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

OMB NO. 0938-0463 Expires: 12/31/2021

			EMP11 001 127 017 2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315333	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/24/2024 1:36 pm

				5/24	1/2024 1:	36 PM
PART I - COST I	REPORT STATUS					
Provi der	1. [ X ] Electronically prepared cost rep	oort		Date: 5/24/2024	Time:	1: 36 pr
use only	2. [ ] Manually prepared cost report	] Manually prepared cost report				
	3. [ 0 ] If this is an amended report ent	ter the number	r of times the provider	r resubmitted this cos	st report	
	3.01 [ ] No Medicare Utilization. Enter "	'Y" for yes o	r 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 I	Provider CCN		
	(3) Settled with audit	9. NPR Date:	•			
	(4) Reopened	10.[ 0 ] f	ine 4, column 1 is "4":	 Enter number of time	es reoper	ned
	(5) Amended		r Vendor Code	4		
	5. Date Received:		care Utilization. Ente	r "F" for full, "L" fo	or low, o	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 COMPLETE CARE AT ARBORS LLC ( 315333 ) 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 FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX		
	1		2	SI GNATURE STATEMENT	
1	Sha	alom Stein	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	Shalom Stein			2
3	Signatory Title	CE0			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	145, 634	925	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	145, 634	925	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 COMPLETE CARE AT ARBORS LLC In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315333 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/24/2024 1:36 pm 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 1750 ROUTE 37 WEST PO Box: 1.00 2.00 Ci ty: TOMS RIVER State: NJ Zi p Code: 08757 2.00 3.00 County: OCEAN CBSA Code: 35154 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF COMPLETE CARE AT ARBORS 315333 07/14/1994 N Р Ν 4.00 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 N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 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 90, 386 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 90.386 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 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0 0

Heal th	Financial Systems	COMPLETE CARE AT AF	COMPLETE CARE AT ARBORS LLC In L				
	D NURSING FACILITY AND SKILLED NURSING X INDENTIFICATION DATA	From 01/01/2023 F To 12/31/2023 D		Worksheet S-2 Part I Date/Time Pre 5/24/2024 1:3	pared:		
					Y/N 1.00	-	
	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.						
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		N	43. 00	
	If line 43 is yes, enter the home officoffice on lines 45, 46 and 47.	ce chain number and enter	the name and addre	ess of the home		44. 00	
	1. 00	2. 00		3. 00			
	If this facility is part of a chain or	ganization, enter the nam	e and address of th	he home office on the	lines		
	bel ow.	lo , , , , , ,				45.00	
	Name:	Contractor's Name:	Cont	tractor's Number:		45. 00	
	Street:	PO Box:				46. 00	
47. 00	City:	State:	Zi p	Code:		47. 00	

Heal th	Financial Systems	COMPLETE CARE AT AF	BORS LLC		In lie	eu of Form CMS-	-2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING FACILIEX REIMBURSEMENT QUESTIONNAIRE			No.: 315333	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II	2
					Y/N	5/24/2024 1:3 Date	
					1. 00	2. 00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fo	r Yes or "N"	for No. For all	the date	
1.00	Provider Organization and Operation  Has the provider changed ownership immediately reporting period? If column 1 is "Y", enter instructions)	ly prior to the beg the date of the cha	inning of nge in col	the cost umn 2. (see	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. 00	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or relationships? (see instructions)	tions, including ma ., chain home offic d to the provider o l, or members of th	nagement es, drug r its e board	Y			3. 00
				Y/N 1.00	Type 2. 00	Date 3.00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements preparate Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complete.	" for Audited, "C"	for	Y	C C	3.00	4. 00
5.00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If or reconciliation.	revenues different	from	N			5. 00
					Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	and 2 (V/N) Column 2		nnovi don tho	N	N N	4.00
6. 00 7. 00 8. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained durin	s? (Y/N) see instru	ctions.		N N	IN IN	6. 00 7. 00 8. 00
	School and/or Allied Health Program? (Y/N) so		<u> </u>			Y/N	
						1. 00	
9. 00 10. 00	Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				st reporting	Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wa	ived? If "	Y", see instr	ructi ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	iod?lf"Y			N	12. 00
		Descriptio	n	Y/N	art A Date	Part B Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
13. 00				Y	04/26/2024	Y	13. 00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N		N	14.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	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

Health Financial Systems COMPLETE CA			T ARBORS LLC		In Lieu of Form CMS-2540-10		
	D NURSING FACILITY AND SKILLED NURSING FACILITY	Y HEALTH CARE	Provi der		Period: From 01/01/2023	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				Γο 12/31/2023	Date/Time Pre 5/24/2024 1:3	
			1.	00	2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title,	/position	ALEXANDER		SOCHACKI		19. 00
	held by the cost report preparer in columns 1,	, 2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost re	eport	HEALTH CARE RE	SOURCES			20. 00
	preparer.						
21.00	Enter the telephone number and email address of	of the cost	609-987-1440		AL. SOCHACKI @HCF	RNJ. NET	21. 00
	report preparer in columns 1 and 2, respective	el y.					

Health Financial Systems COMPLETE CARE A SKILLED NURSING FACILITY HEALTH CARE COMPLETE CARE AT ARBORS LLC

COMPLEX REIMBURSEMENT QUESTIONNAIRE

OOMI EE	A RETINDORGENIERT GOESTFORWITE			То	Date/Time Pre 5/24/2024 1:3	
		Part B	<u> </u>			
		Date				
		4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	04/26/2024				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					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						16, 00
10.00	adjustments made to PS&R data for					10.00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17. 00						17. 00
	adjustments made to PS&R data for Other?					
40.00	Describe the other adjustments:					40.00
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		PREPARER			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
	-			1		'

Health Financial Systems COMPLETE CARE A SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/24/2024 1:36 pm

					7 12/31/2023	5/24/2024 1: 36	
				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	120	43, 800		6, 824	23, 419	1.00
2.00	NURSING FACILITY	0	0			0	2.00
3.00	I CF/IID	0	0			0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST	0	0	0	0	0	4. 00 5. 00
6.00	Other Long Term Care SNF-Based CMHC		U				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	120	43, 800		6, 824		8. 00
	1	Inpatient D			Di scharges		
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1 00	CKILLED NUDCING FACILLETY	6.00	7. 00	8. 00	9. 00 189	10.00	1. 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	6, 361	36, 604 0		189	0	2. 00
3.00	ICF/IID	0	0	U			3. 00
4. 00	HOME HEALTH AGENCY COST	0	0				4. 00
5. 00	Other Long Term Care	o	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)	6, 361	36, 604	0	189		8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	303	502		36. 11	2, 341. 90	1.00
2.00	NURSING FACILITY	0	0			0.00	2.00
3. 00 4. 00	HOME HEALTH AGENCY COST	U U	U			0.00	3. 00 4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC		O				6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8.00	Total (Sum of lines 1-7)	303	502				8. 00
		Average Length		Admi s	si ons		
		of Stay	T' 11 \	T: 11 \0.0111	T' 11 VIV	011	
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1. 00	SKILLED NURSING FACILITY	72. 92			19.00		1. 00
2.00	NURSING FACILITY	0.00		230	7	0	2. 00
3. 00	ICF/IID	0.00			0	اة	3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			· ·		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	l .	7. 00
8. 00	Total (Sum of lines 1-7)	72.92 Admi ssi ons	Full Time	238 Faui val ent	9	258	8. 00
			2	,			
	Component	Total	Employees on	Nonpai d			
		24.22	Payrol I	Workers			
1. 00	SKILLED NURSING FACILITY	21.00	22. 00 80. 00	23.00			1. 00
2.00	NURSING FACILITY	0					2. 00
3.00	ICF/IID						3. 00
4. 00	HOME HEALTH AGENCY COST		0.00				4. 00
5. 00	Other Long Term Care	o					5. 00
6.00	SNF-Based CMHC		0.00				6. 00
7.00	HOSPI CE	0					7. 00
8. 00	Total (Sum of lines 1-7)	505	80. 00	0.00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION

				Т	o 12/31/2023	Date/Time Prep 5/24/2024 1:30	
		Amount	Reclass. of	Adjusted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.		Wage (col. 3 ÷	
		·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	4, 938, 341	0	4, 938, 341	166, 524. 00	29. 66	1.00
2.00	Physician salaries-Part A	0	0	0	0.00		2.00
3.00	Physician salaries-Part B	0	0	0	0.00		3.00
4.00	Home office personnel	0	0	0	0.00		4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5.00
6.00	Revised wages (line 1 minus line 5)	4, 938, 341	0	4, 938, 341	166, 524. 00	29. 66	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	4, 938, 341	0	4, 938, 341	166, 524. 00	29. 66	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	1, 070, 528	0	1, 070, 528			14.00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	594, 064	0	594, 064			17.00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22. 00	Total Adjusted Wage Related cost (see	594, 064	0	594, 064			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315333

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/

				'	0 12/31/2023	5/24/2024 1: 30	
	·	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	0	)  C	0.00	0.00	1. 00
2.00	Administrative & General	482, 994	0	482, 994	10, 667. 00	45. 28	2. 00
3.00	Plant Operation, Maintenance & Repairs	96, 157	0	96, 157	3, 285. 00	29. 27	3. 00
4.00	Laundry & Linen Service	0	0	) C	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	) C	0.00	0.00	5. 00
6.00	Di etary	556, 077	0	556, 077	27, 513. 00	20. 21	6. 00
7.00	Nursing Administration	408, 804	0	408, 804	11, 101. 00	36. 83	7. 00
8.00	Central Services and Supply	12, 548	0	12, 548	508.00	24. 70	8. 00
9.00	Pharmacy	0	0	) c	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	27, 922	0	27, 922	1, 279. 00	21. 83	10.00
11. 00	Soci al Servi ce	67, 871	0	67, 871	1, 890. 00	35. 91	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	168, 597	0	168, 597	8, 461. 00	19. 93	13.00
14. 00	Total (sum lines 1 thru 13)	1, 820, 970	o	1, 820, 970	64, 704. 00	28. 14	14. 00

Health Financial Systems	COMPLETE CARE AT ARBORS LLC	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315333	
		From 01/01/2023   Part IV
		To 12/21/2022 Date/Time Prepared:

	To 12/31/2		
		Amount Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	
3.00	Qualified and Non-Qualified Pension Plan Cost	0	
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	
6.00	Legal /Accounting/Management Fees-Pension Plan	0	
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	82, 439	
9.00	Prescription Drug Plan	761	
10.00		1, 061	
11. 00	1	1, 203	
12. 00		0	
13.00	,	0	
14.00		0	
15. 00		77, 380	
16. 00		. 0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	368, 641	
18. 00		0	
19. 00		0	
20.00	State or Federal Unemployment Taxes	62, 579	20. 00
	OTHER		
21. 00	Executive Deferred Compensation	0	
22. 00	9	0	
	Tuition Reimbursement	0	
24.00	Total Wage Related cost (Sum of lines 1 - 23)	594, 064	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

					rom 01/01/2023	Part V	
					o 12/31/2023	Date/Time Prep 5/24/2024 1:30	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	) pili
	occupational category	Reported		Sal ari es (col.		Wage (col. 3 ÷	
		Reported	Defici 1 to		Salary in col.	col. 4)	
				1 1 001. 2)	3	001. 1)	
		1.00	2.00	3.00	4.00	5. 00	
	Direct Salaries	1.00	2.00	0.00		0.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	446, 102	57, 012	503, 114	9, 622. 00	52. 29	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 354, 939	173, 161	1, 528, 100	35, 418. 00	43. 14	2.00
3.00	Certified Nursing Assistant/Nursing	1, 316, 330	168, 227	1, 484, 557	56, 780. 00	26. 15	3.00
	Assi stants/Ai des				·		
4.00	Total Nursing (sum of lines 1 through 3)	3, 117, 371	398, 400	3, 515, 771	101, 820. 00	34. 53	4.00
5.00	Physical Therapists	O	0	C	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	C	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	C	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	C	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	C	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	C	0.00	0.00	10.00
11.00	Speech Therapists	0	0	C	0.00	0.00	11.00
12.00	Respiratory Therapists	O	0	C	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	C	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0		C	0.00		14.00
15. 00	Licensed Practical Nurses (LPNs)	20, 661		20, 661			15.00
16. 00	Certified Nursing Assistant/Nursing	338, 783		338, 783	12, 099. 00	28. 00	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	359, 444		359, 444	·		17. 00
18. 00	Physical Therapists	183, 438		183, 438	·	1	18. 00
19. 00	Physical Therapy Assistants	145, 988		145, 988			
20. 00	Physical Therapy Aides	0		C	0.00		20.00
21. 00	Occupational Therapists	198, 062		198, 062	·	1	21. 00
22. 00	Occupational Therapy Assistants	124, 345		124, 345			22. 00
23. 00	Occupational Therapy Aides	0		0	0.00		23.00
24. 00	Speech Therapists	59, 250		59, 250			24.00
25. 00	Respiratory Therapists	0		C			
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315333 

1.00		'	0 12/31/2023	Date/lime Pre 5/24/2024 1:3	
1.00				Days	
2.00				2. 00	
3. 0.0					
1.00					
5.00					•
7.00 800 801 801 802 803 804 805 806 806 807 807 807 807 808 807 808 808 807 808 808	5. 00		RHX		5. 00
H. OD					•
9.00 10.00 11.00 12.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 1					•
10.00   RUG   10.00   RUG   10.00   RUG   11.00   RUG					
11 00   RIGH   11 00   RIGH   12 00   RIGH   12 00   RIGH   13 00   RIGH   14 00   RIGH   14 00   RIGH   15 0					
13.00   RVC   13.00   RVA   14.00   RVA   15.00   RVA					
14.00   RVB					
15.00   RVA					
16.00					
17.00   RHB					•
19,00   RNC					
20,00   RMB					
21.00   RIMA   21.00   RILB   22.00   RILA   22.00   RILA   23.00   RILA   23.0					
RLB   22,00     RLB   22,00     RLB   23,00     RLB   23,00     RLB   23,00     RLB   25,00     RLB   25,00     RLB   25,00   RLB   26,00   RLB   28,00					
23.00   RIA   23.00   ES3   24.00   ES3   24.00   ES5   25.00   ES5   26.00   ES5   26					
25.00   ES2   25.00   CS1   26.00   ES2   26.00   CS2   26.00   ES3   27.00   ES3   28.00   ES3   28.00   ES3   28.00   ES3   29.00   ES3   29	23. 00		RLA		23. 00
25, 00   ES1   26, 00   HE2   27, 00   HE2   27, 00   HE2   27, 00   HE2   27, 00   HE1   28, 00   HE2   29, 00   HE1   28, 00   HE1   30, 00   HD1   30, 00   HD1   30, 00   HD1   30, 00   HD1   32, 00   HC1   32, 00   HC2   31, 00   HC2   32, 00   HC2   33, 00   HC2   44, 00   HC2   45, 00   HC2   46, 00   HC2   47, 00   HC2   47, 00   HC2   48, 00   HC2   47, 00   HC2   48, 00   HC2   48, 00   HC2   49, 00					
27.00 28.00 29.00 HE1 28.00 HE1 28.00 HE1 28.00 HE1 29.00 HE1 30.00 HE1 30.00 HE1 30.00 HE1 31.00 HE2 31.00 HE2 31.00 HE2 33.00 HE2 33.00 HE2 33.00 HE2 33.00 HE2 33.00 HE2 33.00 HE2 35.00 HE3 35.00 HE2 35.00 HE3 37.00 HE3 37.00 HE3 38.00 HE4 38.00 HE4 38.00 HE5 40.00 HE5					1
28 00   HET   22 00   O					
30.00   HD1   30.00   HC2   31.00   32.00   HC1   32.00   33.00   HC1   32.00   34.00   HC2   33.00   34.00   HC2   33.00   34.00   HC2   33.00   34.00   HC2   33.00   36.00   HC2   35.00   36.00   LE1   36.00   37.00   LE1   36.00   LC2   37.00   38.00   LD1   38.00   LC2   39.00   39.00   LD1   38.00   LC2   39.00   LD1   38.00   LC2   39.00   LC3					
31.00   16.2   31.00   32.00   33.00   34.00   35.00   36.00   36.00   36.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   38.00   37.00   37.00   38.00   37.00   37.00   38.00   37.00   37.00   38.00   37.00					
32.00 34.00 34.00 34.00 35.00 36.00 36.00 36.00 37.00 38.00 38.00 39.00 30.00					
33.00     882   33.00     881   34.00     881   34.00     881   34.00     881   34.00     881   34.00     881   34.00     882   35.00     882   36.00     881   39.00     882   39.00     882   39.00     882   39.00     882   39.00     882   39.00     882   39.00     882   39.00     882   39.00     882   39.00     882   39.00     881   39.00     881   39.00     882   39.00     882   39.00     881   39.00     881   39.00     881   39.00     882   39.00     881   39.00     882   39.00     881   39.00     882   39.00     881   39.00     882   39.00     881   39.00     882   39.00     881   39.00     89.0					
34. 00   HB1   34. 00   16. 12. 12. 13. 50   16. 12. 13. 50   16. 12. 13. 50   16.					•
36.00 37.00 38.00 38.00 38.00 38.00 40.00 40.00 41.00 41.00 41.00 41.00 41.00 42.00 43.00 62.00 64.00 65.00 66.00					
37. 00 38. 00 39. 00 40. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 46. 00 47. 00 48. 00 48. 00 49. 00 49. 00 40					
Section   Sect					
39.00 40.00 41.00 41.00 41.00 42.00 42.00 43.00 42.00 44.00 42.00 43.00 44.00 65.00 66.00 67.00 68.00 66.00 61.00 62.00 63.00 64.00 65.00 66.00 66.00 66.00 67.00 68.00 66.00 68.00 66.00					
40.00 41.00 42.00 42.00 43.00 43.00 44.00 45.00 46.00 47.00 48.00 47.00 48.00 49.00					
42 00					•
43. 00 44. 00 45. 00 46. 00 46. 00 46. 00 46. 00 47. 00 68. 00 69. 00 60					
44. 00 45. 00 46. 00 46. 00 47. 00 48. 00 48. 00 49. 00 50. 00 50. 00 51. 00 52. 00 53. 00 54. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 57. 00 58. 00 59. 00 59. 00 60 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 67. 00 69. 00 67. 00 69. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 77. 00 79. 00 77. 00					
45. 00					
47,00   CC2					
48.00   CC1					
49.00   CB2					
50.00       CB1       50.00         51.00       CA2       51.00         52.00       CA1       52.00         53.00       SE3       53.00         54.00       SE3       53.00         55.00       SE1       55.00         56.00       SSC       56.00         57.00       SSB       57.00         58.00       SSA       58.00         59.00       IB2       59.00         60.00       IB1       60.00         61.00       IA2       61.00         62.00       BB2       63.00         64.00       BB2       63.00         64.00       BB1       64.00         65.00       BA1       66.00         67.00       BA2       65.00         68.00       PE2       67.00         68.00       PD1       70.00         70.00       PD2       69.00         70.00       PC2       71.00         72.00       PC3       73.00         74.00       PB1       74.00					
51.00       CA2       51.00         52.00       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       SSB       57.00         59.00       SSA       58.00         59.00       IB2       59.00         60.00       I B1       60.00         61.00       I A2       61.00         62.00       I A1       62.00         63.00       BB2       63.00         64.00       BB2       63.00         65.00       BA2       65.00         66.00       BA1       66.00         67.00       BA2       65.00         68.00       PE1       68.00         69.00       PD2       69.00         70.00       PD1       70.00         71.00       PC2       71.00         72.00       PB2       73.00         74.00       PB1       74.00					
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       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA1       60. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PPE1       68. 00         69. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00	51. 00		CA2		51.00
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     IB2     59.00       60.00     IB1     60.00       61.00     IA2     61.00       62.00     IA1     62.00       63.00     BB2     63.00       64.00     BB1     64.00       65.00     BA2     65.00       66.00     BA2     65.00       67.00     BA1     66.00       67.00     PE2     67.00       68.00     PE1     68.00       69.00     PD2     69.00       70.00     PD2     69.00       71.00     PC2     71.00       72.00     PC1     72.00       74.00     PB1     74.00					
55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       63. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB2     65. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE2     67. 00       68. 00     PD2     69. 00       70. 00     PD1     70. 00       71. 00     PC2     71. 00       72. 00     PB2     73. 00       74. 00     PB1     74. 00					
56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00					
57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PP1       68. 00         69. 00       PD1       70. 00         70. 00       PC2       71. 00         72. 00       PC3       PP3       73. 00         74. 00       PP81       74. 00					56. 00
59. 00         60. 00         61. 00         62. 00         63. 00         64. 00         64. 00         65. 00         66. 00         67. 00         68. 00         69. 00         70. 00         71. 00         72. 00         73. 00         74. 00			SSB		57. 00
60. 00 61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 66. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BB1  BB1  60. 00 BB2 63. 00 BB2 63. 00 BB1 64. 00 BB2 65. 00 BB1 66. 00 BB1 67. 00 BB1 68. 00 BB1 69. 00 PE2 69. 00 PD1 70. 00 PD1 70. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB2 PB3 PB3 PB4 PB7 PB1 PB7 PB1 PB7					
61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 65. 00 66. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 71. 00 72. 00 73. 00 74. 00  61. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 65. 00 66. 00 67. 00 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70. 00 71. 00 71. 00 72. 00 73. 00 74. 00					
62. 00 63. 00 64. 00 65. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 71. 00 72. 00 73. 00 74. 00  RB1 62. 00 RB2 63. 00 RB1 64. 00 RB2 65. 00 RB4 64. 00 RB4 65. 00 RB4 66. 00 RB4 66. 00 RB4 67. 00 RB4 68. 00 RB4 69. 00 R					
64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BB1 64. 00 BA2 65. 00 BA1 66. 00 PE2 67. 00 PE1 68. 00 PP1 70. 00 PP0 PP0 PP0 PP1 70. 00 PP0 PP0 PP0 PP0 PP0 PP0 PP0 PP0 PP0			I A1		62. 00
65. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 74. 00					
66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 74. 00					
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 72. 00 73. 00 74. 00 74. 00					
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PE1 68. 00 PP02 69. 00 PP01 70. 00 PC2 71. 00 PC2 71. 00 PC3 PP1 72. 00 PR2 73. 00 PR3 PR3 PR4 PR5 PR5 PR6 PR7 PR7 PR7 PR8 PR9					
70. 00 71. 00 72. 00 73. 00 74. 00 PC2 PC1 PC1 PC2 PC1 PC2 PC3 PC1 PC3	68. 00		PE1		68. 00
71. 00 72. 00 73. 00 74. 00 PB1 74. 00					
72. 00 73. 00 74. 00 PB1 72. 00 PB2 73. 00 PB1 74. 00					
73. 00 74. 00 PB1 73. 00 74. 00					
74. 00 PB1 74. 00					
75. 00   PA2   75. 00	74. 00		PB1		74. 00
	75. 00		PA2		75. 00

