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

OMB NO. 0938-0463

Expires: 12/31/2021

			EXPIT 65. 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315445	From 01/01/2022 To 12/31/2022	Worksheet S Parts I, II & III Date/Time Prepared: 5/30/2023 11:07 am

			37 30	72023 II. 07 di	.111
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost rep	oort	Date: 5/30/2023	Time: 11:07	am
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent	er the number of times the provider	resubmitted this cos	t report	
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.			
Contractor	4. [1] Cost Report Status	6. Contractor No.	<u></u>		
use only	(1) As Submitted	7.[N] First Cost Report for this	Provider CCN		
	(2) Settled without audit	8.[N] Last Cost Report for this F	Provider CCN		
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened	10.[0]If line 4, column 1 is "4":	 Enter number of time	s reopened	
	(5) Amended	11.Contractor Vendor Code	4		
	5. Date Received:	12.[F] Medicare Utilization. Ente	r "F" for full, "L" fo	or low, or "N"	
		TOT TIO GETTI Zati OII.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THE ARBOR AT LAUREL CIRCLE (315445) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Brian	Alexopoulos	Y	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	Bri an Al exopoul os			2
3	Signatory Title	EXECUTI VE DI RECTOR			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	17, 324	0	0	1. 00
2.00 NURSING FACILITY	0			0	2. 00
3. 00 ICF/IID				0	3. 00
4.00 SNF - BASED HHA I	0	0	0		4. 00
5. 00 SNF - BASED RHC I	0		0		5. 00
6.00 SNF - BASED FQHC I	0		0		6. 00
7. 00 SNF - BASED CMHC I	0		0		7. 00
7. 10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	17, 324	0	0	100. 00

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

Health Financial Systems THE ARBOR AT LAUREL CIRCLE In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315445 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:07 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 100 MONROE STREET PO Box: 1.00 2.00 City: BRIDGEWATER State: NJ Zi p Code: 08807 2.00 3.00 County: SOMERSET CBSA Code: 35154 Urban/Rural: U 3.00 3.01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF THE ARBOR AT LAUREL 315445 06/19/1988 N Р Ν 4.00 CI RCLE 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 | SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related N 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 723 905 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 723, 905 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 166, 976 0 0

Health Financial Systems THE ARBOR AT LAUREL CIRCLE In Lieu of						2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3154		Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	pared:
					5/30/2023 11:	07 am
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative	and General cost	N	42. 00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing co	ost centers and		
	amounts.					
43.00	Are there any home office costs as defi	ined in CMS Pub. 15-1, Cha	apter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addre	ess of the home		44.00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3.00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of th	ne home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Cont	ractor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47. 00	Ci ty:	State:	Zi p	Code:		47. 00

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE	Provi der	No.: 315445	Peri od:	Worksheet S-	-2
	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022	Part II	
						5/30/2023 11	
					Y/N 1. 00	2. 00	-
	General Instruction: For all column 1 respons	ses enter in column	າ 1, "Y" fo	r Yes or "N"			
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites						
00	Provider Organization and Operation	ly prior to the be	alaniaa of	the cost	N	I	1
00	Has the provider changed ownership immediately reporting period? If column 1 is "Y", enter instructions)	the date of the ch	ange in col	umn 2. (see	IN		'
	instructions)			Y/N 1.00	Date 2.00	V/I 3. 00	
00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of			N	2.00	0.00	2
	3, "V" for voluntary or "I" for involuntary.						
00	Is the provider involved in business transaction contracts, with individuals or entities (e.g.			N			;
	or medical supply companies) that are related	d to the provider (or its				
	officers, medical staff, management personnel						
	of directors through ownership, control, or relationships? (see instructions)	ramiry and other s	IIIIII I ai				
				Y/N	Туре	Date	
	Financial Data and Reports			1. 00	2. 00	3.00	
00	Column 1: Were the financial statements prepare			N			
	Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit comple						
	available in column 3. (see instructions) If						
00	Are the cost report total expenses and total			N			
	those on the filed financial statements? If or reconciliation.	column 1 is "Y", s	ubmi t				
	,				Y/N	Legal Oper.	
					1. 00	2.00	
	Approved Educational Activities						
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column :	2: Is the	provider the	N	N	
	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	, ,		provider the		N	
00	Column 1: Were costs claimed for Nursing Scho	s? (Y/N) see instr	uctions.	•	N N N	N	
00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instr ng the cost report	uctions.	•	N		
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000 000	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the school and the provider so the program of the power and the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. (See Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00	11 11 11 11 11 11
000	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the school and school a	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00	11 1 1 1 1 1
000 000	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the second of the provider seeking reimbursement for base of the provider seeking reimbursement for base of the provider is bad debugeriod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 Y	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	11 1 1 1 1 1
000 000	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the school and the provider school and the PS&R used to prepare this cost report in cols. 2 and to prepare this 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 the program and the provider of the PS&R used to prepare this cost report in columns 2 and the ps&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 Y	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	1 1 1 1 1
.00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the second of the provider seeking reimbursement for base of the provider seeking reimbursement for base of the provider is bad debugeriod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 Y	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	10 11 11 11 11 11 11 11 11 11 11 11 11 1
.00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the school and the provider's bad debuger of the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00 Y	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	10 11 11 11 11 11 11 11 11 11 11 11 11 1
000 000	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so the school and the provider school and the provider school and the program to the passes of the school and the provider school and the provider school and the provider school and the proprame this cost report in columns 2 and the program that the program	s? (Y/N) see instring the cost reportiee instructions. d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Descripti 0	instructions instruction y change du aived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00 Y	t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	11 12 12

Health Financial Systems	THE ARBOR AT LAU	UREL CIRCLE		In Lieu	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILI COMPLEX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 11:	pared:
		<u>'</u>	<u> </u>			
		1.	00	2. 0	00	
Cost Report Preparer Contact Information						
19.00 Enter the first name, last name and the titl	e/position AD	DAM		DAVI TZ		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	report WI	IPFLI LLP				20. 00
preparer.						
21.00 Enter the telephone number and email address		14-480-1273		ADAM. DAVI TZ@WI P	PFLI.COM	21. 00
report preparer in columns 1 and 2, respecti	vel y.					

Health Financial Systems In Lieu of Form CMS-2540-10 THE ARBOR AT LAUREL CIRCLE SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315445 Peri od: Worksheet S-2 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II

From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 11:07 am Part B Date 4.00 PS&R Data 05/01/2023 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 14.00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 3.00

In Lieu of Form CMS-2540-10 THE ARBOR AT LAUREL CIRCLE

Health Financial Systems THE ARBOR AT LASKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315445

				T	o 12/31/2022	Date/Time Prep 5/30/2023 11:0	oared: 07 am
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	64	23, 360 0	0	5, 866	0	1. 00 2. 00
3. 00	ICF/IID	0	0	0		0	3. 00
4. 00	HOME HEALTH AGENCY COST			0	0	ő	4. 00
5.00	Other Long Term Care	35	12, 775				5.00
6.00	SNF-Based CMHC						6. 00
6. 10 7. 00	SNF-Based CORF HOSPI CE	0	0	0	0	o	6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	99	36, 135		5, 866	Ö	8. 00
		Inpatient [Days/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	6. 00	7. 00	8.00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	9, 616	15, 482	0	316	0	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0			0	3. 00 4. 00
5. 00	Other Long Term Care	9, 400	9, 400				5. 00
6.00	SNF-Based CMHC						6.00
6. 10	SNF-Based CORF						6. 10
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	19, 016	24, 882	0	0 316	0	7. 00 8. 00
0.00	Total (sam of fines 1 7)	Di sch			age Length of		0.00
	Company	O+box	Total	Ti +l o V	T: +1 o V/////	Ti +Lo VIV	
	Component	0ther 11.00	Total 12.00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
1. 00	SKILLED NURSING FACILITY	222	538		18. 56	0.00	1. 00
2.00	NURSING FACILITY	0	0			0.00	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0			0.00	3. 00 4. 00
5. 00	Other Long Term Care	1	1				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF			0.00	0.00	0.00	6. 10
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	223	0 539		0. 00 18. 56	0. 00 0. 00	7. 00 8. 00
	1.000	Average Length			si ons	3.33	
	Companent	of Stay Total	Title V	Title XVIII	Title XIX	Othor	
	Component	16. 00	17. 00	18. 00	19. 00	0ther 20.00	
1.00	SKILLED NURSING FACILITY	28. 78	0		0	174	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3. 00 4. 00	ICF/IID HOME HEALTH AGENCY COST	0. 00			0	0	3. 00 4. 00
5. 00	Other Long Term Care	9, 400. 00				1	5. 00
6.00	SNF-Based CMHC						6. 00
6. 10 7. 00	SNF-Based CORF HOSPI CE	0. 00	0	0	0	0	6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	46. 16	0		0	175	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
	·		Payrol I	Workers			
1.00	SKILLED NURSING FACILITY	21.00	22. 00 141. 51	23.00			1. 00
2. 00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	0	0. 00	0.00			3.00
4. 00 E. 00	HOME HEALTH AGENCY COST		0.00				4. 00 E. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	1	17. 82 0. 00				5. 00 6. 00
6. 10	SNF-Based CORF		0.00				6. 10
7.00	HOSPI CE	0	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	488	159. 33	0.00		l	8. 00

				Ť	0 12/31/2022	Date/Time Prep 5/30/2023 11:0	
		Amount	Reclass, of	Adjusted	Pai d 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)	7, 511, 081	0	7, 511, 081			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)	7, 511, 081	0	7, 511, 081			6. 00
7.00	Other Long Term Care	788, 995	0	788, 995	37, 056. 00	21. 29	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0.00		10.00
11. 00	Other excluded areas	909, 150	0	909, 150	29, 797. 00	30. 51	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	1, 698, 145	0	1, 698, 145	66, 853. 00	25. 40	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	5, 812, 936	0	5, 812, 936	264, 538. 00	21. 97	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	1, 659, 635	0	1, 659, 635	i i		
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15. 00
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
	Wage-related costs core (See Part IV)	1, 809, 064	l .	1, 809, 064			17. 00
18. 00	Wage-related costs other (See Part IV)	25, 423	0	25, 423			18. 00
19. 00	Wage related costs (excluded units)	414, 751	0	414, 751			19. 00
20. 00	Physician Part A - WRC	0	0	0			20. 00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 419, 736	0	1, 419, 736			22. 00
	instructions)						

SNF WAGE INDEX INFORMATION

Provi der No.: 315445

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

5/30/2023 11:07 am Amount Reclass. of Adj usted Paid Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0.00 1.00 2.00 Administrative & General 586, 154 0 586, 154 16, 743. 00 35. 01 2.00 3.00 Plant Operation, Maintenance & Repairs 480, 018 0 480, 018 19, 054. 00 25. 19 3.00 4.00 Laundry & Linen Service 54, 782 54, 782 3, 600. 00 15.22 4.00 5.00 Housekeepi ng 572, 154 0 572, 154 37, 427. 00 15. 29 5.00 1, 410, 027 0 1, 410, 027 92, 109, 00 Di etary 15.31 6.00 6.00 50.70 Nursing Administration 469, 774 469, 774 9, 265. 00 7.00 7.00 8.00 Central Services and Supply 0 0 0.00 0.00 8.00 9.00 0 0 0.00 0.00 9.00 Pharmacy OI Medical Records & Medical Records Library 86, 939 10.00 86, 939 4, 642. 00 18.73 10.00 Social Service 11.00 66,845 0 66, 845 1, 829. 00 36.55 11.00 12.00 Nursing and Allied Health Ed. Act. 12.00 13.00 Other General Service 107, 337 0 107, 337 5, 309. 00 20. 22 13.00 14.00 Total (sum lines 1 thru 13) 3, 834, 030 0 3, 834, 030 189, 978. 00 20. 18 14. 00

