 8, 144. 00	23.83	3.00
4.00	Laundry & Linen Service	0	0		0.00	0.00	4.00
5.00	Housekeepi ng	508, 674	0	508, 67	4 37, 770. 00	13.47	5.00
6.00	Dietary	906, 796	0	906, 79	6 46, 224. 00	19.62	6.00
7.00	Nursing Administration	1,050,520	0	1, 050, 52	35, 705. 00	29.42	7.00
8.00	Central Services and Supply	0	0		0.00	0.00	8.00
9.00	Pharmacy	0	0		0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0		0.00	0.00	10.00
11.00	Soci al Servi ce	160, 525	0	160, 52	5 2, 419. 00	66.36	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	373, 807	0	373, 80	7 21, 385. 00	17.48	13.00
14.00	Total (sum lines 1 thru 13)	3, 852, 619	0	3, 852, 61	9 167, 308. 00	23.03	14.00

	Financial Systems	BARTLEY NURSING AND			u of Form CMS-2	
SNF W	AGE RELATED COSTS	P	rovider No.: 315288	Period: From 01/01/2023	Worksheet S-3 Part IV	
				To 12/31/2023		pared
					5/30/2024 12:	
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					-
	Part A - Core List RETIREMENT COST					-
00	401K Employer Contributions				0	1 1 0
. 00 2. 00	Tax Sheltered Annuity (TSA) Employer Con	tribution			0	
3.00 3.00	Qualified and Non-Qualified Pension Plan				8, 520	
1.00	Prior Year Pension Service Cost	cost			0, 520	
. 00	PLAN ADMINISTRATIVE COSTS (Paid to Exter	nal Organization)			0	4.0
5.00	401K/TSA Plan Administration fees				0	5.0
. 00	Legal /Accounting/Management Fees-Pension	PI an			0	
. 00	Employee Managed Care Program Administra				0	
	HEALTH AND INSURANCE COST					
. 00	Health Insurance (Purchased or Self Fund	ed)			214, 119	8.0
. 00	Prescription Drug Plan	,			0	
0. 00	Dental, Hearing and Vision Plan				0	10.0
1.00	Life Insurance (If employee is owner or	benefi ci ary)			0	11. (
2.00	Accident Insurance (If employee is owner	or beneficiary)			0	12. (
3.00	Disability Insurance (If employee is own	er or beneficiary)			0	13. (
4.00	Long-Term Care Insurance (If employee is	owner or beneficiary)			0	
5.00	Workers' Compensation Insurance				337, 397	
6.00	Retirement Health Care Cost (Only curren	t year, not the extraordir	ary accrual require	d by FASB 106.	0	16. (
	Non cumulative portion)					
	TAXES				(05 540	1 4 7 4
	FICA-Employers Portion Only				695, 540	
8.00 9.00	Medicare Taxes - Employers Portion Only Unemployment Insurance				0 243, 908	
	State or Federal Unemployment Taxes				243, 908	1
0.00	OTHER				11, 301	20.1
1.00	Executive Deferred Compensation				0	21. (
	Day Care Cost and Allowances				0	
3.00					0	
4.00		- 23)			1, 511, 045	
					Amount	
					Reported	
					1.00	
	Part B - Other than Core Related Cost					
5.00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.0

Heal th	Financial Systems	BARTLEY NURSIN	G AND REHAB		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES		Provi der		Peri od:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023		norod.
					To 12/31/2023	5/30/2024 12:	
	Occupational Category	Amount	Fringe	Adj usted	Paid Hours	Average Hourly	
		Reported	Benefits	Salaries (col		Wage (col. 3 ÷	
				1 + col. 2)	5	col. 4)	
		1.00		2.00	3	5.00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	5.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	981, 882	160, 341	1, 142, 22	3 21, 851.00	52.27	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 761, 643	287, 676				2.00
3.00	Certified Nursing Assistant/Nursing	2, 714, 706	443, 311				3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	5, 458, 231	891, 328	6, 349, 55	9 168, 514. 00		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	0	0		0.00		7.00
8.00	Occupational Therapists	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 Therapi sts	0	0		0 0.00		
12.00	Respiratory Therapists	0	0		0 0.00		12.00
13.00	Other Medical Staff Contract Labor	0	0		0 0.00	0.00	13.00
	Nursing Occupations						
14.00	Registered Nurses (RNs)	284, 654		284, 65	4 3, 116. 00	91.35	14.00
15.00	Licensed Practical Nurses (LPNs)	937, 594		937, 59			15.00
16.00	Certified Nursing Assistant/Nursing	2,035,115		2, 035, 11			16.00
	Assi stants/Ai des	_,,		_,, .			
17.00	Total Nursing (sum of lines 14 through 16)	3, 257, 363		3, 257, 36	3 71, 562. 00	45.52	17.00
18.00	Physical Therapists	428, 843		428, 84	3 4, 131. 00	103.81	18.00
19.00	Physical Therapy Assistants	96, 513		96, 51	3 1, 116. 00	86.48	19.00
20.00	Physical Therapy Aides	0			0 0.00		
21.00	Occupational Therapists	628, 674		628, 67			
22.00	Occupational Therapy Assistants	103, 809		103, 80			22.00
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapi sts	108, 599		108, 59			
25.00	Respiratory Therapists	0			0 0.00 0 0.00		
26.00	Other Medical Staff	0		I	U U. UU	0.00	26.00

OSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider No.:	313200	Period: From 01/01/2023	Worksheet S	
			To 12/31/2023	Date/Time F 5/30/2024 1	repared 2:47 pm
			Group	Days	
00			1.00 RUX	2.00	1. (
00			RUL		2.0
00			RVX		3. (
00			RVL		4.0
00			RHX		5.0
00 00 00 00 00 00 00 00 00 00 00 00 00			RHL RMX		6.0
00			RML		8.0
00			RLX		9. (
0. 00			RUC		10. (
. 00			RUB		11. (
2. 00 3. 00			RUA RVC		12.0
. 00			RVB		14. (
. 00			RVA		15. (
. 00			RHC		16. (
. 00			RHB		17. (
. 00			RHA		18. (
. 00			RMC		19. (
0.00			RMB		20.0
. 00			RMA RLB		21.0
a. 00			RLA		22.0
. 00			ES3		24.0
. 00			ES2		25.
. 00			ES1		26.
. 00			HE2		27.0
. 00 . 00			HE1 HD2		28. 29.
. 00			HD2 HD1		30.
. 00			HC2		31.
. 00			HC1		32.
. 00			HB2		33.
. 00			HB1		34.
. 00			LE2		35.
. 00 . 00			LE1 LD2		36. 37.
. 00			LD2 LD1		37.
. 00			LC2		39.
.00			LC1		40.
. 00			LB2		41.
. 00			LB1		42.
00			CE2		43.
00 00 00 00 00 00 00 00 00 00 00 00 00			CE1 CD2		44. 45.
00			CD2 CD1		45.
00			CC2		47.
00			CC1		48.
00			CB2		49.
00			CB1		50.
00			CA2		51.
00 00 00 00 00 00 00 00 00 00 00 00 00			CA1 SE3		52. 53.
00			SE2		53.
00			SE1		55.
00			SSC		56.
00			SSB		57.
00			SSA		58.
00 00 00 00 00 00 00 00 00 00 00 00 00			I B2 I B1		59. 60.
00			I A2		61.
00			I A1		62.
00			BB2		63.
00			BB1		64.
00			BA2		65.
00			BA1		66.
00			PE2		67.
00 00 00 00 00 00 00 00 00 00 00 00 00			PE1 PD2		68. 69.
00			PD2 PD1		70.
00			PC2		71.
00			PC1		72.
. 00			PB2		73.
00			PB1		74.

Health Financial Systems	BARTLEY NURSING AM	ND REHAB		In Lie	u of Form CM	MS-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315288	Peri od:	Worksheet	S-7
				From 01/01/2023 To 12/31/2023		
				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 V payments beginning 10/01/2003. Congress expe expenses. For lines 101 through 106: Enter i column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" f with direct patient care and related expense (See instructions)	ected this increase n column 1 the amou or each category to for yes or "N" for n	to be used nt of the total SNF o if the s	l for direct expense for d revenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Li	ne 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00

RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315288	Period:	Worksheet A	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/30/2024 12:	pared:
	Cost Center Description	Sal ari es	Other	Total (col	1 Recl assi fi cati	Reclassi fi ed	
		our ur roo	othor	+ col . 2)	ons	Trial Balance	
					Increase/Decre		
					ase (Fr Wkst	col. 4)	
					A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		6, 275, 528			6, 275, 528	1.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 520, 202			1, 520, 202	3.00
4.00	00400 ADMINI STRATI VE & GENERAL	658, 189	4, 028, 265			4, 686, 454	•
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	194, 108	779, 082	973, 19		973, 190	•
6.00	00600 LAUNDRY & LINEN SERVICE	0	31, 812			31, 812	•
7.00	00700 HOUSEKEEPI NG	508, 674	89, 215			597, 889	•
8.00	00800 DI ETARY	906, 796	666, 912			1, 573, 708	•
9.00	00900 NURSING ADMINISTRATION	1, 050, 520	1, 500			1, 052, 020	
10.00	01000 CENTRAL SERVICE & SUPPLY	0	355, 588	355, 58		355, 588	•
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	12.00
13.00	01300 SOCIAL SERVICE	160, 525	0	160, 52		160, 525	
15.00	01500 PATIENT ACTIVITIES	373, 807	27, 688	401, 49	95 0	401, 495	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	5, 458, 230	3, 480, 863	8, 939, 09		8, 939, 093	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 I CF/I I D	0	0		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS		FF 025	FF 0		FF 025	1 40 00
40.00	04000 RADI OLOGY	0	55, 935			55, 935	•
41.00	04100 LABORATORY	0	112, 810	112, 81		112, 810	•
42.00	04200 INTRAVENOUS THERAPY	0	04 052	04.01	0 0 52 0	04.052	
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0	94, 952	94, 95		94, 952	•
44.00	04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY	0	525, 356 732, 483	525, 35 732, 48		525, 356 732, 483	
45.00	04600 SPEECH PATHOLOGY	0	108, 599			108, 599	
48.00	04700 ELECTROCARDI OLOGY	0	106, 399	106, 5	0 0	108, 599	47.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
48.00	04900 DRUGS CHARGED TO PATIENTS	0	443, 293	443, 29		443, 293	
49.00 51.00	05100 SUPPORT SURFACES	0	443, 273	443, 2	0 0	443, 293	51.00
51.00	OTHER REIMBURSABLE COST CENTERS	<u>Ч</u>	0		0 0	0	51.00
71.00	07100 AMBULANCE	0	90, 524	90, 52	24 0	90, 524	71.00
/ 1. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>	70, 021	,0,0.	- 1 0	70, 021	1 1.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80.00
81.00	08100 I NTEREST EXPENSE		0		0 0	0	81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	82.00
83.00	08300 H0SPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	9, 310, 849	19, 420, 607	28, 731, 4	56 0	28, 731, 456	
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	,,,				1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	•
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
			0		0 0	0	94.00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	94.00

RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre	epared:
						5/30/2024 12:	47 pm
	Cost Center Description	Adjustments_to					
			For Allocation				
		Wkst A-8)	(col. 5 +-				
			col. 6)				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-3, 164, 320					1.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 520, 202				3.00
4.00	00400 ADMINISTRATIVE & GENERAL	-1, 304, 840					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	973, 190				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	31, 812				6.00
7.00	00700 HOUSEKEEPI NG	0	597, 889				7.00
8.00	00800 DI ETARY	0	1, 573, 708				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	1, 052, 020				9.00
10.00	01000 CENTRAL SERVICE & SUPPLY	0	355, 588				10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0				12.00
13.00	01300 SOCIAL SERVICE	0	160, 525				13.00
15.00	01500 PATIENT ACTIVITIES	0	401, 495				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	-1, 200	8, 937, 893				30.00
31.00	03100 NURSING FACILITY	0	0				31.00
32.00	03200 CF/I D	0	0				32,00
33.00	03300 OTHER LONG TERM CARE	0					33.00
	ANCI LLARY SERVICE COST CENTERS	-	-				
40.00	04000 RADI OLOGY	0	55, 935				40.00
41.00	04100 LABORATORY	0					41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0				42.00
	04300 OXYGEN (INHALATION) THERAPY	0	94, 952				43.00
44.00	04400 PHYSI CAL THERAPY	0	525, 356				44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	732, 483				45.00
	04600 SPEECH PATHOLOGY	0	108, 599				46.00
47.00	04700 ELECTROCARDI OLOGY	0	0				47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48.00
	04900 DRUGS CHARGED TO PATIENTS	0	443, 293				49.00
49.00 51.00	05100 SUPPORT SURFACES	0					51.00
51.00	OTHER REIMBURSABLE COST CENTERS	0	0				51.00
71.00	07100 AMBULANCE	0	90, 524				71.00
71.00	SPECIAL PURPOSE COST CENTERS	0	90, 324				/1.00
80, 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0				00.00
							80.00
	08100 I NTEREST EXPENSE	0					81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	-				82.00
83.00	08300 HOSPI CE	0	0				83.00
89.00	SUBTOTALS (sum of lines 1-84)	-4, 470, 360	24, 261, 096				89.00
00.00	NONREI MBURSABLE COST CENTERS		2				00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0					90.00
	09100 BARBER AND BEAUTY SHOP	0					91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0				92.00
	09300 NONPAI D WORKERS	0	0				93.00
94.00	09400 PATIENTS LAUNDRY	0	0				94.00
100.00	TOTAL	-4, 470, 360	24, 261, 096				100.00

Health Financial Systems	BARTLEY NURSING AN	d rehab		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315288	Period: From 01/01/2023	Worksheet A-6)
					Date/Time Pre 5/30/2024 12:	epared: 47 pm
			Increases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS			_			
	Total Reclassificat of columns 4 and 5 equal sum of column 9)	must		0	0	100. 00

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

Health Financial Systems	BARTLEY NURSING AN	D REHAB		In Lie	u of Form CMS	-2540-10	
RECLASSI FI CATI ONS		Provi der	No.: 315288	Period: From 01/01/2023	Worksheet A-	6	
					Date/Time Pr 5/30/2024 12	epared: 2:47 pm	
		Decreases					
	Cost Cente	r	Line #	Sal ary	Non Salary		
	6.00		7.00	8.00	9.00		
TOTALS							
100.00				0		0 100. 00	

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

	n Financial Systems	BARTLEY NURSIN				In Lie	u of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315288	Period: From 01/0	1 /2022	Worksheet A-7	
						1/2023	Date/Time Prep	hared
					10 12/0	17 2020	5/30/2024 12:4	47 pm
				Acqui si ti on	S			
	Description	Begi nni ng	Purchases	Donati on	Tota	al	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00	4.0	0	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALA	NCES						
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	0	0		0	0	0	3.00
4.00	Building Improvements	44, 261	185, 681		0 1	85, 681	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	74, 671	823, 111		0 8	23, 111	0	6.00
7.00	Subtotal (sum of lines 1-6)	118, 932	1, 008, 792		0 1,0	08, 792	0	7.00
8.00	Reconciling Items	0	0		0	0	0	8.00
9.00	Total (line 7 minus line 8)	118, 932	1, 008, 792		0 1,0	08, 792	0	9.00
	Description	Endi ng Bal ance	Fully					
		_	Depreciated					
			Assets					
		6.00	7.00					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALA	NCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	229, 942	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	897, 782	0					6.00
7.00	Subtotal (sum of lines 1-6)	1, 127, 724	0					7.00
8.00	Reconciling Items	0	0					8.00
9.00	Total (line 7 minus line 8)	1, 127, 724	0					9.00

	Financial Systems MENTS TO EXPENSES	BARTLEY NURSIN		No.: 315288	Period:	u of Form CMS-2 Worksheet A-8	
100031	MENTS TO EAFENSES		FIOVIDEI		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 12:	pared:
					lassification on ch the Amount is ⁻		
	Description (1)	(2) Basis For Adjustment	Amount	Cos	t Center	Line No.	
		1.00	2.00		3. 00	4.00	
. 00	Investment income on restricted funds (chapter 2)	В	-6, 201	CAP REL COST FIXTURES	S - BLDGS &	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0			0.00	3.00
1.00	Rental of provider space by suppliers (chapter 8)		0			0.00	4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	5.00
5.00	Television and radio service (chapter 21)		0			0.00	6.00
7.00	Parking lot (chapter 21)		0			0.00	
3.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0				8.00
9.00	Home office cost (chapter 21)		0			0.00	9.00
0.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
1.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	11.00
2.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-3, 158, 119				12.00
3.00	Laundry and linen service		0			0.00	
	Revenue – Employee meals		0			0.00	
	Cost of meals - Guests		0			0.00	
6.00	Sale of medical supplies to other than patients		0			0.00	16.00
7.00	Sale of drugs to other than patients		0			0.00	17.00
	Sale of medical records and abstracts		0			0.00	
	Vending machines		0			0.00	
20.00	Income from imposition of interest, finance		0			0.00	20.00
	or penalty charges (chapter 21)						
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21.00
22.00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW - SNF	82.00	22.00
23.00	(chapter 21) Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.00
				FI XTURES			
	Depreciationmovable equipment	_			ter Deleted ***	2.00	
	PSYCH EVAL	A			ING FACILITY	30.00	
		A			VE & GENERAL	4.00	
	DRAWINGS - PTE	A			VE & GENERAL	4.00	
	BAD DEBT DI SALLOWED	A			VE & GENERAL	4.00	
	NJ FRANCHISE TAX EXPENSE Total (sum of lines 1 through 99) (Transfer	A	-430, 246 -4, 470, 360		VE & GENERAL	4.00	25.04 100.00
00.00	to Worksheet A, col. 6, line 100)		-4, 470, 300				100.00

(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.

Health Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	eu of Form CMS-	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ			No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-II Date/Time Pre 5/30/2024 12:	epared:
	Line No.	Cost (Center	Expens	e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	TED ORGANI ZATI ONS	S OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEE		1.00
2.00		CAP REL COSTS	- BLDGS &	RENT		2.00
3.00	0.00					3.00
4.00	0.00					4.00
5.00	0.00					5.00
6.00	0.00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9,00
10.00 TOTALS (sum of lines 1-9). Transfer column	0.00					10.00
6, line 100 to Worksheet A-8, column 3, line						10.00
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu			
	Cost	Wkst. A, col.	col. 5)			
		5				
	4,00	5.00	6,00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI				TED ORGANIZATION	S OR	
CLAIMED HOME OFFICE COSTS:						
1.00	1, 109, 430			0		1.00
2.00	2, 921, 881	6, 080, 000	-3, 158, 1	19		2.00
3.00	0	0		0		3.00
4.00	0	0		0		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	4, 031, 311	7, 189, 430	-3, 158, 1	19		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						

Health Financial Systems	BARTLEY NURSING	G AND REHAB	In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provider No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-II Date/Time Prep 5/30/2024 12:4	bared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00		Α	0.00	1.00
2.00		A	0.00	2.00
3.00			0.00	3.00
4.00		А	0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial)		0.00	100.00
	speci fy:			

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in

related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of	Type of Business	
		Ownershi p		
	4.00	5.00	6.00	
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/OR HOME OFFICE:			

