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

			EXPITES. 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315176	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared:

			4/20/	2024 TO. 24 am
PART I - COST	REPORT STATUS	·		
Provi der	1. [X] Electronically prepared cost re	oort	Date: 4/26/2024	Time: 10:24 am
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report en	ter the number of times the provide	r resubmitted this cost	t report
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes or leave blank for no.		
Contractor	4. [1] Cost Report Status	6. Contractor No.		
use only		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	s reopened
	(5) Amended	11. Contractor Vendor Code	4	
	5. Date Received:	12.[F] Medicare Utilization. Ento	er "F" for full, "L" fo	rlow, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEDFORD NRSG& CONVA. CENTER (315176) 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	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Rich	ard Pineles	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Ri chard Pi nel es			2
3	Signatory Title	ADMI NI STRATOR			3
4	Date	(Dated when report is electronica			4

			Title XVIII			
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-20, 439	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-20, 439	0	0	100.00

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

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

Health Financial Systems MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315176 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 4/26/2024 10:24 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 185 TUCKERTON RD PO Box: 1.00 2.00 City: MEDFORD State: NJ Zi p Code: 08055 2.00 3.00 County: BURLINGTON CBSA Code: 15804 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF MEDFORD NRSG& CONVA. 315176 07/01/1980 N Р Ν 4.00 CENTER 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12 00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 45 501 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 45, 501 23.00 23.00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0

Heal th	Financial Systems	MEDFORD NRSG& CONVA	. CENTER	In Lieu	u of Form CMS-2	2540-10
SKI LLE	KILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315176 Period:				Worksheet S-2	
COMPLE	COMPLEX INDENTIFICATION DATA From 01/01/2023				Part I	
						pared:
					4/26/2024 10:	24 am
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid losse	e and General cost	N	42.00		
	center? Enter Y or N. If yes, check box	κ, and submit supporting s	schedule listing co	ost centers and		
	amounts.		9			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1. Cha	pter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addre	ess of the home		44.00
	office on lines 45. 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address of th	he home office on the	lines	
	bel ow.	g= ==,				
45. 00	Name:	Contractor's Name:	Cont	tractor's Number:		45. 00
	Street:	PO Box:	John	. asto. sumbor.		46. 00
			7: 5	Codo		47.00
47. 00	ici ty:	State:	ZI P	Code:		47.00

Health Financial Systems	MEDFORD NRSG& CONVA	CENTER		In lie	eu of Form CMS	S-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILI COMPLEX REIMBURSEMENT QUESTIONNAIRE			No.: 315176	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P	-2 repared:
			,	Y/N	4/26/2024 1 Date	0: 24 am
General Instruction: For all column 1 respon	usos ontor in column	1 "V" fo	r Voc or "N"	1. 00	2. 00	
responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ises effer the corumn	1, 1 10	i res or in	TOI NO. FOI AIT	the date	
1.00 Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)	N		1. 00			
			Y/N 1.00	Date 2.00	V/I 3. 00	
2.00 Has the provider terminated participation in			N N	2.00	3.00	2. 00
3, "V" for voluntary or "I" for involuntary. 1s the provider involved in business transact contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or						3.00
relationships? (see instructions)			Y/N	Type	Date	
<u></u>			1.00	2. 00	3. 00	
Financial Data and Reports 4.00 Column 1: Were the financial statements prep	pared by a Certified	Public	Y	С		4.00
Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	A" for Audited, "C" ete copy or enter da ⁻ no, see instructio	for te ns.				
5.00 Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			N			5. 00
				Y/N 1. 00	Legal Oper. 2.00	
Approved Educational Activities						
6.00 Column 1: Were costs claimed for Nursing Sch legal operator of the program? (Y/N)	nool? (Y/N) Column 2	: Is the	provider the	N	N	6. 00
7.00 8.00 Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s	ng the cost reporti		for Nursing	N N		7. 00 8. 00
					Y/N 1.00	
Bad Debts						
9.00 Is the provider seeking reimbursement for ba10.00 If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	ot collection policy	change du	ıring this cos		Y N	9. 00
11.00 If line 9 is "Y", are patient deductibles an Bed Complement	nd/or coi nsurance wa	ived? If "	Y", see insti	ructi ons.	N N	11.00
12.00 Have total beds available changed from prior	cost reporting per	iod? If "Y			N Dt D	12. 00
	Description	n	Y/N	art A Date	Part B Y/N	
DS&D Data	0		1.00	2. 00	3. 00	
PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			Y	02/14/2024	Y	13. 00
14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N		N	14.00
15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	l .		N		N	15. 00
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			N		N	17. 00
18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions.			N		N	18. 00

Heal th	Financial Systems	MEDFORD NRSG& C	ONVA. CENTER	}	In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provi de	er No.: 315176	Peri od: From 01/01/2023 To 12/31/2023		pared:	
		-		1. 00	2	00	
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the titl held by the cost report preparer in columns respectively.		KI TTY		BLISSIT		19. 00
20. 00	Enter the employer/company name of the cost preparer.	report	HEALTH CARE	RESOURCES			20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respecti		609-987-1440		KI TTY. BLI SSI T@	HCRNJ. NET	21. 00

Health Financial Systems MEDFORD NRSG& C
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE MEDFORD NRSG& CONVA. CENTER Provi der No.: 315176

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE

					To	12/31/2023	Date/Time Pre 4/26/2024 10:	
		Part B					17 207 202 1 10.	
		Date	1					
		4. 00						
	PS&R Data							
13. 00	Was the cost report prepared using the PS&R	02/14/2024						13. 00
	only? If either col. 1 or 3 is "Y", enter							
	the paid through date of the PS&R used to							
	prepare this cost report in cols. 2 and 4. (see Instructions.)							
14. 00	Was the cost report prepared using the PS&R		ŀ					14. 00
14.00	for total and the provider's records for							14.00
	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.							
15. 00	If line 13 or 14 is "Y", were adjustments							15. 00
	made to PS&R data for additional claims that							
	have been billed but are not included on the PS&R used to file this cost report? If "Y",							
	see Instructions.							
16. 00	If line 13 or 14 is "Y", then were		ŀ					16, 00
	adjustments made to PS&R data for							10.00
	corrections of other PS&R Report							
	information? If yes, see instructions.							
17.00	If line 13 or 14 is "Y", then were							17. 00
	adjustments made to PS&R data for Other?							
40.00	Describe the other adjustments:							10.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.							18. 00
	provider s records? IT if see Histractions.							
				3. 00				
	Cost Report Preparer Contact Information							
19. 00	Enter the first name, last name and the title		PREPARE	IR .				19. 00
	held by the cost report preparer in columns 1	, 2, and 3,						
00.00	respectively.							00.00
20. 00	Enter the employer/company name of the cost r	eport						20. 00
21. 00	preparer. Enter the telephone number and email address	of the cost						21. 00
21.00	report preparer in columns 1 and 2, respective							21.00
	1F FPar or 111 00. amile 1 and 2, 100p00011	,	1					1

In Lieu of Form CMS-2540-10 MEDFORD NRSG& CONVA. CENTER

Health Financial Systems MEDFORD NRSG& CONTROL NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provi der No.: 315176 Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

					7 12/31/2023	4/26/2024 10: 2	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	,	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	SKILLED NURSING FACILITY	180	· ·		2, 764	28, 918	1. 00
2.00	NURSING FACILITY	0	0			0	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0	0	0	0	3. 00 4. 00
5. 00	Other Long Term Care	0	0	0	0		5. 00
6. 00	SNF-Based CMHC		_				6. 00
7.00	HOSPI CE	0	0	0	0	0	7.00
8. 00	Total (Sum of lines 1-7)	180		0	2, 764	28, 918	8. 00
		Inpatient [Days/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	8, 332	40, 014		79	232	1. 00
2.00	NURSING FACILITY	0	0	0		0	2. 00
3.00	I CF/II D	0	0			0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST	0	0				4. 00 5. 00
6. 00	Other Long Term Care SNF-Based CMHC		0				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8.00	Total (Sum of lines 1-7)	8, 332	40, 014	0	79	232	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1.00	TOWN TO AN INCIDENCE THE TOWN	11. 00	12.00	13.00	14.00	15. 00	
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	293	l		34. 99	124. 65 0. 00	1. 00 2. 00
3.00	I CF/IID	0				0.00	3. 00
4. 00	HOME HEALTH AGENCY COST					0.00	4. 00
5.00	Other Long Term Care	0	0				5.00
6. 00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0.00			7. 00
8. 00	Total (Sum of lines 1-7)	293 Average Length			34. 99 si ons	124. 65	8. 00
		of Stay		Adilii S	31 0113		
	Component	Total	Title V	Title XVIII	Title XIX	0ther	
		16.00	17. 00	18. 00	19. 00	20.00	
1. 00	SKILLED NURSING FACILITY	66. 25	l .	89	201	305	1. 00
2.00	NURSING FACILITY	0.00	l .		0	0	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0. 00			U	0	3. 00 4. 00
5. 00	Other Long Term Care	0. 00				o	5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0. 00		0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	66. 25 Admi ssi ons		Equi val ent	201	305	8. 00
	Component	Total	Employees on	Nonpai d			
		21. 00	Payrol I 22. 00	Workers 23.00			
1. 00	SKILLED NURSING FACILITY	595					1. 00
2. 00	NURSING FACILITY	0	ł				2. 00
3.00	ICF/IID	0					3.00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	0	l e				5. 00
6. 00 7. 00	SNF-Based CMHC HOSPI CE	0	0. 00 0. 00				6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	595					8. 00
	1 (1 0,0		3.00		'	

Health Financial Systems
SNF WAGE INDEX INFORMATION A. CENTER In Lieu of Form CMS-2540-10
Provider No.: 315176 Period: Worksheet S-3
From 01/01/2023 Part II MEDFORD NRSG& CONVA. CENTER

					rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	nared.
						4/26/2024 10:	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
4 00	SALARI ES	7 740 077		7 740 077	054 (/4 00	20 / 5	4 00
1.00	Total salaries (See Instructions)	7, 713, 077	0	7, 713, 077			1. 00
2.00	Physician salaries-Part A	0	0	0	0. 00 0. 00		2. 00 3. 00
3. 00 4. 00	Physician salaries-Part B Home office personnel	0	0	0	0.00	0.00	4. 00
5. 00	Sum of lines 2 through 4	0	0	0	0.00	0.00	4. 00 5. 00
6. 00	Revised wages (line 1 minus line 5)	7, 713, 077	0	7, 713, 077			6. 00
7. 00	Other Long Term Care	7,713,077	0	1, 113, 077	0.00		7. 00
8. 00	HOME HEALTH AGENCY COST	0	0	0	0.00		8. 00
9. 00	CMHC	0	0		0.00		
10.00	HOSPI CF	0	0		0.00		
11. 00	Other excluded areas	0	0	0	0.00		
12. 00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00		
12.00	through 11)		0	Ĭ	0.00	0.00	12.00
13. 00	Total Adjusted Salaries (line 6 minus line	7, 713, 077	0	7, 713, 077	251, 661. 00	30. 65	13. 00
10.00	12)	,,,,,,,,,,,	Ĭ	,,,,,,,,,,	2017001100	00.00	
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	895, 841	0	895, 841	15, 430. 00	58. 06	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 177, 862	0	1, 177, 862			17.00
	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	,	0	0	0			19. 00
20. 00	Physician Part A - WRC	0	0	0			20. 00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 177, 862	0	1, 177, 862			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION MEDFORD NRSG& CONVA. CENTER Provi der No.: 315176