Health Financial Systems	THE ARBOR AT LAUREL CIRCLE	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315445	
		From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared

	To 12/31/2022		
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	104, 943	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	651, 227	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	12, 924	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	4, 466	11. 00
12.00		0	12.00
13.00		0	13. 00
14.00		0	14.00
15.00		328, 249	15. 00
16. 00		0	
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	565, 213	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
	State or Federal Unemployment Taxes	142, 042	20. 00
	OTHER		
21. 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 - 23)	1, 809, 064	24. 00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	25, 423	25. 00

L CIRCLE In Lieu of Form CMS-2540-10
Provider No.: 315445 Period: Worksheet S-3
From 01/01/2022 Part V

				F	rom 01/01/2022 o 12/31/2022	Part V Date/Time Pre	aarad.
				''	0 12/31/2022	5/30/2023 11:0	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	57 GIII
	g ,	Reported		Salaries (col.		Wage (col. 3 ÷	
		,			Salary in col.	col . 4)	
				,	3	,	
		1.00	2.00	3.00	4. 00	5. 00	
	Direct Salaries			•			
	Nursing Occupations						
1.00	Registered Nurses (RNs)	718, 943	175, 593	894, 536	17, 210. 00	51. 98	1.00
2.00	Licensed Practical Nurses (LPNs)	393, 093	96, 008	489, 101	11, 756. 00	41. 60	2. 00
3.00	Certified Nursing Assistant/Nursing	866, 869	211, 722	1, 078, 591	46, 281. 00	23. 31	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	1, 978, 905	483, 323	2, 462, 228	75, 247. 00	32. 72	4.00
5.00	Physical Therapists	0	0	0	0. 00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0. 00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0. 00	0.00	7.00
8.00	Occupational Therapists	o	0	0	0. 00	0.00	8. 00
9.00	Occupational Therapy Assistants	o	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0. 00	0.00	10.00
11. 00	Speech Therapists	o	0	0	0. 00	0.00	11.00
12.00	Respi ratory Therapi sts	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	87, 271		87, 271	1, 175. 00	74. 27	14.00
15. 00	Licensed Practical Nurses (LPNs)	171, 245		171, 245	2, 893. 00	59. 19	15.00
16.00	Certified Nursing Assistant/Nursing	228, 681		228, 681	6, 866. 00	33. 31	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	487, 197		487, 197			
18. 00	Physical Therapists	485, 052		485, 052	·		18.00
19.00	Physical Therapy Assistants	0		0	0. 00		
20. 00	Physical Therapy Aides	0		0	0. 00	0. 00	
21. 00	Occupational Therapists	532, 829		532, 829	8, 089. 00	65. 87	21.00
22. 00	Occupational Therapy Assistants	0		0	0. 00	0. 00	22.00
23. 00	Occupational Therapy Aides	0		0	0. 00	0. 00	
24. 00		120, 237		120, 237			
25. 00	Respi ratory Therapi sts	34, 320		34, 320			
26. 00	Other Medical Staff	0		0	0. 00	0. 00	26. 00

Peri od: Worksheet S-7 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 11:07 am

	l l	0 12/31/2022	5/30/2023 11:0	
		Group	Days	
		1. 00	2.00	
1.00		RUX		1. 00
2.00		RUL		2. 00
3.00		RVX		3. 00
4.00		RVL		4. 00
5.00		RHX		5. 00
6. 00		RHL		6. 00
7.00		RMX		7. 00
8.00		RML		8. 00
9.00		RLX		9.00
10. 00 11. 00		RUC RUB		10. 00 11. 00
12. 00		RUA		12. 00
13. 00		RVC		13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18.00		RHA		18. 00
19.00		RMC		19. 00
20.00		RMB		20.00
21.00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00 30. 00		HD2 HD1		29. 00 30. 00
31. 00		HC2		30.00
32. 00		HC1		32.00
33. 00		HB2		33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37. 00
38. 00		LD1		38. 00
39.00		LC2		39. 00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00		CE2		43.00
44. 00		CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00 50. 00
50. 00 51. 00		CB1 CA2		50.00
52. 00		CA2 CA1		52. 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		I B2		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 65. 00		BB1 BA2		64. 00 65. 00
66. 00		BA2 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		PC1		72.00
73. 00		PB2		73. 00
74.00		PB1		74.00
75. 00		PA2		75. 00

Health Financial Systems THE ARBOR AT LAUREL CIRCI			In Lieu of Form CMS-2540-10				
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315445	Peri od:	Worksheet S-7	7	
				From 01/01/2022 To 12/31/2022			
				Group	Days		
				1. 00	2. 00		
76. 00				PA1		76. 00	
99. 00				AAA		99. 00	
100. 00 TOTAL						100. 00	
			Expenses	Percentage	Y/N		
			1. 00	2. 00	3. 00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101. 00 Staffi ng						101. 00	
102.00 Recruitment						102.00	
103.00 Retention of employees						103. 00	
104. 00 Trai ni ng						104.00	
105. 00 OTHER (SPECIFY)						105. 00	
106.00 Total SNF revenue (Worksheet G-2, Part I, I	rne i, corumn 3)		I			106. 00	

Heal th	Financial Systems	THE ARBOR AT LAUR	EL CIRCLE		In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 01/01/2022	Worksheet A	
					To 12/31/2022		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati	5/30/2023 11: Reclassi fi ed	07 alli
	·			+ col . 2)	ons	Trial Balance	
					Increase/Decre ase (Fr Wkst	(col. 3 +- col. 4)	
					A-6)	COI. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		1, 653, 454	1, 653, 45	4 0	1, 653, 454	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		342, 642			342, 642	2.00
3.00	00300 EMPLOYEE BENEFITS	0	1, 834, 488			1, 834, 488	
4.00	00400 ADMINISTRATIVE & GENERAL	586, 154	2, 713, 512			3, 299, 666	
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	480, 018 54, 782	1, 310, 952 8, 419	1		1, 790, 970 63, 201	1
7. 00	00700 HOUSEKEEPING	572, 154	97, 802			669, 956	1
8.00	00800 DI ETARY	1, 410, 027	1, 087, 605			2, 497, 632	
9.00	00900 NURSI NG ADMINI STRATI ON	469, 774		107,77		469, 774	1
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	152, 560	152, 56	0	152, 560	10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	86, 939	0	86, 93	9 0	86, 939	
13. 00	01300 SOCIAL SERVICE	66, 845	21, 738			88, 583	1
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14. 00
15. 00	O1500 ACTIVITIES	107, 337	15, 280	122, 61	7 0	122, 617	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	1, 978, 906	649, 133	2, 628, 03	9 0	2, 628, 039	30.00
31. 00	03100 NURSING FACILITY	0	0 17, 100	2,020,00	ó	0	31. 00
32.00	03200 CF/IID	0	0		0 0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	788, 995	17, 739	806, 73	4 0	806, 734	33.00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	25, 759	25, 75	9 0	25, 759	40.00
41. 00	04100 LABORATORY	0	62, 514			62, 514	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	46, 970			46, 970	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	551, 143 455, 008			551, 143 455, 008	
46. 00	04600 SPEECH PATHOLOGY	0	131, 842			131, 842	
47. 00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55, 330			55, 330	1
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	380, 715 0	1	0 0	380, 715 0	1
51. 00	05100 SUPPORT SURFACES	Ö	0	1	0 0	Ő	1
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC		0	ı	0 0	0	60.00
61.00		0	0		0 0	0	
62. 00	06200 FQHC						62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		0 0	0	
72.00	07200 CORF	0	0		0 0	0	72. 00
73.00	07300 CMHC	0	0		0	0	
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80.00
	08100 NTEREST EXPENSE		0		0 0	0	
82. 00		0	0		0	0	
83. 00 84. 00		0	0		0 0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	6, 601, 931	11, 614, 605	18, 216, 53	6 0	18, 216, 536	
	NONREI MBURSABLE COST CENTERS			1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
	09300 NONPALD WORKERS	O	0		0 0	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	1	0 0	0	94.00
	O9500 OTHER NONREIMBURSABLE COST CENTERS O9501 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	95. 00 95. 01
	09502 MARKETING	325, 923	480, 411	806, 33	4 0	806, 334	
95. 03	09503 COMMUNITY HOME HEALTH	99, 794	936	100, 73	0 0	100, 730	95. 03
	09504 INDEPENDENT LIVING	483, 433	53, 516			536, 949	
100.00	TOTAL	7, 511, 081	12, 149, 468	19, 660, 54	9 0	19, 660, 549	1100.00

Heal th FinancialSystemsTHE ARBORRECLASSIFICATIONAND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No.: 315445 Period:

				To 12/31/2022 Date/Time Pro 5/30/2023 11:	
	Cost Center Description	Adjustments to			
			For Allocation		
		Wkst A-8)	(col. 5 +-		
		6.00	col. 6) 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-443, 444	1, 210, 010		1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0			2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 834, 488	l e e e e e e e e e e e e e e e e e e e	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL	-995, 406			4. 00 5. 00
6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	-82, 569 0		·	6.00
7. 00	00700 HOUSEKEEPI NG	0		•	7. 00
8. 00	00800 DI ETARY	-196		1	8. 00
9.00	00900 NURSING ADMINISTRATION	0	469, 774		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	152, 560		10. 00
11.00	01100 PHARMACY	0	0		11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0		l e e e e e e e e e e e e e e e e e e e	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION				14. 00
15. 00	01500 ACTIVITIES	0			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 SKILLED NURSING FACILITY	0			30. 00
31.00	03100 NURSING FACILITY	0			31. 00
32. 00	03200 I CF/II D	0			32. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	806, 734	•	33. 00
40. 00	04000 RADI OLOGY	1 0	25, 759		40.00
41. 00	04100 LABORATORY	0			41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0			42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	46, 970		43. 00
44. 00	04400 PHYSI CAL THERAPY	0	551, 143		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	455, 008		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	131, 842		46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		1	I and the second	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	380, 715	1	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		l .	50.00
51.00	05100 SUPPORT SURFACES	0	0		51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		52. 00
(0.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0	Ο	J	1,0,00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0		•	60.00
62. 00	06200 FQHC				62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		63. 00
	OTHER REIMBURSABLE COST CENTERS				
70. 00	07000 HOME HEALTH AGENCY COST	0		•	70. 00
71.00	07100 AMBULANCE	0	0		71.00
	07200 CORF 07300 CMHC	0	0		72. 00 73. 00
	07400 OTHER REIMBURSABLE COST	0			74.00
, ,, ,,	SPECIAL PURPOSE COST CENTERS			1	7 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80.00
81. 00	08100 I NTEREST EXPENSE	0	0		81. 00
82.00	08200 UTILIZATION REVIEW	0	0		82. 00
83. 00	08300 HOSPI CE	0	0		83. 00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	-1, 521, 615	16, 694, 921		84. 00 89. 00
69.00	NONREI MBURSABLE COST CENTERS	-1, 321, 613	10, 094, 921		09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
93.00	09300 NONPALD WORKERS	0	0		93.00
94.00	09400 PATIENTS LAUNDRY		0		94.00
95. 00 95. 01	09500 OTHER NONREIMBURSABLE COST CENTERS 09501 OTHER NONREIMBURSABLE COST CENTERS				95. 00 95. 01
	09501 OTHER NONRETWIBURSABLE COST CENTERS		806, 334		95. 02
95. 03	1		100, 730	l e e e e e e e e e e e e e e e e e e e	95. 03
	09504 I NDEPENDENT LIVING	0			95. 04
100.00	TOTAL	-1, 521, 615	18, 138, 934		100. 00