Health Financial Systems	COMPLETE CARE AT ARBORS LLC		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315333	Peri od:	Worksheet S-7	'
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
			Group	Days	
			1. 00	2. 00	
76. 00			PA1		76. 00
99. 00			AAA		99. 00
100. 00 TOTAL					100.00
		Expenses	Percentage	Y/N	
		1.00	2. 00	3. 00	
A notice published in the Federal Register 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 "V" with direct patient care and related expens (See instructions)	pected this increase to be used in column 1 the amount of the for each category to total SNF for yes or "N" for no if the s	I for direct pexpense for expense for expense from spending refle	oatient care and each category. En Worksheet G-2, P ects increases as	related ter in art I, sociated	
101.00 Staffing					101. 00 102. 00
102.00 Recruitment 103.00 Retention of employees					102.00
104.00 Training					104. 00
1 3					
105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, I	ine 1, column 3)				105. 00 106. 00

Health Financial Systems	COMPLETE CARE AT	ARBORS LLC		In Lie	eu of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023		narod:
			'	o 12/31/2023	5/24/2024 1: 3	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
			+ col . 2)	ons	Trial Balance	
				I ncrease/Decre	,	
				ase (Fr Wkst	col . 4)	
	1.00			A-6)	5.00	
CENEDAL CEDIUSE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1.00 GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES		2, 686, 924	2, 686, 924		2, 686, 924	1.00
2. 00   00200 CAP REL COSTS - BLDGS & FIXTURES		2,000,924	2, 000, 924		2, 666, 924	2.00
3. 00 00300 EMPLOYEE BENEFITS		631, 333	1	_	631, 333	3.00
4. 00   00400   ADMI NI STRATI VE & GENERAL	482, 994	2, 199, 161			2, 682, 155	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	96, 157	339, 145			435, 302	5. 00
6. 00   00600 LAUNDRY & LINEN SERVICE	0	40, 800			40, 800	6. 00
7. 00 00700 HOUSEKEEPI NG	O	427, 262			427, 262	7. 00
8. 00   00800   DI ETARY	556, 077	427, 689			983, 766	8. 00
9.00 00900 NURSING ADMINISTRATION	408, 804	0	408, 804	0	408, 804	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	12, 548	165, 761	178, 309	0	178, 309	10.00
11. 00   01100   PHARMACY	0	0	C	0	0	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	27, 922	0	27, 922		27, 922	12. 00
13.00 O1300 SOCIAL SERVICE	67, 871	6, 927	74, 798	0	74, 798	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	_		14. 00
15. 00 O1500 PATIENT ACTIVITIES	168, 597	36, 292	204, 889	0	204, 889	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				_		
30. 00 03000 SKILLED NURSING FACILITY	3, 117, 371	483, 272	3, 600, 643	0	3, 600, 643	30.00
31. 00 03100 NURSING FACILITY	0	0		0	0	31.00
32.00   03200   I CF/I I D 33.00   03300   OTHER LONG TERM CARE	0	0		0	0	32.00
ANCI LLARY SERVI CE COST CENTERS	J U	0		U	0	33. 00
40. 00 04000 RADI OLOGY	l	4, 776	4, 776	0	4, 776	40. 00
41. 00   04100   LABORATORY		65, 795				41. 00
42. 00 04200 I NTRAVENOUS THERAPY		00,770	00,770		00,770	42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	o	668	668	0	668	43. 00
44. 00 04400 PHYSI CAL THERAPY	o	319, 908	319, 908	0	319, 908	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	O	325, 746	325, 746	0	325, 746	45. 00
46.00 04600 SPEECH PATHOLOGY	0	65, 802	65, 802	0	65, 802	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	240, 944	240, 944	0	240, 944	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	<u> </u>	0	0	50.00
51. 00 05100 SUPPORT SURFACES	0	0	<u> </u>	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						(0.00
60. 00   06000   CLI NI C 61. 00   06100   RURAL HEALTH   CLI NI C	0	0	C	0	0	60. 00 61. 00
62. 00   06200 FQHC		U		U		62.00
OTHER REI MBURSABLE COST CENTERS						02.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71. 00   07100   AMBULANCE	o	29, 187			29, 187	•
73. 00 07300 CMHC	o	0		0	0	73. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>					
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	C	0	0	80. 00
81.00 08100 INTEREST EXPENSE		0	C	0	0	81. 00
82.00 08200 UTILIZATION REVIEW - SNF	0	0	C	0	0	82. 00
83. 00   08300   HOSPI CE	0	0	C	0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	4, 938, 341	8, 497, 392	13, 435, 733	0	13, 435, 733	89. 00
NONREI MBURSABLE COST CENTERS			1	_	_	
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C		0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP	0	5, 926	5, 926	0	5, 926	
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0			0	92.00
93. 00   09300   NONPAI D WORKERS 94. 00   09400   PATI ENTS LAUNDRY		0		0	0	93. 00 94. 00
100.00 TOTAL	4, 938, 341	8, 503, 318	13, 441, 659		13, 441, 659	
. 55. 55 <sub>1</sub>   1017/E	1, 750, 541	5, 505, 510	10, 441, 007	١	10, 441, 007	1.00.00

 
 Heal th Financial
 Systems
 COMPLETE C

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315333 

				То	12/31/2023	Date/Time Pro 5/24/2024 1:3	
	Cost Center Description	Adjustments to	Net Expenses			3/24/2024 1.	JO PIII
	<b>'</b>		For Allocation				
		Wkst A-8)	(col. 5 +-				
			col . 6)				
	CENEDAL CEDVICE COCT CENTEDO	6.00	7. 00				
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES	-196, 376	2, 490, 548				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	-170, 370	2, 490, 548	1			2.00
3. 00	00300 EMPLOYEE BENEFITS	0	631, 333	1			3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	-745, 294	1, 936, 861	•			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	435, 302	•			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	40, 800				6. 00
7.00	00700 HOUSEKEEPI NG	0	427, 262				7. 00
8.00	00800 DI ETARY	-1, 592	982, 174	•			8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	0	408, 804	•			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	178, 309	1			10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0 27 022	1			11. 00 12. 00
12.00	01300 SOCIAL SERVICE	0	27, 922 74, 798				13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	74, 770	1			14. 00
15. 00	01500 PATIENT ACTIVITIES	0	204, 889	•			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	3, 600, 643				30. 00
31. 00	03100 NURSING FACILITY	0	0				31. 00
32. 00	03200   CF/IID	0	0	•			32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0				33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		4, 776				40. 00
41. 00	04100 LABORATORY	0	65, 795	1			41. 00
42. 00	04200   NTRAVENOUS THERAPY	0	03, 773	•			42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	O	668	1			43. 00
44.00	04400 PHYSI CAL THERAPY	0	319, 908	•			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	325, 746				45. 00
46. 00	04600 SPEECH PATHOLOGY	0	65, 802	1			46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	ł			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	240, 944 0	1			49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	0	1			51.00
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>				31.00
60.00	06000 CLI NI C	0	0				60.00
61.00	06100 RURAL HEALTH CLINIC	0	0				61. 00
62.00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS	ام	ما	T			
70.00	07000 HOME HEALTH AGENCY COST	0	0 107	•			70.00
71.00	07100 AMBULANCE 07300 CMHC	0	29, 187 0				71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	U <sub>I</sub>				73.00
80. 00		0	0				80. 00
81.00	08100 I NTEREST EXPENSE	0	O				81. 00
82.00	08200 UTILIZATION REVIEW - SNF	0	o				82. 00
83. 00	08300 H0SPI CE	0	0	l .			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-943, 262	12, 492, 471				89. 00
00.05	NONREI MBURSABLE COST CENTERS	1	=1				
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 5, 926				90.00
	09200 PHYSICIANS PRIVATE OFFICES		5, 926	1			91. 00 92. 00
	09300 NONPALD WORKERS		0	1			93. 00
	09400 PATIENTS LAUNDRY		ol				94. 00
100.00		-943, 262	12, 498, 397				100.00

Health Financial Systems	COMPLETE CARE AT ARI	BORS LLC		In Lieu of Form CMS-2540		
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	,
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
			Increases			
	Cost Center	r	Li ne #	Sal ary	Non Salary	
	2. 00		3.00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	0	100.00
	of columns 4 and 5	must				
	equal sum of column	s 8 and				
	9)					

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

Health Financial Systems	COMPLETE CARE AT ARBORS LLC In Lieu of Form CMS-					2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315333	Peri od:	Worksheet A-6	)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/24/2024 1: 3	6 pm
	Decreases					
	Cost Center	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COMPLETE CARE AT ARBORS LLC In Lieu of Form CMS-2540-10

| Peri od: | Worksheet A-7 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315333

				10	) 12/31/2023	5/24/2024 1: 3	
			,	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	3					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	74, 734	576, 935	0	576, 935	0	4. 00
5.00	Fixed Equipment	376, 744	7, 784	0	7, 784	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	451, 478	584, 719	0	584, 719	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	451, 478	584, 719	0	584, 719	0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5	_1				
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	651, 669	0				4. 00
5.00	Fixed Equipment	384, 528	0				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	Subtotal (sum of lines 1-6)	1, 036, 197	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	1, 036, 197	0				9. 00