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

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

for purposed of or arming for mour comone under er			
1.00	PCA MANAGEMENT LLC	O. OOMANAGEMENT	1.00
2.00	PCA MANAGEMENT LLC	O. OOMANAGEMENT	2.00
3.00		0.00	3.00
4.00	BARTLEY HOLDING CO	0. 00 RENT	4.00
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	BARTLEY NURSI				eu of Form CMS-2	2540-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		CAPI TAL			5/30/2024 12:	47 pm
		RELATED COSTS				
Cost Center Description	Net Expenses for Cost	BLDGS & FI XTURES	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	
	Allocation	TINTORES	DENEITIS			
	(from Wkst A					
	col. 7)					
	0	1.00	3.00	3A	4.00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES	3, 111, 208	3, 111, 208				1.00
3. 00 00300 EMPLOYEE BENEFITS	1, 520, 202			12		3.00
4. 00 00400 ADMI NI STRATI VE & GENERAL	3, 381, 614				3, 656, 567	4.00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	973, 190					5.00
6.00 00600 LAUNDRY & LINEN SERVICE	31, 812			0 107, 588		•
7. 00 00700 HOUSEKEEPI NG	597, 889					•
8. 00 00800 DI ETARY	1, 573, 708			2, 116, 685		
9. 00 00900 NURSING ADMINISTRATION	1, 052, 020	48, 591	171, 52	1, 272, 132	225, 758	9.00
10.00 01000 CENTRAL SERVICE & SUPPLY	355, 588	0		0 355, 588	63, 104	10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	-,		0 6, 875		
13.00 01300 SOCIAL SERVICE	160, 525					13.00
15. 00 01500 PATIENT ACTIVITIES	401, 495	223, 475	61, 03	686, 002	121, 741	15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	8, 937, 893	1 024 140	001.1	78 11, 763, 219	2 007 554	20.00
30. 00 03000 SKILLED NURSING FACILITY 31. 00 03100 NURSING FACILITY	8, 937, 893	1, 934, 148 0		0 11, 763, 219		30.00
32. 00 03200 I CF/I I D	0	-		0 0		31.00
33. 00 03300 OTHER LONG TERM CARE	0			0 0		33.00
ANCI LLARY SERVICE COST CENTERS			1	0 0		
40. 00 04000 RADI OLOGY	55, 935	0		0 55, 935	9, 926	40.00
41.00 04100 LABORATORY	112, 810	0		0 112, 810	20, 020	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	94, 952			0 104, 326		
44.00 04400 PHYSI CAL THERAPY	525, 356			0 574, 207		•
45. 00 04500 OCCUPATI ONAL THERAPY	732, 483			0 779, 303		
46. 00 04600 SPEECH PATHOLOGY	108, 599			0 120, 421		
47. 00 04700 ELECTROCARDI OLOGY	0	0		0 0 4.323	-	•
48. 0004800MEDI CALSUPPLI ESCHARGEDTOPATI ENTS49. 0004900DRUGSCHARGEDTOPATI ENTS	0 443, 293	4, 323 20, 572		0 4, 323 0 463, 865		48.00
51. 00 05100 SUPPORT SURFACES	443, 293			0 403, 805		1
OTHER REIMBURSABLE COST CENTERS	0				0	1 51.00
71. 00 07100 AMBULANCE	90, 524	0		0 90, 524	16, 065	71.00
SPECIAL PURPOSE COST CENTERS		-		-1		
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100 INTEREST 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)	24, 261, 096	3, 111, 208	1, 520, 20	24, 261, 096	3, 656, 567	89.00
		~	1	0		00.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00 09100 BARBER AND BEAUTY SHOP	0				0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSICIANS PRIVATE OFFICES					0	
93. 00 09300 NONPAID WORKERS	0				0	•
94. 00 09400 PATIENTS LAUNDRY	0			0 0	0	
98.00 Cross Foot Adjustments	0	0		0 0	0	•
99.00 Negative Cost Centers	0	0		0 0	0	99.00
100. 00 TOTAL	24, 261, 096	3, 111, 208	1, 520, 20	24, 261, 096	3, 656, 567	100.00
						-

Heal th	Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	u of Form CMS-2	2540-10
	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315288	Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	nared
			_		10 12/01/2020	5/30/2024 12:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NO		NURSI NG	
		OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. & REPAIRS					
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 296, 904					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	34, 517	161, 198				6.00
7.00	00700 HOUSEKEEPI NG	4, 792		,			7.00
8.00	00800 DI ETARY	179, 890				1 504 407	8.00
9.00	00900 NURSING ADMINISTRATION	22, 133		14, 41		1, 534, 437	9.00
10.00	01000 CENTRAL SERVICE & SUPPLY	0	-	2.02	0 0	0	10.00
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	3, 131 5, 053				0	12.00 13.00
15.00	01500 PATIENT ACTIVITIES	101, 795				0	15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	101,773	0	00,27	0 0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	881,019	161, 198	573, 73	2, 789, 357	1, 534, 437	30.00
31.00	03100 NURSING FACILITY	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	0	0		0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS		1	1			
40.00	04000 RADI OLOGY	0			0 0	0	40.00
41.00	04100 LABORATORY	0	-		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	-		0 0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	4, 270 22, 252		2, 78	•	0	43.00 44.00
44.00	04400 PHYSICAL THERAPY 04500 OCCUPATI ONAL THERAPY	22, 252				0	44.00
45.00	04600 SPEECH PATHOLOGY	5, 385	-			0	46.00
47.00	04700 ELECTROCARDI OLOGY	0,000			0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,969				0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	9, 371	0	6, 10	02 0	0	49.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OTHER REIMBURSABLE COST CENTERS		1	1			
71.00	07100 AMBULANCE	0	0		0 0	0	71.00
~~ ~~	SPECIAL PURPOSE COST CENTERS		1	1			
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 82.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00 82.00
82.00	08200 UTLETZATION REVIEW - SNF	0	0		0	0	82.00
89.00	SUBTOTALS (sum of lines 1-84)	1, 296, 904	161, 198	818, 96	2, 789, 357	1, 534, 437	89.00
07.00	NONREI MBURSABLE COST CENTERS	1,270,704	101,170	010,70	2,107,337	1, 334, 437	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00	Negative Cost Centers	1 204 004	0	010.07		0	99.00
100.00	D TOTAL	1, 296, 904	161, 198	818, 96	2, 789, 357	1, 534, 437	100.00

COST ALLOGATION - GENERAL SERVICE COSTS Provider No.: 31528 Provider No.: 300 Provider	Heal th	Financial Systems	BARTLEY NURSING	G AND REHAB		In Lie	u of Form CMS-	2540-10
Cost Center Description Central SERVICE 4 SERVICE 5 SERVICE 4 SERVICE 5 SERVICE 5 SeRVICE 4 SERVICE 5 SERVICE 5 SERV				Provi der	No.: 315288			
Cost Center Description CENTRAL SERVICE SUPPLY MEDIGAL SERVICE SUPPLY SOCIAL SERVICE LIBRARY SOCIAL SERVICE SUPPLY Subtotal Stavice Activities Subtotal Subtotal 100 00300 [EVELOTE EDEST - SLLDGS & LITRES 00300 [EVELOTE EDEST ITS 0.00 13.00 13.00 15.00 16.00 100 00300 [EVELOTE EDEST ITS 0.00 0.00 12.00 13.00 15.00 16.00 1.00 00300 [EVELOTE EDEST ITS 0.00 0.00 12.00 13.00 15.00 16.00 0.00 00500 [PLAIT OPFRATION_MAINT & REPAIRS 0.00 0.00 0.00 0.00 0.00 10.00 12.00 13.00 13.265 12.00 13.00 13.00 10.00 13.00 01300 SOCIAL SERVICE & SUPPLY 418,692 13.265 12.00 13.00								norod.
Cost Center Description CENTRAL SERVICE & SUPPLY MEDICAL SERVICE UBARY COCIAL SERVICE PATIENT LIBARY OTHER CENERAL PATIENT ACTIVITES Subtotal Subtotal ACTIVITES 1.00 00100 CAP RELCOST CENTRES 10.00 13.00 15.00 16.00 1.00 00100 CAP RELCOST S - BLOS & FLIXURES 10.00 13.00 15.00 16.00 0.00 00400 ADMIN STRATIVE & CENTRAL 0.00 COSD (LAINORY & LINEN SERVICE 0.00 COSD (LAINORY & LINEN SERVICE 0.00 COSD (LAINORY & LINEN SERVICE 0.00 COSD (URSING FACILITY 418.692 13.265 241.278 9.00 10.00 01030 CENTRAL SERVICE & SERVICE 0.00 COSD (URSING FACILITY 418.692 13.265 241.278 975.822 21,439.577 30.00 10.00 03000 SKILED MURSING FACILITY 418.692 13.265 241.278 975.822 21,439.577 30.00 10.00 0000 SKILED MURSING FACILITY 418.692 13.265 241.278 975.822 21,439.577 30.00 10.00 0000 SKILED MURSING FACILITY 418.692 13.265 241.278 975.822 21,439.577 30.00 10.00 000 0 000						10 12/31/2023	5/30/2024 12	47 nm
Cost Center Description CENTRAL SERVICE & SUPPLY MEDICAL RECORDS & UIREARY SOCIAL SERVICE (A) 13.00 SUPPLY (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 13.00 Supply (A) 10.00 100 000000 CPA PEI, COST CENTERS 10.00 13.00 15.00 16.00 000 000000 CPA PEI, COST CENTERS 0 0.00						OTHER GENERAL	10/00/2021 121	l'i più
SFRVICE & SUPPLY RECORDS & LIBRARY ACTIVITIES 1.00 12.00 13.00 15.00 16.00 1.00 00100 (AP REL COST - BLICS & FIXTURES 00100 (AP REL COST - BLICS & FIXTURES 000000 ADM INSTRATIVE & GENERAL 0.000000 ADM INSTRATIVE & GENERAL 0.000000 ADM INSTRATIVE & GENERAL 0.000000 ADM INSTRATIVE & GENERAL 0.0000000 ADM INSTRATIVE & GENERAL 0.000000 ADM INSTRATIVE & GENERAL 0.0000000 ADM INSTRATIVE & GENERAL 0.0000000 ADM INSTRATIVE & GENERAL 0.00000000 ADM INSTRATIVE & GENERAL 0.000000000 ADM INSTRATIVE & GENERAL 0.000000000 ADM INSTRATIVE 0.00000000 ADM INSTRATIVE & GENERAL 0.000000000 ADM INSTRATIVE & GENERAL 0.0000000000 ADM INSTRATIVE & GENERAL 0.000000000 ADM INSTRATIVE & GENERAL 0.0000000000 ADM INSTRATIVE & GENERAL 0.00000000000 ADM INSTRATIVE & GENERAL 0.000000000000 ADM INSTRATIVE & GENERAL 0.0000000000000000 ADM INSTRATIVE & GENERAL 0.00000000000000 ADM INSTRATIVE & GENERAL 0.00000000000000000000000000000000000								
SUPPLY LIBRARY		Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVI	CE PATIENT	Subtotal	
THE OUT OF CONTROL 10.00 12.00 13.00 15.00 16.00 1.00 00100 CAP REL COSTS - BLOSS & FLXTURES 0.00			SERVICE &	RECORDS &		ACTI VI TI ES		
CENTERAL SERVICE COST CENTERS 1.00 1.00 00300 CAP REL COST CENTERS 1.00 0.00 00300 CAP REL COST CENTERS 1.00 0.00 00300 CAP NEL COST CENTERS 1.00 0.00 00500 PLANT OPERATION, MAINT: & REPAIRS 5.00 0.00 00000 UNESING ADMINISTRATION 8.00 0.00 00700 HOUSEKEEPING 9.00 0.00 00700 UNESING ADMINISTRATION 0.00 0.00 00700 UNESING ADMINISTRATION 0.00 0.00 00700 UNESING ADMINISTRATION 0.00 12.00 01300 UNESING ADMINISTRATION 0.00 13.00 13.005 241,278 975,828 15.00 01300 UNESING ADMINISTRATION 0.00 0.00 15.00 01300 UNESING ADMINISTRATION 0.00 0.00 13.00 13.00 13.005 13.265 241,278 975,828 21,439,577 30.00 03000 UTHER LONG TENN CALL RECONT CENTERS 0.00 0.00 0.00 22,00 33.00 033000 UTHER LONG TENN CALL THERS 0.00								
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100.00 101AL 418,692 13,265 241,278 975,828 24,261,096 100.00		5		0)	0 0		
	100.00	I IUIAL	418, 692	13, 265	p 241, 2	/8 975, 828	24, 261, 096	1100.00