Health Financial Systems	THE ARBOR AT LAUREL	CIRCLE		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od: From 01/01/2022 To 12/31/2022	Worksheet A-6 Date/Time Pre	
				10 12/31/2022	5/30/2023 11:	
		Increases				
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassificat	Total Reclassifications (Sum			0	100. 00
	of columns 4 and 5 must					
	equal sum of columns 8 and					
	9)					

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

Health Financial Systems	THE ARBOR AT LAUREL	CIRCLE		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315445	Peri od:	Worksheet A-6)
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	
					5/30/2023 11:	07 am
	Decreases					
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS THE ARBOR AT LAUREL CIRCLE In Lieu of Form CMS-2540-10 | Peri od: | Worksheet A-7 | From 01/01/2022 | To 12/31/2022 | Date/Ti me Prepared: Provi der No.: 315445

				10	12/31/2022	5/30/2023 11:0	
				Acqui si ti ons		37 307 2023 11.	57 diii
	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	S					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	98, 581	49, 982		49, 982		2.00
3.00	Buildings and Fixtures	454, 606	210, 709		210, 709		3. 00
4.00	Building Improvements	1, 743, 133	1, 220, 837		1, 220, 837		4. 00
5.00	Fi xed Equi pment	657, 297	138, 770		138, 770		5. 00
6.00	Movable Equipment	2, 283, 974	155, 716		155, 716		6. 00
7.00	Subtotal (sum of lines 1-6)	5, 237, 591	1, 776, 014	0	1, 776, 014	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	5, 237, 591	1, 776, 014	0	1, 776, 014	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		al				4 00
1.00	Land	0	0				1.00
2.00	Land Improvements	148, 563	0				2. 00
3. 00	Buildings and Fixtures	665, 315	0				3. 00
4.00	Building Improvements	2, 963, 970	0				4. 00
5. 00	Fi xed Equi pment	796, 067	0				5. 00
6. 00	Movable Equipment	2, 439, 690	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	7, 013, 605	0				7. 00
8. 00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	7, 013, 605	0				9. 00

Peri od: Worksheet A-8

From 01/01/2022
To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/30/2023 11:	
			<u> </u>	Expense Classification on		
				To/From Which the Amount is		
				Toy I Tolli Will cit the Amount 13	to be haj astea	
	Decemintion (1)	(2) Basis For	Amount	Coot Conton	Li ne No.	
	Description (1)	()	Amount	Cost Center	LITTE NO.	
		Adjustment	0.00			
1 00		1.00	2. 00	3. 00	4. 00	1.00
1. 00	Investment income on restricted funds		0)	0.00	1. 00
	(chapter 2)		_			
2.00	Trade, quantity, and time discounts (chapter		0)	0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)	A	-77, 389	PLANT OPERATION, MAINT. &	5.00	6. 00
				REPAI RS		
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	
11.00	Capital expenditures (chapter 24)				0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	0			12. 00
12.00	related organizations (chapter 10)	A-0-1	0			12.00
13. 00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0		0.00	
15. 00	Cost of meals - Guests		0		0.00	
			_	1		
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		1	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	
19. 00	Vending machines		0		0.00	
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW	82.00	22. 00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25.00	ADDITIONAL MEALS INCOME	В	-196	DI ETARY	8.00	25. 00
25. 01	TRANSPORTATION	В	-921	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	GUEST ROOM	В		CAP REL COSTS - BLDGS &	1.00	
		_	,	FIXTURES		
25. 03	MANAGEMENT FEE G&A OVERHEAD G&A	Α	-985 559	ADMINISTRATIVE & GENERAL	4 00	25. 03
25. 04	MAI NTENANCE	В		PLANT OPERATION, MAINT. &		25. 04
20.01	IN THE IN THOSE		0, 100	REPAIRS	0.00	20.01
25. 05	LEASE FEES	Α	-426 266	CAP REL COSTS - BLDGS &	1.00	25. 05
20.00			120, 200	FI XTURES	1.00	20.00
25. 06	FLOWERS & MEMORIALS	Α	_1 554	ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 00	MI SCELLANEOUS	B		ADMINISTRATIVE & GENERAL	4.00	
25. 07	AMORTIZATION INCOME OTHER INCOME/EXP	A		CAP REL COSTS - BLDGS &	1	
25.00	AWOR I ZATION INCOME DITER INCOME/EAP	A	-5, 193	FIXTURES	1.00	25.00
25 00	DAMACE CLAIMS DALD	_	111		4 00	25 00
25. 09	DAMAGE CLAIMS PAID	A		ADMINISTRATIVE & GENERAL		25. 09
25. 10		A		ADMINISTRATIVE & GENERAL	4. 00	
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 521, 615			100. 00
	to Worksheet A, col. 6, line 100)	1		1	1	l
(1) Do	scription all chapter references in this co	Lump portain to	CMC Dub 1E 1	1		

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

Provider No.: 315445 | Period: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2022	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/30/2023 11:	07 am
			DI DOC A	MOVARUE	EMBLOVEE		
	Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
		Allocation		240112111	52.12.1.10		
		(from Wkst A					
		col. 7)	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS		1.00	2.00	0.00	571	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1, 210, 010	1, 210, 010				1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	342, 642 1, 834, 488	0	342, 642 0	1, 834, 488		2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	2, 304, 260	13, 657		143, 161	2, 464, 945	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 708, 401	5, 001		117, 239	1, 832, 057	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	63, 201	5, 493		13, 380	83, 629	6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	669, 956 2, 497, 436	5, 508 69, 662		139, 742 344, 382	816, 766 2, 931, 206	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	469, 774	7, 712		114, 737	594, 407	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	152, 560	0	_	0	152, 560	1
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	86, 939	0	0	0 21, 234	0 108, 173	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	88, 583	4, 097	_	16, 326	110, 166	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	122, 617	0	0	26, 216	148, 833	15. 00
30. 00	03000 SKILLED NURSING FACILITY	2, 628, 039	154, 477	43, 744	483, 319	3, 309, 579	30.00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0 806, 734	0 113, 355	0 32, 099	0 192, 703	0 1, 144, 891	32. 00 33. 00
33.00	ANCI LLARY SERVICE COST CENTERS	600, 734	113, 333	32, 099	192, 703	1, 144, 091	33.00
40.00	04000 RADI OLOGY	25, 759	0	0	0	25, 759	40. 00
41.00	04100 LABORATORY	62, 514	0	0	0	62, 514	41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	46, 970	0	0	0	0 46, 970	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	551, 143	2, 490		Ö	554, 338	•
45. 00	04500 OCCUPATI ONAL THERAPY	455, 008	0		0	455, 008	1
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	131, 842	0	_	0	131, 842 0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	55, 330	874		o	56, 451	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	380, 715	0	0	0	380, 715	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	-	o	0	52. 00
	OUTPATIENT SERVICE COST CENTERS				ام		
60. 00 61. 00	O6000 CLI NI C O6100 RURAL HEALTH CLI NI C	0	0	-	0	0	60. 00 61. 00
62. 00	06200 FQHC		9		Ĭ,	Ü	62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
70 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	O	0	70. 00
71. 00	07100 AMBULANCE	0	0	Ö	ő	0	
72.00	07200 CORF	0	0	_	0	0	72. 00
73. 00 74. 00	07300 CMHC 07400 OTHER REI MBURSABLE COST	0	0	0	0	0	73. 00 74. 00
7 1. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>		o o	<u> </u>		7 1. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81. 00 82. 00
83. 00	08300 HOSPI CE	0	0	0	О	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	16, 694, 921	382, 326	108, 263	1, 612, 439	15, 410, 809	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	0	o	0	91. 00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		4, 238	1, 200	0	5, 438	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	95. 00
95. 01 95. 02	09501 OTHER NONREI MBURSABLE COST CENTERS 09502 MARKETI NG	0 806, 334	0	0	0 79, 603	0 885, 937	95. 01 95. 02
95. 02 95. 03	09503 COMMUNITY HOME HEALTH	100, 730	0	0	24, 373	125, 103	95. 02 95. 03
95. 04	09504 I NDEPENDENT LI VI NG	536, 949	823, 446	233, 179	118, 073	1, 711, 647	95. 04
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00	1 1 0	18, 138, 934	1, 210, 010		1, 834, 488	18, 138, 934	
	•						

| Peri od: | Worksheet B | From 01/01/2022 | Part I | | Part I | | Date/Time Prepared: | 5/30/2023 | 11:07 am | Prepared: | Pr Provi der No.: 315445

				''	J 12/31/2022	5/30/2023 11:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	07 4111
		4.00	REPAI RS 5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1. 00 2. 00 3. 00 4. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	2, 464, 945					1. 00 2. 00 3. 00 4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	288, 115 13, 152	2, 120, 172 9, 776	1			5. 00
7.00	00700 HOUSEKEEPI NG	128, 447	9, 802	0	955, 015	0 570 544	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	460, 970 93, 478	123, 972 13, 725		56, 363 6, 240	3, 572, 511 0	8. 00 9. 00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	23, 992	0	0	0	0	10. 00 11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	17, 012	7 201	0	0	0	12. 00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	17, 325 0	7, 291 0	0	3, 315 0	0	13. 00 14. 00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	23, 406	0	0	0	0	15. 00
30.00	03000 SKILLED NURSING FACILITY	520, 480	274, 912	106, 557	124, 986	1, 436, 593	1
31. 00 32. 00	03100 NURSING FACILITY 03200 ICF/IID	0	0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	180, 049	201, 730	0	91, 714	888, 011	33. 00
40. 00	04000 RADI OLOGY	4, 051	0	0	0	0	40. 00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	9, 831	0	0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	7, 387	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	87, 177	4, 432	0	2, 015	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	71, 556	0	0	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	20, 734	0	0	0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 878	1, 555	ő	707	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	59, 872	0	0	o	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	51. 00 52. 00
	OUTPATIENT SERVICE COST CENTERS	1 0			al	-	
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0		0	0	60. 00 61. 00
62. 00	06200 FQHC				Ŭ	Ü	62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	63. 00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72. 00 73. 00	07200 CORF 07300 CMHC	0	0	0	0	0	72. 00 73. 00
	07400 OTHER REIMBURSABLE COST	0	0	ő	0	0	1
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			•			82. 00
83. 00	08300 H0SPI CE	0	0	0	О	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	(47.105	0	0	0	84.00
89. 00	SUBTOTALS (sum of lines 1-84) NONRELMBURSABLE COST CENTERS	2, 035, 912	647, 195	106, 557	285, 340	2, 324, 604	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	0	0	0	91. 00
92. 00 93. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
94.00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	855	7, 542	0	3, 429	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
95. 01	09501 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	95. 01
95. 02 95. 03	09502 MARKETI NG 09503 COMMUNI TY HOME HEALTH	139, 325 19, 674	0	0	0	0	95. 02 95. 03
95. 03 95. 04	09504 I NDEPENDENT LIVING	269, 179	1, 465, 435	0	666, 246	1, 247, 907	95. 03
98. 00	Cross Foot Adjustments	0	0	o o	0	0	98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	0 2, 464, 945	0 2, 120, 172	0 106, 557	955, 015	0 3, 572, 511	99.00
100.00	/ ITOTAL	2,404,740	2, 120, 1/2	100,557	955, 015	3, 372, 311	1,00.00