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared:

				1	0 12/31/2023	4/26/2024 10:	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	C	0	0.00	0.00	1. 00
2.00	Administrative & General	529, 026	C	529, 026	16, 148. 00	32. 76	2. 00
3.00	Plant Operation, Maintenance & Repairs	128, 919	C	128, 919	5, 523. 00	23. 34	3. 00
4.00	Laundry & Linen Service	59, 909	C	59, 909	3, 553. 00	16. 86	4. 00
5.00	Housekeepi ng	513, 577	(c	513, 577	28, 029. 00	18. 32	5. 00
6.00	Di etary	711, 919	(711, 919	34, 298. 00	20. 76	6. 00
7.00	Nursing Administration	912, 286	C	912, 286	20, 871. 00	43. 71	7. 00
8.00	Central Services and Supply	35, 351	C	35, 351	1, 979. 00	17. 86	8. 00
9.00	Pharmacy	0	C	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	C	0	0.00	0.00	10.00
11. 00	Soci al Servi ce	128, 981	C	128, 981	2, 138. 00	60. 33	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	218, 883	C	218, 883	10, 867. 00	20. 14	13. 00
14.00	Total (sum lines 1 thru 13)	3, 238, 851	C	3, 238, 851	123, 406. 00	26. 25	14. 00

Health Fina	ancial Systems	MEDFORD NRSG& CONVA	A. CENTER	In Lie	u of Form CMS-2	2540-10
SNF WAGE R	ELATED COSTS		Provi der No.: 315176	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 4/26/2024 10:	pared:
			<u>'</u>		Amount Reported 1.00	
PART	IV - WAGE RELATED COSTS			<u> </u>		
Part	A - Core List					
	REMENT COST					
1.00 4011	K Employer Contributions				0	1.00

		Amount	
		Reported	
	DARK IV. WAS DELATED GOOTS	1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST	T _	
1. 00	401K Empl oyer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	873	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	314, 179	
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	17, 417	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 859	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	913	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	99, 257	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	588, 292	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	155, 072	20. 00
	OTHER		
21. 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 177, 862	24. 00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
		. '	•

				Т	o 12/31/2023	Date/Time Prep 4/26/2024 10:2	
	Occupational Category	Amount	Fri nge	Adjusted	Paid Hours	Average Hourly	
	3 3	Reported		Salaries (col.		Wage (col. 3 ÷	
		· ·		1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations				1		
1.00	Registered Nurses (RNs)	1, 073, 485	164, 565				1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 297, 091	198, 844		·		2. 00
3.00	Certified Nursing Assistant/Nursing	1, 613, 434	247, 339	1, 860, 773	62, 487. 00	29. 78	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 984, 010	610, 748		·		4.00
5.00	Physical Therapists	287, 487	44, 072	331, 559	·		5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		6. 00
7.00	Physical Therapy Aides	0	0	0	0.00		7. 00
8.00	Occupational Therapists	141, 681	21, 720	1	·	1	8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00		10.00
11.00	Speech Therapists	61, 048	9, 359	70, 407	·		
12.00	Respiratory Therapists	0	0	0	0.00		12.00
13. 00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
14.00	Nursing Occupations	(1.025		(1.005	224.00	105 40	14.00
14. 00	Registered Nurses (RNs)	61, 925		61, 925			14.00
15.00	Licensed Practical Nurses (LPNs)	407, 883		407, 883			15.00
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	422, 183		422, 183	9, 275. 00	45. 52	16. 00
17. 00	Total Nursing (sum of lines 14 through 16)	891, 991		891, 991	15, 360. 00	58. 07	17. 00
18. 00	Physical Therapists	091, 991		071, 771	0.00		18. 00
19. 00	Physical Therapy Assistants				0.00	1	19. 00
20. 00	Physical Therapy Assistants Physical Therapy Aides				0.00		20. 00
21. 00	Occupational Therapists				0.00		21. 00
22. 00	Occupational Therapy Assistants				0.00		22. 00
23. 00	Occupational Therapy Assistants				0.00		23. 00
24. 00	Speech Therapists				0.00		24. 00
25. 00	Respiratory Therapists	3, 850		3, 850			25. 00
26. 00	Other Medical Staff	3, 830		3, 830			
20.00	other mear our otari	і Ч		1	3.00	0.00	20.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider No.: 315176 Peri od: Worksheet S-7 From 01/01/2023 12/31/2023 Date/Time Prepared: 4/26/2024 10: 24 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB2 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52 00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00

PD2

PD1

PC2

PC1

PB2

PB1

PA₂

69.00

70.00

71.00

72.00

73.00

74.00 75.00

69.00

70.00

71.00

72.00

73.00

74.00

75. 00

Health Financial Systems	MEDFORD NRSG& CONVA	. CENTER		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315176	Peri od:	Worksheet S-	-7
				From 01/01/2023 To 12/31/2023	Date/Time Pr 4/26/2024 10	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL			1			100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register payments beginning 10/01/2003. Congress expexpenses. For lines 101 through 106: Enter column 2 the percentage of total expenses f line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expens (See instructions)	ected this increase in column 1 the amou for each category to for yes or "N" for no	to be used nt of the total SNF o if the s	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101. 00 Staffing						101. 00
102.00 Recruitment						102.00
103.00 Retention of employees						103.00
104. 00 Training						104.00
105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, I	ino 1 column 2)					105. 00 106. 00
100.00 Total SNF Levenue (WOLKSheet G-2, Part I, I	THE I, COLUMN 3)		I			1100.00

Health Financial Systems	MEDFORD NRSG& CONVA	. CENTER		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315176 F	eri od:	Worksheet A	
				rom 01/01/2023	D-+- /T: D	
				o 12/31/2023	Date/Time Pre 4/26/2024 10:	pared:
Cost Center Description	Sal ari es	0ther	Total (col 1	Recl assi fi cati	Reclassi fi ed	24 4111
oost conten boscii pti on	Jan ar res	Other	+ col . 2)	ons	Trial Balance	
				Increase/Decre	(col . 3 +-	
				ase (Fr Wkst	col . 4)	
				A-6)	.,	
	1. 00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES		1, 335, 937	1, 335, 937	0	1, 335, 937	1. 00
3.00 00300 EMPLOYEE BENEFITS	o	1, 182, 392	1, 182, 392	0	1, 182, 392	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	529, 026	1, 686, 398	2, 215, 424	0	2, 215, 424	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	128, 919	574, 631	703, 550	o	703, 550	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	59, 909	14, 414	74, 323	o	74, 323	6. 00
7. 00 00700 HOUSEKEEPI NG	513, 577	69, 306	582, 883	o	582, 883	7. 00
8. 00 00800 DI ETARY	711, 919	624, 884	1, 336, 803	o	1, 336, 803	8. 00
9.00 00900 NURSING ADMINISTRATION	912, 286	0	912, 286	o	912, 286	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	35, 351	158, 366	193, 717	o o	193, 717	10.00
12. 00 01200 MEDICAL RECORDS & LIBRARY	o	0		o	0	12.00
13. 00 01300 SOCIAL SERVICE	128, 981	0	128, 981	0	128, 981	13.00
15. 00 01500 RECREATION	218, 883	15, 758	234, 641	0	234, 641	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	3, 984, 010	932, 075	4, 916, 085	0	4, 916, 085	30.00
31.00 03100 NURSING FACILITY	o	0	(o	0	31. 00
32. 00 03200 I CF/I I D	o	0	(ol	0	32. 00
33.00 03300 OTHER LONG TERM CARE	o	0		o	0	33. 00
ANCILLARY SERVICE COST CENTERS	<u>'</u>					
40. 00 04000 RADI OLOGY	0	5, 640	5, 640	0	5, 640	40. 00
41. 00 04100 LABORATORY	o	8, 446	8, 446	o	8, 446	41.00
42. 00 04200 I NTRAVENOUS THERAPY	o	2, 928	2, 928	o o	2, 928	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	o	9, 396	9, 396	o	9, 396	43.00
44. 00 04400 PHYSI CAL THERAPY	287, 487	35	287, 522	o o	287, 522	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	141, 681	441	142, 122	o o	142, 122	45.00
46. 00 04600 SPEECH PATHOLOGY	61, 048	0	61, 048	o o	61, 048	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	(0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	(0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	O	109, 480	109, 480	0	109, 480	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	O	0	(0	0	50.00
51. 00 05100 SUPPORT SURFACES	0	0	(0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	0	(0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	(0	0	61.00
62. 00 06200 FQHC						62.00
OTHER REIMBURSABLE COST CENTERS						
70.00 O7000 HOME HEALTH AGENCY COST	0	0	(1	0	70. 00
71. 00 07100 AMBULANCE	0	9, 389	9, 389	0	9, 389	71. 00
73. 00 07300 CMHC	0	0	(0	0	73. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(1	0	80.00
81.00 08100 INTEREST EXPENSE		0	(0	0	0
82.00 08200 UTILIZATION REVIEW - SNF	0	0	(0	0	82. 00
83. 00 08300 HOSPI CE	0	0	(0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	7, 713, 077	6, 739, 916	14, 452, 993	0	14, 452, 993	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	833	833		833	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	1, 922	1, 922	의 이	1, 922	
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	(이	0	92.00
93. 00 09300 NONPAI D WORKERS	0	0	(이	0	93. 00
94. 00 09400 PATI ENTS LAUNDRY	0	0	(0	0	94. 00
100. 00 TOTAL	7, 713, 077	6, 742, 671	14, 455, 748	8 0	14, 455, 748	100. 00

