## Health Financial Systems COUNTRY ARCH CARE CENTER In Lieu of Form CMS-2540-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expires: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315433 Worksheet S Parts I, II & III Peri od. From 01/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: То 5/30/2023 12:20 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/30/2023 Time: 12:20 pm use only ] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 3.01 [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11.Contractor Vendor Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received:

for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 COUNTRY ARCH CARE CENTER (315433) 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	Joe F	Blachorsky	ř	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Joe Blachorsky			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
Cost Cente	r Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
PART III – SETTI	EMENT SUMMARY					
1.00 SKILLED NURSING	FACI LI TY	0	306, 137	4, 382	0	1.00
2.00 NURSING FACILIT	(	0			0	2.00
3.00 ICF/IID					0	3.00
4.00 SNF - BASED HHA	1	0	0	0		4.00
5.00 SNF - BASED RHC	1	0		0		5.00
6.00 SNF - BASED FQH		0		0		6.00
7.00 SNF - BASED CMH		0		0		7.00
100. 00 TOTAL		0	306, 137	4, 382	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.

OMPLI	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA	<u>COUNTRY ARCI</u> TY HEALTH CAR		Provider No	.: 315433	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/30/20	et S-2 me Pre	pared:
	1.00	2.00			3.00					
	Skilled Nursing Facility and Skilled Nursing		nplex Add	iress:						-
. 00		PO Box:								1.00
. 00	City: PITTSTOWN	State: NJ		Zip Code:08	867					2.00
. 00	County: HUNTERDON	CBSA Code: 35	5084	Urban/Rural	: U					3.00
. 01		CBSA Code:								3.01
			Compone	ent Name	Provi der	Date	Payme	ent Syst	em (P,	
					CCN	Certified		0, or N	)	
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			1	00	2.00	3.00	4.00		6.00	
	SNF and SNF-Based Component Identification:			00	2.00	3.00	1 4.00	1 0.00	0.00	
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00		CENT	IER							
. 00	Nursing Facility									5.00
. 00	I CF/I I D									6.00
. 00	SNF-Based HHA									7.00
. 00	SNF-Based RHC									8.00
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0. 00	SNF-Based CMHC									10.00
	SNF-Based OLTC				1					11.00
2.00	SNF-Based HOSPICE					1		1		12.00
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4 00	Cost Departing Depied (my (dd (my m))					1.00		2.0		14.00
	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/	2022	14.00
5.00	Type of Control (See Instructions)						5			15.00
								Y/		1
								1.0	00	
	Type of Freestanding Skilled Nursing Facility	/								
6.00	Is this a distinct part skilled nursing facil	ity that meet	ts the r	equirements	set forth	in 42 CFR		Y	,	16.00
	section 483.5?	. <b>,</b>								
00	Is this a composite distinct part skilled nur	sing facility	v that m	eets the re	aui rements	set forth	in	Ν	1	17.0
. 00	42 CFR section 483.5?	Sing facility	y that in	leets the re	qui i ellerit s	Set Ioi th		N.	I	17.0
										10.00
8 1	Are there any costs included in Worksheet A t			anaaati ana	with rolot	a d		V	,	
5.00								Y	,	18.00
3.00	organizations as defined in CMS Pub. 15-1, ch							Y		18.00
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		napter 10? I1	fyes, c	omplete Wor	ksheet A-8	-1.		Y		18.00
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9. 00 9. 01 1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 7. 00 8. 00 9. 00 0. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization cost re If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y", Depreciation - Enter the amount of depreciati Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22 If depreciation is funded, enter the balance Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a (Y/N) Did you cease to participate in the Medicare applies? (Y/N) Was there a substantial decrease in health in reports? (Y/N) If this facility contains a public or non-pub- of the lower of the costs or charges enter "Y exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a regardless of the level of care given for Tit	state that ce e insurance v & XIX p e insurance?	f yes, c ite with ictor's c "N" for in this and of th current current and of th portion o that qu component c	a "Y", for a "Y", for riteria for no. SNF for the e period. ng period? or any pri e period to f allowable alifies for and type of alifies for and type of the provic ? (Y/N)	ksheet A-8 yes, or "N filing a method ir (Y/N) or cost re which thi cost from f service	Porting per s cost repo prior cost that qualif	Li nes i od? rt <u>Part</u> 1.00 e appl i es f( N	N N N N N N N N N N N N N N N N N N N	2. 22, 549 ( 22, 549 ( 22, 549 ( 0 ) 0 1 ) N	19.00 19.0 20.00 21.00 22.00 23.00
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Heal th	Financial Systems	COUNTRY ARCH CARE	CENTER	In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 3154		Worksheet S-2	2
COMPLE	X INDENTIFICATION DATA			From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	nared
				10 12/31/2022	5/30/2023 12:	
					Y/N	
					1.00	
	Are malpractice premiums and paid losse				N	42.00
	center? Enter Y or N. If yes, check box	c, and submit supporting s	schedule listing co	ost centers and		
	amounts.					
	Are there any home office costs as defi				N	43.00
	If line 43 is yes, enter the home offic	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	he 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:	Zip	Code:		47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2022 To 12/31/2022	Date/Time Pr	epared
	· · · · · · · · · · · · · · · · · · ·				Y/N	5/30/2023 12 Date	2:20 pm
					1.00	2.00	-
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	ו 1, "Y" fc	r Yes or "N"	for No. For all	the date	
00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)			umn 2. (see	N		1. (
				Y/N	Date	V/I	_
00	Has the provider terminated participation in	the Medicare Progr	am?lf	1.00 N	2.00	3.00	2.
00	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personne of directors through ownership, control, or	of termination and tions, including ma ., chain home offic d to the provider c I, or members of th	in column anagement ces, drug pr its ne board	Y			3.
	relationships? (see instructions)	raining and other si	mirai				
				Y/N	Туре	Date	
	Financial Data and Departs			1.00	2.00	3.00	_
00	Financial Data and Reports Column 1: Were the financial statements preparation of the financial statements and the financial statements and the financial statements of the financial statements and the financial statements of the financial statements and the financial statements of the financial statem	" for Audited, "C" te copy or enter da no, see instructic revenues different	for ate ons. t from	Y	C		4. 5.
	those on the filed financial statements? If reconciliation.	column 1 is "Y", su	ubmi t				
					Y/N	Legal Oper.	
					1.00	2.00	_
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2	. Is the	provider the	N	N	6.
	llogal operator of the program? (V/N)						
00 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) sc	ng the cost reporti	uctions.		NN		
	Were costs claimed for Allied Health Program Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	ng the cost reporti	uctions.		N	Y/N 1.00	
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Health Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der		Period:	Worksheet S-2	
COMPLEX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022		pared:
					5/30/2023 12:	20 pm
						1
		1.	00	2. (	00	
Cost Report Preparer Contact Informatic	n .					
19.00 Enter the first name, last name and the	e title/position	CHARLES		REED		19.00
held by the cost report preparer in col	umns 1, 2, and 3,					
respecti vel y.						
20.00 Enter the employer/company name of the	cost report	EXECUCARE ASSO	CI ATES			20.00
preparer.						
21.00 Enter the telephone number and email ad		(609)738-3200		CRWASSC@NETSCAF	PE. NET	21.00
report preparer in columns 1 and 2, res	specti vel y.					

Heal th	Financial Systems	COUNTRY ARCH O	CARE CENTER		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 12:	pared:
		Part B					
		Date					
	PS&R Data	4.00					
	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	03/17/2023					13.00
14.00	4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and						14.00
15.00	4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",						15.00
16. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.						16.00
17.00	adjustments made to PS&R data for Other? Describe the other adjustments:						17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.						18.00
		-	3	. 00	_		
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		/I CE-PRESI DEN	Τ			19.00
20.00	Enter the employer/company name of the cost r	report					20.00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						21.00