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

				10 12/31/2023	5/24/2024 1: 3	
				Expense Classification on		
				To/From Which the Amount is		
				TO, I TO MINIOUS ELLO TEMBRETE TO	to be maj deted	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
	bescription (1)	Adjustment	Amount	COST CENTER	LITIC NO.	
		1.00	2.00	3. 00	4.00	
1.00	Investment income on restricted funds	B		BADMI NI STRATI VE & GENERAL	4.00	1. 00
1.00	(chapter 2)	ь	-4, 255	SADWINI STRATI VE & GENERAL	4.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
2.00	8)				0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0	1	0.00	4. 00
4.00	(chapter 8)		0		0.00	4.00
5.00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
3.00	(chapter 21)				0.00	3.00
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7. 00	Parking lot (chapter 21)		0		0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	0		0.00	8. 00
6.00	physician adjustment	A-0-2	0	7		8.00
9. 00	1. 3		0		0.00	9. 00
	Home office cost (chapter 21)		1 0		1	
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		U	1	0.00	11. 00
12 00	Capital expenditures (chapter 24)	۸ 0 1	E70 744			12 00
12. 00	Adjustment resulting from transactions with	A-8-1	-570, 746			12. 00
13. 00	related organizations (chapter 10)				0.00	13. 00
	Laundry and linen service		1 500	) DI ETADY		
14.00	Revenue - Employee meals	В	-1,592	DIETARY	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
47.00	patients				0.00	47.00
17. 00	Sale of drugs to other than patients		0	)	0.00	17. 00
18.00	Sale of medical records and abstracts	В	-807	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		0	)	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			LITTLE TATE ON BENJEW ONE		
22. 00	Utilization reviewphysicians' compensation		0	OUTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)			0.45 551 00070 51500 4		
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
			_	FI XTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2. 00	24. 00
				EQUI PMENT		
25. 00	CORPORATE TAX	Α		ADMINISTRATIVE & GENERAL	4. 00	25. 00
25. 01	MI SC REVENUE	В		ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	MARKETI NG	A		ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	BAD DEBT	A		ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 05	RESIDENT MISSING ITEMS	A	-699	ADMINISTRATIVE & GENERAL	4.00	25. 05
25. 06	FINES & PENALTIES	A	-5, 000	ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 07	PRIOR PERIOD EXPENSE	A	-27, 098	BADMINISTRATIVE & GENERAL	4.00	25. 07
100.00	Total (sum of lines 1 through 99) (Transfer		-943, 262	2		100.00
	to Worksheet A, col. 6, line 100)					
(4) 5			ONC DI 4E 4			

<sup>(1)</sup> 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.

COMPLETE CARE AT ARBORS LLC

Heal th Financial Systems COMPLETE CARE AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315333 OFFICE COSTS

OFFICE COSTS				o 12/31/2023	Date/Time Pr 5/24/2024 1:	
	Line No.	Cost (	Center	Expense		
	1.00	2.		3. (		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:					OR	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	RENT		1.00
2.00		ADMI NI STRATI VE		REALTY ADMIN CO		2.00
3. 00	4. 00	ADMI NI STRATI VE	& GENERAL	COMPLETE CARE N	IGMT	3.00
4. 00	0. 00					4.00
5. 00	0. 00					5.00
6. 00	0. 00					6. 00
7. 00	0. 00					7.00
8. 00	0. 00					8. 00
9.00	0. 00					9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						1
	Amount	Amount	Adjustments			
	Allowable In Cost	Included in Wkst. A, col.	(col. 4 minus col. 5)			
	COST	5 S	COI. 3)			
	4.00	5. 00	6, 00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICATION OF THE COSTS:				D ORGANI ZATI ONS	OR	
1. 00	2, 202, 475	2, 398, 851	-196, 376			1.00
2.00	67, 637	0	67, 637	,		2. 00
3.00	272, 301	714, 308	-442, 007			3. 00
4.00	0	0	C	)		4. 00
5. 00	o	0	C	)		5. 00
6.00	0	0	C	)		6. 00
7. 00	0	0	C	)		7. 00
8.00	o	0	C			8. 00
9.00	0	0	0			9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	2, 542, 413	3, 113, 159	-570, 746			10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider No.: 315333 From 01/01/2023 Worksheet A-8-1 Parts I-II Date/Time Prepared:

12/31/2023

5/24/2024 1:36 pm 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.

To parposes or oral mility for mount comorre and or er er				
1.00	В	PEACE CAPITAL LLC	59.00	1.00
2.00	В	EEF CAPITAL LLC	40.00	2.00
3.00	В	MALKA STEIN	1.00	3.00
4. 00	В	PEACE CAPITAL LLC	100.00	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		REALTY ARBORS	59. 00 REALTY	1.00
2.00		REALTY ARBORS	40. 00 REALTY	2.00
3.00		REALTY ARBORS	1. 00 REALTY	3.00
4.00		COMPLETE CARE MANAGEMENT	100.00 MANAGEMENT COMPANY	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.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre	
			CAPI TAL REL	ATED_COSTS		5/24/2024 1: 3	6 pm
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	FI XTURES	EQUI PMENT	BENEFI TS	Subtotal	
		Allocation (from Wkst A					
		col . 7)					
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	3A	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	2, 490, 548	2, 490, 548				1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	_	C			2. 00
3. 00 4. 00	OO300	631, 333 1, 936, 861	0 104, 767	0		2, 103, 375	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	435, 302	172, 399	_		619, 994	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	40, 800	91, 005	_	<u> </u>	131, 805	6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	427, 262 982, 174	39, 279 388, 364			466, 541 1, 441, 629	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	408, 804	21, 576		1	482, 643	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	178, 309	14, 730		.,	194, 643	10.00
11. 00 12. 00	O1100   PHARMACY   O1200   MEDI CAL RECORDS & LI BRARY	27, 922	0 7, 192	_		0 38, 684	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	74, 798	8, 990		-,	92, 465	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C		0	14.00
15. 00	O1500   PATIENT ACTIVITIES     INPATIENT ROUTINE SERVICE COST CENTERS	204, 889	61, 408	C	21, 554	287, 851	15. 00
30.00	03000 SKILLED NURSING FACILITY	3, 600, 643	1, 466, 943	С	398, 534	5, 466, 120	30. 00
31.00	03100 NURSING FACILITY	0	0	_		0	31.00
32. 00 33. 00	03200   CF/IID   03300   OTHER LONG TERM CARE		0	-		0	32. 00 33. 00
	ANCILLARY SERVICE COST CENTERS			_			
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	4, 776 65, 795	0	-		4, 776	40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY	05, 795	0			65, 795 0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	668	0	C		668	43. 00
44. 00 45. 00	04400   PHYSI CAL THERAPY   04500   OCCUPATI ONAL THERAPY	319, 908	57, 605			377, 513 364, 057	44. 00 45. 00
46. 00	04500 SPEECH PATHOLOGY	325, 746 65, 802	38, 311 6, 915			72, 717	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	C	_	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	240 044	11 044	[		0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	240, 944	11, 064 0			252, 008 0	50.00
51. 00	05100 SUPPORT SURFACES	0	0			0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS    O6000   CLINIC	l ol	0	С	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC		0			0	61.00
62. 00	06200 FQHC						62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS  O7000 HOME HEALTH AGENCY COST	l ol	0	С	0	0	70. 00
71. 00	07100 AMBULANCE	29, 187	0			29, 187	71.00
73. 00	07300 CMHC	0	0	C	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 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	12, 492, 471	0 2, 490, 548			0 12, 492, 471	83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	12, 172, 171	2, 170, 010		001,000	12, 172, 171	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	5, 926 0	0	[		5, 926 0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS	0	0	ď		0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	C		0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	[		0	98. 00 99. 00
100.00		12, 498, 397	2, 490, 548	-		12, 498, 397	

				T	0 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	O PIII
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	/ 00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 103, 375					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	125, 452	745, 446				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	26, 670	30, 650	189, 125			6.00
7.00	00700 HOUSEKEEPI NG	94, 402	13, 229	0	574, 172		7. 00
8.00	00800 DI ETARY	291, 705	130, 797	0	107, 046	1, 971, 177	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	97, 660	7, 267	0	5, 947	0	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	39, 385	4, 961	0	4, 060	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	7, 827	2, 422		1, 982	0	12.00
13.00	01300 SOCIAL SERVICE	18, 710	3, 028		2, 478	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	20. (02	0	1/ 02/	0	14.00
15. 00	O1500   PATIENT ACTIVITIES     INPATIENT ROUTINE SERVICE COST CENTERS	58, 245	20, 682	0	16, 926	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	1, 106, 042	494, 051	189, 125	404, 339	1, 971, 177	30.00
31. 00	03100 NURSING FACILITY	1, 100, 042	494, 051		404, 339	1, 9/1, 1//	31.00
32. 00	03200   CF/11D		0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	0	0	0	33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1 0	<u> </u>	0	33.00
40. 00	04000 RADI OLOGY	966	0	0	0	0	40. 00
41. 00	04100 LABORATORY	13, 313	0	ő	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	o	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	135	0	o	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	76, 387	19, 401	0	15, 878	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	73, 665	12, 903	0	10, 560	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	14, 714	2, 329	0	1, 906	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	50, 992	3, 726	0	3, 050	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	U	0	51.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	ol	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0		0	0	61.00
62. 00	06200 FQHC	١	O		O	O	62.00
02.00	OTHER REIMBURSABLE COST CENTERS	1		1			02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00	07100 AMBULANCE	5, 906	0	o	0	0	71.00
73.00	07300 CMHC	0	0	o	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 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	2, 102, 176	745, 446	189, 125	574, 172	1, 971, 177	89. 00
00.00	NONREI MBURSABLE COST CENTERS			1 0		0	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	1 100	0	0	0	0	
91.00	09200 PHYSICIANS PRIVATE OFFICES	1, 199	0		0	0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS		0		0	0	93.00
94. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94.00
98. 00	Cross Foot Adjustments		0	0	0	0	98.00
99. 00	Negative Cost Centers		0	٥	o	0	99.00
100.00		2, 103, 375	745, 446	189, 125	574, 172	_	
	1		, ,		, .=1		

					12/31/2023	5/24/2024 1: 3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY	500 547					8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	593, 517	040.040				9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	243, 049				10.00
11. 00	01100 PHARMACY	0	0	0	FO 01F		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	50, 915 0	11/ /01	12.00
13. 00 14. 00	O1300   SOCIAL SERVICE   O1400   NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	116, 681 0	13. 00 14. 00
15. 00	01500 PATIENT ACTIVITIES	0	0		0	0	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	l o		l o		U	15.00
30. 00	03000 SKILLED NURSING FACILITY	593, 517	99, 060	0	50, 915	116, 681	30. 00
31. 00	03100 NURSING FACILITY	373, 317	77, 000	i	00, 719	0	31.00
32. 00	03200   CF/IID	o o	0	-	0	Ö	32. 00
33. 00	03300 OTHER LONG TERM CARE	o	0		0	Ö	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>			00.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41.00	04100 LABORATORY	o	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	o	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	143, 989	0	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC	0	0	О	0	0	(0.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62. 00	06200 FQHC	١	U	U	0	U	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	O	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	o	0		0	0	71. 00
73.00	07300 CMHC	o	0	О	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0		0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	593, 517	243, 049	0	50, 915	116, 681	89. 00
00 00	NONREIMBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		0	0	00.00
90. 00 91. 00	09100 BARBER AND BEAUTY SHOP	0	0	-	0	0	90. 00 91. 00
91.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	91.00
93.00	09300 NONPALD WORKERS		0		0	0	93.00
94. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		0	· ·	0		98. 00
99. 00	Negative Cost Centers		0	О	n	0	
100.00	1 1 0	593, 517	243, 049		50, 915	_	
	1 2	. =:=/=:/	= := : = : :	, 91	,		