In Lieu of Form CMS-2540-10 MEDFORD NRSG& CONVA. CENTER

 Heal th Financial
 Systems
 MEDFORD NR

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Cost Center Description					To 1.	2/31/2023	Date/Time	
Expenses (FF For All Docat on West A-B) Cecil. 5 + Cecil. 5		Cost Center Description	Adjustments to	Net Expenses			4/20/2024	10. 24 aiii
Cocl. 6)		,						
CENERAL SERVICE COST CENTERS			Wkst A-8)	(col. 5 +-				
SENERAL SERVICE COST CENTERS 1.00 0.000 (CAP REL COSTS - BLIDGS & FIXTURES -4,098 1,331,839 1.00 3.00 0.0000 (EMPLOYEE BENEFITS 0.0 1,182,392 3.00 4.00 0.0040 (ADMIN ISTRATI VE & GENERAL -410,829 1,804,595 4.00 0.0040 (ADMIN ISTRATI VE & GENERAL -410,829 1,804,595 4.00 0.0040 (ADMIN ISTRATI VE & GENERAL -410,829 1,804,595 4.00 0.0040 (ADMIN ISTRATIVE & GENERAL -410,829 1,804,595 4.00 0.0040 (ADMIN ISTRATIVE & GENERAL -410,829 1,804,595 4.00 0.0040 (ADMIN ISTRATION 6.00 0.0040 (ADMINI ISTRATION 6.0040 0.0040 (ADMINI ISTRATION 6.0040 (ADMINI ISTRATION 6.0040 0.0040 (ADMINI ISTRATION 6.0040 (ADMINI ISTRATI								
1.00			6.00	7. 00				
3.0 0 03000 PAPLOYEE BENEFITS			1					
4.00		I I	-4, 098					
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 0 703.550 5.00		I I	440 000					
0.000 0.0000 LAUNDIY & LINEN SERVICE		1 1	1 _1					•
7. 00 00700 HOUSEKEEPING		I I	١					
8. 00 006000 DIETARY -80 1,336,723 8. 00 0. 00 0. 00 0. 01000 URST NX ADMINISTRATION 0 0 192,286 9. 00 0. 01 0. 00 0. 01000 ENTARY 0 192,717 10. 00 0. 01		I I	١					
9.00 009900 NURSI NO ADMINISTRATION 0 912,286 9,00 120,0		I I	١					
10. 00 010000 CENTRAL SERVICES & SUPPLY 0 193,717 10. 00 120,00 130,00 01300 SOCIAL SERVICE 0 128,981 13. 00 1500 SOCIAL SERVICE 0 128,981 13. 00 1500 DECEMBRION 0 234,641 15. 00 1500 DECEMBRION 0 234,641 15. 00 1500 DECEMBRION 0 0 0 0 0 0 0 0 0			1					
12 00 01200 MEDICAL RECORDS & LIBRARY 0 0 128, 961 13, 30 15, 00 01500 SCOLAL SERVICE 0 128, 961 13, 30 15, 00 1500 SCORRATION 15, 00 15,		I I	0					
13.00 01300 SOCIAL SERVICE 0 128, 991 15.00 100 1000 RECREATION 0 234, 641 15.00 100 1000 RECREATION 0 0 0 0 100 1000 SKILLED NURSING FACILITY 0 0 0 0 31.00 03100 NURSING FACILITY 0 0 0 0 32.00 03300 CF/H ID 0 0 0 32.00 33.00 03300 CF/H ID 0 0 0 0 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 1000 1000 1000 1000 1000 40.00 40.00 1000 1000 1000 1000 40.00 40.00 1000 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 1000 40.00 40.00 40.00 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 1000 1000 1000 40.00 40.00 40.00 1000 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40		I I	0					
15. 00 01500 RECREATION			o	128, 981				1
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.00 32.00 1.00 32.00 32.00 1.00 32.00 33.			0					1
30. 00 03000 SILLED NURSI NG FACILITY								
32.00 03200 ICF/I I D	30.00		0	4, 916, 085				30. 00
33.00	31.00	03100 NURSING FACILITY	0	0				31.00
ANCILLARY SERVICE COST CENTERS	32.00		0	0				32. 00
40.00	33. 00		0	0				33. 00
41.00								
42.00 04200 INTRAVENOUS THERAPY 0 2,928 42.00			0					
43. 00 44. 00 440 00 44		I I	0					
44. 00 04400 PHYSI CAL THERAPY 0 287, 522 44. 00		I I	0					
45. 00 04500 OCCUPATI ONAL THERAPY 0 142, 122 46. 00 04600 SPEECH PATHOLOGY 0 61,048 46. 00 447. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 47. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					1
46. 00			0					1
47. 00			0					
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 109,480 49,00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 60. 00 06000 CLIN C 0 0 0 61. 00 66000 RURAL HEALTH CLINIC 0 0 0 62. 00 06200 FOHC 0 0 OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 9,389 71. 00 71. 00 07100 AMBULANCE 0 9,389 71. 00 73. 00 07300 CMHC 0 0 9 80. 00 08100 INTEREST EXPENSE 0 0 0 81. 00 08100 INTEREST EXPENSE 0 0 0 82. 00 08200 UTILIZATION REVIEW - SNF 0 0 0 83. 00 08300 MOSPICE SUBJOANNIA SUBJOAN		I I						
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 109, 480 50. 00 550.		I I						
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0				- 1				
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0			0					
OUTPATIENT SERVICE COST CENTERS O			0	- 1				
60. 00				-1				
62. 00	60.00		0	0				60.00
OTHER REIMBURSABLE COST CENTERS O	61.00	06100 RURAL HEALTH CLINIC	o	O				61. 00
70. 00	62.00	06200 FQHC						62. 00
71. 00								
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 0			1	- 1				
SPECIAL PURPOSE COST CENTERS SO		I I	1					
80. 00	73. 00		0	0				73. 00
81. 00	00.00			ما				
82. 00			0	- 1				
83. 00		I I	0	- 1				
89. 00 SUBTOTALS (sum of lines 1-84)								1
NONREI MBURSABLE COST CENTERS 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 833 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 1,922 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 92.00 93.00 09300 NONPAI D WORKERS 0 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 94.00 94.00		I I	-415 007					
90. 00	07.00		413,007	17, 037, 700				J 57. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 1, 922 91. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 94. 00 0 0 0 0 0 0 0 0 0	90 00		nl	833				90.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 94. 00 09400 PATI ENTS LAUNDRY 0 0 94. 00 94. 00		I I		1				•
93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 94. 00 94. 00 94. 00 94. 00 95. 00 95. 00 96. 00			0					
94.00 09400 PATI ENTS LAUNDRY 0 0 94.00				-1				1
100. 00 TOTAL -415, 007 14, 040, 741 100. 00	94.00		0	O				94. 00
	100.00	TOTAL	-415, 007	14, 040, 741				100. 00

Health Financial Systems	MEDFORD NRSG& CONVA.	CENTER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315176	Peri od:	Worksheet A-6	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					4/26/2024 10:	24 am_
			Increases			
	Cost Center	-	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificati	ions (Sum		0	0	100. 00
	of columns 4 and 5 i	must				
	equal sum of columns	s 8 and				
	9)					

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

Health Financial Systems	MEDFORD NRSG& CONVA	CENTER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	epared:
					4/26/2024 10:	
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10 Provi der No.: 315176 Worksheet A-7

Peri od: From 01/01/2023

					To 12/31/2023	Date/Time Prep 4/26/2024 10:2	oared: 24 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		_1			_	
1.00	Land	118, 000	0		0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	5, 073, 049	7, 550		0 7, 550	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equipment	0	0		0	0	5. 00
6. 00	Movable Equipment	3, 263, 576	0		0 0	0	6. 00
7. 00	Subtotal (sum of lines 1-6)	8, 454, 625	7, 550		0 7, 550	0	7. 00
8. 00	Reconciling Items	0	0		0 0	0	8. 00
9. 00	Total (line 7 minus line 8)	8, 454, 625	7, 550		0 7, 550	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		7.00				
1.00	Land	118,000	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	5, 080, 599	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5. 00	Fi xed Equipment	0	0				5. 00
6. 00	Movable Equipment	3, 263, 576	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	8, 462, 175	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	8, 462, 175	O				9. 00

Provi der No.: 315176

Peri od: Worksheet A-8

From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	4/26/2024 10:	
			<u>'</u>	Expense Classification on		
				To/From Which the Amount is		
					•	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	• • • • • •	Adjustment				
		1.00	2. 00	3.00	4. 00	
1. 00	Investment income on restricted funds	В	-1, 598	CAP REL COSTS - BLDGS &	1.00	1.00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7.00	Parking Lot (chapter 21)		Ō		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-46, 046			12.00
	related organizations (chapter 10)					
13.00	Laundry and linen service		Ō		0.00	13. 00
14.00	Revenue - Employee meals	В	-80	DI ETARY	8. 00	14. 00
15.00	Cost of meals - Guests		0		0.00	15. 00
16.00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17.00	Sale of drugs to other than patients		0		0.00	17. 00
18.00	Sale of medical records and abstracts	В	-60	ADMINISTRATIVE & GENERAL	4. 00	18. 00
19.00	Vendi ng machi nes		0		0.00	19. 00
20.00	Income from imposition of interest, finance		Ō		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		0	*** Cost Center Deleted ***	2. 00	24. 00
25.00			0		0.00	25. 00
25. 01	MISC INCOME	В		ADMINISTRATIVE & GENERAL	4. 00	
25. 02	WAREHOUSE INCOME	В	-2, 500	CAP REL COSTS - BLDGS &	1.00	25. 02
				FI XTURES		
25. 03	BAD DEBTS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07	LOST PROPERTY REIMBURSEMENT	A		ADMINISTRATIVE & GENERAL	4.00	
25. 08		A		ADMINISTRATIVE & GENERAL	4.00	
25. 10	PENALTIES & FINES	A	-672	ADMINISTRATIVE & GENERAL	4.00	25. 10
100.00	Total (sum of lines 1 through 99) (Transfer		-415, 007	1		100. 00
	to Worksheet A, col. 6, line 100)					
(1) De	scription - all chapter references in this co	lumn pertain to	CMS Pub. 15-1	l.		

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

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

B. Amount Received - if cost cannot be determined.

Health Financial Systems MEDFORD NRSG& COSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME MEDFORD NRSG& CONVA. CENTER Provi der No.: 315176

OFFICE COSTS

OTTTOL	00313			Т	o 12/31/2023	Date/Time Pre 4/26/2024 10:	
	·	Li ne No.	Cost (Center	Expense	Items	
		1. 00	2.	00	3. (00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:				D ORGANIZATIONS	OR	
1.00			CENTRAL SERVIC		MEDI CAL SUPPLI E	S	1.00
2.00			ADMI NI STRATI VE	& GENERAL	SHARED SERVICE		2.00
3.00		0.00	l .				3.00
4. 00 5. 00		0. 00 0. 00					4. 00 5. 00
6. 00		0.00	l .				6.00
7. 00		0.00	l .				7.00
8. 00		0.00					8.00
9. 00		0.00					9. 00
10.00	TOTALS (sum of lines 1-9). Transfer column						10.00
	6, line 100 to Worksheet A-8, column 3, line						
	12.						
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minus			
		Cost	Wkst. A, col.	col . 5)			
		4.00	5 5. 00	6, 00	-		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF				D ORGANI ZATLONS	OR .	
	CLAIMED HOME OFFICE COSTS:				D OROANI ZATI ONS	- Oit	
1.00		2, 850					1. 00
2.00		108, 832	154, 878	-46, 046			2. 00
3.00		0	0	0			3.00
4.00		0	0	0			4.00
5. 00 6. 00		0	0	0			5. 00 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	111, 682	157, 728	-46, 046			10.00
	6, line 100 to Worksheet A-8, column 3, line	,					
	12.						