Heal th Financial Systems BARTLEY NURSING AND REHAB In Lieu of Form CMS-254C COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315288 Period: From 01/01/2023 To 12/31/2023 Worksheet B Part I Date/Time Prepare 5/30/2024 12: 47 pt Cost Center Description Post Stepdown Adjustments Total Vorksheet B 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 17.00 18.00 3.00 00300 EMPLOYEE BENEFITS 1 4.00 00400 ADMINI STRATIVE & GENERAL 5 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LINEN SERVICE 6 7.00 00300 DI ETARY 8 9.00 00900 NURSING ADMINI STRATION 9 10.00 01000 CENTRAL SERVICE & SUPPLY 10
Cost Center Description Post Stepdown Adjustments Total 17.00 18.00 GENERAL SERVI CE COST CENTERS 17.00 100 00100 CAP REL COSTS - BLDGS & FIXTURES 1 3.00 00300 EMPLOYEE BENEFITS 3 4.00 00400 ADMI NI STRATI VE & GENERAL 3 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LI NEN SERVI CE 6 7.00 00700 B.00 00800 DI ETARY 8 9.00 00900
Cost Center Description Post Stepdown Adjustments Total Adjustments 17.00 18.00 17.00 18.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1 3.00 00300 EMPLOYEE BENEFITS 3 4.00 00400 ADMINISTRATIVE & GENERAL 3 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 4 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LINEN SERVICE 6 7.00 00700 HOUSEKEEPING 7 8.00 00800 DI ETARY 8 9.00 00900 NURSI NG ADMINISTRATION 9
Adj ustments Adj ustments 17.00 18.00 GENERAL SERVI CE COST CENTERS 17.00 1.00 00100 CAP REL COSTS - BLDGS & FI XTURES 3.00 00300 EMPLOYEE BENEFI TS 4.00 00400 ADMI NI STRATI VE & GENERAL 5.00 00500 PLANT OPERATION, MAI NT. & REPAI RS 6.00 00600 LAUNDRY & LI NEN SERVI CE 7 8.00 00800 DI ETARY 9.00 00900 NURSI NG ADMI NI STRATI ON 9
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1 3.00 00300 EMPLOYEE BENEFITS 3 4.00 00400 ADMI NI STRATI VE & GENERAL 4 5.00 00500 PLANT OPERATI ON, MAI NT. & REPAI RS 5 6.00 00600 LAUNDRY & LI NEN SERVI CE 6 7.00 00700 HOUSEKEEPI NG 7 8.00 00800 DI ETARY 8 8 9.00 00900 NURSI NG ADMI NI STRATI ON 9
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1 3.00 00300 EMPLOYEE BENEFITS 3 4.00 00400 ADMINISTRATIVE & GENERAL 4 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LINEN SERVICE 6 7.00 00700 HOUSEKEEPING 7 6 8.00 00800 DIETARY 8 9 9.00 00900 NURSING ADMINISTRATION 9
3.00 00300 EMPLOYEE BENEFITS 3 4.00 00400 ADMINISTRATIVE & GENERAL 4 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LINEN SERVICE 6 7.00 00700 HOUSEKEEPING 7 8.00 00800 DIETARY 8 9.00 00900 NURSING ADMINISTRATION 9
4.00 00400 ADMI NI STRATI VE & GENERAL 4 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LI NEN SERVICE 6 7.00 00700 HOUSEKEEPING 7 8.00 00800 DI ETARY 8 9.00 00900 NURSI NG ADMINI STRATI ON 9
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 6.00 00600 LAUNDRY & LINEN SERVICE 6 7.00 00700 HOUSEKEEPING 7 8.00 00800 DIETARY 8 9.00 00900 NURSING ADMINISTRATION 9
6.00 00600 LAUNDRY & LI NEN SERVICE 6 7.00 00700 HOUSEKEEPING 7 8.00 00800 DIETARY 8 9.00 00900 NURSING ADMINISTRATION 9
7.00 00700 HOUSEKEEPING 7 8.00 00800 DIETARY 8 9.00 00900 NURSING ADMINISTRATION 9
8.00 00800 DIETARY 8 9.00 00900 NURSI NG ADMINISTRATION 9
9. 00 00900 NURSI NG ADMI NI STRATI ON 9
12. 00 01200 MEDICAL RECORDS & LIBRARY 12
13. 00 01300 SOCIAL SERVICE 13
15. 00 01500 PATIENT ACTIVITIES 15
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00 03000 SKI LLED NURSING FACILITY 0 21, 439, 577 30
31.00 03100 NURSING FACILITY 0 0 0 31
32. 00 03200 I CF/I I D 0 0 32
33. 00 03300 OTHER LONG TERM CARE 0 0 33
ANCI LLARY SERVI CE COST CENTERS
40. 00 04000 RADI OLOGY 0 65, 861 40
41. 00 04100 LABORATORY 0 132, 830 41
42. 00 04200 I NTRAVENOUS THERAPY 0 0 42
43. 00 04300 0XYGEN (INHALATION) THERAPY 0 129, 891 43
44. 00 04400 PHYSI CAL THERAPY 0 712, 851 44
45. 00 04500 OCCUPATI ONAL THERAPY 0 952, 816 45
46. 00 04600 SPEECH PATHOLOGY 0 150, 683 46
47. 00 04700 ELECTROCARDI OLOGY 0 0 47
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 8, 341 48
49. 00 04900 DRUGS CHARGED TO PATI ENTS 0 561, 657 49
51.00 05100 SUPPORT SURFACES 0 0 51
OTHER REIMBURSABLE COST CENTERS
71. 00 07100 AMBULANCE 0 106, 589 71
SPECIAL PURPOSE COST CENTERS
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80
81.00 08100 I NTEREST EXPENSE 81
82. 00 08200 UTILIZATION REVIEW - SNF 82
83. 00 08300 HOSPI CE 0 83
89.00 SUBTOTALS (sum of lines 1-84) 0 24, 261, 096 89
NONREI MBURSABLE COST CENTERS
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90
91.00 09100 BARBER AND BEAUTY SHOP 0 0 91
92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0
93. 00 09300 NONPAID WORKERS 0 0 0 93
94. 00 09400 PATIENTS LAUNDRY 0 0 94
98.00 Cross Foot Adjustments 0 0 98
99.00 Negative Cost Centers 0 0 99
100.00 TOTAL 0 24,261,096 100

	Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023		pared: 47 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDGS & FI XTURES	Subtotal	EMPLOYEE BENEFI TS	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	3.00	4.00	
	GENERAL SERVICE COST CENTERS	1	1	1			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS	0			0 0		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	0					
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	96, 556			8, 954	
6.00	00600 LAUNDRY & LINEN SERVICE	0				875	
7.00	00700 HOUSEKEEPI NG	0	10, 520			5, 621	7.00
8.00	00800 DI ETARY	0	394, 923			17, 207	1
9.00	00900 NURSI NG ADMI NI STRATI ON	0	10/0/1	48, 59		10, 341	1
10.00	01000 CENTRAL SERVICE & SUPPLY	0			0 0	2, 891	1
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0,0,0			56	1
13.00	01300 SOCIAL SERVICE	0	,				
15.00	01500 PATIENT ACTIVITIES	0	223, 475	223, 4	75 0	5, 577	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	1 024 140	1 024 1	10	05 (15	200.00
30.00	03000 SKILLED NURSING FACILITY	0		1, 934, 14			
31.00	03100 NURSING FACILITY	0			0 0		
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0			0 0	0	
33.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	33.00
40.00	04000 RADI OLOGY	0	0	1	0 0	455	40.00
41.00	04100 LABORATORY	0			0 0	917	
42.00	04200 I NTRAVENOUS THERAPY	0			0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0		9, 3	0	848	
44.00	04400 PHYSI CAL THERAPY	0	48, 851			4, 668	
45.00	04500 OCCUPATI ONAL THERAPY	0				6, 335	
46.00	04600 SPEECH PATHOLOGY	0				979	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 323	4, 32	23 0	35	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	20, 572			3, 771	49.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OTHER REIMBURSABLE COST CENTERS						
71.00	07100 AMBULANCE	0	0		0 0	736	71.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0			0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	3, 111, 208	3, 111, 20	0 80	167, 489	89.00
	NONREI MBURSABLE COST CENTERS		1				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			0 0	-	
91.00	09100 BARBER AND BEAUTY SHOP	0			0 0	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	
98.00	Cross Foot Adjustments		_		0	_	98.00
99.00	Negative Cost Centers		0	0 444 0	0 0	0	
100.00	TOTAL	0	3, 111, 208	3, 111, 20	0 8	167, 489	1100.00

Heal th	Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS			No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/30/2024 12:	
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		NURSI NG ADMI NI STRATI ON	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	405 540					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	105, 510					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	2,808			21		6.00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY	390		16, 53			7.00
8.00 9.00		14, 635	0	2,30		41 024	8.00 9.00
9.00 10.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICE & SUPPLY	1, 801 0	0	25	0 0	61, 024 0	9.00
12.00	01200 MEDICAL RECORDS & LIBRARY	255			41 0	0	12.00
12.00	01300 SOCIAL SERVICE	411			56 0	0	12.00
15.00	01500 PATIENT ACTIVITIES	8, 282				0	15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0,202	0	1, 5		0	15.00
30, 00	03000 SKI LLED NURSI NG FACI LI TY	71, 676	79, 459	11, 58	429, 130	61, 024	30.00
31.00	03100 NURSING FACILITY	0	0	,	0 0	01,021	31.00
32.00	03200 CF/I D	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS			1			
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0			0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	347	0		56 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 810	0	29		0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	1, 735		28		0	45.00
46.00	04600 SPEECH PATHOLOGY	438		-	71 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	-		0 0	0	47.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	160			26 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	762		12		0	49.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
71.00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	71.00
71.00	SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	/1.00
80, 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			80, 00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	105, 510	79, 459	16, 53	429, 130	61, 024	89.00
07.00	NONREI MBURSABLE COST CENTERS	1007010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10,00	12,7100	01/021	07100
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments		0		0 0	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	D TOTAL	105, 510	79, 459	16, 53	429, 130	61, 024	100. 00