KILLE	Financial Systems D NURSING FACILITY AND SKILLED NURSING X STATISTICAL DATA	COUNTRY ARCH C G FACILITY HEALTH CARE		F	Period: From 01/01/2022 To 12/31/2022		pared:
				l np	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	130	47, 450	C		24, 454	1.00
. 00 . 00	NURSING FACILITY	0	0	C	)	0	2.00 3.00
. 00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
00	Other Long Term Care	о	0			J	5.00
00	SNF-Based CMHC						6.00
. 00	HOSPICE	0	0	C	-	0	7.00
. 00	Total (Sum of lines 1-7)	130 Inpatient D	47, 450 avs/Visits	C	0 6, 225 Di scharges	24, 454	8.00
			ay3/ v1 31 t 3		Di Scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
00		6.00	7.00	8.00	9.00	10.00	1.00
00 00	SKILLED NURSING FACILITY NURSING FACILITY	7, 151	37, 830	C		72 0	1.00 2.00
00		0	0	C C		0	3.00
00	HOME HEALTH AGENCY COST	0	0			-	4.00
00	Other Long Term Care	0	0				5.00
. 00	SNF-Based CMHC						6.00
. 00 . 00	HOSPICE Total (Sum of lines 1-7)	7, 151	0 37, 830	C	198	0 72	7.00 8.00
. 00		Di scha		Avei	rage Length of		0.00
	Component	0ther 11.00	Total 12.00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
. 00	SKILLED NURSING FACILITY	196	466	0.00		339.64	1.00
. 00	NURSING FACILITY	0	0	0.00		0.00	
. 00	ICF/IID	0	0			0.00	3.00
00	HOME HEALTH AGENCY COST		0				4.00 5.00
00	Other Long Term Care SNF-Based CMHC	0	0				6.00
. 00	HOSPI CE	о	0	0.00	0.00	0.00	
. 00	Total (Sum of lines 1-7)	196	466	0.00		339.64	8.00
		Average Length		Admi s	sions		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
. 00	SKILLED NURSING FACILITY	81.18	0	245		204	1.00
00	NURSING FACILITY	0.00	0		0	0	2.00
00 00	ICF/IID HOME HEALTH AGENCY COST	0.00			0	0	3.00 4.00
00	Other Long Term Care	0.00				0	5.00
00	SNF-Based CMHC						6.00
. 00	HOSPICE	0.00	0				
. 00	Total (Sum of lines 1-7)	81.18 Admissions	O Full Time		36	204	8.00
		Auliii SSI UIIS	run nime				
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I	Workers	-		
00	SKILLED NURSING FACILITY	21.00	22.00 89.63	23.00	)		1.00
00	NURSING FACILITY	0	0.00				2.00
	ICF/IID	0	0.00	0.00	)		3.00
	HOME HEALTH AGENCY COST		0.00				4.00
. 00			0 00	0.00	11		5.00
. 00 . 00	Other Long Term Care	0	0.00				
. 00 . 00 . 00 . 00 . 00	Other Long Term Care SNF-Based CMHC HOSPICE	0	0.00 0.00 0.00	0.00	)		6. 00 7. 00

Heal th	Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS-2	2540-10
SNF WA	IGE INDEX INFORMATION				Period: From 01/01/2022 To 12/31/2022	5/30/2023 12:	pared: 20 pm
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
	L	1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARIES	1		1	1		
1.00	Total salaries (See Instructions)	4, 877, 365	C	4, 877, 36			
2.00	Physician salaries-Part A	0	C		0 0.00		2.00
3.00	Physician salaries-Part B	0	C		0 0.00		
4.00	Home office personnel	0			0 0.00		
5.00	Sum of lines 2 through 4	0			0 0.00		
6.00	Revised wages (line 1 minus line 5)	4, 877, 365		4, 877, 36			6.00
7.00	Other Long Term Care	0			0 0.00		
8.00	HOME HEALTH AGENCY COST	0			0 0.00		
9.00	CMHC	0			0 0.00		
10.00	HOSPI CE	0			0 0.00		
11.00	Other excluded areas	0			0 0.00		
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0			0 0.00		
13.00	Total Adjusted Salaries (line 6 minus line	4, 877, 365	C	4, 877, 36	5 186, 432. 00	26.16	13.00
	12) OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	2, 121, 318		2, 121, 31	8 43, 080. 00	49.24	14.00
14.00	Contract Labor: Physician services-Part A	2, 121, 310			0 43,080.00 0 0.00		
16.00	Home office salaries & wage related costs	0	-		0.00		
10.00	WAGE-RELATED COSTS	0		1	0.00	0.00	10.00
17.00	Wage-related costs core (See Part IV)	803, 352	0	803, 35	2		17.00
18.00	Wage-related costs other (See Part IV)	000,002		000,00	0		18.00
19.00	Wage related costs (excluded units)	0			0		19.00
20.00	Physician Part A - WRC	0			0		20.00
21.00	Physician Part B - WRC	0			0		21.00
22.00	Total Adjusted Wage Related cost (see	803, 352		803, 35	2		22.00
	instructions)						

Heal th	Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2022 To 12/31/2022		narod.
					10 12/31/2022	5/30/2023 12:2	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES				1		
1.00	Employee Benefits	0	0		0.00		1.00
2.00	Administrative & General	757, 380		757, 380			2.00
3.00	Plant Operation, Maintenance & Repairs	103, 491	0	103, 491	1 3, 824. 00	27.06	3.00
4.00	Laundry & Linen Service	0	0	(	0.00	0.00	4.00
5.00	Housekeepi ng	288, 138	0	288, 138	3 15, 231. 00	18. 92	5.00
6.00	Dietary	511, 968	0	511, 968	3 26, 080. 00	19.63	6.00
7.00	Nursing Administration	279, 393	0	279, 393	3 8, 383. 00	33. 33	7.00
8.00	Central Services and Supply	0	0	(	0.00	0.00	8.00
9.00	Pharmacy	0	0	(	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	(	0.00	0.00	10.00
11.00	Soci al Servi ce	110, 569	0	110, 569	3, 278. 00	33. 73	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	192, 989	0	192, 989	9 13, 425. 00	14.38	13.00
14.00	Total (sum lines 1 thru 13)	2, 243, 928	0	2, 243, 928	3 101, 852. 00	22.03	14.00
	•						

alth Financial Systems	COUNTRY ARCH CARE			u of Form CMS-2	
F WAGE RELATED COSTS		Provider No.: 315433	Period: From 01/01/2022	Worksheet S-3 Part IV	
			To 12/31/2022		par
				5/30/2023 12:	
				Amount	
				Reported	
DADT IN WARE DELATED COSTO				1.00	
PART IV - WAGE RELATED COSTS					-
Part A - Core List RETIREMENT COST					-
20 401K Employer Contributions				-206	1 1
00 Tax Sheltered Annuity (TSA) Emplo	wor Contribution			-208	
00 Qualified and Non-Qualified Pensi				0	
00 Prior Year Pension Service Cost				0	-
PLAN ADMINISTRATIVE COSTS (Paid t	o External Organization)				
00 401K/TSA Plan Administration fees				0	1 5
D0 Legal /Accounting/Management Fees				0	
00 Employee Managed Care Program Adr				0	
HEALTH AND INSURANCE COST					
00 Health Insurance (Purchased or Se	elf Funded)			253, 004	18
00 Prescription Drug Plan				0	0
00 Dental, Hearing and Vision Plan				0	1(
00 Life Insurance (If employee is ow	vner or beneficiary)			0	1
00 Accident Insurance (If employee i				0	12
00 Disability Insurance (If employee				0	1:
00 Long-Term Care Insurance (If empl	oyee is owner or beneficiary)			0	14
00 Workers' Compensation Insurance				105, 447	
00 Retirement Health Care Cost (Only	, current year, not the extraor	dinary accrual require	d by FASB 106.	0	10
Non cumulative portion)					
TAXES				420.214	1 1
00 FICA-Employers Portion Only 00 Medicare Taxes - Employers Portio				439, 314	
00 Medicare Taxes - Employers Portic 00 Unemployment Insurance	лгонгу			0	
00 State or Federal Unemployment Tax	(05			5, 793	
OTHER	(es			3, 793	20
00 Executive Deferred Compensation				0	2
00 Day Care Cost and Allowances				0	
00 Tuition Reimbursement				0	
00 Total Wage Related cost (Sum of I	ines 1 - 23)			803, 352	
				Amount	
				Reported	
				1.00	
Part B - Other than Core Related	Cost				