OFFICE COSTS

From 01/01/2023 12/31/2023 Parts I-II Date/Time Prepared:

4/26/2024 10: 24 am Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

res paypoon or as as an area of the second o	1	1	The second secon	1
1. 00	G	R. PINELES	0.00	1.00
2.00	G	R. PINELES	0.00	2. 00
3.00			0.00	3. 00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6. 00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10. 00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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. 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	JERSEY HC RESOURCES	O. OOMEDICAL SUPPLIER	1.00
2. 00	TANDEM MANAGEMENT	O. OOMANAGEMENT, A&G SUPPORT	2.00
3. 00		0. 00	3.00
4. 00		0.00	4. 00
5. 00		0.00	5. 00
6. 00		0.00	6. 00
7. 00		0.00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100. 00
speci fy:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315176 | Peri od: | Worksheet B | From 01/01/2023 | Part | I | Part | Part | I | Part | I | Part | P

Date/Time Prepared: 12/31/2023 4/26/2024 10:24 am CAPI TAL RELATED COSTS ADMI NI STRATI VE Cost Center Description Net Expenses **EMPLOYEE** Subtotal BLDGS & for Cost **FLXTURES** BENEFITS & GENERAL Allocation (from Wkst A col. 7) 1.00 3.00 ЗА 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS - BLDGS & FLXTURES 1, 331, 839 1, 331, 839 1 00 3.00 00300 EMPLOYEE BENEFITS 1, 182, 392 24, 978 1, 207, 370 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 1,804,595 56, 472 82, 811 1, 943, 878 1, 943, 878 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 44, 383 768, 113 5 00 703 550 20, 180 123, 430 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 74, 323 31, 151 9, 378 114,852 18, 456 6.00 7.00 00700 HOUSEKEEPI NG 582, 883 17, 062 80, 393 680, 338 109, 326 7.00 8.00 00800 DI ETARY 1, 336, 723 190, 565 111, 440 1, 638, 728 263, 332 8.00 00900 NURSING ADMINISTRATION 142, 805 169, 546 9 00 912, 286 1, 055, 091 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 193, 717 5, 534 199, 251 32, 018 10.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 0 12.00 01300 SOCIAL SERVICE 128, 981 20, 190 149, 171 23, 971 13.00 13.00 0 01500 RECREATION 15.00 234, 641 34, 263 268, 904 43, 211 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 4, 916, 085 919, 815 623, 640 6, 459, 540 1,037,997 30.00 03100 NURSING FACILITY 31.00 31.00 0 0 32 00 03200 LCE/LLD 0 C 0 0 0 32 00 03300 OTHER LONG TERM CARE 33.00 33.00 0 0 ANCILLARY SERVICE COST CENTERS 40.00 40.00 04000 RADI OLOGY 5,640 5,640 906 0 O 41.00 04100 LABORATORY 8,446 Ω 8, 446 1, 357 41.00 2, 928 2, 928 04200 I NTRAVENOUS THERAPY 471 42.00 42.00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 9, 396 9, 396 1,510 43.00 0 04400 PHYSI CAL THERAPY 44 00 287, 522 45, 002 371, 706 59, 731 44.00 39, 182 04500 OCCUPATIONAL THERAPY 45.00 142, 122 C 22, 178 164, 300 26, 402 45.00 04600 SPEECH PATHOLOGY 46.00 61,048 9,556 70,604 11, 346 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 C 0 0 0 48.00 109, 480 04900 DRUGS CHARGED TO PATIENTS 0 17, 593 49.00 49.00 109, 480 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 C 0 0 O 50.00 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 70.00 07100 AMBULANCE 9.389 0 0 9.389 1,509 71 00 71 00 07300 CMHC 73.00 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81 00 81 00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 HOSPI CE 83.00 83.00 89.00 SUBTOTALS (sum of lines 1-84) 14, 037, 986 1, 323, 608 1, 207, 370 14, 029, 755 1, 942, 112 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 833 833 134 90.00 0 09100 BARBER AND BEAUTY SHOP 0 91.00 91.00 1,922 8, 231 10, 153 1,632 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 92.00 0 0 C 0 09300 NONPALD WORKERS 0 93.00 93.00 0 C 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 0 0 98.00 Cross Foot Adjustments 0 0 98.00 99 00 Negative Cost Centers 99 00 0 0 100.00 TOTAL 14, 040, 741 1, 331, 839 1, 207, 370 14, 040, 741 1, 943, 878 100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provi der No.: 315176

				To	12/31/2023	Date/Time Prep 4/26/2024 10:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	24 4111
	, , , , , , , , , , , , , , , , , , ,	OPERATI ON,	LINEN SERVICE			ADMI NI STRATI ON	
		MAINT. &					
		REPAI RS					
	I	5. 00	6. 00	7.00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		I	1			1 00
1.00	00300 EMPLOYEE BENEFITS			•			1. 00 3. 00
3. 00 4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	891, 543		•			5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	23, 029	ł .				6. 00
7. 00	00700 HOUSEKEEPI NG	12, 613	1	802, 277			7. 00
8.00	00800 DI ETARY	140, 876	1	132, 049	2, 174, 985		8. 00
9. 00	00900 NURSI NG ADMINI STRATI ON	0	o o	0	_,,	1, 224, 637	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	O	0	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	О	0	0	12. 00
13.00	01300 SOCIAL SERVICE	0	0	0	0	0	13.00
15.00	01500 RECREATION	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	679, 975	156, 337	637, 374	2, 174, 985		30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/ D	0		0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY			0		0	40.00
40. 00 41. 00	04100 LABORATORY				0		40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY				0		41.00
43. 00	04300 OXYGEN (INHALATION) THERAPY				0		43. 00
44. 00	04400 PHYSI CAL THERAPY	28, 965		27, 151	0	Ö	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	20, 700		27, 131	0	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY			o o	0		46. 00
47. 00	04700 ELECTROCARDI OLOGY		o o	0	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	o	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	О	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0		0	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200 FOHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0		0	0		70. 00 71. 00
73.00	07300 CMHC			0	0		73.00
73.00	SPECIAL PURPOSE COST CENTERS		,ı <u>U</u>	<u> </u>		,, 0	73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE	0	0	О	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	885, 458	156, 337	796, 574	2, 174, 985	1, 224, 637	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	6, 085	0	5, 703	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	_	9	0	0	94.00
98. 00	Cross Foot Adjustments	0	-	0	0	0	98. 00
99.00	Negative Cost Centers	001 543		000 077	0 174 005	0	99.00
100.00) TOTAL	891, 543	156, 337	802, 277	2, 174, 985	1, 224, 637	100.00

Provi der No.: 315176

						4/26/2024 10:	<u> 24 am </u>
					OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	RECREATI ON	Subtotal	
		SERVICES &	RECORDS &				
		SUPPLY	LI BRARY				
		10.00	12.00	13.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	231, 269					10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	201,207	C				12. 00
13. 00	01300 SOCI AL SERVI CE		Č	173, 142			13. 00
15. 00	01500 RECREATION			0	312, 115		15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		η σ	312, 113		13.00
30. 00	03000 SKILLED NURSING FACILITY	136, 740	C	173, 142	312, 115	12, 992, 842	30. 00
	03100 NURSING FACILITY				312, 113	12, 992, 042	
31. 00		0	C	0	0		31.00
32.00	03200 CF/ D	0	C	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0)[U _I	0	33. 00
10.00	ANCILLARY SERVICE COST CENTERS			, al	ام	, 547	40.00
40.00	04000 RADI OLOGY	0	C	1	0	6, 546	40.00
41. 00	04100 LABORATORY	0	C	0	0	9, 803	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	C	0	0	3, 399	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	C	0	0	10, 906	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	C	0	0	487, 553	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	C	0	0	190, 702	45. 00
46.00	04600 SPEECH PATHOLOGY	0	C	0	0	81, 950	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	C	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	94, 529	C	0	0	221, 602	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	O	C	o	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS				,		
60.00	06000 CLI NI C	0	C	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	ol	C	ol	o	0	61.00
62. 00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>					
70.00	07000 HOME HEALTH AGENCY COST	0	C	o	0	0	70. 00
71. 00	07100 AMBULANCE	0	C	1	o	10, 898	71. 00
73. 00	07300 CMHC	0	C	1	0	0	73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		ή	<u> </u>		73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						
	08200 UTILIZATION REVIEW - SNF						81.00
82. 00					0	0	82.00
83. 00	08300 HOSPI CE	004 040	C	0	040 445	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	231, 269	C	173, 142	312, 115	14, 016, 201	89. 00
	NONREI MBURSABLE COST CENTERS	ام		.l	ام		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	967	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	0	0	23, 573	91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	C	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	C	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	C	0	0	0	94. 00
98. 00	Cross Foot Adjustments	0			0	0	98. 00
99. 00	Negative Cost Centers	0	C	이	0	0	99. 00
100.00	D TOTAL	231, 269	C	173, 142	312, 115	14, 040, 741	100. 00

In Lieu of Form CMS-2540-10 Health Financial Systems MEDFORD NRSG& CONVA. CENTER Peri od: Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315176

From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 4/26/2024 10:24 am Cost Center Description Post Stepdown Total Adjustments 17.00 18.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 5 00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9.00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 01300 SOCIAL SERVICE 13 00 13 00 15.00 01500 RECREATION 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 12, 992, 842 30.00 31.00 03100 NURSING FACILITY 31.00 32.00 03200 | CF/IID 0 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 0 40.00 04000 RADI OLOGY 6, 546 41.00 04100 LABORATORY 9,803 41.00 0000000000 04200 I NTRAVENOUS THERAPY 42.00 3, 399 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 10, 906 43.00 44. 00 04400 PHYSI CAL THERAPY 487, 553 44.00 45.00 04500 OCCUPATIONAL THERAPY 190, 702 45.00 04600 SPEECH PATHOLOGY 46.00 81, 950 46.00 04700 ELECTROCARDI OLOGY 47.00 Λ 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 49.00 221,602 05000 DENTAL CARE - TITLE XIX ONLY 50.00 50.00 C 05100 SUPPORT SURFACES 0 51.00 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 61 00 06100 RURAL HEALTH CLINIC 0 61 00 Ω 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 07100 AMBULANCE 0 71.00 10, 898 71.00 07300 CMHC 73.00 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00

14, 016, 201

14, 040, 741

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99 00

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93.00

94.00

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99 00

100.00

08300 H0SPI CE

SUBTOTALS (sum of lines 1-84)

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

NONREI MBURSABLE COST CENTERS

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

TOTAL

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315176

				To	12/31/2023	Date/Time Prep 4/26/2024 10:	
			CAPI TAL				
	Cost Center Description	Directly	RELATED COSTS BLDGS &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	osst somes possi persi.	Assigned New	FIXTURES	oub to tu.	BENEFITS	& GENERAL	
		Capi tal					
		Related Costs 0	1.00	2A	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	271	0.00	1. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS	0	24, 978		24, 978	FO 40F	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	56, 472 44, 383		1, 713 417	58, 185 3, 695	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE		31, 151		194		6.00
7. 00	00700 HOUSEKEEPI NG	0	17, 062		1, 663		7. 00
8.00	00800 DI ETARY	0	190, 565	190, 565	2, 305		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	2, 954		9.00
10. 00 12. 00	01000 CENTRAL SERVICES & SUPPLY 01200 MEDICAL RECORDS & LIBRARY	0	0	0	114 0	958	10. 00 12. 00
13. 00	01300 SOCIAL SERVICE			0	418		13. 00
15. 00	01500 RECREATION	0	Ö	Ö	709		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1 ,		12, 903	31, 070	
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0		0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE				0	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS			<u> </u>			00.00
40. 00	04000 RADI OLOGY	0	0	0	0	27	40. 00
41. 00	04100 LABORATORY	0	0	-	0	41	41. 00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0	0	0	0	14	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		39, 182	39, 182	931	1, 788	
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	· ·	459		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	198	340	
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 527	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY			0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	Ö		0		
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	1		0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	-		0	45	
73. 00	07300 CMHC] 0	0	0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	1 I	0		0	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	1, 323, 608	1, 323, 608	24, 978	58, 132	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	ol	0	4	90. 00
91. 00		0	8, 231	8, 231	0	49	
92. 00		0	0	0	0	0	
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00 98. 00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0	0	0	0	94. 00 98. 00
99.00	, ,	1	0	0	0	o	
100.00		0	1, 331, 839	1, 331, 839	24, 978		
				· ·			