	Financial Systems	BARTLEY NURSIN		N 015005		u of Form CMS-	2540-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315288	Period: From 01/01/2023	Worksheet B Part II	
					To 12/31/2023	Date/Time Pre 5/30/2024 12:	
					OTHER GENERAL	373072024 12.	47 pm
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVI		Subtotal	
		SERVICE &	RECORDS &		ACTI VI TI ES		
		SUPPLY 10.00	LI BRARY 12.00	13.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	10.00	12.00	15.00	13.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00							8.00
9.00 10.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICE & SUPPLY	2, 891					9.00
10.00	01200 MEDICAL RECORDS & LIBRARY	2,891	7, 227	,			12.00
12.00	01300 SOCIAL SERVICE	0	1,221		78		12.00
15.00	01500 PATIENT ACTIVITIES	0	(0 238, 672		15.00
101.00	INPATIENT ROUTINE SERVICE COST CENTERS			·]	200,012		101.00
30.00	03000 SKILLED NURSING FACILITY	2, 891	7, 22	7 13, 1	78 238, 672	2, 944, 601	30.00
31.00	03100 NURSING FACILITY	0	(0 0	0	31.00
32.00	03200 I CF/I I D	0	(D	0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	(0 0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS			1			-
40.00	04000 RADI OLOGY	0	(0 0	455	
41.00	04100 LABORATORY	0	(0 0	917	
42.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	(0 0 0 0	10 425	
43.00	04400 PHYSI CAL THERAPY	0	(0 0	10, 625 55, 622	
45.00	04500 OCCUPATI ONAL THERAPY	0	(0 0	55, 170	
46.00	04600 SPEECH PATHOLOGY	0	(0 0	13, 310	
47.00	04700 ELECTROCARDI OLOGY	0	(0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0	4, 544	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	(0 0	25, 228	49.00
51.00	05100 SUPPORT SURFACES	0	(0 0	0	51.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
71.00	07100 AMBULANCE	0	(ן	0 0	736	71.00
00.00	SPECIAL PURPOSE COST CENTERS			1			00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00
81.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	(0	0	
89.00	SUBTOTALS (sum of lines 1-84)	2, 891	7, 227	13, 1	78 238, 672	3, 111, 208	
	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	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	(0 0	0	
93.00	09300 NONPAI D WORKERS	0	(0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	(ן ע	0 0	0	
98.00	Cross Foot Adjustments	0			0	0	
99.00	Negative Cost Centers	0) 	1 10 1	0 0	0	
100.00	D TOTAL	∠, 891	7, 227	7 13, 1	78 238, 672	3, 111, 208	1100.00

Heal th	Financial Systems	BARTLEY NURSIN	G AND REHAB		In Lieu of Form CMS-	2540-10
	TION OF CAPITAL RELATED COSTS			No.: 315288	Period: Worksheet B	
					From 01/01/2023 Part II	
					To 12/31/2023 Date/Time Pre 5/30/2024 12:	
	Cost Center Description	Post Step-Down	Total		575072024 12.	
	best benter beschiption	Adjustments	rotar			
		17.00	18.00	1		
	GENERAL SERVICE COST CENTERS	· ·				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300 EMPLOYEE BENEFITS					3.00
4.00	00400 ADMINI STRATI VE & GENERAL					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600 LAUNDRY & LINEN SERVICE					6.00
7.00	00700 HOUSEKEEPI NG					7.00
8.00	00800 DI ETARY					8.00
9.00	00900 NURSING ADMINISTRATION					9.00
10.00	01000 CENTRAL SERVICE & SUPPLY					10.00
12.00	01200 MEDICAL RECORDS & LIBRARY					12.00
13.00	01300 SOCIAL SERVICE					13.00
15.00	01500 PATIENT ACTIVITIES					15.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 SKILLED NURSING FACILITY	0	2, 944, 601			30.00
31.00	03100 NURSING FACILITY	0	0			31.00
32.00	03200 I CF/I I D	0	0			32.00
33.00	03300 OTHER LONG TERM CARE	0	0			33.00
	ANCILLARY SERVICE COST CENTERS					
40.00	04000 RADI OLOGY	0	455			40.00
41.00	04100 LABORATORY	0	917			41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0			42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	10, 625			43.00
44.00	04400 PHYSI CAL THERAPY	0	55, 622			44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	55, 170			45.00
46.00	04600 SPEECH PATHOLOGY	0	13, 310			46.00
47.00	04700 ELECTROCARDI OLOGY	0	0			47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 544	1		48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	25, 228	1		49.00
51.00	05100 SUPPORT SURFACES	0	0			51.00
	OTHER REIMBURSABLE COST CENTERS					
71.00	07100 AMBULANCE	0	736			71.00
	SPECIAL PURPOSE COST CENTERS					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	08100 INTEREST EXPENSE					81.00
82.00	08200 UTILIZATION REVIEW - SNF					82.00
83.00	08300 HOSPI CE	0	0			83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	3, 111, 208	1		89.00
	NONREI MBURSABLE COST CENTERS	· · · · ·		1		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0			91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0			92.00
93.00	09300 NONPAI D WORKERS	0	0			93.00
94.00	09400 PATIENTS LAUNDRY	0	0	•		94.00
98.00	Cross Foot Adjustments	0	0			98.00
99.00	Negative Cost Centers	0	0			99.00
100.00	D TOTAL	0	3, 111, 208	1		100.00

Heal th	Financial Systems	BARTLEY NURSIN	IG AND REHAB		In Lie	u of Form CMS-2	2540-10
COST /	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2023	Worksheet B-1	
					0 12/31/2023		pared:
		CAPI TAL				5/30/2024 12:	47 pm
		RELATED COSTS					
	Cost Center Description	BLDGS &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	PLANT	
		FI XTURES	BENEFITS		& GENERAL	OPERATI ON,	
		(SQUARE FEET)	(GROSS		(ACCUM COST)	MAINT. &	
			SALARI ES)			REPAI RS (SQUARE FEET)	
		1.00	3.00	4A	4.00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	59, 739					1.00
3.00	00300 EMPLOYEE BENEFITS	0	9, 310, 849		20 (04 520		3.00
4.00 5.00	00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS	3, 216 1, 854	658, 189 194, 108			54 660	4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 854	194, 100		1, 101, 438	54, 669 1, 455	
7.00	00700 HOUSEKEEPING	202	508, 674		691, 461	202	
8.00	00800 DI ETARY	7, 583	906, 796		2, 116, 685	7, 583	
9.00	00900 NURSI NG ADMI NI STRATI ON	933	1, 050, 520		1, 272, 132	933	
10.00	01000 CENTRAL SERVICE & SUPPLY	0	0	0	355, 588	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	132	0	0	6, 875	132	
13.00	01300 SOCIAL SERVICE	213	160, 525	0		213	13.00
15.00		4, 291	373, 807	0	686, 002	4, 291	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				T		
30.00	03000 SKILLED NURSING FACILITY	37, 138	5, 458, 230			37, 138	
31.00	03100 NURSING FACILITY	0	0	0		0	31.00
32.00	03200 I CF/I I D	0	0	0		0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	0	EE 02E	0	40.00
40.00	04100 LABORATORY	0	0			0	40.00
41.00	04200 I NTRAVENOUS THERAPY	0	0		112, 810	0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	180	0		104, 326	180	
44.00	04400 PHYSI CAL THERAPY	938	0	0	574, 207	938	
45.00	04500 OCCUPATI ONAL THERAPY	899	0	0	779, 303	899	
46.00	04600 SPEECH PATHOLOGY	227	0	0	120, 421	227	
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	83	0	0	4, 323	83	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	395	0	0	463, 865	395	49.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OTHER REIMBURSABLE COST CENTERS	-1		-		-	
71.00		0	0	0	90, 524	0	71.00
00 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00 81.00
81.00	08200 UTILIZATION REVIEW - SNF						81.00
83.00	08300 HOSPI CE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	59, 739	9, 310, 849	-3, 656, 567	20, 604, 529	54,669	
07100	NONREI MBURSABLE COST CENTERS	0,,,0,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,000,007	20/001/02/	01,007	
90.00		0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPAID 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						98.00
99.00							99.00
102.00		3, 111, 208	1, 520, 202		3, 656, 567	1, 296, 904	102.00
102 0	Part I)	E2 000015	0 1/0070		0 1774/4	22 722044	102 00
103.00		52.080015	0. 163272		0. 177464		
104.00	Part II)		0		167, 489	105, 510	104.00
105.00			0. 000000		0. 008129	1. 929979	105, 00
. 50. 0			2. 000000				
				-	•		

Heal th	Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	u of Form CMS-	2540-10
	LLOCATION - STATISTICAL BASIS			No.: 315288	Peri od:	Worksheet B-1	
					From 01/01/2023		
					To 12/31/2023		
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	NURSI NG	5/30/2024 12: CENTRAL	47 piii
	Cost center bescription	LINEN SERVICE) ADMI NI STRATI ON		
		(PATI ENT	(040/112 1221)			SUPPLY	
		CENSUS)			(DI RECT	(COSTED	
					NURSI NG)	REQUIS.)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1		r			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE	68, 978	50.010				6.00
7.00	00700 HOUSEKEEPING	0	53, 012				7.00
8.00		0	7, 583				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	933		0 240, 075	255 500	9.00
10.00	01000 CENTRAL SERVICE & SUPPLY	0	0		0 0	355, 588	1
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	132 213		0 0	0	
15.00	01500 PATIENT ACTIVITIES		4, 291		0 0	0	1
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 271		0 0	0	15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	68, 978	37, 138	206, 93	4 240, 075	355, 588	30.00
31.00	03100 NURSING FACILITY	00,770	0		0 240,075	0	1
32.00	03200 CF/I D	0	0		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	
00.00	ANCI LLARY SERVICE COST CENTERS		0	1	0		00.00
40.00	04000 RADI OLOGY	0	0)	0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	180		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	938		0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	899		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	227	1	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	83		0 0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	395		0 0	0	
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
-4 -0	OTHER REIMBURSABLE COST CENTERS						1 74 00
71.00	07100 AMBULANCE	0	0		0 0	0	71.00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
81.00	08200 UTILIZATION REVIEW - SNF						81.00
82.00	08300 HOSPI CE	0	0		0	o	1
89.00	SUBTOTALS (sum of lines 1-84)	68, 978	53, 012	206, 93	4 240, 075	355, 588	1
07.00	NONREI MBURSABLE COST CENTERS	00,770	55, 012	200, 75	4 240,073	555, 500	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0		91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	1
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00		161, 198	818, 962	2, 789, 35	7 1, 534, 437	418, 692	1
	Part I)					-	
103.00		2. 336948	15. 448615	13. 47945			103.00
104.00		79, 459	16, 531	429, 13	0 61, 024	2, 891	104.00
	Part II)						
105.00		1. 151947	0. 311835	2.07375	3 0. 254187	0. 008130	105.00
	1)	I	l	I	1	l	I