Heal th	Financial Systems	COUNTRY ARCH (	CARE CENTER		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Pre	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to	5/30/2023 12: Average Hourly Wage (col. 3 ÷ col. 4)	<u>20 pm</u>
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	297, 349	50, 382	347, 73	1 5, 424. 00	64.11	1.00
2.00	Licensed Practical Nurses (LPNs)	537, 976	91, 152				2.00
3.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	1, 270, 808	215, 321	1, 486, 12	55, 217. 00	26. 91	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 106, 133	356, 855				4.00
5.00	Physical Therapists	316, 701	53, 661	370, 36			5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	122, 560	20, 766	143, 32	6 2, 832.00	50.61	8.00
9.00	Occupational Therapy Assistants	0	0		0 0.00		9.00
10.00	Occupational Therapy Aides	0	0		0 0.00		10.00
11.00	Speech Therapists	88, 043	14, 918	102, 96			11.00
12.00	Respi ratory Therapi sts	0	0		0 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)	649, 656		649, 65			14.00
15.00	Licensed Practical Nurses (LPNs)	608, 749		608, 74			15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	836, 052		836, 05			16.00
17.00	Total Nursing (sum of lines 14 through 16)	2, 094, 457		2, 094, 45			17.00
18.00	Physical Therapists	0			0 0.00		
19.00	Physical Therapy Assistants	0			0 0.00		
20.00	Physical Therapy Aides	0			0 0.00		20.00
21.00	Occupational Therapists	0			0 0.00		21.00
22.00	Occupational Therapy Assistants	0			0 0.00		
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapists	26, 861		26, 86			
25.00	Respiratory Therapists	0			0 0.00		25.00
26.00	Other Medical Staff	0		1	0 0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	CARE CENTER Provider No.: 315	433 Period:	Worksheet S-	-2540-10 7
		From 01/01/2022 To 12/31/2022	Date/Time Pr	epared:
		Group	5/30/2023 12 Days	:20 pm
		1.00	2.00	
1.00 2.00		RUX RUL		1.00
3.00		RVX		3.00
4.00		RVL		4.00
5.00		RHX		5.00
6.00 7.00		RHL RMX		6.00 7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00		RUC		10.00
11. 00 12. 00		RUB RUA		11.00
13.00		RVC		13.00
14.00		RVB		14.00
15.00		RVA		15.00
16. 00 17. 00		RHC RHB		16.00 17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00 22.00		RMA RLB		21.00
23. 00		RLA		23.00
24.00		ES3		24.00
25.00		ES2		25.00
26. 00 27. 00		ES1 HE2		26.00 27.00
28.00		HE1		28.00
29.00		HD2		29.00
30. 00		HD1		30.00
31.00 32.00		HC2 HC1		31.00
33.00		HB2		33.00
34.00		HB1		34.00
35.00		LE2		35.00
36. 00 37. 00		LE1 LD2		36.00
38.00		LD2 LD1		38.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00 42.00		LB2 LB1		41.00
43.00		CE2		43.00
44.00		CE1		44.00
45. 00		CD2		45.00
46. 00 47. 00		CD1 CC2		46.00
48.00		CC1		48.00
49.00		CB2		49.00
50.00		CB1		50.00
51.00 52.00		CA2 CA1		51.00 52.00
53. 00		SE3		53.00
54. 00		SE2		54.00
55. 00 56. 00		SE1 SSC		55.00 56.00
57.00		SSC		56.00
58.00		SSA		58.00
59.00		1 B2		59.00
50.00 51.00		I B1 I A2		60.00 61.00
52.00		I A2		62.00
53. 00		BB2		63.00
54.00		BB1		64.00
65.00 66.00		BA2 BA1		65.00 66.00
57. 00		PE2		67.00
58.00		PE1		68.00
59.00		PD2		69.00
70. 00 71. 00		PD1 PC2		70.00
72.00		PC2 PC1		71.00
			1	
73. 00 74. 00		PB2 PB1		73.00

Health Financial Systems	COUNTRY	ARCH CARE	CENTER		In Lie	eu of Form CN	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA			Provi der	No.: 315433	Period:	Worksheet S	5-7
					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 V payments beginning 10/01/2003. Congress expe expenses. For lines 101 through 106: Enter i column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" f with direct patient care and related expense (See instructions)	cted this n column r each ca or yes or	increase 1 the amoun tegory to "N" for no	to be used nt of the total SNF p if the s	l for direct expense for revenue from pending refl	batient care and each category. Er Worksheet G-2, F ects increases as	related nterin Partl, ssociated	
101.00 Staffing							101.00
102.00 Recruitment							102.00
103.00 Retention of employees							103.00
							104.00 105.00
105.00 OTHER (SPECIFY)	no 1 ool						
106.00 Total SNF revenue (Worksheet G-2, Part I, li	ne i, coi	uminis)		1		I	106.00

	Financial Systems	COUNTRY ARCH CA				u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315433	Period: From 01/01/2022	Worksheet A	
					To 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	Sal ari es	Other		1 Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ONS	Trial Balance	
					Increase/Decre ase (Fr Wkst	(col. 3 +- col. 4)	
					A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		2, 225, 849			2, 225, 849	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		22, 947	22, 9		22, 947	2.00
3.00	00300 EMPLOYEE BENEFITS	0	826, 401	826, 40		826, 401	3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	757, 380 103, 491	2, 331, 262 467, 846	3, 088, 64 571, 3		3, 088, 642 571, 337	4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	103, 491	11,842	11, 8		11, 842	6.00
7.00	00700 HOUSEKEEPI NG	288, 138	61, 753			349, 891	7.00
8.00	00800 DI ETARY	511, 968	464, 146			976, 114	
9.00	00900 NURSING ADMINISTRATION	279, 393	54, 870	334, 20		334, 263	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	206, 356	206, 3	56 0	206, 356	10.00
11.00	01100 PHARMACY	0	30, 776	30, 7	76 0	30, 776	
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	12.00
13.00	01300 SOCIAL SERVICE	110, 569	0	110, 50		110, 569	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	100,000	0		0 0	0	14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	192, 989	70, 260	263, 24	49 0	263, 249	15.00
30.00	03000 SKILLED NURSING FACILITY	2, 106, 133	2,093,846	4, 199, 9	79 0	4, 199, 979	30.00
31.00	03100 NURSING FACILITY	2, 100, 100	2,070,010		0 0	0	31.00
32.00	03200   CF/  I D	0	0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	9, 906	9, 90		9, 906	40.00
41.00	04100 LABORATORY	0	7, 560	7, 50		7, 560	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	316, 701	48,000	364, 70		0 364, 701	43.00 44.00
44.00	04400 PHISICAL THERAPT	122, 560	48, 000 0	122, 50		122, 560	
46.00	04600 SPEECH PATHOLOGY	88, 043	26, 861	114, 9		114, 904	46.00
47.00	04700 ELECTROCARDI OLOGY	0	20,001		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 106	19, 10	0 0	19, 106	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	243, 396	243, 39	96 0	243, 396	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0 0		61.00
62.00	06200 FQHC	0	0		0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	II		1		1	
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	0		0 0		
73.00	07300 CMHC	0	0		0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0	0	80.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	
82.00	08200 UTI LI ZATI ON REVIEW - SNF	0	0		0 0	0	82.00
83.00	08300 HOSPI CE	Ő	0		0 0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	4, 877, 365	9, 222, 983	14, 100, 34	48 0	14, 100, 348	
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	0			0	
	09300 NONPALD WORKERS	0	0				
	09400 PATIENTS LAUNDRY	0	0		0 0	0	
100.00		4, 877, 365	9, 222, 983	14, 100, 34	48 0	-	
	· ·						•

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	COUNTRY ARCH		No.: 315433	Period:	u of Form CMS-254 Worksheet A	<u>40-10</u>
RECLAS	STFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	F EXPENSES	Provi der	NO.: 315433	From 01/01/2022		
					To 12/31/2022	Date/Time Prepar 5/30/2023 12:20	
	Cost Center Description	Adjustments to					
			For Allocation				
		Wkst A-8)	(col. 5 +-				
		6.00	col. 6) 7.00	-			
	GENERAL SERVICE COST CENTERS	0.00	1.00	1	· · · ·		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-1, 497, 286	728, 563	6		·	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0					2.00
3.00	00300 EMPLOYEE BENEFITS	0	826, 401				3.00
4.00	00400 ADMINI STRATI VE & GENERAL	-936, 296	2, 152, 346			1	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	571, 337	7		Ę	5.0
5.00	00600 LAUNDRY & LINEN SERVICE	0	11, 842	2		6	6.0
7.00	00700 HOUSEKEEPI NG	0	349, 891				7.0
3.00	00800 DI ETARY	0	976, 114	-			8.0
9.00	00900 NURSI NG ADMI NI STRATI ON	0	334, 263	1			9.0
10.00	01000 CENTRAL SERVICES & SUPPLY	0	206, 356	1			10. 0
11.00	01100 PHARMACY	0	30, 776	1			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0				12.00
13.00	01300 SOCIAL SERVICE	0	110, 569				13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES	0	263, 249	'			15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.750	4 000 700				~ ~
	03000 SKI LLED NURSI NG FACI LI TY	32, 753		1			30.00
31.00	03100 NURSING FACILITY	0					31.00
32.00	03200 I CF/I I D	0		•			32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	<u> </u>	/		3.	33.00
40.00	04000 RADI OLOGY	0	9, 906				40. 00
41.00	04100 LABORATORY	0	7, 560	1			40.00 41.00
42.00	04200 INTRAVENOUS THERAPY		, 50C	1			42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0					43.0
44.00	04400 PHYSI CAL THERAPY	0	364, 701	<b>′</b>			44.0
45.00	04500 OCCUPATI ONAL THERAPY	0	122, 560	1			45.0
46.00	04600 SPEECH PATHOLOGY	0	114, 904				46.0
47.00	04700 ELECTROCARDI OLOGY	0	)	1			47.0
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	19, 106				48.0
49.00	04900 DRUGS CHARGED TO PATIENTS	0	243, 396				49.0
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0					50. 00
51.00	05100 SUPPORT SURFACES	0				5	51.00
	OUTPATIENT SERVICE COST CENTERS						
50.00	06000 CLI NI C	0	0	)		60	60.00
51.00	06100 RURAL HEALTH CLINIC	0	0 0			6	61.00
52.00	06200 FQHC					62	62.00
	OTHER REIMBURSABLE COST CENTERS		-	1			
70.00	07000 HOME HEALTH AGENCY COST	0		•			70.00
	07100 AMBULANCE	0					71.00
73.00	07300 CMHC	0	0 0			7:	73.00
	SPECIAL PURPOSE COST CENTERS		1	1			
30.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0					80.00
31.00	08100 I NTEREST EXPENSE	0					81.00
32.00	08200 UTI LI ZATI ON REVI EW - SNF	0					82. O
33.00	08300 HOSPI CE	0					B3.00
39.00	SUBTOTALS (sum of lines 1-84)	-2, 400, 829	11, 699, 519	1		80	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN			1			90.00
91.00	09100 BARBER AND BEAUTY SHOP						91.00
	09200 PHYSI CLANS PRI VATE OFFI CES	1 0	η C	1			92.00
	00200 NONDALD WODKEDS						12 01
93.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0					93.00 94.00