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315176 Period:

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

12/31/2023 4/26/2024 10: 24 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATI ON, LINEN SERVICE ADMI NI STRATI ON MAINT. & REPAI RS 9. 00 7.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4 00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 48, 495 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 1, 253 33, 150 6.00 00700 HOUSEKEEPING 7.00 686 22, 683 7.00 00800 DI ETARY 8.00 7,663 3, 733 212, 148 8.00 9.00 00900 NURSING ADMINISTRATION 0 0 0 8,029 9.00 01000 CENTRAL SERVICES & SUPPLY 0 0 10.00 10.00 C 0 0 01200 MEDICAL RECORDS & LIBRARY 12 00 0 0 0 0 12.00 Ω 13.00 01300 SOCIAL SERVICE 0 C 0 0 0 13.00 15.00 01500 RECREATION 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 029 03000 SKILLED NURSING FACILITY 30.00 30.00 36, 986 33, 150 18,021 212, 148 31.00 03100 NURSING FACILITY 0 31.00 03200 | CF/IID 0 0 o 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 33 00 0 0 0 0 0 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 0 42 00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 44.00 1,576 768 0 44.00 04500 OCCUPATIONAL THERAPY 45 00 0 Ω 45 00 0 0 04600 SPEECH PATHOLOGY 0 46.00 0 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 0 0 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 49 00 Ω 0 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 0 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 Ω O 0 60 00 0 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 0 73.00 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 08300 H0SPI CE 83.00 0 83.00 SUBTOTALS (sum of lines 1-84) 212, 148 8, 029 89.00 48, 164 33, 150 22, 522 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 90.00 С 0 09100 BARBER AND BEAUTY SHOP 0 91.00 91.00 331 0 161 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 09300 NONPALD WORKERS 0 93.00 0 0 0 O 93.00 09400 PATIENTS LAUNDRY 94.00 0 C 0 0 0 94.00 98.00 Cross Foot Adjustments \mathcal{C} 0 0 0 98.00 99.00 Negative Cost Centers 0 99.00

48, 495

33, 150

22, 683

212, 148

8, 029 100. 00

100.00

TOTAL

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				'	0 12/31/2023	4/26/2024 10:	
					OTHER GENERAL		
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE		Subtotal	
	oost denter beschiptron	SERVICES &	RECORDS &	SOUTHE SERVICE	REOREMITON	oubtotal	
		SUPPLY	LI BRARY				
		10.00	12. 00	13.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	10.00	12.00	13.00	13.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	I		T	1		1 00
							1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00		1, 072					10.00
12. 00		0	(12.00
13. 00		O	(1, 136			13. 00
15. 00			(1	1		15. 00
15.00		UU		7	2,002		15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(0.4		1 400	0.000	4 075 004	
30. 00		634	C	1 .,	1	1, 275, 894	1
31. 00		0	C		0	0	1
32. 00	03200 CF/IID	0	C) (0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	C		0	0	33.00
	ANCILLARY SERVICE COST CENTERS						1
40.00	04000 RADI OLOGY	0	C		0	27	40.00
41. 00	l i	o	(41	1
42. 00		ام			ار	14	
43. 00	l i					45	1
					, J		
44. 00	l i		(44, 245	1
45. 00	l i	0	(1, 249	1
46. 00		0	C)	ol ol	538	1
47. 00		0	C		0	0	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C) () 0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	438	C		0	965	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0	0	50.00
51.00	05100 SUPPORT SURFACES	o	C	ol c	ol	0	51.00
	OUTPATIENT SERVICE COST CENTERS	·		•	'		1
60.00		0	(0	0	60.00
61. 00			Č	1		0	1
62. 00				1	ή	O	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00			C		\ \ \ \	0	70.00
70.00		0					
71. 00		0	C		1	45	1
73. 00		0			0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						1
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	l ol	C	ol c	ol ol	0	83. 00
89. 00		1, 072	C	1, 136	2, 002	1, 323, 063	1
07.00	NONREI MBURSABLE COST CENTERS	., 0, 2		,, .,,,,,	2,002	1,020,000	07.00
90. 00		O	(4	90.00
91. 00			(í j	8, 772	
		- 1	(1	1		
92.00		0	(1 1	0	1
93.00		0	C	1	미	0	1
94. 00		0	C) C	0	0	1
98. 00		0			0	0	1
99. 00		0	C		0	0	
100.0	O TOTAL	1, 072	C	1, 136	2, 002	1, 331, 839	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MEDFORD NRSG& CONVA. CENTER

Provi der No.: 315176

A
SENERAL SERVICE COST CENTERS
GENERAL SERVICE COST CENTERS 1.00 0.00
1.00
3. 00 03300 EMPLOYEE BENEFITS
4. 00
5. 00 00500 DANT OPERATION, MAINT & REPAIRS 5. 00 6. 00 00500 LAUNDRY & LINEN SERVICE 7. 00 6. 00 00500 LAUNDRY & LINEN SERVICE 7. 00 8. 00 00800 DIETARY 8. 00 00800 DIETARY 8. 00 00800 DIETARY 9. 00 00 00900 NURSING ADMINISTRATION 9. 00 12. 00 12.00 MEDICAL RECORDS & LIBRARY 12. 00 13. 00 01300 SOCI AL SERVICE 13. 00 01500 RECREATION 15. 00 11. 275, 894 15. 00 15. 00 15. 00 10. 00 15. 0
6. 00 00500 LAUNDRY & LINEN SERVICE
7. 00 8. 00 00700 DUSKKEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 9. 00 10
8. 00 00800 DI ETARY 00900 NURSI NG ADMINISTRATION 9. 00 10. 00 1000 CENTRAL SERVICES & SUPPLY 10. 00 12. 00 11. 0
9. 00 0900 NURSI NG ADMINISTRATION 9. 00 10. 00 10. 00 01000 CENTRAL SERVICES & SUPPLY 12. 00 13. 00 15. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY 10. 00 12. 00 01200 MEDI CAL RECORDS & LIBRARY 12. 00 13. 00 01300 SOCI AL SERVICE 13. 00 15. 00 1
12.00 01200 MEDI CAL RECORDS & LI BRARY 12.00 13.00 01300 SOCI AL SERVI CE 15.00 01500 RECREATI ON 15.00 15.00 15.00 RECREATI ON 15.00
13. 00 01300 SOCIAL SERVICE 13. 00 15. 00 IDSOO RECREATION 15. 00 INPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 3300 SKI LLED NURSING FACILITY 0 0 0 0 31. 00 33. 00 33. 00 03200 ICF/I ID 0 0 0 0 33. 00 33. 00 33. 00 03200 ICF/I ID 0 0 0 0 33. 00 33. 00 33. 00 03200 ICF/I ID 0 0 0 0 0 33. 00 03200 ICF/I ID 0 0 0 0 0 0 0 0 0
15. 00
30.00 03000 SKI LLED NURSI NG FACI LITY 0 1, 275, 894 30.00 31.00 03100 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0
31. 00 03100 NURSING FACILITY 0 0 0 0 32. 00 32.00 1CF/I ID 0 0 0 0 32. 00 33.00 0THER LONG TERM CARE 0 0 0 0 33.00 0THER LONG TERM CARE 0 0 0 0 0 0 0 0 0
32.00 03200 ICF/II D 0 0 0 0 0 33.00 OTHER LONG TERM CARE 0 0 0 0 0 0 33.00 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
33.00
ANCILLARY SERVICE COST CENTERS 40.00
40. 00
41. 00
42. 00 04200 INTRAVENOUS THERAPY 0 14 42. 00 43. 00 04300 OXYGEN (INHALATION) THERAPY 0 45 43. 00 44. 00 04400 PHYSI CAL THERAPY 0 44, 245 44. 00 45. 00 04500 OCCUPATIONAL THERAPY 0 1, 249 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 538 46. 00 47. 00 04700 ELECTROCARDIOLOGY 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 965 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 50. 00 0
43. 00
44. 00
45. 00
46. 00
47. 00
48. 00
49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 51. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 OUTPATIENT SERVICE COST CENTERS 60. 00 06100 RURAL HEALTH CLINIC 0 0 0 61. 00 06200 FOHC 0 0 OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 50. 00 0 0 0 50. 00 0 0 50. 00 0 0 50. 00 0 0 50. 00 0 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 0 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 60. 00 60. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 67. 00 67. 00 68. 00 69. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 67. 00 68. 00 69. 00 60. 00
51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
OUTPATIENT SERVICE COST CENTERS
60. 00 61. 00 61. 00 62. 00 062. 00 070. 00
62. 00 06200 FOHC 62. 00 OTHER REIMBURSABLE COST CENTERS 0 0 0 700. 00 70. 00
OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST 0 0 70. 00
70. 00 07000 HOME HEALTH AGENCY COST 0 0 70. 00
71. 00 07100 AMBULANCE 0 45 71. 00
73. 00 07300 CMHC 0 0 73. 00
SPECIAL PURPOSE COST CENTERS
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80. 00
81. 00 08100 I NTEREST EXPENSE 81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF
83. 00 08300 HOSPICE 0 0 83. 00 89. 00 SUBTOTALS (sum of Lines 1-84) 0 1.323. 063 89. 00
89. 00 SUBTOTALS (sum of lines 1-84) 0 1,323,063 89. 00 NONREI MBURSABLE COST CENTERS
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 4 90. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0
92. 00 09200 PHYSI CI ANS PRI VATE 0FFI 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 TOTAL 0 1, 331, 839 100. 00