				''	J 12/31/2022	5/30/2023 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		0.00	SUPPLY	11 00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12. 00	13.00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	707, 850					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	O	176, 552				10.00
11. 00	01100 PHARMACY	0	0	0			11. 00
12.00		0	0	0	125, 185		12. 00
13. 00	1	0	0	0	0	138, 097	13. 00
14. 00	1	0	0	0	0	0	14. 00
15. 00		0	0	0	0	0	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	707.050	40.074		00 770	00.440	00.00
30.00	1	707, 850	42, 371	0	93, 778		30.00
31. 00 32. 00	1	0	0	0	0	0	31. 00 32. 00
33. 00			25, 726		0	20, 122	33. 00
33.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	25, 720	0	0	20, 122	33.00
40. 00		0	0	0	292	0	40. 00
41. 00	I I	O	0	0	735		41.00
42.00	04200 I NTRAVENOUS THERAPY	O	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	60	0	43. 00
44. 00		0	0	0	11, 299	0	44. 00
45.00		0	0	0	9, 768	0	45. 00
46. 00	I I	0	0	0	3, 812	0	46. 00
47. 00		0	0	0	0	0	47. 00
48. 00	1	0	0	0	984	0	48. 00
49. 00		0	0	0	4, 457	0	49. 00
50.00		0	0	0	0	0	50.00
51. 00 52. 00	1	0	0] 0 0	0	0	51. 00 52. 00
32.00	OUTPATIENT SERVICE COST CENTERS	J U	U	0		0	32.00
60. 00		O	0	0	0	0	60.00
61. 00		0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63.00		0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS	1				1 -	
70.00	1	0	0	0	0	0	70.00
71. 00 72. 00		0	0	0	0	0	71. 00 72. 00
73. 00	07300 CMHC		0	0	0	0	73.00
74. 00			0	0	0	Ö	74. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-				
80.00							80. 00
81. 00							81. 00
82. 00							82. 00
83. 00		0	0	0	0	0	83. 00
84. 00		0	0	0	0	0	84. 00
89. 00		707, 850	68, 097	0	125, 185	53, 264	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00			0	0	0		91.00
92. 00			0	0	0	0	92. 00
93. 00			0	0	0	o o	93. 00
94. 00	1	o	0	o o	0	0	94. 00
95. 00		0	108, 455	0	0	84, 833	95. 00
95. 01	09501 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 01
95. 02		0	0	0	0	0	95. 02
95. 03	1	0	0	0	0	0	95. 03
95. 04		0	0	0	0	0	95. 04
98. 00		0	0	_	=	_	98. 00
99.00		707.950	17/ 550] 0	125 105	139 007	99.00
100.0	0 TOTAL	707, 850	176, 552	0	125, 185	138, 097	1100.00

				'	0 12/31/2022	5/30/2023 11:	
	Cost Center Description	NURSING AND ALLIED HEALTH	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION 14.00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	16.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0					1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
30. 00	NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	41, 336	6, 691, 584	0	6, 691, 584	30.00
31. 00	1 1	0		0,071,001	1	0	31.00
32.00		0		0.533.046	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	25, 097	2, 577, 340) 0	2, 577, 340	33. 00
40. 00		0	0	30, 102	2 0	30, 102	40. 00
41. 00	1 1	0	0	73, 080	o		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	42.00
43. 00 44. 00		0	0	54, 417 659, 261		54, 417 659, 261	43. 00 44. 00
45. 00	1 1	0	0	536, 332		536, 332	45. 00
46. 00	1 1	0	O	156, 388		156, 388	1
47. 00	1	0	0	C	-	0	47. 00
48. 00	1	0	0	68, 575		68, 575	48. 00
49. 00 50. 00	+ I	0	0	445, 044	0	445, 044 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	o o		o o	Ö	51.00
52.00	1 1	0	0	C	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS		1				
60.00	1	0				0	60.00
61. 00 62. 00		0	0			0	61. 00 62. 00
63. 00		0	0	C	o	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	1	0	0	C	0	0	70. 00
71. 00 72. 00	1	0	0			0	71. 00 72. 00
	07300 CMHC	0	0			-	73.00
74. 00	1	Ö	Ö	Č	o o		1
	SPECIAL PURPOSE COST CENTERS						
80. 00 81. 00							80. 00 81. 00
82. 00							82.00
83. 00		0	0	c	o	0	83. 00
84. 00	1 1	0		C	O	0	84. 00
89. 00	, ,	0	66, 433	11, 292, 123	0	11, 292, 123	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			ا ما	0	90.00
91. 00		0			-	-	91.00
92. 00		0	0	C	0	0	92. 00
93. 00		0	0	C	0	0	93. 00
94. 00 95. 00	1	0	0 105, 806	17, 264 299, 094		17, 264 299, 094	94. 00 95. 00
95. 00 95. 01	09501 OTHER NONREIMBURSABLE COST CENTERS	0	103, 808	277, 094		299, 094	95. 00
95. 02	1 1	0	Ö	1, 025, 262	2 0	1, 025, 262	95. 02
95. 03		0	0	144, 777	0	144, 777	95. 03
95. 04		0	0	5, 360, 414	0	5, 360, 414	
98. 00 99. 00	1 1	0				0 0	98. 00 99. 00
100.0		0		18, 138, 934	0	_	•
	•						

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315445

			То	12/31/2022	Date/Time Pre 5/30/2023 11:	
		CAPI TAL REL	ATED COSTS		7 307 2023 11.	07 4111
Cook Cooking Bookingting	D:+1	DI DCC 0	MOVARIE	Ch.tt1	EMDL OVEE	
Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
	Capi tal	TTXTORES	EQUIT MENT		DENEIT 13	
	Related Costs					
OFFICE OF	0	1.00	2. 00	2A	3. 00	
1. 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	O	o	0	o	0	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	0	13, 657	3, 867	17, 524	0	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	0	5, 001	1, 416	6, 417	0	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE 7.00 00700 HOUSEKEEPING	0	5, 493 5, 508	1, 555 1, 560	7, 048 7, 068	0	6. 00 7. 00
8. 00 00800 DI ETARY		69, 662	19, 726	89, 388	0	8.00
9. 00 00900 NURSING ADMINISTRATION	o	7, 712	2, 184	9, 896	0	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
11. 00 01100 PHARMACY	0	0	0	0	0	11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE		4, 097	1, 160	5, 257	0	12. 00 13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION		4, 077	0	0, 237	0	14. 00
15. 00 01500 ACTIVITIES	0	O	0	0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS		454 433	10.711	400 004		
30.00 03000 SKILLED NURSING FACILITY 31.00 03100 NURSING FACILITY	0	154, 477	43, 744	198, 221	0	30. 00 31. 00
32. 00 03200 CF/IID		ol	0	ol	0	32.00
33.00 03300 OTHER LONG TERM CARE	o	113, 355	32, 099	145, 454	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	0	0	0	0	0	40.00
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY		0	0	0	0	41. 00 42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	o	o	0	o	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	O	2, 490	705	3, 195	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	46. 00 47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		874	247	1, 121	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	49. 00
50.00 O5000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00 05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0	0	U	0	52. 00
60. 00 06000 CLINIC	0	0	0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00 06200 FQHC					0	62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	<u> </u>	U	U	U U	0	63. 00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	O	o	0	o	0	71. 00
72. 00 07200 CORF	0	0	0	0	0	
73.00 07300 CMHC 74.00 07400 OTHER REIMBURSABLE COST	0	0	0	0	0	73. 00 74. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u>U</u>	U _I	<u> </u>	0	74.00
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			0	0	0	82. 00 83. 00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPECI AL PURPOSE COST CENTERS		0	0	0	0	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	o	382, 326	108, 263	490, 589	0	89. 00
NONREI MBURSABLE COST CENTERS						
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP 92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	91. 00 92. 00
93. 00 09300 NONPAI D WORKERS		o	Ö	ő	0	93. 00
94.00 09400 PATIENTS LAUNDRY	O	4, 238	1, 200	5, 438	0	94. 00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
95. 01 09501 OTHER NONREI MBURSABLE COST CENTERS 95. 02 09502 MARKETI NG	0	0	0	0	0	95. 01 95. 02
95. 02 09502 MARKETING 95. 03 09503 COMMUNITY HOME HEALTH		0	0	ol Ol	0	95. 02 95. 03
95. 04 09504 I NDEPENDENT LIVING		823, 446	233, 179	1, 056, 625	0	95. 04
98.00 Cross Foot Adjustments				o		98. 00
99.00 Negative Cost Centers 100.00 TOTAL		1 210 010	242 442	1 552 453	0	99. 00 100. 00
100.00 101AL	0	1, 210, 010	342, 642	1, 552, 652	Ü	1100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315445

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

5/30/2023 11:07 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 17, 524 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 2,048 8, 465 5.00 00600 LAUNDRY & LINEN SERVICE 93 7, 180 6.00 6.00 39 00700 HOUSEKEEPI NG 7.00 913 39 C 8.020 7.00 93, 633 8.00 00800 DI ETARY 3, 277 495 0 473 8.00 9.00 00900 NURSING ADMINISTRATION 0 52 9.00 665 55 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 171 C 0 Ω 11.00 01100 PHARMACY 0 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 121 0 0 12.00 01300 SOCIAL SERVICE 29 0 28 13.00 13.00 0 123 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 C 0 0 14.00 15.00 01500 ACTI VI TI ES 166 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 37, 652 03000 SKILLED NURSING FACILITY 1, 098 30.00 30.00 3 700 7, 180 1 050 03100 NURSING FACILITY 31.00 C 0 31.00 32.00 03200 | CF/IID 0 0 32.00 C 0 0 33.00 03300 OTHER LONG TERM CARE 1, 280 805 0 770 23, 274 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 29 0 0 0 0 40.00 41.00 04100 LABORATORY 70 0 0 41.00 0 0 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 0 0 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 53 C 0 43.00 04400 PHYSI CAL THERAPY 620 18 0 17 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 509 0 0 0 0 45.00 04600 SPEECH PATHOLOGY 46 00 0 0 46 00 147 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 6 48.00 48.00 63 6 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 426 0 0 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 Ω 50 00 0 51.00 05100 SUPPORT SURFACES 0 C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 63.00 0 0 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 0 0 07200 CORF 0 72.00 0 0 72.00 0 73.00 07300 CMHC 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS r 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 14, 474 2,584 7, 180 396 60, 926 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 Λ 90 00 09100 BARBER AND BEAUTY SHOP 91.00 0 C 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 0 0 92.00 0 ol 09300 NONPALD WORKERS 0 93.00 93.00 C 0 09400 PATIENTS LAUNDRY 0 29 94.00 6 30 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95.00 09501 OTHER NONREIMBURSABLE COST CENTERS 95. 01 0 0 0 0 0 95.01 95 02 09502 MARKETI NG 990 O 0 95 02 C 0 09503 COMMUNITY HOME HEALTH 0 95.03 140 0 95.03 09504 INDEPENDENT LIVING 1, 914 5, 851 0 5, 595 32, 707 95.04 95.04 98.00 Cross Foot Adjustments 0 0 98.00 99 00 99 00 Negative Cost Centers 0 0 100.00 TOTAL 17, 524 8, 465 7. 180 8, 020 93, 633 100. 00