Health Financial Systems	COUNTRY ARCH CARE	CENTER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315433	Period: From 01/01/2022	Worksheet A-6	D
					Date/Time Pre 5/30/2023 12:	
			Increases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
TOTALS			_			
	Total Reclassificat of columns 4 and 5 equal sum of column 9)	must		0	0	100. 00

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

Health Financial Systems	COUNTRY ARCH CARE	CENTER		In Lie	u of Form CMS	-2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2022	Worksheet A-	6
					Date/Time Pr 5/30/2023 12	
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
TOTALS						
100.00				0		0 100. 00

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

	Financial Systems	COUNTRY ARCH				eu of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315433	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		nared
					10 12/31/2022	5/30/2023 12:	20 pm
				Acquisition			
	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	
1.00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	<u>-5</u>	0		0	0	1.0
2.00	Land Improvements	0	0		0 0	0	2.0
2.00	Buildings and Fixtures	0	0		0 0	0	3.0
4.00	Building Improvements	1, 480, 200	0		0 0	0	4.0
5.00	Fixed Equipment	1, 400, 200	0			0	5.0
5.00	Movable Equipment	216, 923	0		0 0	0	6.0
7.00	Subtotal (sum of lines 1-6)	1, 697, 123	0		0 0	0	7.0
8.00	Reconciling Items	0	0		0 0	0	8.0
9.00	Total (line 7 minus line 8)	1, 697, 123	0		0 0	0	9.0
	Description	Endi ng Bal ance	Fully				
		J. J	Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCI	<u>ES</u>					
1.00	Land	0	0				1.0
2.00	Land Improvements	0	0				2.0
3.00	Buildings and Fixtures	0	0				3.0
4.00	Building Improvements	1, 480, 200	0				4.0
5.00	Fixed Equipment	214 000	0				5.0
6.00 7.00	Movable Equipment	216, 923	0				6.0 7.0
7.00 8.00	Subtotal (sum of lines 1-6) Reconciling Items	1, 697, 123	0				8. C
8.00 9.00	Total (line 7 minus line 8)	1, 697, 123	0				9.0
7.00		1, 077, 123	0	1			7.0

	Financial Systems MENTS TO EXPENSES	COUNTRY ARCH C		No.: 315433		u of Form CMS-2 Worksheet A-8	
12021	MENTS TO EXPENSES		Provi der	NO.: 315433	Period: From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 12:2	pare
	· · · · · · · · · · · · · · · · · · ·			Expense C	lassification on		<u>20 p</u>
				To/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount		t Center	Line No.	
		Adjustment	Allount	COS	t center	LITTE NO.	
	F	1.00	2.00		3. 00	4.00	
00	Investment income on restricted funds	В	-2, 078	ADMI NI STRATI	VE & GENERAL	4.00	1
00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		C			0.00	2
00	Refunds and rebates of expenses (chapter 8)		C			0.00	3
00	Rental of provider space by suppliers (chapter 8)		C			0.00	
00	Tel ephone services (pay stations excluded) (chapter 21)		0			0.00	5
)0 )0	Television and radio service (chapter 21) Parking lot (chapter 21)		0			0.00 0.00	
00	Remuneration applicable to provider-based physician adjustment	A-8-2	C			0.00	8
0	Home office cost (chapter 21)		C	)		0.00	9
00 00	Sale of scrap, waste, etc. (chapter 23) Nonallowable costs related to certain		C C			0.00 0.00	
00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	-1, 465, 843				12
00	related organizations (chapter 10) Laundry and linen service		C			0.00	13
00	Revenue - Employee meals		0			0.00	
00	Cost of meals - Guests		C	)		0.00	15
00	Sale of medical supplies to other than		C			0.00	16
~~	patients					0.00	
00 00	Sale of drugs to other than patients Sale of medical records and abstracts		0				
00	Vendi ng machi nes		0			0. 00 0. 00	
00	Income from imposition of interest, finance		0			0.00	
	or penalty charges (chapter 21)		-				
00	Interest expense on Medicare overpayments and borrowings to repay Medicare		C			0.00	21
00	overpayments Utilization reviewphysicians' compensation (chapter 21)		C	UTI LI ZATI ON	REVIEW - SNF	82.00	22
00	Depreciationbuildings and fixtures		C	CAP REL COST FIXTURES	S - BLDGS &	1.00	23
00	Depreciationmovable equipment		C	CAP REL COST EQUI PMENT	S - MOVABLE	2.00	24
00	P/R ASSISTANT ADM	A		ADMI NI STRATI		4.00	25
01	MANAGEMENT FEES	A			VE & GENERAL	4.00	
02	PROMOTI ONAL ADS	A			VE & GENERAL	4.00	
03	MI SC EXPENSES	A			VE & GENERAL	4.00	
04	DENTAL FEES	A		SKILLED NURS		30.00	
. 05	OTHER INCOME	В	-8, 608	ADMI NI STRATI	VE & GENERAL	4.00	
. 06			0			0.00	
J. 00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-2, 400, 829	1			100

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

Health Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ. OFFICE COSTS				Period: From 01/01/2022 To 12/31/2022	Date/Time Pr 5/30/2023 12	epared:
	Line No.		Center		e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANIZATIONS	S OR	
1.00		CAP REL COSTS FIXTURES	- BLDGS &	RENT		1.00
2.00	4, 00	ADMI NI STRATI VE	& GENERAL	REALTY ADMIN		2.00
3.00		SKILLED NURSIN		AIDES		3.00
4.00		SKILLED NURSIN		LPNS AND RNS		4.00
5.00	0, 00		0 17101 21 11			5.00
6.00	0, 00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	0.00					10.00
6, line 100 to Worksheet A-8, column 3, line 12.						10.00
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu			
	Cost	Wkst. A, col.	col. 5)			
		5				
	4.00	5.00	6,00	_		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:				ED ORGANIZATI ONS	S OR	
1.00	542, 714	2, 040, 000	-1, 497, 28	36		1.00
2.00	76	0		76		2.00
3.00	11, 244	10, 828	4	16		3.00
4.00	835, 561	804, 610	30, 95	51		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 389, 595	2, 855, 438	-1, 465, 84	13		10.00
6, line 100 to Worksheet A-8, column 3, line 12.	1, 307, 373	2, 035, 430	- 1, 403, 04			10.00
12.	I I		I	I		I

Health Financial Systems	COUNTRY ARCH CA	ARE CENTER	In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME	Provi der No.: 315433	From 01/01/2022	Worksheet A-8 Parts I-II Date/Time Prep 5/30/2023 12:2	pared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00	А	J ROSENBERG	92.00	1.00
2.00	А	E ROSENBERG	8.00	2.00
3.00	D	MINDY ROSENBERG	0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

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

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

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

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

related organization.

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

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

	Related Organization(s) and/or Home Office				
	Name	Percentage of	Type of Business		
		Ownershi p			
	4.00	5.00	6.00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ATION(S) AND/OR HOME OFFICE:				

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

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

1.00	COUNTRY MOUNTAIN	50. 00 REALTY	1.00
2.00	COUNTRY MOUNTAIN	50.00 REALTY	2.00
3.00	PEACE OF MIND STAFFING	100.00 NURSING AGENCY	3.00
4.00		0.00	4.00
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