Health Financial Systems MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10 COST ALLOCATION - STATISTICAL BASIS Provider No.: 315176 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 4/26/2024 10:24 am CAPI TAL RELATED COSTS Cost Center Description BLDGS & **EMPLOYEE** Reconciliation ADMINISTRATIVE **PLANT FIXTURES** OPERATION, BENEFITS & GENERAL (SQUARE FEET) (GROSS MAINT. & (ACCUM COST) SALARI ES) REPAI RS (SQUARE FEET) 1.00 3.00 4. 00 5. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS - BLDGS & FLXTURES 1 00 46,602 3.00 00300 EMPLOYEE BENEFITS 874 7, 713, 077 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 1,976 529, 026 -1, 943, 878 12, 096, 863 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 1 553 128, 919 768, 113 42 199 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 1,090 59, 909 0 114,852 1,090 6.00 7.00 00700 HOUSEKEEPI NG 597 513, 577 680, 338 597 7.00 00800 DI ETARY 711, 919 0 1, 638, 728 8.00 8.00 6.668 6.668 00900 NURSING ADMINISTRATION 0 9 00 912, 286 1, 055, 091 9 00 0 0 10.00 01000 CENTRAL SERVICES & SUPPLY 0 35, 351 0 199, 251 0 10.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 0 12.00 01300 SOCIAL SERVICE 128, 981 0 149, 171 13.00 13.00 0 0 01500 RECREATION 0 15.00 218, 883 268, 904 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 32, 185 30.00 32, 185 3, 984, 010 0 6, 459, 540 30.00 03100 NURSING FACILITY 0 31.00 31.00 0 32 00 03200 LCE/LLD 0 C 0 0 0 32 00 03300 OTHER LONG TERM CARE 0 33.00 33.00 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 5,640 40.00 0 0 0 0 41.00 04100 LABORATORY C 8, 446 Λ 41.00 2, 928 04200 I NTRAVENOUS THERAPY 0 0 42.00 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 9, 396 43.00 0 04400 PHYSI CAL THERAPY 44 00 287.487 0 371, 706 1, 371 44.00 1, 371 04500 OCCUPATIONAL THERAPY 45.00 0 141, 681 0 164, 300 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 61,048 70,604 0 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 C 0 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49.00 109, 480 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY C 0 0 50.00 05100 SUPPORT SURFACES 0 51.00 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 61.00 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 07100 AMBULANCE 0 0 9.389 71 00 C 0 71 00 07300 CMHC 73.00 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81 00 81 00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 83.00 0 89.00 SUBTOTALS (sum of lines 1-84) 46, 314 7, 713, 077 -1, 943, 878 12, 085, 877 41, 911 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 833 n 90.00 09100 BARBER AND BEAUTY SHOP 288 91.00 0 10, 153 288 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 92.00 0 0 0 0 09300 NONPALD WORKERS 0 93.00 93.00 0 C 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 98.00 Cross Foot Adjustments 98 00 99 00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 1, 331, 839 1, 207, 370 1, 943, 878 891, 543 102. 00 21. 127112 103. 00 103.00 Unit cost multiplier (Wkst. B, Part I) 28. 579009 0.156535 0.160693 48, 495 104, 00

24, 978

0.003238

58, 185

0.004810

1. 149198 105. 00

Part II)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

104.00

105.00

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315176

Period: Worksheet B-1 From 01/01/2023

12/31/2023 Date/Time Prepared: 4/26/2024 10:24 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG CENTRAL LINEN SERVICE (MEALS SERVED) ADMINISTRATION SERVICES & (SQUARE FEET) (PATI ENT **SUPPLY** CENSUS) (DI RECT (COSTED NURSI NG) REQUIS.) 6.00 7.00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 00300 EMPLOYEE BENEFITS 3.00 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 40,014 6.00 6.00 00700 HOUSEKEEPI NG 7.00 40, 512 7 00 8.00 00800 DI ETARY 0 6,668 120, 042 8.00 9.00 00900 NURSING ADMINISTRATION 0 131, 476 9.00 0 01000 CENTRAL SERVICES & SUPPLY 267.846 10 00 Ω 0 10 00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 C 0 0 0 12.00 13.00 01300 SOCIAL SERVICE 0 C 0 0 0 13.00 01500 RECREATION 15.00 0 0 0 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 40,014 32, 185 120, 042 131, 476 158, 366 30.00 03100 NURSING FACILITY 31.00 0 0 31.00 0 03200 | CF/IID 32 00 0 0 0 32 00 0 0 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 C 0 40.00 04100 LABORATORY 0 0 0 41.00 C 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42.00 C 0 0 42.00 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 43.00 0 44.00 04400 PHYSI CAL THERAPY 0 0 1.371 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 0 45 00 45.00 C 0 46.00 04600 SPEECH PATHOLOGY 0 0 Ω 46.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47.00 47.00 0 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 109, 480 0 49 00 C 49 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 50.00 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 \cap O 0 Λ 70.00 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 73.00 0 0 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 H0SPI CE Λ 83.00 89.00 SUBTOTALS (sum of lines 1-84) 40,014 40, 224 120, 042 <u>131, 476</u> 267, 846 89.00 NONREI MBURSABLE COST CENTERS 90.00 90 00 09000 GLET, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 288 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 C 0 92.00 0 o 09300 NONPALD WORKERS 0 93.00 93.00 0 0 94.00 09400 PATIENTS LAUNDRY 0 C 0 0 0 94.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102 00 Cost to be allocated (per Wkst. B, 156, 337 802, 277 2 174 985 1, 224, 637 231, 269 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 3.907058 19.803441 18.118534 9. 314529 0. 863440 103. 00 1, 072 104. 00 104.00 Cost to be allocated (per Wkst. B, 33, 150 22, 683 212, 148 8,029 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.828460 0.559908 1.767281 0.061068 0.004002 105.00

II)

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315176

Peri od: Worksheet B-1 From 01/01/2023

Date/Time Prepared:

12/31/2023

4/26/2024 10:24 am OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCIAL SERVICE RECREATI ON RECORDS & (CENSUS) LI BRARY (PATI FNT (PATI ENT CENSUS) CENSUS) 12.00 13.00 15.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS - BLDGS & FLXTURES 1 00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 01200 MEDICAL RECORDS & LIBRARY 40, 014 12.00 12.00 01300 SOCIAL SERVICE 40, 014 13.00 13.00 01500 RECREATION 15.00 40,014 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 40,014 40,014 40, 014 30.00 03100 NURSING FACILITY 31.00 31.00 0 32 00 03200 LCE/LLD 0 C 0 32 00 03300 OTHER LONG TERM CARE 0 0 33.00 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 0 0 41.00 04100 LABORATORY C 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 000000 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 44.00 0 0 44.00 0 45.00 04500 OCCUPATIONAL THERAPY C 45.00 04600 SPEECH PATHOLOGY 46.00 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS C 48.00 0 04900 DRUGS CHARGED TO PATIENTS 0 49.00 49.00 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 61.00 C 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 07100 AMBULANCE 0 0 71 00 C 71 00 07300 CMHC 73.00 0 C 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81 00 81 00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 HOSPI CE 83.00 83.00 89.00 SUBTOTALS (sum of lines 1-84) 40,014 40,014 40,014 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 90.00 0 09100 BARBER AND BEAUTY SHOP 0 0 91.00 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 92.00 0 09300 NONPALD WORKERS 0 0 93.00 C 93.00 94.00 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, 173, 142 312, 115 102.00 4. 327036 103.00 103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 7.800145 104.00 104.00 Cost to be allocated (per Wkst. B, 2.002 1, 136 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.028390 0.050032 105.00

Health Financial Systems	MEDFORD NRSG& CONVA.	CENTER	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY	AND OUTPATIENT COST CENTERS	Provi der No. : 315176	From 01/01/2023	Worksheet C Date/Time Prepared: 4/26/2024 10:24 am
Cost Center Description		Total (from Wkst. B, Pt	Total Charges	Ratio (col. 1 divided by

		1	0 12/31/2023	4/26/2024 10:2	
Cost Center Description		Total (from	Total Charges		24 (1111
5551 5511151 25551 Pt 1 511		Wkst. B, Pt I,	rotal onal goo	di vi ded by	
		col. 18)		col. 2	
		1. 00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS					
40. 00 04000 RADI OLOGY		6, 546	5, 199	1. 259088	40.00
41. 00 04100 LABORATORY		9, 803	15, 401	0. 636517	41.00
42. 00 04200 I NTRAVENOUS THERAPY		3, 399	9, 511	0. 357376	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY		10, 906	0	0.000000	43.00
44. 00 04400 PHYSI CAL THERAPY		487, 553	388, 801	1. 253991	44.00
45. 00 04500 OCCUPATI ONAL THERAPY		190, 702	422, 499	0. 451367	45.00
46. 00 04600 SPEECH PATHOLOGY		81, 950	153, 187	0. 534967	46.00
47. 00 04700 ELECTROCARDI OLOGY		0	0	0.000000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENT	S	0	244	0.000000	48.00
49.00 O4900 DRUGS CHARGED TO PATIENTS		221, 602	108, 530	2. 041850	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY		0	0	0.000000	50.00
51. 00 05100 SUPPORT SURFACES		0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
60. 00 06000 CLI NI C		0	0	0.000000	60.00
61.00 06100 RURAL HEALTH CLINIC					61.00
62. 00 06200 FQHC					62.00
71. 00 07100 AMBULANCE		10, 898	0	0.000000	71.00
100. 00 Total		1, 023, 359	1, 103, 372		100. 00

Health Financial Systems	MEDFORD NRSG&	CONVA. CENTER		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII (1)	Skilled Nursing		24 alli
				Facility		
		Heal th Care Pi	rogram Charges	Health Care	Program Cost	
	Datio of Cost	Part A	Part B	Don't A (ool 1	Dowt D (and 1	
	Ratio of Cost to Charges	Part A	Part B	Part A (col. 1 x col. 2)	x col. 3)	
	(Fr. Wkst. C			X COI. 2)	X COI. 3)	
	Col umn 3)					
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	1. 259088			0 1, 381	0	
41. 00 04100 LABORATORY	0. 636517			0 199	0	
42. 00 04200 NTRAVENOUS THERAPY	0. 357376			0 2, 888	0	
43. 00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 253991			0 194, 306	0	
45. 00 04500 0CCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY	0. 451367			0 89, 163	0	1 .0.00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0. 534967 0. 000000			0 36, 824	0	
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000				0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	2. 041850	l .		0 135, 444	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			133, 444	0	50.00
51. 00 05100 SUPPORT SURFACES	0. 000000				0	
OUTPATIENT SERVICE COST CENTERS	0.00000	· · · · · ·		0		31.00
60. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	71.00
100.00 Total (Sum of lines 40 - 71)		497, 393		0 460, 205	0	100. 00
(1) For title V and VIV use solumns 1 2 and 4 and	.1					

⁽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.