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 11:07 am

		Cost Center Description	NURSI NG	CENTRAL	PHARMACY		5/30/2023 11: SOCI AL SERVI CE	37 am
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
	loeuen.	AL 05504 05 000T 0514500	9.00	10.00	11. 00	12.00	13. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00		CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00		EMPLOYEE BENEFITS						3. 00
4.00	1	ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00		HOUSEKEEPI NG						7. 00
8.00		DI ETARY						8. 00
9. 00 10. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	10, 668	171				9. 00 10. 00
11. 00	1	PHARMACY		0				11. 00
12.00	1	MEDICAL RECORDS & LIBRARY	0	0	0	121		12. 00
13.00		SOCIAL SERVICE	0	0	0	0	5, 437	13.00
14. 00 15. 00		NURSING AND ALLIED HEALTH EDUCATION ACTIVITIES		0	I -	0	0	14. 00 15. 00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30.00	1	SKILLED NURSING FACILITY	10, 668	41	0	91	1, 305	30. 00
31. 00 32. 00		NURSING FACILITY ICF/IID	0	0	1	0	0	31. 00 32. 00
33. 00		OTHER LONG TERM CARE	l o	25		0	792	33. 00
		LARY SERVICE COST CENTERS						
40. 00 41. 00		RADI OLOGY LABORATORY	0	0	0	0	0	40. 00 41. 00
42.00		INTRAVENOUS THERAPY		0	0	0	0	42.00
43.00	1	OXYGEN (INHALATION) THERAPY	O	0	0	0	0	43. 00
44.00		PHYSI CAL THERAPY	0	0	0	11	0	44. 00
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	4	0	45. 00 46. 00
47. 00		ELECTROCARDI OLOGY	o	0	Ö	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1	0	48. 00
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0	0	0	4	0	49. 00 50. 00
51.00		SUPPORT SURFACES		0	0	0	0	51. 00
52.00		OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	O	0	O	O	0	60. 00
61.00	1	RURAL HEALTH CLINIC		0		0	0	61. 00
62. 00	06200	FQHC						62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	0	0	0	0	0	63. 00
70. 00		HOME HEALTH AGENCY COST	T ol	0	0	0	0	70. 00
71. 00	07100	AMBULANCE	o	0	0	0	0	71. 00
72.00	07200		0	0	0	0	0	72.00
73. 00 74. 00	07300	OTHER REIMBURSABLE COST		0	0	0	0	73. 00 74. 00
	SPECIA	AL PURPOSE COST CENTERS	-1	·	-	-,	_	
		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW						81. 00 82. 00
83. 00		HOSPI CE	o	0	0	0	0	83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	10, 668	66	0	121	2, 097	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	o	0	0	0	0	91. 00
92.00		PHYSICIANS PRIVATE OFFICES	0	0		0	0	92.00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY		0	1	0	0	93. 00 94. 00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	o	105	0	0	3, 340	95. 00
95. 01	1	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 01
95. 02 95. 03		MARKETING COMMUNITY HOME HEALTH		0	0	0 0	0	95. 02 95. 03
95. 04	1	I NDEPENDENT LI VI NG	0	0	1	ő	0	95. 04
98.00		Cross Foot Adjustments	0	0	I -	_	_	98. 00
99. 00 100. 00		Negative Cost Centers TOTAL	10, 668	0 171		0 121	0 5 437	99. 00 100. 00
. 55. 50	-1	· - · · · -	10,000	171	١	121	5, 457	

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315445

				Т	o 12/31/2022	Date/Time Pre 5/30/2023 11:	
			OTHER GENERAL			3/30/2023 11.	U7 alli
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION 14.00	15.00	1/ 00	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14.00	15. 00	16. 00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY						11. 00 12. 00
	01300 SOCIAL SERVICE						13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
	01500 ACTIVITIES	0	l .				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 SKILLED NURSING FACILITY	0	40	261, 046	0	261, 046	30. 00
	03100 NURSING FACILITY	0			1	0	31. 00
	03200 CF/ I D	0	•		1	0	
33. 00	03300 OTHER LONG TERM CARE	0	24	172, 424	0	172, 424	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	29	0	29	40.00
41. 00	04100 LABORATORY			1		71	1
	04200 I NTRAVENOUS THERAPY		1	1		0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	O	53	0	53	1
44.00	04400 PHYSI CAL THERAPY	0	0	3, 861	0	3, 861	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	518	0	518	45. 00
	04600 SPEECH PATHOLOGY	0	0	151	0	151	1
	04700 ELECTROCARDI OLOGY	0	0	1	,	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1, 197		1, 197	1
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY			1		430 0	1
51. 00	05100 SUPPORT SURFACES		_	1	1	0	1
	05200 OTHER ANCILLARY SERVICE COST CENTERS					0	1
	OUTPATIENT SERVICE COST CENTERS	•	•				1
60.00	06000 CLI NI C	0	1		0	0	60. 00
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	
62.00	06200 FOHC					0	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0) <u> </u>	0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
	07100 AMBULANCE					0	1
72.00	07200 CORF	0	O		0	0	1
73.00	07300 CMHC	0	0) c	0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0) <u> </u>	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	0			0	0	1
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	o		0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	64	439, 780	0	439, 780	89. 00
	NONREI MBURSABLE COST CENTERS	_					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	0	0	
	09100 BARBER AND BEAUTY SHOP	0	_		0	0	
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0				0	
	09400 PATIENTS LAUNDRY			5, 503		5, 503	93. 00 94. 00
	09500 OTHER NONREIMBURSABLE COST CENTERS		102			3, 547	1
	09501 OTHER NONREIMBURSABLE COST CENTERS			0,017) o	0,017	1 .
	09502 MARKETI NG			990	o o	990	1
95. 03	09503 COMMUNITY HOME HEALTH		0	140		140	1
95. 04	09504 I NDEPENDENT LI VI NG	0	0	1, 102, 692	2 0	1, 102, 692	1
98. 00	Cross Foot Adjustments	0	0	0	0	0	
99. 00	Negative Cost Centers	0	1	1	0	1 552 453	
100.00	TOTAL	0	166	1, 552, 652	2 0	1, 552, 652	1100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315445

				1	o 12/31/2022	Date/Time Pre 5/30/2023 11:	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
			, ,	SALARI ES)		,	
	GENERAL SERVICE COST CENTERS	1. 00	2.00	3. 00	4A	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	240, 989					1. 00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	240, 989	1			2. 00 3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2,720	١			15, 673, 989	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	996	996	480, 018	0	1, 832, 057	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 094	1, 094			83, 629	6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	1, 097 13, 874	1, 097 13, 874			816, 766 2, 931, 206	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	1, 536	l			594, 407	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	C	0	152, 560	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0	86, 939	0	0 108, 173	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	816	816			110, 166	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1	0	_	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	107, 337	0	148, 833	15. 00
30.00	03000 SKILLED NURSING FACILITY	30, 766	30, 766	1, 978, 906	0	3, 309, 579	30.00
31. 00	03100 NURSING FACILITY	0	0	C	_	0	31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	22, 576	0 22, 576	788, 995	0	_	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	22,310	22,370	700, 770		1, 144, 071	33.00
40.00	04000 RADI OLOGY	0	1	1		,	40. 00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0		0	62, 514 0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0			0	46, 970	43.00
44. 00	04400 PHYSI CAL THERAPY	496	496	C	0	554, 338	44. 00
45. 00	04500 OCCUPATIONAL THERAPY	0	0	C	0	455, 008	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		0	131, 842 0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	174	174	Ö	0	56, 451	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	380, 715	49. 00
50. 00 51. 00	O5000 DENTAL CARE - TITLE XIX ONLY O5100 SUPPORT SURFACES	0	0		0	0	50. 00 51. 00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS				0	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0		0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	o c	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS	1		J		1 0	70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			0	70. 00 71. 00
	07200 CORF	0	Ö		0	ō	
73.00	07300 CMHC	0	0	0	0	0	73.00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0) (0	0	74. 00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 NTEREST EXPENSE						81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0		0	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	Ö		Ö	ő	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	76, 145	76, 145	6, 601, 931	-2, 464, 945	12, 945, 864	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0				0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0			0	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0) c	0	0	92. 00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0		0	0	93.00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	844	844 0		0	5, 438 0	94. 00 95. 00
95. 01	09501 OTHER NONREIMBURSABLE COST CENTERS	0	0) c	0	0	95. 01
95. 02	09502 MARKETI NG	0	0	325, 923		885, 937	95. 02
95. 03 95. 04	O9503 COMMUNITY HOME HEALTH O9504 INDEPENDENT LIVING	164, 000	164, 000	99, 794 483, 433		125, 103 1, 711, 647	95. 03 95. 04
98. 00	Cross Foot Adjustments	101,000	101,000	100, 400		1,,,,,,,,	98. 00
99. 00	Negative Cost Centers		2.5				99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 210, 010	342, 642	1, 834, 488		2, 464, 945	102. 00
103.00		5. 021018	1. 421816	0. 244238		0. 157263	103. 00

Health Financial S	Systems	THE ARBOR AT L	AUREL CIRCLE		In Lie	eu of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS			Provi der		Period: From 01/01/2022	Worksheet B-1	
					Го 12/31/2022	Date/Time Pre 5/30/2023 11:	
		CAPITAL REL	_ATED COSTS				
Cost (Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		(SQUARE TEET)	(SQUARE TEET)	SALARI ES)		(ACCOM. COST)	
		1. 00	2.00	3.00	4A	4. 00	
104.00 Cost Part	to be allocated (per Wkst. B, II)				D	17, 524	104. 00
105.00 Unit (cost multiplier (Wkst. B, Part			0.00000		0. 001118	105. 00

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

						5/30/2023 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION, MAINT. &	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		REPAI RS	LAUNDRY)			(DIRECT NURS.	
		(SQUARE FEET)				HRS.)	
	T	5. 00	6. 00	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS	1	ı	ı		ı	1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	237, 273					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 094					6. 00
7.00	00700 HOUSEKEEPI NG	1, 097	0	235, 082			7. 00
8.00	00800 DI ETARY	13, 874		13, 874			8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	1, 536	0	1, 536	0	60, 758	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	816		816	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0				Ö	14. 00
15. 00	01500 ACTIVITIES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	30, 766	77, 410	30, 766	45, 621	60, 758	
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	0	0	00.57/	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	22, 576	0	22, 576	28, 200	0	33. 00
40. 00	04000 RADI OLOGY	0	1	0	0	0	40.00
41. 00	04100 LABORATORY			· -	_	1	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	•	Ö	0	Ö	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	496	0	496	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	174	0	174	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	174	•	174	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		1		0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	•	٥	0	Ö	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS	1					
60.00	06000 CLINIC	0		0		0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200 FOHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS				0		03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72.00	07200 CORF	0	0	0	0	0	72. 00
	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REI MBURSABLE COST	0	0	0	0	0	74.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		I	1		I	80.00
80.00	08100 NTEREST EXPENSE	1					81.00
82. 00	08200 UTI LI ZATI ON REVI EW	1					82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	72, 429	77, 410	70, 238	73, 821	60, 758	89. 00
	NONREI MBURSABLE COST CENTERS	1	Ι .	Ι .	1	1 -	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	1	0	0	0	90. 00 91. 00
91. 00 92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		0	_	0	91.00
93. 00	09300 NONPALD WORKERS		•		0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	844	0	844	0	Ö	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
95. 01	09501 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 01
95. 02	09502 MARKETI NG	0	0	0	0	0	95. 02
95. 03	09503 COMMUNITY HOME HEALTH	0	0	0	0	0	95. 03
95. 04	09504 INDEPENDENT LIVING	164, 000	0	164, 000	39, 629	0	95. 04
98. 00 99. 00	Cross Foot Adjustments	1					98. 00 99. 00
102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 120, 172	106, 557	955, 015	3, 572, 511	707, 850	•
102.00	Part I)	2, 120, 172	100, 557	755,015	3, 372, 311	707, 630	102.00
103.00		8. 935581	1. 376528	4. 062476	31. 489740	11. 650318	103. 00
104.00	Cost to be allocated (per Wkst. B,	8, 465	l .				104. 00
	Part II)	1					