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

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

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

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

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

Heal th	Financial Systems	COUNTRY ARCH (	CARE CENTER		In Lie	u of Form CMS-2	2540-10
	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/30/2023 12:	pared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
	r	0	1.00	2.00	3.00	3A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	728, 563	728, 563	[			1.00
2.00 3.00 4.00 5.00	00200 CAP REL COSTS - BEDGS & TEXTRES 00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFI TS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATI ON, MAI NT. & REPAI RS	22, 947 826, 401 2, 152, 346 571, 337	0 35, 370 51, 916	22, 94 1, 11	0 826, 401 4 128, 327	2, 317, 157 642, 423	2.00 3.00 4.00 5.00
6.00 7.00 8.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG 00800 DI ETARY	11, 842 349, 891 976, 114	23, 329 2, 736 73, 426	73 8	5 0 6 48, 821	35, 906 401, 534 1, 138, 599	6. 00 7. 00
9.00 10.00 11.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	334, 263 206, 356 30, 776	1, 687 39, 760 0	5 1, 25	3 47, 339	383, 342 247, 368 30, 776	9.00 10.00
12.00 13.00 14.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0 110, 569 0	1, 180 1, 048 0	3	7 0 3 18, 734 0 0	1, 217 130, 384 0	12.00 13.00 14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	263, 249	24, 852	78	3 32, 699	321, 583	15.00
30.00 31.00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY	4, 232, 732 0	433, 482 0	13, 65	0 0	5, 036, 721 0	30. 00 31. 00
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0		0 0	0	32.00 33.00
	ANCILLARY SERVICE COST CENTERS						
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	9,906	0		0 0	9,906	40.00 41.00
41.00	04200 I NTRAVENOUS THERAPY	7, 560	0		0 0	7, 560 0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	364, 701	34, 469	1, 08		453, 917	44.00 45.00
45.00 46.00	04600 SPEECH PATHOLOGY	122, 560 114, 904	0		0 20, 766 0 14, 918	143, 326 129, 822	45.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	19, 106	2, 654	-	4 0	21, 844	48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	243, 396	0		0 0 0 0	243, 396 0	49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	F	0 0	0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0	61.00
02.00	OTHER REIMBURSABLE COST CENTERS	1					62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00 73.00	07100 AMBULANCE 07300 CMHC	0	0 0		0 0 0 0	0	71.00 73.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1					80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	0 725, 909	22, 86	0 0	0 11, 696, 781	83.00 89.00
69.00	NONREI MBURSABLE COST CENTERS	11,099,519	125, 909	22, 80	826, 401	11, 090, 781	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	2, 654	8	4 0	2, 738 0	91.00 92.00
92.00 93.00	09300 NONPAID WORKERS	0	0		0 0	0	92.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00 100.00	Negative Cost Centers TOTAL	0 11, 699, 519	0 728, 563	22, 94	0 0 7 826, 401	0 11, 699, 519	99.00 100.00
100.00		1,077,017	120, 505	22,74	. 020, 401	11,077,017	1.00.00

	Financial Systems	COUNTRY ARCH (				u of Form CMS-	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	5/30/2023 12: DI ETARY	20 pm
	1	4.00	5.00	6.00	7.00	8.00	
1.00 2.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00 2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	2, 317, 157					3.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	158, 659 8, 868	801, 082 29, 142		<u>,</u>		5.00 6.00
7.00	00700 HOUSEKEEPING	99, 166	3, 418		504, 118		7.00
8.00	00800 DI ETARY	281, 199	91, 724		60, 167	1, 571, 689	1
9.00	00900 NURSI NG ADMI NI STRATI ON	94, 674	2, 108		1, 383	0	
10.00	01000 CENTRAL SERVICES & SUPPLY	61, 092	49, 669		32, 580	0	1
11.00	01100 PHARMACY	7, 601	0	) (	0 0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	301	1, 473	s (	967	0	12.00
13.00	01300 SOCIAL SERVICE	32, 201	1, 310	) (	0 859	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0 0	0	14.00
15.00	01500 ACTI VI TI ES	79, 421	31, 045	i (	20, 364	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKI LLED NURSI NG FACI LI TY	1, 243, 918	541, 505			1, 571, 689	1
31.00	03100 NURSING FACILITY	0	0		0 0	0	
32.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0			0	1
33.00	ANCI LLARY SERVICE COST CENTERS	0	0	γ <u></u>	0	0	33.00
40.00	04000 RADI OLOGY	2,446	C		0 0	0	40.00
40.00	04100 LABORATORY	1,867	0			0	
42.00	04200 I NTRAVENOUS THERAPY	0	0			0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
44.00	04400 PHYSI CAL THERAPY	112, 103	43, 058		28, 244	0	
45.00	04500 OCCUPATIONAL THERAPY	35, 397	0		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	32, 062	0	) (	0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	C	) (	0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 395	3, 315	5 (	2, 175	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	60, 111	0	) (	0 0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0 0	0	
51.00	05100 SUPPORT SURFACES	0	0	) (	0 0	0	51.00
(0.00		0	0			0	1 (0 00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	
62.00	06200 FQHC	0	U		0	0	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	Ő		0 0	0	
73.00	07300 CMHC	0	C		0 0		73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	C	0 0	0 0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	2, 316, 481	797, 767	73, 916	501, 943	1, 571, 689	89.00
00.05	NONREI MBURSABLE COST CENTERS	-		J	-	-	00.05
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	
91.00	09100 BARBER AND BEAUTY SHOP	676	3, 315		2, 175	0	
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0			0	
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0			0	
94.00 98.00	Cross Foot Adjustments	0	0			0	1
98.00 99.00	Negative Cost Centers	0				0	
100.00		2, 317, 157	801, 082	73, 916	504, 118		
100.00		2, 517, 157	001,002	1 75,710	507,110	1, 571, 007	1.00.00

	Financial Systems	COUNTRY ARCH				u of Form CMS-2	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315433	Period: From 01/01/2022 To 12/31/2022		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS			1			1 4 66
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 5.00	00400 ADMINI STRATI VE & GENERAL						4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5.00 6.00
7.00	00700 HOUSEKEEPING						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	481, 507					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	390, 709				10.00
11.00	01100 PHARMACY	0	0	38, 3	77		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 3, 958		12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	164, 754	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTI VI TI ES	0	0		0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	481, 507	390, 709	38, 3	77 3, 958	164, 754	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200   CF/I   D	0	0		0 0		32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS			1	0	0	40.00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	0	0		0 0	0	40.00
41.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0			0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS				-	-	
60.00	06000 CLINIC	0	0		0 0		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	1	0 0	0	70.00
71.00	07100 AMBULANCE	0	0		0 0		71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS			1		-	
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	481, 507	390, 709	38, 3	77 3, 958	164, 754	89.00
	NONREI MBURSABLE COST CENTERS	-					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments	0	0		0	0	98.00 99.00
99.00 100.00	Negative Cost Centers TOTAL	481, 507	0 390, 709	38, 3	77 3, 958		
100.00		401, 507	370, 709	1 30, 3	5, 700	1 104,734	1.00.00

Heal th	Financial Systems	COUNTRY ARCH	CARE CENTER	1		In Lie	u of Form CMS-	2540-10
	ALLOCATION - GENERAL SERVICE COSTS			der No.: 315433			Worksheet B Part I Date/Time Pre 5/30/2023 12:	pared:
			OTHER GENE	RAL			10/00/2020 121	
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	SERVICE ACTIVITIE	S Subtota		st Stepdown djustments	Total	
		14.00	15.00	16.00		17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS	T	1					1 1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT							1.00
3.00	00300 EMPLOYEE BENEFITS							3.00
4.00	00400 ADMI NI STRATI VE & GENERAL							4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS							5.00
6.00	00600 LAUNDRY & LINEN SERVICE							6.00
7.00	00700 HOUSEKEEPI NG							7.00
8.00	00800 DI ETARY							8.00
9.00	00900 NURSI NG ADMI NI STRATI ON							9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY							10.00
12.00	01200 MEDICAL RECORDS & LIBRARY							12.00
13.00	01300 SOCIAL SERVICE							13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0						14.00
15.00	01500 ACTI VI TI ES	0	452,	413				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 SKILLED NURSING FACILITY	0	452,	413 10, 354	, 671	0	10, 354, 671	30.00
31.00	03100 NURSING FACILITY	0		0	0	0	0	
32.00	03200 I CF/I I D	0		0	0	0	0	
33.00	03300 OTHER LONG TERM CARE	0		0	0	0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0		0 12	, 352	0	12, 352	40.00
40.00	04100 LABORATORY	0			, 427	0	9, 427	1
42.00	04200 I NTRAVENOUS THERAPY	0		o ,	0	0	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0		0	0	0	0	1
44.00	04400 PHYSI CAL THERAPY	0		0 637	, 322	0	637, 322	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0			, 723	0	178, 723	1
46.00	04600 SPEECH PATHOLOGY	0		0 161	, 884	0	161, 884	1
47.00	04700 ELECTROCARDI OLOGY	0		0 22	0	0	0	
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			, 729 , 507	0	32, 729 303, 507	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY			0 303	, 507	0	303, 307	1
51.00	05100 SUPPORT SURFACES	0		0	Ö	0	0	1
	OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0		0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0		0	0	0	0	
62.00								62.00
70 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0		0	0	0	0	70.00
	07100 AMBULANCE	0		0	0	0		71.00
	07300 CMHC	0		0	0	0	0	
	SPECIAL PURPOSE COST CENTERS		I		-			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81.00	08100 INTEREST EXPENSE							81.00
82.00	08200 UTILIZATION REVIEW - SNF	_					_	82.00
83.00	08300 HOSPI CE	0	450	0	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	452,	413 11, 690	, 615	0	11, 690, 615	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		-	, 904	0	8, 904	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0		0	0	0	0	1
93.00	09300 NONPAI D WORKERS	0		0	0	0	0	1
94.00	09400 PATIENTS LAUNDRY	0		0	0	0	0	
98.00	Cross Foot Adjustments	0		0	0	0	0	
99.00	Negative Cost Centers	0	450	U 412 11 400	U 510	0	0 11, 699, 519	
100.00	)   TOTAL	1 0	452,	413 11, 699	, 514	0	11, 077, 519	100.00