Heal th Fi	inancial Systems	MEDFORD NRSG& (CONVA. CENTER		In Lie	eu of Form CMS-2	2540-10
	NMENT OF ANCILLARY AND OUTPATIENT COSTS				Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III	pared:
	Title XVIII Skilled Nursing Facility						
Cost Center Description							
D/	ART II - APPORTIONMENT OF VACCINE COST					1.00	
1. 00 2. 00 3. 00	1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49) 2.00 Program vaccine charges (From your records, or the PS&R)				2. 041850 0 0	2. 00	
	Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
			Allied Health		Cost (From	& Allied	
			(From Wkst. B,			Heal th Costs	
		18		Costs to Tota	, , , , , , , , , , , , , , , , , , , ,	for Pass	
			14)	Costs - Part		Through (Col.	
	(Col. 2 / Col. 1)					3 x Col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
PA	ART III - CALCULATION OF PASS THROUGH COSTS			3.00	4.00	3.00	
	NCILLARY SERVICE COST CENTERS	TOTAL MOTOR ING. W.	ALLE ED HEALTH				1
	4000 RADI OLOGY	6, 546	0	0.00000	1, 381	0	40. 00
41.00 04	4100 LABORATORY	9, 803		0.00000		0	41.00
42. 00 04	4200 INTRAVENOUS THERAPY	3, 399	l o	0. 00000	2, 888	0	42.00
43. 00 04	4300 OXYGEN (INHALATION) THERAPY	10, 906	l o	0. 00000	0	0	43.00
44. 00 04	4400 PHYSI CAL THERAPY	487, 553	0	0.00000	194, 306	0	44. 00
45. 00 04	4500 OCCUPATIONAL THERAPY	190, 702	0	0.00000	00 89, 163	0	45. 00
46. 00 04	4600 SPEECH PATHOLOGY	81, 950	0	0.00000	36, 824	0	46. 00
47. 00 04	4700 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	47. 00
48. 00 04	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0 0	0	48. 00
49. 00 04	4900 DRUGS CHARGED TO PATIENTS	221, 602	0	0.00000	135, 444	0	49. 00
50.00 05	5000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	0 0	0	50.00
51.00 05	5100 SUPPORT SURFACES	0	0	0.00000	0 0	0	51.00
100.00	Total (Sum of lines 40 - 52)	1, 012, 461	0)	460, 205	0	100. 00

	Financial Systems MEDFORD NRSG& CONV ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315176	Peri od:	u of Form CMS-2 Worksheet D-1	
JOINI O	ATTON OF THE ATTENT ROUTINE COSTS	110vider No. : 313170	From 01/01/2023 To 12/31/2023	Parts I-II Date/Time Prep 4/26/2024 10:2	pared
		Title XVIII	Skilled Nursing Facility	PPS	
			lacifity		
	DADT I GALOULATION OF INDATIENT DOUTINE COOTS			1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS				1
00	Inpatient days including private room days			40, 014	1.
00	Private room days			0	1
00	Inpatient days including private room days applicable to the P	rogram		2, 764	3.
. 00	Medically necessary private room days applicable to the Program			0	4.
. 00	Total general inpatient routine service cost			12, 992, 842	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
. 00	General inpatient routine service charges			13, 644, 326	
00	General inpatient routine service cost/charge ratio (Line 5 d	ivided by line 6)		0. 952252	1
00	Enter private room charges from your records			0	
00	Average private room per diem charge (Private room charges line 2)	e 8 divided by private	room days, line	0. 00	9.
0. 00	Enter semi-private room charges from your records			0	10.
1.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by					11.
	semi -private room days)	onar geo Trito To, ai Trao	u 2)	0.00	
2. 00	Average per diem private room charge differential (Line 9 minus	s line 11)		0.00	12.
3. 00	Average per diem private room cost differential (Line 7 times	line 12)		0. 00	13.
4. 00	Private room cost differential adjustment (Line 2 times line 1			0	1
5. 00	General inpatient routine service cost net of private room cos PROGRAM INPATIENT ROUTINE SERVICE COSTS	t differential (Line 5	minus line 14)	12, 992, 842	15.
5. 00	Adjusted general inpatient service cost per diem (Line 15 div	ided by line 1)		324. 71	16
7. 00	Program routine service cost (Line 3 times line 16)			897, 498	
3. 00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	1
9. 00	Total program general inpatient routine service cost (Line 17	plus line 18)		897, 498	19.
0. 00	Capital related cost allocated to inpatient routine service cos	sts (From Wkst. B, Par	t II column 18,	1, 275, 894	20.
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)				
1.00	Per diem capital related costs (Line 20 divided by line 1)			31. 89	
2. 00	Program capital related cost (Line 3 times line 21)			88, 144 809, 354	
3.00	00 Inpatient routine service cost (Line 19 minus line 22) 00 Aggregate charges to beneficiaries for excess costs (From provider records)				
5. 00	Total program routine service costs for comparison to the cost		nus line 24)	0 809, 354	
5. 00	Enter the per diem limitation (1)	Trim tation (Line 25 iii	1103 11116 24)	007, 334	26.
	00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)				27.
	00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)				28.
	(Transfer to Worksheet E, Part II, line 4) (See instructions)				
) Li	nes 26 and 27 are not applicable for title XVIII, but may be us	ed for title V and or t	itle XIX		
				4.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	EOD DDS DASS TUDOUCU		1. 00	
. 00	Total SNF inpatient days	TUN PPS PASS-THKUUGH	I	40, 014	1.
. 00	Program inpatient days (see instructions)			2, 764	1
. 00	Total nursing & allied health costs. (see instructions)(Do not	complete for titles V	or XLX)	2, 704	1
. 00	Nursing & allied health ratio. (line 2 divided by line 1)		//	0. 069076	
	J	3 times line 4)	1		5.

Health Financial Systems	MEDFORD I	NRSG& CONVA.	CENTER		In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOI	R TITLE XVIII		Provider No.:		From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 4/26/2024 10:24 am
			Title XVI	111	Skilled Nursing Facility	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS		1.00		
1.00	Inpatient PPS amount (See Instructions)		1, 859, 714	1. 00	
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	3		1, 859, 714	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			331, 400	5. 00
6.00	Allowable bad debts (From your records)			190, 731	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		123, 151	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			123, 975	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)			1, 652, 289	11. 00
12.00	Interim payments (See instructions)			1, 639, 682	12.00
13. 00	Tentati ve adj ustment			0	13. 00
14. 00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration		0	14. 50	
14. 55	Demonstration payment adjustment amount after sequestration		0	14. 55	
14. 75	Sequestration for non-claims based amounts (see instructions)		2, 480		
14. 99	Sequestration amount (see instructions)			30, 566 -20, 439	14. 99
15. 00					15. 00
16. 00	O Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY				16. 00
17. 00	Ancillary services Part B	UF CUST UR CHARGES - I	TILE AVIII UNLY	0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			0	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)	ŕ		0	24. 02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26.00	Interim payments (See instructions)		0	26. 00	
27.00	Tentati ve adjustment		0	27. 00	
28. 00	Other Adjustments (See instructions) Specify		0	28. 00	
28. 50	Demonstration payment adjustment amount before sequestration		0	28. 50	
28. 55	Demonstration payment adjustment amount after sequestration	0	28. 55		
28. 99	Sequestration amount (see instructions)			0	28. 99
	Balance due provider/program (see instructions)			0	29. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2, s	section 115.2	0	30. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 4/26/2024 10: 24 am PPS Skilled Nursing Facility Title XVIII

Total interim payments paid to provider 1,00 2,00 3,00 4,00 1,00 2,00 1,613,435 0 1,00 2,00 1,613,435 0 1,00 2,00 1,613,435 0 1,00 2,00 1,613,435 0 1,00 2,00 1,613,435 0					Facility		
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.01 1.01 1.01 1.00			Inpatien	t Part A	Par	t B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.01 1.01 1.01 1.00			·				
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.01 1.01 1.01 1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Total interim payments paid to provider 1,613,435 0 1.00 0 2.00 1.00 0 2.00				2, 00		4. 00	
InterIm payments payable on Individual bills, either survices rendered in the cost reporting period. If none, enter zero	1. 00	Total interim payments paid to provider					1. 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero				0		0	2.00
Services rendered in the cost reporting period. If none, enter zero Services rendered in the cost reporting period. If none, enter zero Services rendered in the cost reporting psum 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 O6/16/2023 26,247 O 3.01 O 3.02 O 0 0 3.02 O 0 0 3.03 O 0 0 0 3.04 O 0 0 0 3.05 O 0 0 0 0 3.05 O 0 0 0 0 3.05 O 0 0 0 0 0 3.05 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00					Ĭ	2.00
Interval Separate Separate							
1.00 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							
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)	3 00						3 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	0.00						0.00
payment, If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER 06/16/2023 26,247 0 3.01 3.02 0 0 0 3.02 3.03 0 0 0 0 3.03 3.04 0 0 0 0 3.04 3.05 0 0 0 0 3.05 3.06 0 0 0 0 3.05 3.07 Provider to Program ADJUSTMENTS TO PROGRAM 0 0 0 3.55 3.50 0 0 0 0 3.55 3.51 0 0 0 0 3.55 3.51 0 0 0 0 3.55 3.52 0 0 0 0 3.55 3.54 0 0 0 0 3.55 3.54 0 0 0 0 3.55 3.55 0 0 0 0 3.55 3.56 0 0 0 0 3.55 3.57 0 0 0 0 3.55 3.58 0 0 0 0 0 3.55 3.59 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 26,247 0 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 4.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 4.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 5.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 6.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,639,682 0 6.00 4.00 Total interim payments (sum of lines 3.50 0 6.00 4.00 Total interim payments (sum of lines 3.50 0 6.00 4.00 Total interim payments (sum of lines 3.50 0 6.00 4.00 Total interim payments (sum of lines 3.50 0 6.00 4.00 Total interim payments (sum of lines 3.50 0 6.00 4.00 Total interim							
ADJUSTMENTS TO PROVIDER							
3.02 0	3 01		06/16/2023	26 247		0	3 01
3.03 3.04 3.05 3.03 3.04 3.05 3.03 3.05		ADJUSTINIENTS TO TROVIDER	007 107 2023				
3.04						1	
3.05 Provider to Program				-			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50						1	
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50 3. 51 3. 52 0 0 0 3. 51 3. 52 3. 53 0 0 0 0 3. 53 3. 54 0 0 0 0 3. 53 3. 54 0 0 0 0 3. 54 0 0 0 0 3. 54 0 0 0 3. 54 0 0 0 3. 54 0 0 0 3. 54 0 0 0 3. 54 0 0 0 3. 54 0 0 0 5. 50 0 0 Total interim payments (sum of lines 1, 2, and 3. 99) 1, 639, 682 0 (Transfer to Wkst. E, Part I line 12 for Part A, and line 2 6 for Part B)	3.03	Dravidar to Dragram		U		U	3.00
3.51	2 50						2 50
3.52 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.52 0 0 0 3.53 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 26.247 0 3.59 26.247 0 3.59 2.50		ADJUSTMENTS TO PROGRAM				1	
3.53 3.54 0 0 3.53 3.54 0 0 0 3.53 3.54 3.59 3				· ·			
3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 26,247 0 3.99 -3.98				0			
3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 26,247 0 3.99 1,639,682 0 4.00				0			
1,639,682 0 4.00				0			
1,639,682 0 4.00	3. 99			26, 247		0	3. 99
CTRAINSFER TO Wikst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR						_	
26 for Part B) TO BE COMPLETED BY CONTRACTOR	4.00			1, 639, 682		0	4.00
To BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						1	
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER S. 02 O O S. 02 S. 03 O O S. 02 S. 03 O O S. 02 S. 03 O O S. 03 S. 05 O O S. 05 S. 05 O O O S. 05 S. 05 O O O O O O O O O	5.00						5.00
Program to Provider		desk review. Also show date of each payment. If none,					
TENTATIVE TO PROVIDER							
5.02 0						_	
Solution Solution		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5. 03			0		0	5. 03
5.51 5.52 5.52 5.53 5.55						1	
5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00		TENTATI VE TO PROGRAM		0			
5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50				0			
- 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 5.98) 0 0 0 6.00 20,439 0 6.02 7.00 Contractor Name Contractor Name Contractor Number 1.00 2.00	5. 52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00	5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
the cost report. (1) PROGRAM TO PROVIDER PROVIDER TO PROGRAM Total Medicare program liability (see instructions) Contractor Name Contractor Number 1.00 2.00							
6. 01 PROGRAM TO PROVIDER 6. 02 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1. 00 6. 01 20, 439 0 7. 00 Contractor Name Contractor Number 1. 00 2. 00	6.00	Determined net settlement amount (balance due) based on					6. 00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) 20,439 0 6.02 7.00 Contractor Name Contractor Number 1.00 2.00		the cost report. (1)					
7.00 Total Medicare program liability (see instructions) 1,619,243 Contractor Name Contractor Number 1.00 2.00				0		0	
Contractor Name Contractor Number	6.02	PROVI DER TO PROGRAM		20, 439		0	6. 02
1. 00 2. 00	7.00	Total Medicare program liability (see instructions)		1, 619, 243		0	7. 00
1.00 2.00				Contract	or Name	Contractor	
						Number	
8.00 Name of Contractor 8.00				1. (00	2. 00	
	8. 00	Name of Contractor					8. 00