Heal th	Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lieu of Form C	MS-2540-10
	LOCATION - STATISTICAL BASIS	Britteer Honor		No.: 315288	Peri od: Worksheet	
					From 01/01/2023	
					To 12/31/2023 Date/Time	
				OTHER GENERA	5/30/2024	12:47 pm
				SERVI CE		
	Cost Center Description	MEDI CAL	SOCIAL SERVICE			
	cost center bescription	RECORDS &	SUCIAL SERVICE	ACTIVITIES		
		LIBRARY	(PATI ENT	(PATI ENT		
		(PATI ENT	CENSUS)	CENSUS)		
		CENSUS)				
		12.00	13.00	15.00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					1.00
3.00	00300 EMPLOYEE BENEFITS					3.00
4.00	00400 ADMI NI STRATI VE & GENERAL					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00	00600 LAUNDRY & LINEN SERVICE					6.00
	00700 HOUSEKEEPI NG					7.00
8.00	00800 DI ETARY					8.00
	00900 NURSING ADMINISTRATION					9.00
	01000 CENTRAL SERVICE & SUPPLY					10.00
	01200 MEDI CAL RECORDS & LI BRARY	68, 978				12.00
	01300 SOCIAL SERVICE	C				13.00
15.00	01500 PATIENT ACTIVITIES	C	0 0	68, 9	78	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	L		1		
	03000 SKILLED NURSING FACILITY	68, 978		68, 9		30.00
	03100 NURSING FACILITY	C	-		0	31.00
	03200 CF/I D	C			0	32.00
33.00	03300 OTHER LONG TERM CARE	C	0 0		0	33.00
	ANCI LLARY SERVI CE COST CENTERS		-		-	
	04000 RADI OLOGY	C		1	0	40.00
	04100 LABORATORY	C	0		0	41.00
	04200 I NTRAVENOUS THERAPY	C	0		0	42.00
	04300 OXYGEN (INHALATION) THERAPY	(0		0	43.00
	04400 PHYSI CAL THERAPY		0		0	44.00
	04500 OCCUPATI ONAL THERAPY				0	45.00
	04600 SPEECH PATHOLOGY				0	46.00
	04700 ELECTROCARDI OLOGY				0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	48.00
	04900 DRUGS CHARGED TO PATIENTS		-		0	49.00
	05100 SUPPORT SURFACES OTHER REIMBURSABLE COST CENTERS	(<u> </u>	1		51.00
	07100 AMBULANCE	C	0		0	71.00
	SPECIAL PURPOSE COST CENTERS	L C				/1.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES					80.00
	08100 I NTEREST EXPENSE					81.00
	08200 UTI LI ZATI ON REVI EW - SNF					82.00
	08300 HOSPI CE	(0		0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	68, 978	68, 978	68, 9	78	89.00
	NONREI MBURSABLE COST CENTERS	00,770	, 00, 770	00,7		07.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0 0		0	90.00
	09100 BARBER AND BEAUTY SHOP		o o		0	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	-		0	92.00
	09300 NONPAI D WORKERS		0		0	93.00
	09400 PATIENTS LAUNDRY		0		0	94.00
98.00	Cross Foot Adjustments					98.00
99.00	Negative Cost Centers					99.00
102.00	Cost to be allocated (per Wkst. B,	13, 265	241, 278	975, 8	28	102.00
	Part I)					
103.00	Unit cost multiplier (Wkst. B, Part I)	0. 192308	3. 497898	14.1469	45	103.00
104.00	Cost to be allocated (per Wkst. B,	7, 227				104.00
	Part II)					
105.00	Unit cost multiplier (Wkst. B, Part	0. 104773	0. 191046	3. 4601	18	105.00
	11)					

RATIO OF COST TO CHARGES FOR ANCI LLARY AND OUTPATIENT COST Provider No.: 315288 Period: From Of Orksheet C To 12/31/2023 12/31/2023 12/31/2023 12/31/2024 12:47 pm V Cost Center Description Total Form 11/01/2023 Ratio (col. 1 V Cost Center Description Total Cost Center Ratio (col. 1 V 0 04000 RADIOLOGY 65,861 0 0.000000 40.00 40.00 04200 INTRAVENOUS THERAPY 132,830 112,810 1.177467 41.00 42.00 04200 INTRAVENOUS THERAPY 129,891 0 0.000000 43.00 44.00 04400 PHY IOLAGY 952,816 1.026,811 0.927937 45.00 45.00 04500 OCCUPATIONAL THERAPY 952,816 1.026,811 0.927937 45.00 46.00 </th <th>Health Financial Systems BARTLEY NU</th> <th>RSING AND REHAB</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2540-10</th>	Health Financial Systems BARTLEY NU	RSING AND REHAB		In Lie	u of Form CMS-2	2540-10
Image: Cost Center Description Total (from Wkst. B, Pt I, col. 18) Total Charges Ratio (col. 1 divided by col. 2 40.00 04000 RADI OLOGY 1.00 2.00 3.00 40.00 04000 RADI OLOGY 65,861 0 0.000000 40.00 04000 RADI OLOGY 112,810 1.177467 41.00 40.00 04300 OXYGEN (INHALATI ON) THERAPY 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATI ON) THERAPY 129,891 0 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 712,851 562,266 1.267818 44.00 45.00 04500 OXYGEN (INHALATI ON) THERAPY 952,816 1,026,811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 0.000000 48.00 49.00 04300 OXYGEN IONAL THERAPY 952,816 1,026,811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8,341 0 0.000	RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CEN	TERS Provider N			Worksheet C	
ANCLILLARY SERVICE COST CENTERS divided by col. 18) divided by col. 2 40.00 04000 RADI OLOGY 3.00 41.00 04000 RADI OLOGY 65,861 0 0.000000 41.00 04100 LABORATORY 132,830 112,810 1.177467 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 0 0.000000 43.00 45.00 04500 OCCUPATI ONAL THERAPY 952,816 1.026,811 0.927937 46.00 04600 SPEECH PATHOLOGY 952,816 1.026,811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 0.000000 47.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 48.00 48.00 48.00 48.00 48.00 48.00						
ANCI LLARY SERVICE COST CENTERS col. 18) col. 2 1.00 2.00 3.00 4NCI LLARY SERVICE COST CENTERS 0 0.000 RADI OLOGY 41.00 04100 LABORATORY 132,830 112,810 1.177467 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATI ON) THERAPY 0 0 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 0 0.000000 43.00 45.00 04500 OCUPATI ONAL THERAPY 712,851 562,266 1.267818 44.00 46.00 04600 SPEECH PATHOLOGY 150,683 370,174 0.407060 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 48.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8,341 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 561,657 443,293 1.267011	Cost Center Description					
ANCILLARY SERVICE COST CENTERS 40.00 Q4000 RADIOLOGY 65, 861 0 0.000000 40.00 41.00 Q4100 LABORATORY 132, 830 112, 810 1.177467 41.00 42.00 Q4200 INTRAVENOUS THERAPY 0 0.000000 42.00 43.00 Q4300 OXYGEN (1 NHALATI ON) THERAPY 129, 891 0 0.000000 43.00 44.00 Q4400 PHYSI CAL THERAPY 712, 851 562, 266 1.267818 44.00 45.00 Q4500 OCUPATI ONAL THERAPY 712, 851 562, 266 1.267818 44.00 45.00 Q4600 SPECH PATHOLOGY 952, 816 1, 026, 811 0.927937 45.00 46.00 Q4600 SPECH PATHOLOGY 0 0 0.000000 48.00 47.00 Q4700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 Q4800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48.00 9.00 <td></td> <td>W</td> <td></td> <td></td> <td>J</td> <td></td>		W			J	
ANCI LLARY SERVI CE COST CENTERS 40.00 04000 RADI OLOGY 65, 861 0 0.000000 40.00 41.00 04100 LABORATORY 132, 830 112, 810 1.177467 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (I NHALATI ON) THERAPY 129, 891 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 712, 851 562, 266 1.267818 44.00 45.00 04500 OCCUPATI ONAL THERAPY 952, 816 1, 026, 811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0.000000 48.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 48.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48.00 90 049000 DRUGS <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
40.00 04000 RADI OLOGY 65, 861 0 0.000000 40.00 41.00 04100 LABORATORY 132, 830 112, 810 1.177467 41.00 42.00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (I NHALATI ON) THERAPY 129, 891 0 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 712, 851 562, 266 1.267818 44.00 45.00 04500 OCCUPATI ONAL THERAPY 952, 816 1, 026, 811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 150, 683 370, 174 0.407060 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 561, 657 443, 293 1.267011 49.00 51.00 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 10.00 0.000000 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td></td>			1.00	2.00	3.00	
41. 00 04100 LABORATORY 132, 830 112, 810 1.177467 41. 00 42. 00 04200 INTRAVENOUS THERAPY 0 0 0.000000 42. 00 43. 00 04300 OXYGEN (I NHALATI ON) THERAPY 129, 891 0 0.000000 43. 00 44. 00 04400 PHYSI CAL THERAPY 712, 851 562, 266 1. 267818 44. 00 45. 00 04500 OCUPATI ONAL THERAPY 952, 816 1, 026, 811 0. 927937 45. 00 46. 00 04600 SPEECH PATHOLOGY 150, 683 370, 174 0. 407060 46. 00 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48. 00 49. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 561, 657 443, 293 1. 267011 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0.000000 51. 00 0UTPATI ENT SERVI CE COST CENTERS 106, 589 0 0.000000 71. 00						
42.00 04200 INTRAVENOUS THERAPY 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 129,891 0 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 712,851 562,266 1.267818 44.00 45.00 04500 OCUPATIONAL THERAPY 952,816 1,026,811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 150,683 370,174 0.407060 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8,341 0 0.000000 48.00 49.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0 07100 AMBULANCE 106,589 0 0.000000 71.00	40. 00 04000 RADI OLOGY		65, 861	0	0.000000	40.00
43.00 04300 0XYGEN (I NHALATI ON) THERAPY 129,891 0 0.000000 43.00 44.00 04400 PHYSI CAL THERAPY 712,851 562,266 1.267818 44.00 45.00 04500 OCUPATI ONAL THERAPY 952,816 1,026,811 0.927937 45.00 46.00 04600 SPECH PATHOLOGY 150,683 370,174 0.407060 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 8,341 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 561,657 443,293 1.267011 49.00 51.00 0 0 0 0 0.000000 45.00 0 0.5100 SUPPORT SURFACES 0 0 0.000000 51.00 0 07100 AMBULANCE 106,589 0 0.000000 71.00	41. 00 04100 LABORATORY		132, 830	112, 810	1. 177467	41.00
44.00 04400 PHYSI CAL THERAPY 712, 851 562, 266 1.267818 44.00 45.00 04500 OCCUPATI ONAL THERAPY 952, 816 1,026, 811 0.927937 45.00 46.00 04600 SPEECH PATHOLOGY 150, 683 370, 174 0.407060 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 561, 657 443, 293 1.267011 49.00 05100 SUPPORT SURFACES 0 0 0.000000 151.00 0UTPATI ENT SERVICE COST CENTERS 106, 589 0 0.000000 71.00	42. 00 04200 I NTRAVENOUS THERAPY		0	0	0.000000	42.00
45.00 04500 OCCUPATI ONAL THERAPY 952, 816 1, 026, 811 0. 927937 45.00 46.00 04600 SPEECH PATHOLOGY 150, 683 370, 174 0. 407060 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 561, 657 443, 293 1. 267011 49.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0UTPATI ENT SERVICE COST CENTERS 0 0.000000 71.00 71.00 07100 AMBULANCE 106, 589 0 0.000000 71.00	43.00 04300 0XYGEN (INHALATION) THERAPY		129, 891	0	0.00000	43.00
46.00 04600 SPEECH PATHOLOGY 150, 683 370, 174 0. 407060 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0.000000 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 8, 341 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 561, 657 443, 293 1. 267011 49.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0UTPATIENT SERVICE COST CENTERS 0 0.000000 71.00 71.00 0.7100 AMBULANCE 0 0.000000 71.00	44.00 04400 PHYSI CAL THERAPY		712, 851	562, 266	1. 267818	44.00
47. 00 04700 ELECTROCARDI OLOGY 0 0.000000 47. 00 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.000000 48. 00 49. 00 04900 DRUGS CHARGED TO PATI ENTS 561, 657 443, 293 1. 267011 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0.000000 51. 00 0UTPATI ENT SERVI CE COST CENTERS 0 0.000000 71. 00 71. 00 07100 AMBULANCE 00 0.000000 71. 00	45. 00 04500 OCCUPATI ONAL THERAPY		952, 816	1, 026, 811	0. 927937	45.00
48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8, 341 0 0.00000 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 561, 657 443, 293 1.267011 49.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 0UTPATI ENT SERVICE COST CENTERS 106, 589 0 0.000000 71.00	46.00 04600 SPEECH PATHOLOGY		150, 683	370, 174	0. 407060	46.00
49. 00 04900 DRUGS CHARGED TO PATI ENTS 561, 657 443, 293 1. 267011 49. 00 51. 00 05100 SUPPORT SURFACES 0 0 0.000000 51. 00 0UTPATI ENT SERVICE COST CENTERS 0 0.000000 71. 00 07100 AMBULANCE 0 0.000000 71. 00	47. 00 04700 ELECTROCARDI OLOGY		0	0	0.000000	47.00
51. 00 05100 SUPPORT SURFACES 0 0.000000 51. 00 OUTPATI ENT SERVICE COST CENTERS 0 0.000000 71. 00 71.00 07100 AMBULANCE 0 0.000000 71. 00	48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		8, 341	0	0.000000	48.00
OUTPATI ENT SERVICE COST CENTERS 71. 00 07100 AMBULANCE 106, 589 0 0.000000 71. 00	49.00 04900 DRUGS CHARGED TO PATIENTS		561, 657	443, 293	1.267011	49.00
71. 00 07100 AMBULANCE 106, 589 0 0. 000000 71. 00	51.00 05100 SUPPORT SURFACES		0	0	0.000000	51.00
	OUTPATIENT SERVICE COST CENTERS					
	71. 00 07100 AMBULANCE		106, 589	0	0.00000	71.00
	100. 00 Total		2, 821, 519	2, 515, 354		100.00