Provider No.: 315333 | Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				Ť	o 12/31/2023	Date/Time Pre	
			OTHER GENERAL			5/24/2024 1: 3	5 pm
	Cost Center Description	NURSING AND ALLIED HEALTH	SERVI CE PATI ENT ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATI ON					
	I	14.00	15. 00	16. 00	17. 00	18. 00	
4 00	GENERAL SERVICE COST CENTERS						4 00
1. 00 2. 00	OO100   CAP REL COSTS - BLDGS & FIXTURES   OO200   CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15. 00	01500 PATIENT ACTIVITIES	0	383, 704				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 SKI LLED NURSI NG FACI LI TY	0	383, 704	10, 874, 731	0	10, 874, 731	30.00
31.00	03100   NURSING FACILITY   03200   CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		0	0	0	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		00.00
40.00	04000 RADI OLOGY	0	0	5, 742	0	5, 742	40. 00
41. 00	04100 LABORATORY	0	0	79, 108	0	79, 108	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	803	0	803	43. 00
44. 00 45. 00	04400   PHYSI CAL THERAPY   04500   OCCUPATI ONAL THERAPY	0	0	489, 179 461, 185	l I	489, 179 461, 185	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	Ö	o	91, 666		91, 666	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	O	0	o	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	453, 765	l	453, 765	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	O5100   SUPPORT SURFACES   OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	51. 00
60.00	06000 CLINIC	0	0	0	O	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	o	0	61. 00
62.00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	· · · · · · · · · · · · · · · · · · ·	35.003	70.00
71. 00 73. 00	07100   AMBULANCE	0	0	35, 093 0		35, 093 0	71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	o <sub>l</sub>		<u> </u>		73.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)   NONREIMBURSABLE COST CENTERS	0	383, 704	12, 491, 272	0	12, 491, 272	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	7, 125	o	7, 125	
92.00	09200 PHYSICIANS PRIVATE OFFICES	O	0	0	O	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00 99. 00
100.00	Negative Cost Centers   TOTAL	0	383, 704	12, 498, 397	· · · · · · · · · · · · · · · · · · ·	12, 498, 397	
. 55. 50	1.0	١	300, 704		١	.2, 170, 077	

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ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315333

					То	12/31/2023	Date/Time Prep 5/24/2024 1:30	
			CAPI TAL REL	LATED COSTS			372472024 1.3	J piii
	Cook Cooks Decoriation	D:+1	DI DCC 0	MOVADLE		C -+-+-	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT		Subtotal	EMPLOYEE BENEFITS	
		Capi tal	TTATORES	Eggi men			DENETTIO	
		Related Costs						
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00		2A	3. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES			I		T		1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT							2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0		0	0	0	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	104, 767		0	104, 767	0	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	172, 399 91, 005		0	172, 399 91, 005	0	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	0	39, 279		0	39, 279	0	7. 00
8.00	00800 DI ETARY	0	388, 364		0	388, 364	0	8. 00
9.00	00900 NURSING ADMINISTRATION	0	21, 576		0	21, 576	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	14, 730		0	14, 730	0	10.00
11. 00 12. 00	O1100   PHARMACY   O1200   MEDI CAL RECORDS & LI BRARY	0	0 7, 192	•	0	0 7, 192	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	0	8, 990		0	8, 990	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	O	0	1	0	0, 770	0	14. 00
15. 00	01500 PATIENT ACTIVITIES	0	61, 408		0	61, 408	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		4 4 4 4 0 4 0	1				
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	1, 466, 943		0	1, 466, 943 0	0	30. 00 31. 00
32. 00	03200   CF/11D	0	0		0	ol	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	o	Ö		0	Ö	0	33. 00
	ANCILLARY SERVICE COST CENTERS			1				
40.00	04000 RADI OLOGY	0	0	1	0	0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0		0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	57, 605		0	57, 605	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	38, 311		0	38, 311	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	6, 915		0	6, 915	0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS	0	11, 064		0	11, 064	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			ı		ام		
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	•	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		O		٥	ď	U	62. 00
	OTHER REIMBURSABLE COST CENTERS							
70.00	07000 HOME HEALTH AGENCY COST	0	0	•	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0	•	0	0	0	71.00
/3.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	l 0	0		0	0	0	73. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80. 00
81. 00								81. 00
82. 00								82. 00
83.00		0	0		0	0 400 540	0	
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	2, 490, 548		0	2, 490, 548	0	89. 00
90. 00		O	0		0	o	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	ō	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	o	0	92. 00
93.00		0	0		0	0	0	93. 00
94. 00 98. 00	09400 PATIENTS LAUNDRY Cross Foot Adjustments		O		U	0	0	94. 00 98. 00
99. 00			0		0	ol	0	99. 00
100.00		0	2, 490, 548		0	2, 490, 548	0	100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315333

Peri od: Worksheet B From 01/01/2023 Part II

Date/Time Prepared: 12/31/2023 5/24/2024 1:36 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 4.00 7.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFITS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 104, 767 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 6, 249 178, 648 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 1, 328 7, 345 99, 678 6.00 00700 HOUSEKEEPI NG 7.00 4,702 3, 170 0 47, 151 7.00 31, 346 8.00 00800 DI ETARY 14,530 0 8, 791 443, 031 8.00 9.00 00900 NURSING ADMINISTRATION 4,865 1, 741 0 488 9.00 0 01000 CENTRAL SERVICES & SUPPLY 10.00 1,962 1, 189 0 333 10.00 Ω 11.00 01100 PHARMACY 0 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 390 580 0 163 0 12.00 01300 SOCIAL SERVICE 932 0 203 13.00 13.00 726 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 PATIENT ACTIVITIES 2,901 4, 956 1, 390 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 99, 678 30.00 03000 SKILLED NURSING FACILITY 443.031 30.00 55 089 118, 403 33, 205 03100 NURSING FACILITY 31.00 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 48 0 0 0 0 40.00 04100 LABORATORY 41.00 663 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY Ω 0 0 42 00 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 C 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 3,805 4,649 1, 304 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 3,669 3, 092 0 867 0 45.00 04600 SPEECH PATHOLOGY 46 00 0 46 00 733 558 157 0 04700 ELECTROCARDI OLOGY 0 47.00 0 C 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 48.00 48.00 C 0 49.00 04900 DRUGS CHARGED TO PATIENTS 2.540 893 0 250 0 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 C 0 05100 SUPPORT SURFACES 51.00 0 0 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 0 06100 RURAL HEALTH CLINIC 0 61.00 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 0 07100 AMBULANCE 294 0 71.00 r 0 0 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 99, 678 443, 031 SUBTOTALS (sum of lines 1-84) 178, 648 104, 707 47, 151 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 91.00 91.00 60 0 0 0 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 98.00 Cross Foot Adjustments 0 0 Λ 98 00 99.00 Negative Cost Centers 0 0 99.00 100.00 TOTAL 104, 767 178, 648 99, 678 47. 151 443, 031 100. 00

				''	3 12/31/2023	5/24/2024 1: 3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	,	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12.00	13.00	
G	ENERAL SERVICE COST CENTERS	•					
1.00 0	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00 0	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00 0	00300 EMPLOYEE BENEFITS						3. 00
1	00400 ADMINISTRATIVE & GENERAL						4.00
1	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
	00600 LAUNDRY & LINEN SERVICE						6. 00
	00700 HOUSEKEEPI NG						7. 00
	00800 DI ETARY						8. 00
	00900 NURSING ADMINISTRATION	28, 670					9. 00
	01000 CENTRAL SERVICES & SUPPLY	0	18, 214				10.00
	01100 PHARMACY	0	0	0			11. 00
	01200 MEDICAL RECORDS & LIBRARY	0	0	0	8, 325		12. 00
	01300 SOCIAL SERVICE	0	0	0	0	10, 851	•
	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	0	0	0	14. 00
	01500 PATIENT ACTIVITIES	0	0	0	0	Ō	15. 00
	NPATIENT ROUTINE SERVICE COST CENTERS		-				
	03000 SKILLED NURSING FACILITY	28, 670	7, 423	0	8, 325	10, 851	30.00
	03100 NURSING FACILITY	0	0	0	0	0	31. 00
	03200   CF/IID	o	0	0	0		32. 00
	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	NCILLARY SERVICE COST CENTERS	-1	-,		-		
_	04000 RADI OLOGY	0	0	0	0	0	40.00
	04100 LABORATORY	O	0	0	0	0	41.00
	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
	04400 PHYSI CAL THERAPY	0	0	0	0	Ō	44. 00
	04500 OCCUPATI ONAL THERAPY	0	0	0	0	ő	45. 00
	04600 SPEECH PATHOLOGY	0	0	0	0	Ō	46. 00
	04700 ELECTROCARDI OLOGY	0	0	0	0	o o	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	i o	0	ő	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	10, 791	o o	0	ő	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	o	0	o o	0	ő	50.00
	05100 SUPPORT SURFACES	0	0	0	0	Ō	51.00
	OUTPATIENT SERVICE COST CENTERS	-1	-,		-		
	06000 CLI NI C	0	0	0	0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
1	06200 FQHC						62.00
	THER REIMBURSABLE COST CENTERS	'					
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00 0	07100 AMBULANCE	O	o	0	0	0	71. 00
73.00 0	07300 CMHC	0	o	0	0	0	73. 00
S	PECIAL PURPOSE COST CENTERS	•		,			
80.00 0	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 0	08100 INTEREST EXPENSE						81. 00
82.00 0	08200 UTILIZATION REVIEW - SNF						82. 00
83.00 0	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	28, 670	18, 214	0	8, 325	10, 851	89. 00
	IONREI MBURSABLE COST CENTERS	· · · · · ·					İ
90.00 0	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 0	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 0	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00 0	9400 PATIENTS LAUNDRY	0	o	0	0	0	94. 00
98. 00	Cross Foot Adjustments	0	O	0			98. 00
99. 00	Negative Cost Centers	0	o	0	0	0	99. 00
100.00	TOTAL	28, 670	18, 214	0	8, 325	10, 851	100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315333