Health Financial Systems		THE ARBOR AT L	AUREL CIRCLE		In Lie	eu of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASI	S		Provi der		Peri od:	Worksheet B-1	
					rom 01/01/2022		
					o 12/31/2022		
						5/30/2023 11:	<u>07 am</u>
Cost Center Description	on	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(POUNDS OF				
		REPAI RS	LAUNDRY)			(DIRECT NURS.	
		(SQUARE FEET)				HRS.)	
		5.00	6. 00	7.00	8. 00	9. 00	
105.00 Unit cost multiplier	(Wkst. B, Part	0. 035676	0. 092753	0. 034116	0. 825324	0. 175582	105. 00
11)							

CONTRAL SERVICE OF CONTROL SERVI						o 12/31/2022	Date/Time Pre 5/30/2023 11:	
CENTRAL SERVICE COST CENTERS		Cost Center Description				SOCIAL SERVICE	NURSI NG AND	
CHIERT LAYS CRISTS CRIS				(PATIENT DAYS)		(DATIENT DAVS)		
BRYONE 10.00 11.00 12.00 13.00 14.00 1.00						(FAITENT DATS)		
The Company					REVENUE)		TIME)	
1.00 1000 CAP REL COSIS - SILLOS & FIXIORES 2.00 2		OFNEDAL CEDILLOS COCT OFNEDO	10.00	11.00	12. 00	13. 00	14. 00	
2.00 DICCORD CAP REL COSTS - MINANEL EQUIPMENT 3.00	1 00			1				1 1 00
0.000 0.000 DAMIN STRATIVE & CENERAL								2. 00
0.0000 CALT OFFRATION, MAINT, & REPAIRS	3.00							3. 00
0.00 00.000 AURIDAY S. LINEN SERVICE 6 .00 00.000 DI ETARY 6.4 .511 11.00 00.000 DI SARMACY 11.000 00.000 00.000 DI SARMACY 11.000 00.000 00.000 DI SARMACY 11.000 00.000 00.000 DI SARMACY 11.000 00.0000 DI SARMACY 11.000 00.000 00.000 DI SARMACY 11.0000 00.0000 DI SARMACY								4. 00
7. 00 00700 MUSICKEEP ING								1
0.000 0.0000 DETAINY								1
10.00 01000 CENTRAL SERVICES & SUPPLY 0.4,511 10.00 110,687,602 11.100 110,011 11.00 111,011 11.00		l						8. 00
11.00 0 1000 PHARMACY	9.00							9. 00
12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 0			64, 511	1				10.00
13.00 01300 SOCIAL SERVICE 0 0 0 0 64,511 13.0 to 1500 ACTIVITIES 0 0 0 0 0 0 0 0 0		l	0		10 407 402			1
14.00 01400 MURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 15.00		l		_	10, 667, 602			1
IMPATE ENT ROUTE NET ROUTE OST CENTERS 15,492 15,492 15,492 15,492 0.30.00 30.00 31.00 31.00 31.00 31.00 32.00 33.00		l	0	o	0		0	1
30.00 3000 SKILLEN NIRSING FACILITY 15,482 15,482 8,006,343 15,482 0 30.00 31.00 32.00 33.00 33.00 03300 ICF/I I D 0 0 0 0 0 0 32.00 33.00 03300 OIHER LOWIS TERM CARE 9,400 9,400 0 9,400 0 33.00 33.00 OIHER LOWIS TERM CARE 9,400 9,400 0 9,400 0 0 0 0 32.00 03.00 0	15. 00	01500 ACTI VI TI ES	0	o	0	0	0	15. 00
31.00 03100 NURSING FACILITY								
32.00 03200 ICF/1 ID			1		8, 006, 343		0	1
33 00 03300 OTHER LONG TERM CARE			1	-	0	-) 0	
ANCILLARY SERVICE COST CENTERS			1	1 "1	ū	J		1
1.1								1
42.00 0.4200 NTRAVENOUS THERAPY 0 0 0 0 0 0 2.00			1	1	·			
43. 00 04300 DAYSER (INHALATION) THERAPY			0	-1		0	_	
44. 00 04400 PHYSICAL THERAPY 0 0 964, 648 0 0 44. 00		ł ł			J	0		1
46.00 04600 SPEECH PATHOLOGY			0	ol ol		0	_	1
47. 00 04700 ELECTROCARDI OLOCY 0 0 0 0 0 0 0 48. 004 49. 00 4900 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 380, 477 0 0 0 49. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l	0	o	833, 922	0	0	45. 00
48. 00 04800 MEDIC CAL SUPPLIES CHARGED TO PATIENTS		i i	0	0	325, 453	0	0	46. 00
49.00 04900 DRIVAL CARGED TO PATIENTS 0 0 0 380,477 0 0 49.00		1 · · · · · · · · · · · · · · · · · · ·	0		94 004	0	_	1
SOLOD OSDOO DENTAL CARE - TITLE XIX ONLY O						0	_	
S2.00 OS200 OS200 OSCILLARY SERVICE COST CENTERS OSCILLARY SERVICE COST CENTERS		l	0	o o		0	_	1
OUTPATIENT SERVICE COST CENTERS O	51.00	05100 SUPPORT SURFACES	0	o	0	0	0	51.00
60.00 06000 CLINIC 0 0 0 0 0 0 0 0 0	52. 00		0	0	0	0	0	52. 00
61.00 06200 FOLION COLUMN COLUM	60.00			i I	0	1	0	60.00
62.00 06200 O O O O O O O O O		l	1	1				
OTHER REL MBURSABLE COST CENTERS O		l						62. 00
70. 00	63.00		0	0	0	0	0	63. 00
71. 00 07100 AMBULANCE 0 0 0 0 0 0 0 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00	70.00			ا				70.00
72.00 07200 CORF 0 0 0 0 0 0 0 0 0 72.00					0	0		
73.00 07300 CMHC 07400 0 0 0 0 0 0 0 0 0		l			0	0	_	1
SPECIAL PURPOSE COST CENTERS 80.00	73.00	07300 CMHC	0	o	0	0	0	
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81. 00 81. 00 08100 INTEREST EXPENSE 82. 00 08200 UTL LI ZATI ON REVI EW 82. 00 08200 UTL LI ZATI ON REVI EW 82. 00 08200 UTL LI ZATI ON REVI EW 82. 00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0	74. 00		0	0	0	0	0	74. 00
81. 00 08100 INTEREST EXPENSE	90 00			1				90 00
82. 00 08200 UTILIZATION REVIEW 0 0 0 0 0 0 0 0 83. 00 83. 00 08300 HOSPICE 0 0 0 0 0 0 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 84. 00 89. 00 SUBTOTALS (sum of lines 1-84) 24,882 24,882 10,687,602 24,882 0 89. 00 NONNEI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
84. 00								82. 00
89. 00 SUBTOTALS (sum of lines 1-84) 24,882 24,882 10,687,602 24,882 0 89. 00		ł	0	o	0	0	0	
NONREI MBURSABLE COST CENTERS O O O O O O O O O			0	0	0	0		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0	89. 00		24, 882	24, 882	10, 687, 602	24, 882	0	89.00
91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91. 00 92. 00 92. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 94. 00 95.	90. 00		0	n n	n	0	n	90.00
93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 39, 629 39, 629 0 39, 629 0 95. 01 95. 01 09501 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 95. 02 09502 MARKETI NG 0 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 95. 04 09504 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 95. 04			0	o	0	0	0	1
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94. 00 95. 00 9			0	0	0	0		
95. 00 09500 07HER NONREIMBURSABLE COST CENTERS 39,629 39,629 0 39,629 0 95.00 95.00 95.00 07HER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 95.00 95.00 95.00 95.00 07HER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 95.00 95.00 95.00 95.00 07HER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 95.00 95.00 95.00 0 0 0 0 0 0 0 0 0			0	0	0	0		
95. 01 09501 07HER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 95. 01 95. 02 09502 MARKETING 0 0 0 0 0 0 95. 03 09503 09503 09503 09503 0000000117 0000000 0 0 0 95. 04 09504 1 NDEPENDENT LIVING 0 0 0 0 96. 05 09504 09504 09504 0000001 0000000000000000000000000			39 629	39 629	0	39 629) 0	
95. 02 09502 MARKETING 0 0 0 0 0 0 0 0 95. 02 95. 03 09503 COMMUNITY HOME HEALTH 0 0 0 0 0 0 0 0 95. 03 95. 04 09504 INDEPENDENT LIVING 0 0 0 0 0 0 0 0 95. 04 98. 00 99. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			37,027	0	0	0,029		1 .
95. 04 09504 INDEPENDENT LIVING 0 0 0 0 95. 04 98. 00 99. 00 0 0 99. 00 99. 00 0 99. 00 0 99. 00 0 99. 00 0 99. 00 0 99. 00 0 99. 00 0 99. 00 0 99. 00 0 99. 00 0 0 0 0 0 0 0 0 0		09502 MARKETI NG		o o	0	0		
98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 125,185 138,097 0 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 2.736774 0.000000 0.011713 2.140674 0.000000 103.00 104.00 104.00 105.00 10		l	0		0	0	0	
99. 00 Negative Cost Centers 99. 00 125, 185 138, 097 0 102. 00 103. 00 104. 00 104. 00 105. 00		l	0	9	0	0	0	95. 04
102.00 Cost to be allocated (per Wkst. B, Part I) 176,552 0 125,185 138,097 0 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 2.736774 0.000000 0.011713 2.140674 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, 171 0 121 5,437 0 104.00		l I						1
Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, 171 0 121 5, 437 0 104.00		1 1 5	176. 552	0	125. 185	138. 097	0	1
104.00 Cost to be allocated (per Wkst. B, 171 0 121 5,437 0 104.00		Part I)						
			1	1				
	104.00	l ''	171	0	121	5, 437	0	104.00
			<u> </u>	<u> </u>		l l	I	I

Health Financial Systems	THE ARBOR AT L	AUREL CIRCLE		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2022 Fo 12/31/2022		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSING AND	
	SERVICES &	(PATIENT DAYS)	RECORDS &		ALLI ED HEALTH	
	SUPPLY		LI BRARY	(PATIENT DAYS)	EDUCATI ON	
	(PATIENT DAYS)		(GROSS		(ASSI GNED	
			REVENUE)		TIME)	
	10.00	11. 00	12.00	13. 00	14.00	
105.00 Unit cost multiplier (Wkst. B, Part	0. 002651	0. 000000	0. 000011	0. 084280	0.000000	105.00
11)						

THE ARBOR AT LAUREL CIRCLE In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315445