Health Financial Systems	BARTLEY NURSI	NG AND REHAB		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care P	rogram Charge	s Heal th Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT ANCILLARY SERVICE COST CENTERS	TENT COST					+
40. 00 04000 RADI OLOGY	0. 000000	0		0 0	0	40.00
41. 00 04100 LABORATORY	1, 177467			0 645	-	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0 0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	0.000000			0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	1. 267818	352, 504		0 446, 911	0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	0. 927937	580, 633		0 538, 791	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 407060	238, 174		0 96, 951	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 267011	0		0 0	0	49.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
71.00 07100 AMBULANCE (2)	0. 000000			0	0	71.00
100.00 Total (Sum of lines 40 - 71)		1, 171, 859		0 1, 083, 298	0	100.00
(1) For title V and VIV use columns 1 2 and 4 and						

(1) For title V and XIX use columns 1, 2, and 4 only.

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

Health Financial Systems	BARTLEY NURSIN	IG AND REHAB		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/30/2024 12:	pared: 47 pm
		Ti tl	e XVIII	Skilled Nursing Facility		
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00Drugs charged to patients - ratio of co2.00Program vaccine charges (From your reco3.00Program costs (Line 1 x line 2) (TitleE, Part I, line 18)	ords, or the PS&	&R)			1. 267011 4, 594 5, 821	1.00 2.00 3.00
Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	(From Wkst. B,		I I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 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				
ANCI LLARY SERVI CE COST CENTERS	65, 861		0.0000	0 0	0	40,00
41.00 04100 LABORATORY 42.00 04200 INTRAVENOUS THERAPY 43.00 04300 OXYGEN (I NHALATION) THERAPY 44.00 04400 PHYSI CAL THERAPY 45.00 04500 OCCUPATI ONAL THERAPY 46.00 04600 SPEECH PATHOLOGY 47.00 04700 ELECTROCARDI OLOGY 48.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 49.00 04900 DRUGS CHARGED TO PATIENTS 51.00 05100 SUPPORT SURFACES	132, 830 0 129, 891 712, 851 952, 816 150, 683 0 8, 341 561, 657		0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000	00 0 00 446, 911 00 538, 791 00 96, 951 00 0 00 0 00 0	0 0 0 0 0 0 0 0 0 0 0	41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 51.00
100.00 Total (Sum of Lines 40 - 52)	2, 714, 930	0	0.00000	1, 083, 298	Ũ	100.00

MPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315288	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2024 12:	pared
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
00	Inpatient days including private room days			68, 978	1.
00	Private room days			0	2.
00	Inpatient days including private room days applicat	ble to the Program		16, 984	3.
00	Medically necessary private room days applicable to	o the Program		0	4.
00	Total general inpatient routine service cost			21, 439, 577	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges			28, 686, 956	6.
00	General inpatient routine service cost/charge ratio	o (Line 5 divided by line 6)		0.747363	7
00	Enter private room charges from your records			0	8
00	Average private room per diem charge (Private room 2)	charges line 8 divided by private	room days, line	0.00	9
00	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-prisemi-private room days)	rivate room charges line 10, divide	d by	0.00	11
00	Average per diem private room charge differential	(Line 9 minus line 11)		0.00	12
00	Average per diem private room cost differential (Li	ine 7 times line 12)		0.00	13
00	Private room cost differential adjustment (Line 2 f	times line 13)		0	14
00	General inpatient routine service cost net of priva PROGRAM INPATIENT ROUTINE SERVICE COSTS	ate room cost differential (Line 5	minus line 14)	21, 439, 577	15
. 00	Adjusted general inpatient service cost per diem (I	Line 15 divided by line 1)		310. 82	16
	Program routine service cost (Line 3 times line 10			5, 278, 967	
	Medically necessary private room cost applicable to			0	
00	Total program general inpatient routine service cos	st (Line 17 plus line 18)		5, 278, 967	19
00	Capital related cost allocated to inpatient routine line 30 for SNF; line 31 for NF, or line 32 for ICA		t II column 18,	2, 944, 601	20
00	Per diem capital related costs (Line 20 divided by	y line 1)		42.69	21
00	Program capital related cost (Line 3 times line 2	1)		725, 047	22
	Inpatient routine service cost (Line 19 minus line			4, 553, 920	23
	Aggregate charges to beneficiaries for excess costs			0	24
	Total program routine service costs for comparison	to the cost limitation (Line 23 mi	nus line 24)	4, 553, 920	25
	Enter the per diem limitation (1)			l	26
	Inpatient routine service cost limitation (Line 3			l	27
00	Reimbursable inpatient routine service costs (Line	22 plus the lesser of line 25 or	line 27)	1	28

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	68, 978	1.00
2.00	Program inpatient days (see instructions)	16, 984	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 246223	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