				Т	o 12/31/2023	Date/Time Pre 5/24/2024 1:3	
			OTHER GENERAL			3/24/2024 1.3	O pili
			SERVI CE				
	Cost Center Description	NURSI NG AND	PATI ENT	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH	ACTI VI TI ES		Adjustments		
		EDUCATION 14.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	100	10.00	10.00	17.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5.00
7. 00	00700 HOUSEKEEPI NG						6. 00 7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12. 00
13.00	01300 SOCIAL SERVICE						13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	70 /55				14. 00
15. 00	O1500   PATIENT ACTIVITIES     INPATIENT ROUTINE SERVICE COST CENTERS	0	70, 655				15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	70, 655	2, 342, 273	ol	2, 342, 273	30.00
31. 00	03100 NURSING FACILITY	0	0			2, 312, 273	31.00
32. 00	03200   CF/IID	0	0			0	1
33.00	03300 OTHER LONG TERM CARE	0	0	C	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1					
40. 00	04000 RADI OLOGY	0	l "			48	1
41. 00	04100 LABORATORY	0	0		l	663	1
42. 00 43. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0 7	42. 00 43. 00
44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	67, 363		67, 363	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	45, 939	l .	45, 939	1
46. 00	04600 SPEECH PATHOLOGY	0	o	8, 363	l .	8, 363	1
47.00	04700 ELECTROCARDI OLOGY	0	0	C	l l	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	25, 538	I	25, 538	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		0	
51. 00	O5100   SUPPORT SURFACES   OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	51. 00
60. 00	06000 CLINIC	0	0		ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	Ö			0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	_			0	
71.00	07100 AMBULANCE	0	1			294	1
73. 00	07300 CMHC SPECI AL PURPOSE COST CENTERS	0	0	C	0	0	73. 00
80 OO	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 H0SPI CE	0	0	C	0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	70, 655	2, 490, 488	0	2, 490, 488	89. 00
	NONREI MBURSABLE COST CENTERS	I	I		1		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFICES	0	0	60		60	1
93.00	09300 NONPALD WORKERS			i d		0	1
94. 00	09400 PATIENTS LAUNDRY	1 0			-	0	1
98. 00	Cross Foot Adjustments	0	Ö	Č		0	1
99. 00	Negative Cost Centers	0	0	C	О	0	
100.00	TOTAL	0	70, 655	2, 490, 548	0	2, 490, 548	100. 00

BORS LLC In Lieu of Form CMS-2540-10
Provider No.: 315333 | Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					o 12/31/2023	Date/Time Pre	
		CAPITAL REI	LATED COSTS			5/24/2024 1: 3	6 pm
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS		ı			1	
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	36, 015	0	4, 938, 341			1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	OO4OO   ADMINISTRATIVE & GENERAL   OO5OO   PLANT OPERATION, MAINT. & REPAIRS   OO6OO   LAUNDRY & LINEN SERVICE   OO5OO   O	1, 515 2, 493 1, 316	0	482, 994 96, 157	0	619, 994 131, 805	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	568 5, 616 312	0	556, 077 408, 804	0	466, 541 1, 441, 629 482, 643	7. 00 8. 00 9. 00
10. 00 11. 00 12. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	213 0 104	0	12, 548 0 27, 922	0 0	194, 643 0 38, 684	11. 00 12. 00
13. 00 14. 00 15. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 PATIENT ACTIVITIES	130 0 888	0		0	0	14. 00
30. 00 31. 00 32. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID	21, 213 0 0	0 0	C	_	0	30. 00 31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	C	0	0	33. 00
41. 00 42. 00 43. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0	0	C	0	65, 795 0	41. 00 42. 00
44. 00 45. 00 46. 00	04400 OXTGEN (TNIALATTON) THERAPT 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	833 554 100	0			668 377, 513 364, 057 72, 717	44. 00 45. 00
47. 00 48. 00 49. 00	04700 ELECTROCARDI OLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0 0 160	0			0 0 252,008	47. 00 48. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	C	_	0	50. 00
60. 00 61. 00 62. 00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC  06100 RURAL HEALTH CLINIC  06200 FOHC	0	0	C			60. 00 61. 00 62. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00 71. 00 73. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0	C	0	29, 187	70. 00 71. 00 73. 00
80. 00 81. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES  08100 INTEREST EXPENSE						80. 00 81. 00
82. 00 83. 00 89. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 36, 015	-		) -2, 103, 375		
90. 00 91. 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN  09100 BARBER AND BEAUTY SHOP	0	l e				90. 00 91. 00
92. 00 93. 00 94. 00 98. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments	0 0	0	C	0	0 0	92. 00 93. 00 94. 00 98. 00
99. 00 102. 00	Negative Cost Centers	2, 490, 548	0	631, 333	3	2, 103, 375	99. 00
103. 00 104. 00	Unit cost multiplier (Wkst. B, Part I)	69. 153075	0. 000000	0. 127843 C		0. 202344 104, 767	1
105.00				0. 000000		0. 010079	105. 00

				Т	o 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	p
		OPERATION, MAINT. &	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		REPAIRS	(PATI ENT CENSUS)			(DI RECT	
		(SQUARE FEET)	02.1000)			NURSI NG)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS    00100 CAP REL COSTS - BLDGS & FIXTURES	1	I	I			1 00
1. 00 2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	32, 007	ł .				5. 00
6.00	OO6OO  LAUNDRY & LINEN SERVICE   OO7OO  HOUSEKEEPING	1, 316		i			6.00
7. 00 8. 00	00800 DI ETARY	568 5, 616	l e	30, 123 5, 616			7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	312		312		114, 358	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	213	0	213	0	0	10.00
11. 00	01100 PHARMACY	0	0	C	-	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	104	0	104		0	12.00
13. 00 14. 00	01300   SOCIAL SERVICE   01400   NURSING AND ALLIED HEALTH EDUCATION	130		130		0	13. 00 14. 00
15. 00	01500 PATIENT ACTIVITIES	888		888	-	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	21, 213	36, 604	21, 213	109, 812	114, 358	30. 00
31. 00	03100 NURSING FACILITY	0	0	C	0	0	31.00
32. 00 33. 00	03200  CF/  D   03300  OTHER LONG TERM CARE	0		C	0	0	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS			1	0	0	33.00
40.00	04000 RADI OLOGY	0	0	C	0	0	40. 00
41. 00	04100 LABORATORY	0	•	C	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	833	0	833	0	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	554		554		0	45. 00
46.00	04600 SPEECH PATHOLOGY	100		100		0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		C	-	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	-	0	48. 00
49. 00 50. 00	04900   DRUGS CHARGED TO PATIENTS   05000   DENTAL CARE - TITLE XIX ONLY	160	l e	160		0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		-		-	0	51. 00
	OUTPATIENT SERVICE COST CENTERS	_					
60.00	06000 CLI NI C	0				0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	61.00
62. 00	O6200   FQHC   OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71.00	07100 AMBULANCE	0		C	0	0	71. 00
73. 00	07300 CMHC	0	0	C	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	32, 007	36, 604	30, 123	109, 812	114, 358	89. 00
00.00	NONREI MBURSABLE COST CENTERS	1	1				00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	O C	0	0	90. 00 91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES				0	0	92.00
93. 00	09300 NONPAI D WORKERS		Ö	o c	Ö	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	C	0	0	94. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers	745 444	100 105	F74 170	1 071 177	FO2 F17	99.00
102. 00	Cost to be allocated (per Wkst. B, Part I)	745, 446	189, 125	574, 172	1, 971, 177	593, 517	102.00
103.00	1 1	23. 290093	5. 166785	19. 060917	17. 950470	5. 189991	103. 00
104.00	Cost to be allocated (per Wkst. B,	178, 648		1		28, 670	
105.00	Part II)	E E01E00	0.700445	1 5/5000	4 004450	0 250704	105 00
105. 00	Unit cost multiplier (Wkst. B, Part	5. 581529	2. 723145	1. 565282	4. 034450	0. 250704	105.00
	1 1117	1	1	1	ı l		ı

	LLOCATION - STATISTICAL BASIS	OOMI EETE OTHE T		No.: 315333	Peri od:	Worksheet B-1	
					From 01/01/2023	Doto/Time Dro	norod.
					To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(COSTED	RECORDS &		ALLI ED HEALTH	
		SUPPLY	REQUIS.)	LI BRARY	(PATI ENT	EDUCATI ON	
		(COSTED		(PATI ENT	CENSUS)	(ASSI GNED	
		REQUI S) 10. 00	11. 00	CENSUS) 12. 00	13.00	TI ME) 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT					I	2. 00
3.00	00300 EMPLOYEE BENEFITS					I	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL					I	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					I	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE					I	6. 00
7.00	00700 HOUSEKEEPI NG					l	7. 00
8.00	OO8OO  DI ETARY   OO9OO  NURSI NG ADMINI STRATI ON					l	8. 00
9. 00 10. 00	01000 CENTRAL SERVICES & SUPPLY	406, 705					9. 00 10. 00
11. 00	01100 PHARMACY	400, 703	0			I	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	ő	0	36, 604	1	I	12. 00
	01300 SOCI AL SERVI CE	0	0	)	36, 604	I	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		o o	0	14. 00
15.00	01500 PATIENT ACTIVITIES	0	0	(	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	165, 761	0	1		0	
31. 00	03100 NURSING FACILITY	0	0		1 1	0	31. 00
32. 00	03200   CF/IID	0	0	1	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	O <sub>I</sub>	0		0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0	0	J	ol	0	40. 00
41. 00	04100 LABORATORY	0	0	1		0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0			Ö	ı
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		ol ol	Ō	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0		o	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		o	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0		0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	240, 944	0		0	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY   05100 SUPPORT SURFACES	0	0	1	1	0 0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	U <sub>I</sub>	0	1	<u> </u>	0	31.00
60. 00	06000 CLINIC	0			ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	ő	0				61.00
62. 00	06200 FQHC					1	62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	(	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	1	0		
73. 00	07300 CMHC	0	0		0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS			1			00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE					I	80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF					I	82.00
83. 00	08300 H0SPI CE	0	0	,	ol ol	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	406, 705	0				1
	NONREI MBURSABLE COST CENTERS	,	-	22/22	.,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		o	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	1
93. 00	09300 NONPALD WORKERS	0	0		0	0	
94.00	09400 PATI ENTS LAUNDRY	0	0	(	0	0	
98. 00	Cross Foot Adjustments					I	98. 00 99. 00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	243, 049	0	50, 91!	116 601	0	102.00
102.00	Part I)	243, 049	0	50, 91	116, 681	1	102.00
103.00	1 1 1	0. 597605	0. 000000	1. 390968	3. 187657	0. 000000	103. 00
104.00		18, 214	0	8, 32!	1		104. 00
	Part II)					1	
105.00		0. 044784	0. 000000	0. 22743	0. 296443	0. 000000	105. 00
		l I		I	1	i	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMPLETE CARE AT ARBORS LLC In Lieu of Form CMS-2540-10 Provi der No.: 315333 