^{8.00 |}Name of Contractor | | (1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 4/26/2024 10: 24 am

oni y)				127 017 2020	4/26/2024 10:	24 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	Assets					
1. 00	CURRENT ASSETS Cash on hand and in banks	49, 858			0	1.00
2. 00	Temporary investments	49, 838			0	
3. 00	Notes recei vabl e	0			Ö	
4.00	Accounts receivable	1, 724, 599	(o o	0	
5.00	Other receivables	-3, 088	(0	0	
6. 00	Less: allowances for uncollectible notes and accounts	-222, 064	(0	0	6.00
7. 00	recei vabl e I nventory				0	7.00
8. 00	Prepaid expenses	536, 720	`		0	
9. 00	Other current assets	0 0			Ö	
10.00	Due from other funds	0		o o	0	
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 086, 025	(0	0	11.00
	FIXED ASSETS					
12.00	Land	118, 000	1	0	0	1
13.00	Land improvements	0	1	0	0	
14. 00 15. 00	Less: Accumulated depreciation Buildings	5, 080, 599	1		0	
16. 00	Less Accumulated depreciation	-5, 062, 713	1		0	
17. 00	Leasehold improvements	0	1		0	
18.00	Less: Accumulated Amortization	0	(o o	0	18. 00
19. 00	Fi xed equipment	0	(0	0	1
20. 00	Less: Accumulated depreciation	0	(이	0	
21. 00	Automobiles and trucks	75, 701	1	0	0	
22. 00 23. 00	Less: Accumulated depreciation Major movable equipment	-75, 701 3, 187, 875			0	
24. 00	Less: Accumulated depreciation	-3, 097, 100	1		0	
25. 00	Mi nor equi pment - Depreci abl e	3,077,100			Ö	
26. 00	Mi nor equi pment nondepreci abl e	0		o o	0	
27. 00	Other fixed assets	611, 411		o o	0	27. 00
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	838, 072	(0	0	28.00
20.00	OTHER ASSETS		J	ol o	0	29.00
29. 00 30. 00	Investments Deposits on Leases	0		-	0	
31. 00	Due from owners/officers	-2, 090, 710	`		0	
32. 00	Other assets	0			0	
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-2, 090, 710	(o o	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	833, 387	(0	0	34.00
	Liabilities and Fund Balances					-
35. 00	CURRENT LIABILITIES Accounts payable	4, 681, 891			0	35. 00
36. 00	Salaries, wages, and fees payable	456, 213	1		0	
37. 00	Payroll taxes payable	-110	1		Ö	1
38. 00	Notes & Loans payable (Short term)	500, 000	(o	0	
39. 00	Deferred income	228, 703	(0	0	39.00
40.00	Accel erated payments	0			_	40.00
41.00	Due to other funds	0		0	0	
42. 00 43. 00	Other current liabilities TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	474, 464 6, 341, 161	1		0	
43.00	LONG TERM LIABILITIES	0, 341, 101		<u> </u>	0	43.00
44. 00	Mortgage payable	4, 575, 697		ol ol	0	44.00
45.00	Notes payable	0		o o	0	
46. 00	Unsecured Loans	0		0	0	
47.00	Loans from owners:	2, 235, 179	(0	0	
48. 00	Other long term liabilities	0	(0	0	
49.00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	4 910 974		0 0	0	1
50. 00 51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	6, 810, 876 13, 152, 037	1		0	
31.00	CAPITAL ACCOUNTS	13, 132, 037		91 9		31.00
52. 00	General fund balance	-12, 318, 650				52.00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					33.30
				1		1
59. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-12, 318, 650	(0	0	
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	-12, 318, 650 833, 387	1		0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MEDFORD NRSG& CONVA. CENTER In Lieu of Form CMS-2540-10 Provi der No.: 315176

					То	12/31/2023	Date/Time Prep 4/26/2024 10:2	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	2.7. (3.11)
				·				
4 00		1.00	2.00	3.00		4. 00	5. 00	4.00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)		-9, 797, 626 -2, 521, 022			0		1. 00 2. 00
2. 00 3. 00	Total (sum of line 1 and line 2)		-2, 521, 022 -12, 318, 648			0		3. 00
4.00	Additions (credit adjustments)		-12, 310, 040			U		4. 00
5.00	Additions (Credit adjustments)				0		o	5. 00
6. 00					0		0	6. 00
7. 00					0			7. 00
8. 00					0		l ől	8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 5 - 9)		0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)		-12, 318, 648			0		11. 00
12. 00	Deductions (debit adjustments)		1=70107010			_		12. 00
13.00	ROUNDI NG	2			0		o	13.00
14.00		o			0		o	14.00
15.00		o			0		0	15.00
16.00		o			0		0	16.00
17.00		0			0		0	17.00
18.00	Total deductions (sum of lines 13 - 17)		2			0		18.00
19. 00	Fund balance at end of period per balance		-12, 318, 650			0		19.00
	sheet (Line 11 - line 18)	E	DI I					
		Endowment Fund	PI ant	Funa				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	71.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)							2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3.00
4.00	Additions (credit adjustments)							4.00
5.00			0					5.00
6.00			0					6.00
7.00			0					7. 00
8.00			0					8.00
9. 00			0					9. 00
10. 00	Total additions (sum of line 5 - 9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments)							12.00
13.00	ROUNDI NG		0					13.00
14.00			0					14.00
15.00			0					15. 00 16. 00
16. 00 17. 00			0					16. 00 17. 00
18.00	Total deductions (sum of lines 13 - 17)		U		0			17.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (Line 11 - line 18)				U			17.00
	10.1001 (2.1.0 11 11110 10)	ı I	!	1	ļ			

		EDFORD NRSG& CONVA	. CENTER		In Li€	eu of Form CMS-	2540-10	
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315176	Peri od:	Worksheet G-2		
					From 01/01/2023 To 12/31/2023		nared:	
					10 12/31/2023	4/26/2024 10:	24 am	
Cost Center Description Inpatient Outpatient Total								
				1. 00	2. 00	3. 00		
	PART I - PATIENT REVENUES							
	General Inpatient Routine Care Services							
1. 00	SKILLED NURSING FACILITY			13, 644, 32		13, 644, 326	1	
2.00	NURSING FACILITY				0	0		
3.00	ICF/IID				0	0		
4.00	OTHER LONG TERM CARE			40 / 44 0	0	0	1	
5. 00	Total general inpatient care services (Sum of	lines 1 - 4)		13, 644, 32	26	13, 644, 326	5.00	
4 00	AII Other Care Services ANCILLARY SERVICES			1, 103, 3	71 0	1 102 271	6.00	
6. 00 7. 00	CLINIC			1, 103, 3	(1)	.,,	1	
8. 00	HOME HEALTH AGENCY COST					0	1	
9. 00	AMBULANCE					0		
10. 00	RURAL HEALTH CLINIC					0	1	
10. 10	FOHC					0		
11. 00	CMHC				o c	0		
12. 00	HOSPI CE				0	Ō		
13. 00	ROUTINE CHARGES / BED HOLD			370, 4	18	370, 418	13. 00	
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	15, 118, 1	15 C	15, 118, 115	14. 00	
	Worksheet G-3, Line 1)							
	Cost Center Description							
					1. 00	2. 00		
	PART II - OPERATING EXPENSES					T		
1.00	Operating Expenses (Per Worksheet A, Col. 3, L	ine 100)				14, 455, 748	1	
2.00	Add (Specify)				C		2.00	
3. 00 4. 00					C		3.00	
4. 00 5. 00							4. 00 5. 00	
6. 00							6.00	
7. 00							7.00	
8.00	Total Additions (Sum of lines 2 - 7)					0		
9. 00	Deduct (Specify)						9. 00	
10. 00	(3530113)						10.00	
11. 00							11.00	
12. 00							12. 00	
13. 00							13. 00	
14. 00	Total Deductions (Sum of lines 9 - 13)					0		
15. 00	Total Operating Expenses (Sum of lines 1 and 8	, minus line 14)				14, 455, 748	15. 00	
	•				•	•	•	

Hoal th	Financial Systems M	EDFORD NRSG& CONVA	\ CENTED		Inlie	u of Form CMS-2	2540_10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.:	315176	Peri od:	Worksheet G-3	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 4/26/2024 10:	
	_					1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part					15, 118, 115	1. 00
2.00	Less: contractual allowances and discounts on	patients accounts				3, 388, 047	2. 00
3.00	Net patient revenues (Line 1 minus line 2)					11, 730, 068	3. 00
4.00	Less: total operating expenses (From Workshee		ne 15)			14, 455, 748	
5.00	Net income from service to patients (Line 3 mi	nus 4)				-2, 725, 680	5. 00
	Other income:						
6.00	Contributions, donations, bequests, etc					0 1, 598	6. 00
7.00	Income from investments						
8.00							8. 00
9.00							9. 00
10.00	Purchase di scounts					0	10.00
11. 00	Rebates and refunds of expenses					0	
12.00	Parking lot receipts					0	
13.00	Revenue from Laundry and Linen service					0	13. 00
14.00	Revenue from meals sold to employees and gues	ts				80	
15.00	Revenue from rental of living quarters					0	15. 00
16.00	Revenue from sale of medical and surgical supp		n patients			0	16. 00
17.00	Revenue from sale of drugs to other than pation					0	17. 00
18. 00	Revenue from sale of medical records and absti	racts				60	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, e	tc.)				0	19. 00
20.00	Revenue from gifts, flower, coffee shops, can	teen				0	20. 00
21.00	Rental of vending machines					187	21. 00
22. 00	Rental of skilled nursing space					0	22. 00
23.00	Governmental appropriations					0	23. 00
24.00	PRI OR YEAR					154, 733	24. 00
24. 01	NON PATIENT REVENUE					44, 513	24. 01
24. 02	BARBER BEAUTY					3, 487	24. 02
24. 50	COVI D-19 PHE Funding					0	24. 50
25.00	Total other income (Sum of lines 6 - 24)					204, 658	25. 00
26.00	Total (Line 5 plus line 25)					-2, 521, 022	26. 00
27.00	Other expenses (specify)					0	27. 00
28 00						l n	28 00

0 28.00 0 29.00

0 30.00 -2,521,022 31.00

28. 00 29. 00

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