		ING AND REHAB		u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315288	Period: From 01/01/2023	Worksheet E Part I	
			To 12/31/2023	Date/Time Prep	
		Title XVIII	Skilled Nursing	5/30/2024 12:4 PPS	47 pili
			Facility	115	
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REI	MBURSEMENT			
1.00	Inpatient PPS amount (See Instructions)			12, 978, 368	1.00
2.00	Nursing and Allied Health Education Activities (pass throu	ugh payments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			12, 978, 368	3.00
4.00	Primary payor amounts			10, 220	4.00
5.00	Coinsurance			2, 309, 400	5.00
6.00	Allowable bad debts (From your records)			1, 785, 587	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See i	nstructions)		200, 048	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			1, 160, 632	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)			11, 819, 380	
12.00	Interim payments (See instructions)			10, 519, 824	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestrati			0	14.50
14.55	Demonstration payment adjustment amount after sequestration			0	14.55
14.75	Sequestration for non-claims based amounts (see instruction	ons)		23, 213	
14.99	Sequestration amount (see instructions)			213, 175	
15.00	Balance due provider/program (see Instructions)	dense with ONC Dub 15 2 -		1, 063, 168	
16.00	Protested amounts (Nonallowable cost report items in accor PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LE			0	16.00
17.00	Ancillary services Part B	SSER OF COST OR CHARGES - I	TILE AVIII UNLY	0	17.00
17.00	Vaccine cost (From Wkst D, Part II, line 3)			5, 821	18.00
19.00	Total reasonable costs (Sum of Lines 17 and 18)			5, 821	19.00
20.00	Medicare Part B ancillary charges (See instructions)			4, 594	20.00
20.00	Cost of covered services (Lesser of Line 19 or Line 20)			4, 594	20.00
22.00	Primary payor amounts			4, 374	22.00
23.00	Coinsurance and deductibles			0	23.00
24.00	Allowable bad debts (From your records)			0	24.00
24.00	Allowable Bad debts for dual eligible beneficiaries (see i	nstructions)		0	24.00
24.02	Adjusted reimbursable bad debts (see instructions)			0	24.02
25.00	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			4, 594	
26.00	Interim payments (See instructions)			3, 556	
27.00	Tentati ve adjustment			0,000	27.00
28.00	Other Adjustments (See instructions) Specify			Ő	28.00
28.50	Demonstration payment adjustment amount before sequestrati	on		0	28.50
28.55	Demonstration payment adjustment amount after sequestration			Ő	28.55
28.99	Sequestration amount (see instructions)	-		92	28.99
29.00	Balance due provider/program (see instructions)				29.00
	Protested amounts (Nonallowable cost report items) in acco			0	30.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315288	Period: From 01/01/2023 To 12/31/2023		pare
		Ti tl	e XVIII	Skilled Nursing Facility		<u>, 17 p</u>
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	L -	1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		10, 519, 8	0 0	3, 556 0	1. 2.
00	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					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
03				0	0	3
)4				0	0	3
)5				0	0	3
0	Provider to Program ADJUSTMENTS TO PROGRAM		1	0	0	3
1	ADJUSTMENTS TO PROGRAM			0	0	
52				0	0	3
3				0	0	3
54				0	0	3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50			0	0	3
	- 3.98)		10 510		0.554	
00	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)		10, 519, 8	324	3, 556	4
	TO BE COMPLETED BY CONTRACTOR					
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)					5
01	Program to Provider TENTATI VE TO PROVIDER		1	0	0	5
)2				0	0	
)3				0	0	
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52 99	Subtatal (Sum of Linos E 01 - E 40 minus sum of Linos E 50			0	0	5
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVI DER		1, 063, 1	68	946	6
)2	PROVI DER TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		11, 582, 9		4, 502	7
			Contr	actor Name	Contractor	
				1.00	Number 2.00	
	Name of Contractor				2.00	1

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Pre	epared
		General Fund	Speci fi c	Endowment Fund	5/30/2024 12: Pl ant Fund	<u>4/pm</u>
		1.00	Purpose Fund 2.00	3.00	4.00	
	Assets					
0	CURRENT ASSETS Cash on hand and in banks	66, 846	1	0 0	0	1.0
0	Temporary investments	00, 840		0 0	0	
0	Notes receivable	0		0 0	0	
0	Accounts receivable	7, 607, 379		0 0	0	
0	Other receivables	21, 400		0 0	0	
0	Less: allowances for uncollectible notes and accounts receivable	0		0 0	0	6.0
0	Inventory	0		0 0	0	7.0
0	Prepai d'expenses	129, 690		0 0	0	8.0
0	Other current assets	151, 396		0 0	0	
00	Due from other funds	0		0 0	0	
00	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10) FIXED ASSETS	7, 976, 711	<u> </u>	0 0	0	11. (
00	Land	0		0 0	0	12.0
00	Land improvements	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00	Buildings	0		0 0	0	
00 00	Less Accumulated depreciation Leasehold improvements	229, 942		0 0 0 0	0	
00	Less: Accumulated Amortization	229, 942		0 0	0	
00	Fixed equipment	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	20.
00	Automobiles and trucks	0		0 0	0	
00	Less: Accumulated depreciation	0		0 0	0	
00 00	Major movable equipment Less: Accumulated depreciation	897, 782 -115, 808		0 0	0	
00	Minor equipment - Depreciable	-115, 808		0 0	0	
00	Minor equipment nondepreciable	0		0 0	0	
00	Other fixed assets	0		0 0	0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 011, 916		0 0	0	28.
00	OTHER ASSETS Investments	0		0 0	0	29.
00	Deposits on Leases	35, 883		0 0	0	
00	Due from owners/officers	902, 098		0 0	0	
00	Other assets	0		0 0	0	
00	TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	937, 981		0 0	0	
00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	9, 926, 608		0 0	0	34.
	CURRENT LI ABI LI TI ES					
00	Accounts payable	1, 120, 989		0 0	0	35.
00	Salaries, wages, and fees payable	678, 046		0 0	0	
00	Payroll taxes payable	64, 797		0 0	0	
00	Notes & Loans payable (Short term)	1,026,599		0 0	0	
00 00	Deferred income Accelerated payments	1, 179, 861		0 0	0	40.
00	Due to other funds	0		0 0	0	
00	Other current liabilities	4, 129, 315		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	8, 199, 607		0 0	0	43.
~~	LONG TERM LIABILITIES	-			0	
00 00	Mortgage payable Notes payable	0		0 0 0 0	0	
00	Unsecured Loans			0 0	0	
00	Loans from owners:	0		0 0	0	
00	Other long term liabilities	0		0 0	0	48.
00	OTHER (SPECIFY)	0		0 0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0 8, 199, 607		0 0 0 0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	8, 199, 607		0 0	0	51.
00	General fund balance	1, 727, 001				52.
00	Specific purpose fund	.,,		0		53.
00	Donor created - endowment fund balance - restricted			0		54.
00	Donor created - endowment fund balance - unrestricted			0		55.
00	Governing body created - endowment fund balance			0	_	56.
00 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	1 50.
~~	TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	1, 727, 001		0 0	0	59.
00						

Heal th	Financial Systems	BARTLEY NURSIN	G AND REHAB			In Lie	u of Form CMS	-2540-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315288		l:)1/01/2023 2/31/2023	Worksheet G- Date/Time Pr 5/30/2024 12	epared:
		General	Fund	Speci al	Purpose	e Fund	Endowment Fun	
1 00		1.00	2.00	3.00		4.00	5.00	1.00
1.00 2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)		2, 918, 183 -16, 182 2, 902, 001			0		1.00 2.00 3.00 4.00
5.00 6.00		0			0			5.00 6.00
7.00 8.00 9.00		0 0 0			0 0 0			7.00 8.00 9.00
10.00 11.00 12.00 13.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	2, 902, 001		0	0 0		10.00 11.00 12.00 13.00
14. 00 15. 00	DI VI DENDS	1, 175, 000 0			0 0 0			0 14.00 0 15.00
16. 00 17. 00		0			0			16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)		1, 175, 000 1, 727, 001			0 0		18.00 19.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0			0			1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00								5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00	Total additions (sum of line 5 – 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0 0	C		0 0			10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00	DI VI DENDS		C C C C C					14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0			0 0			18.00 19.00

Heal th	Financial Systems	BARTLEY NURSING AN	d rehab			In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315288		riod: om 01/01/2023 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/30/2024 12:4	pared: 47 pm
	Cost Center Description			I npati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			28, 686, 9	56		28, 686, 956	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE				0		0	4.00
5.00	Total general inpatient care services (Sum of	lines 1 - 4)		28, 686, 9	56		28, 686, 956	5.00
	All Other Care Services							
6.00	ANCI LLARY SERVI CES			2, 515, 3	54	0	2, 515, 354	6.00
7.00	CLINIC					0	0	7.00
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9.00
10.00	RURAL HEALTH CLINIC					0	0	10.00
	FQHC					0	0	10. 10
	СМНС					0	0	11.00
	HOSPI CE				0	0	0	12.00
	ROUTINE CHARGES / BED HOLD			52, 72		0	52, 728	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Worksheet G-3, Line 1)	Transfer column 3	to	31, 255, 03	38	0	31, 255, 038	14.00
	Cost Center Description			1				
	· · · · · · · · · · · · · · · · · · ·					1.00	2.00	
	PART II - OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3, L	ine 100)					28, 731, 456	1.00
2.00	Add (Specify)					0		2.00
3.00						0		3.00
4.00						0		4.00
5.00						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00	-					0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8	8, minus line 14)					28, 731, 456	15.00

Heal th	Financial Systems	BARTLEY NURSING A	ND REHAB	In Lie	u of Form CMS-2	2540-10			
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENS	ES	Provi der No. : 31528		Worksheet G-3				
				From 01/01/2023					
				To 12/31/2023	Date/Time Prep 5/30/2024 12:4				
					1.00				
1.00	Total patient revenues (From Wkst. G-2, Par	rt I, col. 3, line 1	14)		31, 255, 038	1.00			
2.00	Less: contractual allowances and discounts of	on patients accounts	5		2, 545, 429	2.00			
3.00	Net patient revenues (Line 1 minus line 2)				28, 709, 609	3.00			
4.00	Less: total operating expenses (From Worksho	eet G-2, Part II, li	ne 15)		28, 731, 456	4.00			
5.00	Net income from service to patients (Line 3	minus 4)			-21, 847	5.00			
	Other income:								
6.00	Contributions, donations, bequests, etc				0	6.00			
7.00	Income from investments				6, 201	7.00			
8.00	Revenues from communications (Telephone and	d Internet service)			0	8.00			
9.00	Revenue from television and radio service				0	9.00			
10.00	Purchase di scounts				0	10.00			
11.00	Rebates and refunds of expenses				0	11.00			
12.00	Parking lot receipts				0	12.00			
13.00	Revenue from laundry and linen service				0	13.00			
14.00	Revenue from meals sold to employees and gue	ests			0	14.00			
15.00	Revenue from rental of living quarters				0	15.00			
16.00	Revenue from sale of medical and surgical su		an patients		0	16.00			
17.00	Revenue from sale of drugs to other than pa				0	17.00			
18.00	Revenue from sale of medical records and abs				0				
19.00	Tuition (fees, sale of textbooks, uniforms,	,			0				
20.00		anteen			0	20.00			
21.00	Rental of vending machines				0	21.00			
22.00	Rental of skilled nursing space				0	22.00			
23.00	Governmental appropriations				0	23.00			
24.00	NON PATIENT REVENUE				-536				
24.50	COVI D-19 PHE Fundi ng				0	24.50			
25.00	Total other income (Sum of lines 6 - 24)					25.00			
26.00	Total (Line 5 plus line 25)				-16, 182				
27.00	Other expenses (specify)				0	27.00			
28.00					0	28.00			
29.00					0	29.00			
30.00					0	30.00			
31.00	Net income (or loss) for the period (Line 20	6 minus line 30)			-16, 182	31.00			