			10 12/31/2023	5/24/2024 1:36 pm
		OTHER GENERAL		0, 2 1, 2021 11 00 piii
		SERVI CE		
	Cost Center Description	PATIENT		
		ACTI VI TI ES (PATI ENT		
		CENSUS)		
		15. 00		
	GENERAL SERVICE COST CENTERS			
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT			2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL			3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE			6. 00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8. 00
9.00	00900 NURSING ADMINISTRATION			9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY			10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY			12.00
13. 00	01300 SOCIAL SERVICE			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15.00	01500 PATIENT ACTIVITIES	36, 604		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0, ,0,1		00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	36, 604		30. 00 31. 00
32. 00	03200   CF/IID			32.00
33. 00	03300 OTHER LONG TERM CARE			33. 00
	ANCILLARY SERVICE COST CENTERS	- 1		
40.00	04000 RADI OLOGY	0		40. 00
41.00	04100 LABORATORY	0		41.00
42.00	04200 I NTRAVENOUS THERAPY	0		42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY			43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY			45. 00
46. 00	04600 SPEECH PATHOLOGY	O		46. 00
47.00	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS	0		49. 00 50. 00
51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0		51. 00
01.00	OUTPATIENT SERVICE COST CENTERS			31. 33
60.00	06000 CLI NI C	0		60. 00
61. 00	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FOHC			62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0		70.00
70.00	07100 AMBULANCE	0		71.00
73. 00	07300 CMHC			73. 00
	SPECIAL PURPOSE COST CENTERS			
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			80. 00
	08100   NTEREST EXPENSE			81.00
82. 00 83. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0		82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	36, 604		89. 00
07.00	NONREI MBURSABLE COST CENTERS	007001		37. 55
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0		91.00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0		92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0		93. 00 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,	383, 704		102. 00
	Part I)			
103.00		10. 482570		103. 00
104.00	Cost to be allocated (per Wkst. B, Part II)	70, 655		104. 00
105.00	1 1 7	1. 930254		105. 00

Health Financial Systems	COMPLETE CARE AT ARBORS LLC	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR A	NCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315333	Period: Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 1:36 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 3.00 col . 18 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 5, 742 4, 776 1. 202261 40.00 41.00 04100 LABORATORY 79, 108 65, 795 1.202341 41.00 42. 00 04200 I NTRAVENOUS THERAPY 0 0 0.000000 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 803 668 1. 202096 43.00 44. 00 04400 PHYSI CAL THERAPY 489, 179 472, 846 1.034542 44.00 04500 OCCUPATIONAL THERAPY 1.059879 45.00 461, 185 435, 130 45.00 04600 SPEECH PATHOLOGY 46.00 91, 666 0.673425 46.00 136, 119 47. 00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 453, 765 240, 944 1.883280 49.00 0.000000 50.00 05000 DENTAL CARE - TITLE XIX ONLY O 50.00 51.00 05100 SUPPORT SURFACES 0.000000 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 60.00 0.000000 0 60.00 0 61.00 06100 RURAL HEALTH CLINIC 61.00 62. 00 06200 FQHC 62.00 71. 00 07100 AMBULANCE 35, 093 1. 202350 71.00 29, 187

1, 616, 541

1, 385, 465

100. 00

100.00

Total

Health Financial Systems	COMPLETE CARE A	AT ARBORS LLC		In Lie	eu of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315333	Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023		
		Ti +Lo	XVIII (1)	Skilled Nursing	5/24/2024 1: 3 PPS	ь рш
		IIIIe	AVIII (1)	Facility	PPS	
		Heal th Care Pi	rogram Charges		Program Cost	
		lilour tir our o'r i	rogram onarges	near throane	11 ogi am oost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1. 00	2. 00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	1. 202261	3, 437		0 4, 132		
41. 00  04100   LABORATORY	1. 202341	20, 401		0 24, 529	0	1
42.00  04200   I NTRAVENOUS THERAPY	0. 000000		)	0	0	
43.00   04300   0XYGEN (INHALATION) THERAPY	1. 202096		1	0	0	43.00
44. 00   04400   PHYSI CAL THERAPY	1. 034542	237, 376	,	0 245, 575	0	44. 00
45. 00  04500 OCCUPATI ONAL THERAPY	1. 059879			0 236, 404	0	
46.00 04600 SPEECH PATHOLOGY	0. 673425			0 63, 341	0	
47. 00   04700   ELECTROCARDI OLOGY	0. 000000	l .	1	0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		1	0	0	1 .0.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 883280			0 197, 897	0	1 . ,
50.00   05000   DENTAL CARE - TITLE XIX ONLY	0. 000000	0	1	0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00  06000   CLI NI C	0. 000000	0	1	0	0	60.00
61.00  06100 RURAL HEALTH CLINIC						61. 00
62. 00   06200   FQHC						62. 00
71.00 07100 AMBULANCE (2)	1. 202350			0	0	
100.00   Total (Sum of lines 40 - 71)		683, 401		0 771, 878	0	100. 00

<sup>(1)</sup> For title V and XIX use columns 1, 2, and 4 only.

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

Heal th	Financial Systems	COMPLETE CARE A	AT ARBORS LLC		In Lie	u of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315333	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/24/2024 1:3	
	Title XVIII Skilled Nursing Facility						
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of cos	st to charges	(From Workshee	t C, column 3	, line 49)	1. 883280	1.00
2.00	Program vaccine charges (From your recoi	rds, or the PS	&R)			2, 550	2. 00
3.00	Program costs (Line 1 x line 2) (Title )	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	4, 802	3. 00
	E, Part I, line 18)			1	1		
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B, Part I, Col.	(From Wkst. B,		Cost (From h Wkst. D Part	& Allied Health Costs	
		18	Part I, Col.	Costs to Tota		for Pass	
		10	14)	Costs - Part		Through (Col.	
			'''	(Col. 2 / Col		3 x Col . 4)	
				1)		,	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	5, 742		, 0.0000		0	
41. 00	04100 LABORATORY	79, 108	(	0.0000			
42.00	04200   NTRAVENOUS THERAPY	0	(	0.00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	803		0.00000		0	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	489, 179 461, 185		0.0000			44. 00 45. 00
46. 00	04500 OCCOPATIONAL THERAPT	91, 666		0.0000		0	46.00
47. 00	04700 ELECTROCARDI OLOGY	91,000 O		0.0000		0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.0000		0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	453, 765		0. 00000		Ö	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		0. 00000		0	50.00
51.00	05100 SUPPORT SURFACES	0		0.00000	00	0	51.00
100.00	Total (Sum of lines 40 - 52)	1, 581, 448	(		771, 878	0	100. 00

	inancial Systems COMPLETE CARE AT AF	Provi der No.: 315333	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 5/24/2024 1:30	pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
P	ART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
-	NPATIENT DAYS				
	npatient days including private room days			36, 604	1.
	rivate room days			0	2.
00	npatient days including private room days applicable to the Pr	ogram		6, 824	3.
о М	ledically necessary private room days applicable to the Program			0	4
00 T	otal general inpatient routine service cost			10, 874, 731	5
PI	RIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges			14, 246, 199	6
	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 763343	7
	inter private room charges from your records			0	8
	verage private room per diem charge (Private room charges line	8 divided by private	room days, line	0. 00	9
- 1	()			0	10
	inter semi-private room charges from your records	h   ! 10   -  ! -  -	-l I	0	10
	werage semi-private room per diem charge (Semi-private room c semi-private room days)	narges iine io, divide	d by	0. 00	11
4	werage per diem private room charge differential (Line 9 minus	line 11)		0. 00	12
- 1	werage per diem private room charge differential (Line 7 times I			0.00	
	Private room cost differential adjustment (Line 2 times line 13			0.00	14
	General inpatient routine service cost net of private room cost	,	minus line 14)	10, 874, 731	15
	ROGRAM INPATIENT ROUTINE SERVICE COSTS	(			
	djusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		297. 09	16
00 P	Program routine service cost (Line 3 times line 16)			2, 027, 342	17
00 M	ledically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18
00 T	otal program general inpatient routine service cost (Line 17	plus line 18)		2, 027, 342	19
	Capital related cost allocated to inpatient routine service cos	ts (From Wkst. B, Par	t II column 18,	2, 342, 273	20
- 1	ine 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1)			63. 99	21
- 1	Program capital related costs (Line 3 times line 21)			436, 668	
- 1	npatient routine service cost (Line 19 minus line 22)			1, 590, 674	23
	aggregate charges to beneficiaries for excess costs (From prov	ider records)		0	24
- 1	otal program routine service costs for comparison to the cost		nus line 24)	1, 590, 674	25
	inter the per diem limitation (1)	,	,	, ,	26
00 1	npatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27
	deimbursable inpatient routine service costs (Line 22 plus the Transfer to Worksheet E, Part II, line 4) (See instructions)	lesser of line 25 or	line 27)		28
	es 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX	l	'
				1. 00	
P	ART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		1.00	
	otal SNF inpatient days	21. 1.0 1.1.00 111100011		36, 604	1
	Oregram impationt days (see instructions)			4 024	

2. 00 3. 00 4. 00 5. 00

6, 824

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

2.00

4. 00 5. 00

Health Financial Systems	COMPLETE CARE AT AR	BORS LLC	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315333	From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/24/2024 1:36 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT	, <u> </u>		
1.00	Inpatient PPS amount (See Instructions)			5, 234, 457	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal ( Sum of lines 1 and 2)			5, 234, 457	3. 00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			837, 600	5.00
6.00	Allowable bad debts (From your records)			332, 586	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		173, 025	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			216, 181	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)			4, 613, 038	11.00
12.00	Interim payments (See instructions)			4, 375, 143	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			4, 324	14. 75
14. 99	Sequestration amount (see instructions)			87, 937	14. 99
15. 00	Balance due provider/program (see Instructions)			145, 634	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			4, 802	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			4, 802	
20. 00	Medicare Part B ancillary charges (See instructions)			2, 550	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			2, 550	
22. 00	Primary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			2, 550	
26. 00	Interim payments (See instructions)			1, 574	
27. 00	Tentative adjustment			0	
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			51	28. 99 29. 00
29. 00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 115 2	925 0	
30.00	Priotested amounts (Nonarrowable Cost report riems) in accordance	e with two rub. 15-2,	SECTION 113. 2	υĮ	30.00

Health Financial Systems	COMPLETE CARE AT AF	RBORS LLC	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	NT TITLE V and TITLE XIX ONLY	Provi der No.: 315333	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part II Date/Time Prepared: 5/24/2024 1:36 pm
		Title XIX	Skilled Nursing Facility	