ALLICATION OF CAPTIAL RELATED COSTS         Provider No.: 319432         Period (br No.: 319432)         Perio	Heal th	Financial Systems	COUNTRY ARCH (	CARE CENTER		In Lie	u of Form CMS-2	2540-10
Directly Assigned New Directly Dir	ALLOCA	TION OF CAPITAL RELATED COSTS				From 01/01/2022	Part II Date/Time Pre	
OF NUMBAL SERVICE COST CENTRES         0         1.00         2.00         22.		Cost Center Description	Assigned New Capital	BLDGS &	MOVABLE	Subtotal		
1.00         OOTOOL GAP REL COSTS - BUDGS A FIXTURES         0				1.00	2.00	2A	3.00	
2.00         00200 (CAP REL COSTS - MOVABLE FOULPMENT         0 <td>4</td> <td></td> <td>1 1</td> <td></td> <td>1</td> <td></td> <td></td> <td>1</td>	4		1 1		1			1
5.00         00500         PLANT OPERATION. MAINT & REPAIRS         0         5.1         6.63         5.53         0         5.00           0.00         00600         LANNEY & LINEN SERVICE         0         2.736         8.6         2.922         0         7.00           0.00         00600         DIFTANY         0         7.04         2.313         75.739         0         8.00           0.00         00000         DIFTANY         0         7.04         9.00         0 <td>2.00 3.00</td> <td>00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>2.00 3.00</td>	2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	0		0		2.00 3.00
6.00         Obcol LAUMORY & LINEN SERVICE         0         2.3, 3.90         7.35         7.40, 6.40         0         6.00           0.00         DOSOD (DISTARY         0         7.3, 4.26         2.3, 33         7.5, 7.39         8.00           0.00         DOSOD (NESIN GARINI STRATION         0         1.647         5.3         1.7, 40         9.00           0.0000 CENTRAL SERVICES & SUPPLY         0         39, 7.60         1.252         411.012         0         10.00           0.1000 CENTRAL SERVICES & SUPPLY         0         37.0         1.217         12.00         10.00           0.1000 DISCAL SERVICES AS LIBBARY         0         1.180         37         1.217         12.00           0.000 SICAL SERVICE OST CENTRES         0         1.086         30         1.081         0.00           0.000 SICAL SERVICE OST CENTRES         0			0					•
7.00         00700 (HUSEKEEPI NG         0         2.736         86         2.822         0         7.00           9.00         00900 (NURSI NG ADMI NI STRATI ON         0         1.467         53         1.740         9.00           9.00         00900 (NURSI NG ADMI NI STRATI ON         0         1.687         53         1.740         9.00           9.00         0100 (PHARBACY         0         39.760         1.252         41.012         0         10.00         11.00         37.77         0         9.00         11.00         11.00         37.71         0         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         12.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         14.00         14.00         14.00         14.00         14.00         14.00         14.00         12.00         33.00         14.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13			0					
9.00         00900 NURSI NG ADMI NI STRATI ON         0         1.687         53         1.740         9.00           11.00         0100 (PHARMACY CES & SUPPLY         0         9.760         1.252         41.1012         0         0.01           12.00         01200 (PHARMACY CES & SUPPLY         0         1.800         37         1.217         12.00           13.00         01300 SOCIAL SERVICE         0         1.048         33         1.081         0         13.00           14.00         01400 NRSI NG ADALLED HEALTH EDUCATION         0         0         0         14.00           15.00         01500 ACTI VITLES         SERVICE COST CENTERS         24.852         783         25.635         15.00           10.00         03000 SKI LED NURSI NG FACI LITY         0         433.482         13.652         447.134         0         30.00           32.00         03200 IFFR I NOR TRACARE         0         0         0         0         0         32.00           33.00         03300 OTHER LONG TREAPY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
10.00         01000 CENTRAL SERVICES & SUPPLY         0         39,760         1,252         41,012         0         10.00         11.00         01000 PARAMACY         0         10.00         11.00			0					
11.00       01100 PHARMACY       0       11.00       0       12.00       0       0       0       0       0       0       0       0       0       13.00       0       0       0       0       0       0       0       0       0       0       13.00       0       0       0       0       0       0       13.00       0       0       0       0       0       0       0       14.00       0       0       0       14.00       0       0       0       14.00       0       0       0       0       14.00       0			0				-	
12.00       01200 MEDICAL RECORDS & LIBRARY       0       1.106       37       1.217       0       12.00         13.00       01300 NURSING AND ALLIED HEALTH EDUCATION       0       0       0       0       13.00         14.00       01400 NURSING AND ALLIED HEALTH EDUCATION       0       0       0       0       0       14.00         10.00       03000 NURSING FACILITY       0       433.482       13.652       447.134       0       30.00         31.00       03100 NURSING FACILITY       0       433.482       13.652       447.134       0       30.00         33.00       03300 OTHER LONG FERM CARE       0       0       0       0       33.00         40.00       64000 RADILOGY       0       0       0       0       41.00         41.00       04000 RADILOGY       0       0       0       0       42.00         30.00       04300 OVEGH CIMHALTION NITHERAPY       0       34.469       1.086       35.555       44.00         42.00       04000 SPECEC NATHOLOGY       0       0       0       0       42.00         43.00       04300 OVEGH CIMHALTION NITHERAPY       0       0       0       0       44.00 <t< td=""><td></td><td></td><td>0</td><td>39, 760</td><td>1, 25</td><td></td><td>-</td><td>1</td></t<>			0	39, 760	1, 25		-	1
13. 00         01300 SOCIAL SERVICE         0         1,048         33         1,081         0         13.00           14. 00         01500 ACTI VITIES         0         24,852         783         25,635         0         15.00           INPART HOR TRUTINE SERVICE COST CENTERS         0         433,482         13,652         447,134         0         30.00         33.00           30. 00         3000 OTHER LOR TERN CARE         0         0         0         0         33.00           30. 00         3000 OTHER LOR TEN CARE         0         0         0         0         33.00           30. 00         3000 OTHER LOR TEN CARE         0         0         0         0         33.00           30. 00         300 OTHER LOR TEN CARE         0         0         0         0         33.00           40. 00 4400 DHAGO THER LOR TEN CARE         0         0         0         0         40.00<			0	1, 180			-	
15:00         01500 ACTUVITIES         0         24.852         783         25.635         0         15:00           NO 00         03000 SKILLED NURSING FACLETY         0         433,482         13,652         447,134         0         30:00         03:00         03:00         03:00         03:00         03:00         0         0         0         0         0         0         0         0         0         0         0         0         33:00         0         33:00         0         33:00         0         33:00         0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td>-</td><td></td></td<>			0				-	
INPATE INT ROUTINE SERVICE COST CENTERS         Image: Center Service Cost Centers			0	•				
30. 00         03000 SKILLED NURSING FACL LITY         0         433, 482         13, 652         447, 134         0         30. 00           30. 00         03200 (CF/11D         0         0         0         0         0         31. 00           33. 00         03200 (TFR LONG TERL CARE         0         0         0         0         33. 00           40. 00         04000 RADIOLOGY         0	15.00		0	24, 852	78	25, 635	0	15.00
31. 00       03100       NURSING FACILITY       0       0       0       0       0       0       31. 00         32.00       03300       OTHER LONG TERM CARE       0       0       0       0       33. 00         ANCILLARY SERVICE COST CENTES	30 00		0	133 183	13.65	2 117 134	0	30.00
32.00         03200         CF/11D         0         0         0         0         0         33.00           AND         03300         OTHER LONG TERM CARE         0         0         0         0         33.00           AND         04000         CADOL RADIOLOSY         0			0		15, 00		-	1
ANCI LLARY SERVICE COST CENTERS         Image: Control of Contrecon			0	0			-	
40. 00         0 <td>33.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>33.00</td>	33.00		0	0		0 0	0	33.00
11.00       04100       LABORATORY       0	10.00				1			10.00
42.00         04200         INTRAVENOUS THERAPY         0<			0			-		1
43.00         04300         0YQEN (I NHALATION) THERAPY         0         0         0         0         0         0         0         0         44.00           44.00         04400         PHYSICAL THERAPY         0         34,469         1,086         35,555         0         44.00           45.00         04500         OCCUPATIONAL THERAPY         0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td>1</td></t<>			0	0		0 0		1
45.00       04500       OCCUPATIONAL THERAPY       0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td>1</td></td<>			0	0		0 0		1
46.00         04600         SPECH PATHOLOGY         0         0         0         0         46.00         46.00         47.00         46.00         47.00         47.00         48.00         48.00         47.00         47.00         47.00         47.00         0         0         0         0         0         0         47.00         48.00           49.00         04900         RUGS CHARGED TO PATIENTS         0         2.654         84         2.738         0         48.00           50.00         05000         DENTAL CARE - TITLE XIX ONLY         0 <td></td> <td>04400 PHYSI CAL THERAPY</td> <td>0</td> <td>34, 469</td> <td>1, 08</td> <td>6 35, 555</td> <td>0</td> <td>44.00</td>		04400 PHYSI CAL THERAPY	0	34, 469	1, 08	6 35, 555	0	44.00
47.00       04700       ELECTROCARDIOLOGY       0       0       0       0       0       0       47.00         48.00       04800       MDICAL SUPPLIES CHARGED TO PATIENTS       0       2,654       84       2,738       0       48.00         90.00       04900       DRUGS CHARGED TO PATIENTS       0       0       0       0       49.00         50.00       DENTAL CARE - TITLE XIX ONLY       0       0       0       0       0       0       50.00         51.00       DUPPART SERVICE COST CENTERS       0       0       0       0       0       61.00       60.00       61.00       62.00       0       0       61.00       61.00       62			0	0			-	1
48.00       04800       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       2,654       84       2,738       0       48.00         49.00       04900       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       49.00       0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></td<>			0	0		0 0	-	
49.00       04900       DRUGS CHARGED TO PATIENTS       0			0	2 654	<u>ج</u>	4 2 738	-	•
51.00         OSTOO         SUPPORT SURFACES         O <td></td> <td></td> <td>0</td> <td>2,001</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0	2,001		0 0	-	
OUTPATI ENT SERVICE COST CENTERS         0         <	50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
60.00         06000         CLINIC         0	51.00		0	0		0 0	0	51.00
61.00       06100       RURAL HEALTH CLINIC       0       0       0       0       61.00         62.00       06200       FOHC       0       0       0       62.00         0THER       REI MBURSABLE COST CENTERS       0       0       0       0       0         0.00       07000       HOME HEALTH AGENCY COST       0       0       0       0       0       70.00         71.00       07100       AMBULANCE       0       0       0       0       0       71.00         73.00       07300       CMHC       EXENTAL PURPOSE COST CENTERS       0       0       0       73.00         80.00       08200       MALPRACTI CE PREMI UMS & PAID LOSSES       80.00       81.00       82.00       80.00       81.00         82.00       08200       UTI LI ZATI ON REVIEW - SNF       81.00       82.00       83.00       83.00       89.00       89.00       89.00       89.00       89.00       89.00       89.00       89.00       90.00       0       0       0       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00	40.00		0	0	1	0 0	0	40.00
62.00         06200         FOHC         62.00           0THER         REIMBURSABLE         COST CENTERS         0			1					1
70.00         O7000         HOME         HEALTH         AGENCY COST         0<				0			, U	
71.00       07100       AMBULANCE       0       0       0       0       0       71.00         73.00       07300       CMHC       0					1			
73.00         OT300         CMHC         O <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
SPECIAL PURPOSE COST CENTERS           80.00         08000         MALPRACTICE PREMIUMS & PAID LOSSES         80.00           81.00         08100         INTEREST EXPENSE         80.00           82.00         08200         UTILIZATION REVIEW - SNF         82.00           83.00         08300         HOSPICE         0         0         0         82.00           89.00         SUBTOTALS (sum of lines 1-84)         0         725,909         22,863         748,772         0         89.00           NONREL MBURSABLE COST CENTERS         0         0         0         0         0         90.00           90.00         09000         GIFT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         90.00           91.00         09100         BARBER AND BEAUTY SHOP         0         2,654         84         2,738         0         91.00           92.00         09200         PHYSICIANS PRIVATE OFFICES         0         0         0         92.00           93.00         09300         NONPAID WORKERS         0         0         0         0         93.00           94.00         09400         PATIENTS LAUNDRY         0         0         0         98.00         98.00								
80.00       08000       MALPRACTICE PREMIUMS & PAID LOSSES       80.00         81.00       08100       INTEREST EXPENSE       81.00         82.00       08200       UTILLIZATION REVIEW - SNF       82.00         83.00       08300       HOSPICE       0       0       0       83.00         89.00       SUBTOTALS (sum of lines 1-84)       0       725,909       22,863       748,772       0       89.00         NONREI MBURSABLE COST CENTERS       0       0       0       0       0       90.00         90.00       09000       GIFT, FLOWER, COFFEE SHOPS & CANTEEN       0       0       0       90.00         91.00       09100       BARBER AND BEAUTY SHOP       0       2,654       84       2,738       0       91.00         92.00       09300       NONPAI D WORKERS       0       0       0       0       92.00         93.00       09300       NONPAI D WORKERS       0       0       0       93.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00 </td <td>73.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>/3.00</td>	73.00		0	0		0 0	0	/3.00
82.00         08200         UTILIZATION REVIEW - SNF         82.00           83.00         08300         HOSPICE         0         0         0         0         83.00           89.00         SUBTOTALS (sum of lines 1-84)         0         725,909         22,863         748,772         0         89.00           NONREIMBURSABLE COST CENTERS           90.00         09100         GFT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         0         90.00           91.00         09100         BARBER AND BEAUTY SHOP         0         2,654         84         2,738         0         91.00           92.00         09200         PHYSI CI ANS PRI VATE OFFICES         0         0         0         0         92.00           93.00         NONAL D WORKERS         0         0         0         0         93.00         93.00         94.00         93.00         94.00         94.00         94.00         94.00         94.00         94.00         94.00         94.00         94.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         98.00         99.00         99.00         0	80.00							80.00
83.00         08300         HOSPICE         0         0         0         0         0         83.00           89.00         SUBTOTALS (sum of lines 1-84)         0         725,909         22,863         748,772         0         89.00           NONREL MBURSABLE COST CENTERS           90.00         09000         GIFT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         0         90.00           91.00         BARBER AND BEAUTY SHOP         0         2,654         84         2,738         0         91.00           92.00         09200         PHYSI CLANS PRI VATE OFFICES         0         0         0         0         92.00           93.00         09300         NONPAI D WORKERS         0         0         0         0         93.00           94.00         09400         PATI ENTS LAUNDRY         0         0         0         94.00           98.00         Cross Foot Adjustments         0         0         0         0         98.00           99.00         Negative Cost Centers         0         0         0         99.00         99.00								
89.00         SUBTOTALS (sum of lines 1-84)         0         725,909         22,863         748,772         0         89.00           NONREI MBURSABLE COST CENTERS           90.00         09000         GIFT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         0         90.00           91.00         09000         BARBER AND BEAUTY SHOP         0         2,654         84         2,738         0         91.00           92.00         09200         PHYSI CI ANS PRI VATE OFFICES         0         0         0         0         92.00           93.00         09300         NONPAI D WORKERS         0         0         0         0         93.00         94.00         94.00         0         0         94.00								
NONREI MBURSABLE COST CENTERS           90.00         09000         GIFT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         0         90.00           91.00         09100         BARBER AND BEAUTY SHOP         0         2,654         84         2,738         0         91.00           92.00         09200         PHYSI CI ANS PRI VATE OFFICES         0         0         0         0         92.00           93.00         09300         NONPAI D WORKERS         0         0         0         93.00         94.00         94.00         0         94.00				U 725 000	22.84	0 0 3 748 772		1
90.00         09000         GIFT, FLOWER, COFFEE SHOPS & CANTEEN         0         0         0         0         0         90.00           91.00         09100         BARBER AND BEAUTY SHOP         0         2,654         84         2,738         0         91.00           92.00         09200         PHYSI CI ANS PRI VATE OFFICES         0         0         0         0         92.00           93.00         09300         NONPAI D WORKERS         0         0         0         0         93.00           94.00         09400         PATI ENTS LAUNDRY         0         0         0         94.00           98.00         Cross Foot Adjustments         0         0         0         98.00         99.00         0         0         99.00	07.00		<u> </u>	125, 909	1 22, 00	740,772	0	07.00
92.00         09200         PHYSICIANS PRIVATE OFFICES         0         0         0         92.00           93.00         09300         NONPAI D WORKERS         0         0         0         0         93.00           94.00         09400         PATI ENTS LAUNDRY         0         0         0         0         94.00           98.00         Cross Foot Adjustments         0         0         0         98.00         98.00           99.00         Negative Cost Centers         0         0         0         0         99.00	90.00		0	0		0 0	0	90.00
93.00         09300         NONPAI D WORKERS         0         0         0         93.00         93.00           94.00         09400         PATI ENTS LAUNDRY         0         0         0         0         94.00         94.00         94.00         94.00         94.00         98.00         98.00         98.00         98.00         98.00         99.00         0         0         0         99.00         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         0         99.00         0         0         0         99.00         0         0         0         0         99.00         0			0	2, 654	8	4 2, 738		1
94.00         09400         PATI ENTS LAUNDRY         0         0         0         94.00         94.00         94.00         98.00         98.00         98.00         98.00         98.00         98.00         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         99.00         0         0         0         0         99.00         0         0         0         99.00         0         0         0         0         99.00			0	0		0 0		
98.00         Cross Foot Adjustments         0         98.00         98.00         99.00         0         0         0         99.00         99.00         0         0         0         99.00         100         99.00         100 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
99.00 Negative Cost Centers 0 0 0 0 99.00				0		0	0	1
100.00         TOTAL       0       728, 563       22, 947       751, 510       0       100.00				0		0 0	0	
	100.00	TOTAL	0	728, 563	22, 94	7 751, 510	0	100. 00