				5/30/2023 11:	
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
			(PATIENT DAYS)		
	CENED	AL SERVICE COST CENTERS	15. 00		
1.00		CAP REL COSTS - BLDGS & FLXTURES			1.00
2. 00		CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00		EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00		LAUNDRY & LINEN SERVICE			6.00
7.00		HOUSEKEEPI NG			7. 00
8. 00 9. 00	1	DIETARY NURSING ADMINISTRATION			8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY			10.00
11. 00		PHARMACY			11. 00
12.00	1	MEDICAL RECORDS & LIBRARY			12. 00
13.00	01300	SOCIAL SERVICE			13. 00
14. 00	01400	NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00		ACTIVITIES	64, 511		15. 00
20.00		TENT ROUTINE SERVICE COST CENTERS	15 400		20.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	15, 482		30.00
32. 00		I CF/IID			32.00
33. 00		OTHER LONG TERM CARE	9, 400		33. 00
		LARY SERVICE COST CENTERS	., ., .,		1
40.00	04000	RADI OLOGY	0		40. 00
41.00	04100	LABORATORY	0		41. 00
42.00	1	I NTRAVENOUS THERAPY	0		42. 00
43.00	1	OXYGEN (INHALATION) THERAPY	0		43.00
44. 00	1	PHYSI CAL THERAPY	0		44. 00
45. 00 46. 00		CCUPATIONAL THERAPY SPEECH PATHOLOGY			45. 00 46. 00
47. 00	1	ELECTROCARDI OLOGY			47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	o		48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0		49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00		SUPPORT SURFACES	0		51. 00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0		52. 00
(0.00		TIENT SERVICE COST CENTERS	O		1,0,00
60. 00 61. 00	1	CLINIC RURAL HEALTH CLINIC	0		60. 00 61. 00
62. 00	06200	1			62. 00
63. 00	1	OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
	OTHER	REIMBURSABLE COST CENTERS			
70. 00		HOME HEALTH AGENCY COST	0		70. 00
		AMBULANCE	0		71.00
72.00	07200	l e e e e e e e e e e e e e e e e e e e	0		72.00
	07300	OTHER REIMBURSABLE COST	0		73. 00 74. 00
74.00		AL PURPOSE COST CENTERS	U U		1 74.00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81. 00		I NTEREST EXPENSE			81. 00
82. 00		UTILIZATION REVIEW			82. 00
83. 00		HOSPI CE	0		83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0		84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	24, 882		89. 00
90. 00	USUUVE	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00		BARBER AND BEAUTY SHOP			91.00
92. 00		PHYSICIANS PRIVATE OFFICES	o o		92.00
93. 00	09300	NONPALD WORKERS	0		93. 00
94. 00	1	PATIENTS LAUNDRY	0		94. 00
95. 00	1	OTHER NONREIMBURSABLE COST CENTERS	39, 629		95. 00
95. 01		OTHER NONREIMBURSABLE COST CENTERS	0		95. 01
95. 02 95. 03	1	MARKETING COMMUNITY HOME HEALTH			95. 02 95. 03
95. 03 95. 04	1	INDEPENDENT LIVING			95. 03
98. 00	3,304	Cross Foot Adjustments			98. 00
99. 00		Negative Cost Centers			99. 00
102.00)	Cost to be allocated (per Wkst. B,	172, 239		102. 00
		Part I)			
103.00	1	Unit cost multiplier (Wkst. B, Part I)	2. 669917		103. 00
104.00	'	Cost to be allocated (per Wkst. B, Part II)	166		104. 00
	1	11 (11)	ı l		1

Health Financial Systems	THE ARBOR AT LAUR	EL CIRCLE	In Lieu	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der No.: 315445	Peri od: From 01/01/2022	Worksheet B-1	
			To 12/31/2022	Date/Time Pre 5/30/2023 11:	pared: 07 am
	OTHER GENERAL				
	SERVI CE				
Cost Center Description	ACTI VI TI ES				
	(PATIENT DAYS)				
	15. 00				
105.00 Unit cost multiplier (Wkst. B, Part	0. 002573				105. 00

Health Financial Systems	THE ARBOR AT LAUREL CIRCLE	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCILLA	RY AND OUTPATIENT COST CENTERS Provider No.: 315445	Peri od: Worksheet C

THE STATE OF	 	From 01/01/2022		
		To 12/31/2022		narod:
		10 12/31/2022	5/30/2023 11:0	
Cost Center Description	Total (from	Total Charges	Ratio (col. 1	07 4111
pro-	Wkst. B, Pt I		di vi ded by	
	col . 18)		col. 2	
	1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS	•			
40. 00 04000 RADI OLOGY	30, 10	24, 915	1. 208188	40. 00
41. 00 04100 LABORATORY	73, 08	62, 713	1. 165309	41. 00
42. 00 04200 I NTRAVENOUS THERAPY		o	0.000000	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY	54, 41	7 5, 127	10. 613809	43.00
44. 00 04400 PHYSI CAL THERAPY	659, 26		0. 683421	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	536, 33	2 833, 922	0. 643144	45. 00
46. 00 04600 SPEECH PATHOLOGY	156, 38			46. 00
47. 00 04700 ELECTROCARDI OLOGY		o o	0. 000000	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	68, 57	5 84,004	0. 816330	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	445, 04	4 380, 477	1. 169700	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY		o	0. 000000	50.00
51. 00 05100 SUPPORT SURFACES		ol	0. 000000	51.00
52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS		o	0.000000	52. 00
OUTPATIENT SERVICE COST CENTERS				
60. 00 06000 CLI NI C	1	0 0	0.000000	60.00
61. 00 06100 RURAL HEALTH CLINIC				61. 00
62. 00 06200 FQHC				62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER		o	0.000000	63. 00
71. 00 07100 AMBULANCE		o lc	0.000000	71. 00
100. 00 Total	2, 023, 19	9 2, 681, 259		100.00
• •	•			

Heal th Financial Systems	THE ARBOR AT L				u of Form CMS-	20.0 .0
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315445	Peri od: From 01/01/2022	Worksheet D Part I	
				To 12/31/2022	Date/Time Pre	nared.
				10 12/01/2022	Date/Time Pre 5/30/2023 11:	07 am
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
				5 1 1 (1 1	lo , o , , ,	
	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	ILIVI COST					-
40. 00 04000 RADI OLOGY	1. 208188	15, 071		0 18, 209	0	40.00
41. 00 04100 LABORATORY	1. 165309			0 41, 670	•	
42. 00 04200 NTRAVENOUS THERAPY	0. 000000			0 0	Ö	
43. 00 04300 0XYGEN (INHALATION) THERAPY	10. 613809			0 40, 110		
44. 00 04400 PHYSI CAL THERAPY	0. 683421	442, 744		0 302, 581	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 643144			0 285, 175	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0. 480524			0 83, 773		46. 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 816330	41, 256		0 33, 679	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 169700	274, 967		0 321, 629	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0	0	
71. 00 07100 AMBULANCE (2)	0. 000000	ł		0	0	
100.00 Total (Sum of lines 40 - 71)		1, 431, 319		0 1, 126, 826	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	V					

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

Heal th	Financial Systems	THE ARBOR AT L	AUREL CIRCLE		In Lie	u of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III Date/Time Pre 5/30/2023 11:	pared: 07 am
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
	PART II - APPORTIONMENT OF VACCINE COST					1. 00	
1. 00	Drugs charged to patients - ratio of co	ost to charges	(From Workshee	t C column 3	line 49)	1. 169700	1.00
2.00	Program vaccine charges (From your reco			t o, coramir o	11110 17)	0	1
3.00	Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	0	
	E, Part I, line 18)	,					
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
		,	Allied Health		Cost (From	& Allied	
			(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col . 2 / Col 1)		3 x Col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	30, 102		1 0.00000		0	40. 00
41.00	04100 LABORATORY	73, 080	0	0.00000		0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0. 00000		0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	54, 417	0	0. 00000			43. 00
	04400 PHYSI CAL THERAPY	659, 261	0	0.00000		0	
	04500 OCCUPATI ONAL THERAPY	536, 332		0.00000		0	
	04600 SPEECH PATHOLOGY	156, 388	0	0.00000		0	
	04700 ELECTROCARDI OLOGY	(0.575	0	0.00000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	68, 575 445, 044	l e	0. 00000 0. 00000		0	48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	440,044		0.00000		0	50.00
51. 00	05100 SUPPORT SURFACES			0.00000		0	
	05200 OTHER ANCILLARY SERVICE COST CENTERS			0.00000		0	
100.00		2, 023, 199	ĺ	1	1, 126, 826	_	100.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, , , , , , , , , , , , , , , , , , , ,	-	1	, , , , , , , , , , , , , , , , , , , ,		

	Financial Systems THE ARBOR AT LAUREL ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315445	Peri od: From 01/01/2022	u of Form CMS-2 Worksheet D-1 Parts I-II	
			To 12/31/2022	Date/Time Prep 5/30/2023 11:0	pareo
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days including private room days			15, 482	1.
00	Private room days			0	2.
00	Inpatient days including private room days applicable to the Pro Medically necessary private room days applicable to the Program	ogram		5, 866 0	3. 4.
00 00	Total general inpatient routine service cost			6, 691, 584	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0, 071, 304	, ,
00	General inpatient routine service charges			8, 006, 343	6
00	General inpatient routine service cost/charge ratio (Line 5 div	vided by line 6)		0. 835785	7
00	Enter private room charges from your records			0	8
00	Average private room per diem charge (Private room charges line	8 divided by private	room days, line	0.00	9
00	2)			0	10
00	Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room cl	argos Lino 10 divido	d by	0 0. 00	
00	semi -private room days)	larges fille 10, divide	u by	0.00	' '
00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12
00	Average per diem private room cost differential (Line 7 times li			0.00	13
00	Private room cost differential adjustment (Line 2 times line 13))		0	14
00	General inpatient routine service cost net of private room cost PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus line 14)	6, 691, 584	15
00	Adjusted general inpatient service cost per diem (Line 15 divid	ded by line 1)		432. 22	16
00	Program routine service cost (Line 3 times line 16)			2, 535, 403	17
00	Medically necessary private room cost applicable to program (I			0	
00	Total program general inpatient routine service cost (Line 17)			2, 535, 403	
00	Capital related cost allocated to inpatient routine service cosine 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ts (From Wkst. B, Par	t II column 18,	261, 046	20
00	Per diem capital related costs (Line 20 divided by line 1)			16. 86	
00	Program capital related cost (Line 3 times line 21)			98, 901	
00	Inpatient routine service cost (Line 19 minus line 22)	dd->		2, 436, 502	
00	Aggregate charges to beneficiaries for excess costs (From provi Total program routine service costs for comparison to the cost		nuc line 24)	0 2, 436, 502	24 25
00	Enter the per diem limitation (1)	Timi tation (Line 23 iii	nus ime 24)	2, 430, 502	25
00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus the		, · · /		28
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		,		
Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS F	OR PPS PASS-THROUGH			
00	Total SNF inpatient days			15, 482	
00	Program inpatient days (see instructions)		VI V	5, 866	
00	Total nursing & allied health costs. (see instructions) (Do not of	complete for titles V	or XIX)	0 270002	3
00	Nursing & allied health ratio. (line 2 divided by line 1)			0. 378892	4

Health Financial Systems	THE ARBOR AT LAUREL	CIRCLE	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	FOR TITLE XVIII	Provi der No.: 315445	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 11:07 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT		11 00	
1.00	Inpatient PPS amount (See Instructions)			3, 791, 049	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)	,		3, 791, 049	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			470, 301	5. 00
6.00	Allowable bad debts (From your records)			29, 477	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			19, 160	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			3, 339, 908	11. 00
12.00	Interim payments (See instructions)			3, 282, 588	
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)			242	14. 75
14. 99	Sequestration amount (see instructions)			39, 754	14. 99
15. 00	.00 Balance due provider/program (see Instructions)				
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)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 11E 2	0	29. 00 30. 00
30.00	Triorested amounts (Monariowable cost report items) in accordance	e with two rub. 15-2,	SECTION 113. 2	υĮ	30.00