	Facility		
		1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		
1.00	Inpatient ancillary services (see Instructions)	0	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5)	0	2. 00
3.00	Outpatient services	0	
4.00	Inpatient routine services (see instructions)	0	
5.00	Utilization reviewphysicians' compensation (from provider records)	0	
6.00	Cost of covered services (Sum of Lines 1 - 5)	0	
7.00	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)	0	
9.00	Pri mary payor amounts	0	
10.00	Total Reasonable Cost (Line 8 minus line 9)	0	10.00
	REASONABLE CHARGES		l
11. 00	Inpatient ancillary service charges	0	11. 00
12.00	Outpatient service charges	0	12.00
13.00	Inpatient routine service charges	0	13.00
14.00	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	0	14.00
15.00	Total reasonable charges	0	15. 00
	CUSTOMARY CHARGES		
16.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	16. 00
17.00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	17. 00
	had such payment been made in accordance with 42 CFR 413.13(e)		l
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)	0.000000	18. 00
19.00	Total customary charges (see instructions)	0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		l
20.00	Cost of covered services (see Instructions)	0	20. 00
21.00	Deducti bl es	0	21.00
22.00	Subtotal (Line 20 minus line 21)	0	22. 00
23.00	Coi nsurance	0	23. 00
24.00	Subtotal (Line 22 minus line 23)	0	24. 00
25.00	Allowable bad debts (from your records)	0	25. 00
26.00	Subtotal (sum of lines 24 and 25)	0	26. 00
27.00	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of	l ol	27. 00
	cost limit		l
28. 00	Recovery of excess depreciation resulting from provider termination or a decrease in program	0	28. 00
	utili zation		l
29. 00	Other Adjustments (see instructions) Specify	0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (	0	30. 00
	if minus, enter amount in parentheses)		l
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)	0	
32.00	Interim payments	0	32. 00
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	0	33. 00
	Instructions)	l l	J

Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 1:36 pm PPS

Title XVIII Skilled Nursing

		11 (1	e Aviii Ji	Facility	FF3	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		4, 383, 996		1, 574	1. 00
2.00	Interim payments payable on individual bills, either		0		l ol	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		_1		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3. 04			0		0	3. 04
3.05			0		0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM	00 /15 /2022	0.053		0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM	08/15/2023	8, 853 0			3. 50 3. 51
3. 51			0			3. 51
3. 52			0			3. 52
3. 54			0			3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-8, 853		0	3. 99
3. 77	- 3.98)		-0, 055		١	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 375, 143		1, 574	4. 00
1. 00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		1, 070, 110		', ', '	1. 00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) PROGRAM TO PROVIDER		145, 634		925	6. 01
6. 02	PROVI DER TO PROGRAM		145, 054		923	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 520, 777		2, 499	7. 00
7.00	1.01a. modification program traditity (300 thisti detroits)		Contract	or Name	Contractor	7.00
			301111 001		Number	
			1. (	00	2. 00	
8. 00	Name of Contractor					8. 00
					•	

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

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

Provider No.: 315333 | Period: From 01/01/202

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 1:36 pm

ıı y)					5/24/2024 1:3	36 p
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	la .	1.00	2. 00	3. 00	4. 00	
	Assets CURRENT ASSETS					+
00	Cash on hand and in banks	141, 736	C	0	0	1
00	Temporary investments	0	d	0		
00	Notes recei vabl e	0	C	0	0	) 3
00	Accounts receivable	2, 604, 759	C	0	0	
00	Other recei vabl es	0	C	0	0	
00	Less: allowances for uncollectible notes and accounts	-120, 351	C	0	0	) (
00	recei vabl e I nventory	0		0	0	, -
0	Prepaid expenses	38, 422	-	Ö	0	
00	Other current assets	21, 541		0	0	
00	Due from other funds	0	C	0	0	1
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 686, 107	C	0	0	1
	FI XED ASSETS	1	1 -	ı .	1	
00	Land	0	C	_	-	
00	Land improvements	22 904	C	_	0	
00	Less: Accumulated depreciation Buildings	-22, 806		_	0	
00	Less Accumulated depreciation			0	0	
00	Leasehold improvements	651, 669		Ö	Ö	
00	Less: Accumulated Amortization	0	d	0	0	
00	Fi xed equipment	0	C	0	0	1
00	Less: Accumulated depreciation	0	C	0	0	2
00	Automobiles and trucks	0	C	0	0	
00	Less: Accumulated depreciation	0	C	_	0	
00	Major movable equipment	388, 954		_	0	
00	Less: Accumulated depreciation	-273, 698	C	0	0	
00	Mi nor equi pment - Depreci abl e	0		0	0	
00	Mi nor equi pment nondepreci abl e Other fi xed assets			0	0	- 1
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	744, 119			•	
00	OTHER ASSETS	, , , , , , ,				1 -
00	Investments	0	C	0	0	2
00	Deposits on Leases	0	C	0	0	3
00	Due from owners/officers	-19, 545		0	0	
00	Other assets	1, 336, 692		_	0	
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 317, 147		_	0	
00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	4, 747, 373	C	0	0	3
	CURRENT LIABILITIES					
00	Accounts payable	542, 740	C	0	0	3
00	Salaries, wages, and fees payable	1, 595, 214				
00	Payroll taxes payable	-2, 956		0	0	3
00	Notes & Loans payable (Short term)	0	C	0	0	
00	Deferred income	842, 313	C	0	0	
00	Accel erated payments	0	_	_	_	4
. 00	Due to other funds	0	C	0	0	1
. 00	Other current liabilities	2 077 211	C		0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) LONG TERM LIABILITIES	2, 977, 311	<u> </u>	0	0	4
00	Mortgage payable	1 0		0	0	4
00	Notes payable					
00	Unsecured Loans	0	l c		Ö	
00	Loans from owners:	0		Ō	0	
00	Other long term liabilities	1, 098, 594	c	0	0	4
00	OTHER (SPECIFY)	0	( C	0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	1, 098, 594		_	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	4, 075, 905	<u> </u>	0	0	5
00	CAPITAL ACCOUNTS	471 4/0				۱.
00	General fund balance Specific purpose fund	671, 468	c			5
00	Donor created - endowment fund balance - restricted			<u></u>		5
	Donor created - endowment fund balance - restricted			0		5
()()	Governing body created - endowment fund balance			0		5
		1			0	
00	Plant fund balance - invested in plant			i contract of the contract of		
00 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	כ וי
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	5
00	Plant fund balance - reserve for plant improvement,	671, 468 4, 747, 373		0	0	5

					To 12/31/2023	Date/Time Prep 5/24/2024 1:30	
		General	Fund	Special P	urpose Fund	Endowment Fund	O pili
		1.00	2.00	2.00	4.00	F 00	
1 00	Fund beloness at beginning of period	1.00	2.00	3. 00	4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)		-173, 037 844, 504		0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)		671, 467		0		3.00
4. 00	Additions (credit adjustments)		071,407		0		4.00
5.00	ROUNDI NG	1			0	0	5.00
6.00	ROUNDING				0	0	6.00
7. 00					0		7.00
8. 00					0		8.00
9. 00					0	0	9.00
10. 00	Total additions (sum of line 5 - 9)		1		0	o o	10.00
11. 00	Subtotal (line 3 plus line 10)		671, 468		0		11.00
12. 00	Deductions (debit adjustments)		071,400				12.00
13. 00	beddetrons (debit adjustillents)	0			0	0	13.00
14. 00					0	Ö	14.00
15. 00					0	Ö	15.00
16. 00					0	Ö	16.00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0		0		18.00
19. 00	Fund balance at end of period per balance		671, 468		0		19.00
. ,	sheet (Line 11 - line 18)		07.17.00				'''
	· · · · · · · · · · · · · · · · · · ·	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0			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)	0			0		3. 00
4.00	Additions (credit adjustments)		_				4. 00
5.00	ROUNDI NG		0				5.00
6.00			0				6.00
7.00			0				7. 00
8.00			0				8.00
9.00	T. I. I. I. ( C. I. E. O)		U				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			0				13.00
14. 00 15. 00			U				14.00
			0				15.00
16.00			U				16.00
17.00	Total deductions (sum of lines 12 17)		U				17.00
18.00	Total deductions (sum of lines 13 - 17)	0			0		18.00
19. 00	Fund balance at end of period per balance	0			U		19. 00
	sheet (Line 11 - line 18)	I I	l		1		I

Heal th	Financial Systems	COMPLETE CARE AT ARBORS LLC			In Lieu of Form CMS-2540-			
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENS	SES	Provi der	No.: 315333	Peri od: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/24/2024 1:3	pared:	
	Cost Center Description			Inpatient	Outpati ent	Total		
				1.00	2. 00	3. 00		
	PART I - PATIENT REVENUES							
	General Inpatient Routine Care Services							

			To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	•
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	14, 246, 1	99	14, 246, 199	1.00
2.00	NURSING FACILITY		0	0	2.00
3.00	ICF/IID		0	0	3. 00
4.00	OTHER LONG TERM CARE		0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	14, 246, 1	99	14, 246, 199	5. 00
	All Other Care Services	·			
6.00	ANCI LLARY SERVI CES	1, 385, 4	64 0	1, 385, 464	6.00
7.00	CLINIC		0	0	7. 00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10. 10	FOHC		0	0	ł
11. 00	CMHC		0	0	ı
12. 00	HOSPI CE		0	0	ı
13. 00	ROUTINE CHARGES / BED HOLD	1	18 0	118	1
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3			15, 631, 781	
	Worksheet G-3, Line 1)	,,		,,	
	Cost Center Description		4.00	0.00	
	DADT II ODEDATING EVDENCES		1. 00	2. 00	
1 00	PART II - OPERATING EXPENSES			12 441 /50	1 00
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			13, 441, 659	
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4. 00
5.00			0		5.00
6.00			0		6.00
7. 00			0	_	7. 00
8. 00	Total Additions (Sum of lines 2 - 7)		_	0	
9.00	Deduct (Specify)		0		9. 00
10.00			0		10.00
11. 00			0		11. 00
12. 00			0		12.00
13.00			0		13. 00
	Total Deductions (Sum of lines 9 - 13)				14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			13, 441, 659	15. 00

Health Financial Systems	COMPLETE CARE AT ARBORS LLC		In Lieu of Form CMS-2540-10			
STATEMENT OF PATIENT REVENUES AND OPERA	ATING EXPENSES	Provi der No.: 315333	Peri od: From 01/01/2023	Worksheet G-3		
			To 12/31/2023	Date/Time Prepared: 5/24/2024 1:36 pm		

STATE	ENT OF TATTERS REVENUES AND OF ENTITING EXCENSES	11001 401 1101 110000	From 01/01/2023	Workshoot o o	
			To 12/31/2023	Date/Time Pre	pared:
				5/24/2024 1: 3	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1	4)		15, 631, 781	1. 00
2.00	Less: contractual allowances and discounts on patients accounts			1, 374, 167	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			14, 257, 614	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)			13, 441, 659	4. 00
5.00	Net income from service to patients (Line 3 minus 4)			815, 955	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			200	6. 00
7.00	Income from investments			4, 253	7. 00
8.00	Revenues from communications (Telephone and Internet service)			0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	1 3			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			807	18. 00
19. 00				0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21. 00				1, 592	
22. 00	Rental of skilled nursing space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	NON PATIENT REVENUE			14, 762	
24. 01	BARBER BEAUTY			6, 935	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)			28, 549	
26. 00	Total (Line 5 plus line 25)			844, 504	26. 00
27. 00	Other expenses (specify)			0	27. 00
28. 00				0	28. 00
29. 00				0	29. 00
	Total other expenses (Sum of lines 27 - 29)			0	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)			844, 504	31.00