	Financial Systems	COUNTRY ARCH (				u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/30/2023 12:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00 2.00 3.00 4.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	36, 484					1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	2, 498 140 1, 562 4, 428 1, 491	56, 049 2, 039 239 6, 418 147	26, 243 0	4, 623	87, 137 0	
10.00 11.00 12.00 13.00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	962 120 5 507	3, 475 3, 475 0 103 92		299 0 0 0 9	0 0 0 0	10.00 11.00 12.00 13.00
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 1, 251	0 2, 172		-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 31.00 32.00 33.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	19, 582 0 0	37, 887 0 0 0		0 0 0 0	87, 137 0 0 0	31.00 32.00
	ANCI LLARY SERVICE COST CENTERS						
40.00 41.00 42.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	39 29 0	0 0 0	c c		0 0 0	41.00
43.00 44.00 45.00	04300 OXYGEN (I NHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0 1, 765 557	0 3, 013 0		0 0 259 0 0	0 0 0	43.00 44.00
46.00 47.00 48.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	505 0 85	0 0 232	c c	0 0 0 0 20	0 0 0	46.00 47.00
49.00 50.00 51.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	947 0	232 0 0 0		0 0 0 0	0 0 0	49.00 50.00
51.00	OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>		0	1 51.00
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	0 0			0	
70.00	OTHER REIMBURSABLE COST CENTERS					0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0			0 0 0	
80. 00 81. 00 82. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						80.00 81.00 82.00
82.00 83.00 89.00	08300 HIELZATION REVIEW - SNP 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 36, 473	0 55, 817	26, 243	0 0 3 4, 603	0 87, 137	83.00
90.00 91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0 11 0 0	0 232 0 0		20 0 0 0 0	0 0 0 0	91.00 92.00 93.00
94.00 98.00 99.00 100.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers TOTAL	0 0 36, 484	0 0 56, 049	26, 243	0 0	0 0 0 87, 137	98.00