From 01/01/2022 To 12/31/2022

2/31/2022 Date/Time Prepared: 5/30/2023 11:07 am d Nursing 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		3, 280, 994		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
5. 00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/28/2023	1, 594		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3. 04			0		0	
3.05			0		0	3. 05
	Provi der to Program		ما			
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51 3. 52			0		0	
3. 52			0		0	
3. 54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		1, 594		0	3. 99
J. 77	- 3.98)		1, 374		٥	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 282, 588		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line		., . ,			
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 02	TENTATIVE TO PROVIDER		0		0	
5. 02			0		0	
0.00	Provider to Program		5			0.00
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)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		47.00			
6. 01	PROGRAM TO PROVIDER		17, 324		0	6. 01
6. 02 7. 00	PROVIDER TO PROGRAM Total Medicare program liability (see instructions)		0 3, 299, 912		0 0	
7.00	Total medicale program frability (see instructions)		3, 299, 912 Contract	or Name	Contractor	7. 00
			COITTI de l	.or maine	Number	
			1. (00	2. 00	
8. 00	Name of Contractor					8. 00

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

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

Provider No.: 315445 | Period: From 01/01/20

| Period: | Worksheet G | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 11:07 am

ni y)			0 10		5/30/2023 11:	07 am
		General Fund	Speci fic Purpose Fund	Endowment Fund	Plant Fund	
Δς	ssets	1.00	2.00	3. 00	4. 00	
	IRRENT ASSETS					
1	ash on hand and in banks	2, 420, 650	0	0	0	
1	emporary investments	0	0	0	0	
	otes recei vabl e	1 104 701	0	0	0	1
	ccounts recei vabl e ther recei vabl es	1, 104, 791	0	0	0	
	ess: allowances for uncollectible notes and accounts	-146, 930	_	0	0	
	ecei vabl e	110,700		ŏ	ŭ	0. \
00 I r	nventory	78, 476	0	o	0	7. (
1	repaid expenses	428, 287	0	0	0	
1	ther current assets	0	0	0	0	1
	ue from other funds	2 005 274	0	0	0	
	OTAL CURRENT ASSETS (Sum of Lines 1 - 10) XED ASSETS	3, 885, 274	ı U	0	U	11.
	and	Ι ο	0	ol	0	12.
	and improvements	148, 563	1	o	0	1
1	ess: Accumulated depreciation	-22, 938		0	0	1
5. 00 Bu	uildings	665, 315	0	o	0	15.
	ess Accumulated depreciation	-241, 298	0	0	0	
1	easehold improvements	2, 963, 970		0	0	
	ess: Accumulated Amortization	-505, 437	1	0	0	
	xed equipment	796, 067		0	0	1
	ess: Accumulated depreciation	-423, 088		0	0	
	utomobiles and trucks	0	0	0	0	
	ess: Accumulated depreciation	2, 439, 690	0	U O	0	
	ajor movable equipment ess: Accumulated depreciation	-1, 001, 330		0	0	
1	inor equipment - Depreciable	-1,001,330		0	0	
	inor equipment nondepreciable	0	o o	Ö	0	
	ther fixed assets	178, 455	_	ol	0	
4	OTAL FIXED ASSETS (Sum of lines 12 - 27)	4, 997, 969		ō	0	
	THER ASSETS	<u> </u>		<u> </u>		
9.00 Ir	nvestments	0	0	0	0	29.
1	eposits on Leases	0	0	0	0	
1	ue from owners/officers	0	0	0	0	
4	ther assets	18, 835, 237	1	0	0	1
1	OTAL OTHER ASSETS (Sum of lines 29 - 32)	18, 835, 237	1	0	0	
	OTAL ASSETS (Sum of lines 11, 28, and 33) abilities and Fund Balances	27, 718, 480	0	0	0	34.
	IRRENT LIABILITIES					1
	ccounts payable	3, 772, 863	0	ol	0	35.
5. 00 Sa	alaries, wages, and fees payable	542, 638		o	0	
7. 00 Pa	ayroll taxes payable	0	0	o	0	37.
	otes & Loans payable (Short term)	0	0	0	0	
	eferred income	14, 265, 668	0	0	0	
	ccel erated payments	0				40
1	ue to other funds	0	_	0	0	
	ther current liabilities	8, 797, 308	1	0	0	
	OTAL CURRENT LIABILITIES (Sum of lines 35 - 42) ONG TERM LIABILITIES	27, 378, 477	0	0	0	43
_	ortgage payable	1 0	0	ol	0	44
1	otes payable		0	0	0	1
1	nsecured Loans	0	o o	Ö	0	
1	pans from owners:	l o	Ö	ol	0	
- 1	ther long term liabilities	6, 031, 451	0	ō	0	
	THER (SPECIFY)	0	o	o	0	
. 00 TO	OTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	6, 031, 451		o	0	50
	OTAL LIABILITIES (Sum of lines 43 and 50)	33, 409, 928	0	0	0	51
	APITAL ACCOUNTS					
- 1	eneral fund balance	-5, 691, 448				52
	pecific purpose fund		0			53
4	onor created - endowment fund balance - restricted			0		54
4	onor created - endowment fund balance - unrestricted			0		55
1	overning body created - endowment fund balance lant fund balance - invested in plant			٥	0	56
1	lant fund balance - rnvested in plant lant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion				U	1 30
	OTAL FUND BALANCES (Sum of lines 52 thru 58)	-5, 691, 448	o	n	0	59
	OTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	27, 718, 480	1	ol	0	
	9)	1	1	-	-	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					10 12/31/2022	5/30/2023 11:	
		General	Fund	Special F	Purpose Fund	Endowment Fund	37 diii
				·			
1.00		1.00	2.00	3. 00	4. 00	5. 00	4 00
1.00	Fund balances at beginning of period		-4, 202, 431		0)	1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		-1, 489, 021 -5, 691, 452				2. 00 3. 00
4. 00	Additions (credit adjustments)		-3, 091, 432			'	4. 00
5.00	ROUND OFF	4			0	0	5. 00
6.00	NOOND OTT	0			0	0	6. 00
7. 00					0	0	7. 00
8. 00		o			o	0	8. 00
9.00		O			0	0	9. 00
10.00	Total additions (sum of line 5 - 9)		4		0		10.00
11. 00	Subtotal (line 3 plus line 10)		-5, 691, 448		0		11. 00
12.00	Deductions (debit adjustments)						12.00
13.00		0			0	0	13. 00
14.00		0			0	0	14.00
15. 00		0			0	0	15. 00
16.00		0			0	0	16. 00
17. 00	T	0			0	0	17. 00
18.00	Total deductions (sum of lines 13 - 17)		U F (01 140		0		18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-5, 691, 448		0	'	19. 00
	Silect (Little 11 - 11the 10)	Endowment Fund	PLant	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)		Ō				4. 00
5.00	ROUND OFF		0				5. 00
6. 00 7. 00			0				6. 00 7. 00
8. 00			0				8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 5 - 9)	0	O		0		10. 00
11. 00	Subtotal (line 3 plus line 10)				0		11. 00
12. 00	Deductions (debit adjustments)						12. 00
13.00			0	,			13.00
14.00			0)			14.00
15.00			0)			15.00
16.00			0				16. 00
17. 00			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	0			0		19. 00
	sheet (Line 11 - line 18)			[

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315445		1/01/2022 2/31/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/30/2023 11:	pared:
	Cost Center Description		I npati ent		pati ent	Total	
			1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES						1
	General Inpatient Routine Care Services			_			
. 00	SKILLED NURSING FACILITY		8, 006, 3	43		8, 006, 343	
2. 00	NURSING FACILITY			0		0	
3. 00	ICF/IID			0		0	
1.00	OTHER LONG TERM CARE		4, 740, 0			4, 740, 051	
5. 00	Total general inpatient care services (Sum of lines 1 - 4)		12, 746, 3	94		12, 746, 394	5.0
	All Other Care Services		1				
. 00	ANCI LLARY SERVI CES		2, 681, 2	59	0	2, 681, 259	
. 00	CLINIC				0	0	
. 00	HOME HEALTH AGENCY COST				O	0	
. 00	AMBULANCE				O	0	
0.00	RURAL HEALTH CLINIC				O	0	
0. 10	FQHC				0	0	1
1. 00	CMHC				O	0	
1. 10	CORF				0	0	1
2. 00	HOSPI CE			0	0	0	1
	OTHER (SPECIFY)		6, 116, 0		0	6, 116, 048	
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	21, 543, 7	01	O	21, 543, 701	14.0
	Worksheet G-3, Line 1)						
	Cost Center Description				1. 00	2. 00	
	PART II - OPERATING EXPENSES				1.00	2.00	
. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)					19, 660, 549	1.0
. 00	Add (Specify)				0	17,000,017	2. 0
. 00	Add (Specify)				o o		3. 0
. 00					o o		4.0
. 00					o o		5.0
. 00					Ö		6.0
. 00					ő		7.0
. 00	Total Additions (Sum of lines 2 - 7)				_	0	
. 00	Deduct (Specify)				o	ū	9.0
0. 00	()/				o o		10.0
1. 00					ő		11. C
2. 00					ő		12. 0
3. 00					Ö		13. 0
4 00	Tatal Dadustians (Com of Lines 0 12)				٩		14.0

0 14.00

19, 660, 549 15. 00

14.00 Total Deductions (Sum of lines 9 - 13)
15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

Heal t	Financial Systems THE	ARBOR AT LAUREL C	IRCLE			In Lie	u of Form CMS-2	2540-10
STATE							Worksheet G-3	
						From 01/01/2022	D-+- /T: D	
						To 12/31/2022	Date/Time Pre 5/30/2023 11:	
							37 307 2023 11.	or alli
							1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col. 3, line 14)					21, 543, 701	1. 00
2.00	Less: contractual allowances and discounts on pat	tients accounts					4, 716, 644	2. 00
3.00	Net patient revenues (Line 1 minus line 2)						16, 827, 057	3. 00
4.00	Less: total operating expenses (From Worksheet G-	-2, Part II, line	15)				19, 660, 549	4. 00
5.00	Net income from service to patients (Line 3 minus	s 4)					-2, 833, 492	5. 00
	Other income:							
6.00	Contributions, donations, bequests, etc						0	6. 00
7.00	Income from investments						0	7. 00
8.00	Revenues from communications (Telephone and Inte	ernet service)					0	8. 00
9.00	Revenue from television and radio service						1, 405	9. 00
10.00	Purchase di scounts						0	10. 00
11. 00	Rebates and refunds of expenses						0	11. 00
12. 00	Parking lot receipts						0	12. 00
13.00	Revenue from Laundry and Linen service						0	13. 00
14.00	Revenue from meals sold to employees and guests						196	14. 00
	Revenue from rental of living quarters						11, 985	
	Revenue from sale of medical and surgical supplied		ati ents	;			0	16. 00
	Revenue from sale of drugs to other than patients						0	17. 00
	Revenue from sale of medical records and abstract						0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)						0	19. 00
20. 00		١					0	20. 00
21. 00							0	21. 00
22. 00	9 1						0	22. 00
	Governmental appropriations						0	23. 00
24. 00	Other miscellaneous revenue (specify)						1, 330, 885	24. 00

0 24. 50

0

0

0 30.00

-1, 489, 021 31. 00

25.00 26.00 27. 00 28. 00 29. 00

1, 344, 471 -1, 489, 021

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

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

28. 00

29. 00