Heal th	Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS-2	2540-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315433	Period: From 01/01/2022 To 12/31/2022		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	3, 391					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	45, 748				10.00
11.00		0	0	1	20		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		0 1, 334	1 (00	12.00
13.00	01300 SOCIAL SERVICE	0	0		0 0	1, 688	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14.00
15.00	01500 ACTIVITIES	0	0		0 0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 201	1E 740	1	20 1, 334	1, 688	20.00
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 391	45, 748 0		20 1, 334 0 0		30.00 31.00
31.00	03200   CF/I   D	0	0		0 0		32.00
32.00	03300 OTHER LONG TERM CARE	0	0		0 0		32.00
33.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	33.00
40.00	04000 RADI OLOGY	0	0		0 0	0	40.00
41.00	04100 LABORATORY	0	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS				- 1		
60.00	06000 CLI NI C	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
	OTHER REIMBURSABLE COST CENTERS	-		1	-1 -	-	
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0		70.00
71.00	07100 AMBULANCE	0	0		0 0		71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00 81.00
81.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00
82.00	08300 HOSPICE	0	0		0 0	0	82.00
89.00	SUBTOTALS (sum of lines 1-84)	3, 391	45, 748	1	20 1, 334		1
09.00	NONREI MBURSABLE COST CENTERS	3, 371	45,740	I	20 1, 334	1,000	07.00
90 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
98.00	Cross Foot Adjustments	0	0		0		98.00
99.00	Negative Cost Centers	0	0		0 0	0	1
100.00		3, 391	45, 748	1	20 1, 334		100.00
							-

Heal th	Financial Systems	COUNTRY ARCH	CARE	CENTER		In Lie	eu of Form CMS-	2540-10
	TION OF CAPITAL RELATED COSTS				No.: 315433	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II	pared:
				GENERAL				
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACT	I VI TI ES	Subtotal	Post Step-Dowr Adjustments	Total	
		14.00	1	5.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS	1	1		1			1 1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT							1.00 2.00
2.00	00300 EMPLOYEE BENEFITS							3.00
4.00	00400 ADMI NI STRATI VE & GENERAL							4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS							5.00
6.00	00600 LAUNDRY & LINEN SERVICE							6.00
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	01100 PHARMACY							11.00
12.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE							12.00
13.00 14.00	01400 NURSING AND ALLIED HEALTH EDUCATION							13.00 14.00
15.00	01500 ACTI VI TI ES		Ś	29, 245				15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS		4	27,240			1	15.00
30.00	03000 SKILLED NURSING FACILITY	0		29, 245	702, 7	65 C	702, 765	30.00
31.00	03100 NURSING FACILITY	0	þ	0		0 0	0	31.00
32.00	03200   CF/IID	0		0		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0		0		0 0	0 0	33.00
	ANCILLARY SERVICE COST CENTERS	1						
40.00	04000 RADI OLOGY	0		0		39 0		1
41.00	04100 LABORATORY	0	2	0		29 C		1
42.00 43.00	04200 INTRAVENOUS THERAPY			0				
43.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY			0	40, 5	-	40, 592	
45.00	04500 OCCUPATI ONAL THERAPY			0		57 0	557	1
46.00	04600 SPEECH PATHOLOGY			0		05 0	505	1
47.00	04700 ELECTROCARDI OLOGY	0	b	0		0 0	0 0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	þ	0	3, 0	75 C	3, 075	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0		0	9	47 C	947	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	D	0		0 0		
51.00	05100 SUPPORT SURFACES	0	)	0		0 0	0 0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS			0		0		
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0		0				
62.00	06200 FQHC		1	0		0 0		62.00
02.00	OTHER REIMBURSABLE COST CENTERS		I					02100
70.00	07000 HOME HEALTH AGENCY COST	0	)	0		0 0	0 0	70.00
71.00	07100 AMBULANCE	0	þ	0		0 0	0	71.00
73.00	07300 CMHC	0		0		0 0	0 0	73.00
	SPECIAL PURPOSE COST CENTERS		1					
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
81.00	08100 I NTEREST EXPENSE							81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF			0		0		82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)			29, 245	748, 5	0 C 09 C		
69.00	NONREI MBURSABLE COST CENTERS	0	<u>и</u>	29, 240	/40, 0	09 <u></u>	/40, 509	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	D	0		0 0	0 0	90.00
91.00	09100 BARBER AND BEAUTY SHOP			0	3, 0	-	3, 001	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	þ	0		0 0	0	1
93.00	09300 NONPAI D WORKERS	0	D	0		0 0	0	1
94.00	09400 PATIENTS LAUNDRY	0	P	0		0 0	0 0	
98.00	Cross Foot Adjustments	0	2	0		0 0	0	
99.00	Negative Cost Centers	0	2	0	754 5	0 0		
100.00	TOTAL	0	4	29, 245	751, 5	10 0	751, 510	100.00

	Financial Systems LLOCATION - STATISTICAL BASIS	COUNTRY ARCH		No.: 315433 F	Period:	u of Form CMS-2 Worksheet B-1	
.01 /1				F	rom 01/01/2022 o 12/31/2022		pared:
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation		
	cost center bescription	FIXTURES	EQUI PMENT	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)		(GROSS		(ACCUM COST)	
			, ,	SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
00	GENERAL SERVICE COST CENTERS	44, 472					1.0
00	00200 CAP REL COSTS - BEDGS & FIXTORES	44,472	44, 472				2.0
00	00300 EMPLOYEE BENEFITS	0					3.0
00	00400 ADMINI STRATI VE & GENERAL	2, 159	2, 159			9, 382, 362	4.0
00	00500 PLANT OPERATION, MAINT. & REPAIRS	3, 169	3, 169	103, 491	0	642, 423	5.0
00	00600 LAUNDRY & LINEN SERVICE	1, 424				35, 906	6.0
00	00700 HOUSEKEEPI NG	167				401, 534	7.0
00		4, 482				1, 138, 599	8.0
00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	103			S 0	383, 342 247, 368	9. C
. 00	01100 PHARMACY	2,427	2,427			30, 776	11.0
	01200 MEDICAL RECORDS & LIBRARY	72	72			1, 217	
. 00	01300 SOCIAL SERVICE	64			0	130, 384	13.0
. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. C
. 00	01500 ACTI VI TI ES	1, 517	1, 517	192, 989	0	321, 583	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1	1		
. 00	03000 SKILLED NURSING FACILITY	26, 460	26, 460				30.0
. 00	03100 NURSING FACILITY	0	0	C		0	31.0
	03200 I CF/I I D	0			-	0	32.0
. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	33.0
. 00	04000 RADI OLOGY	0	0	C	0 0	9, 906	40.0
. 00	04100 LABORATORY	0	0			7, 560	41.0
. 00	04200 I NTRAVENOUS THERAPY	0	0	C	0 0	0	42. (
. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	C	0 0	0	43.0
. 00	04400 PHYSI CAL THERAPY	2, 104	2, 104			453, 917	44.0
. 00	04500 OCCUPATIONAL THERAPY	0	0	122, 560		143, 326	45.0
. 00	04600 SPEECH PATHOLOGY	0	0	88, 043		129, 822	
. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	162	162		0	0 21, 844	47.0 48.0
. 00 . 00	04900 DRUGS CHARGED TO PATIENTS	0				243, 396	40.0
. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		0	0	50.0
. 00	05100 SUPPORT SURFACES	0	-		0 0	-	51.0
	OUTPATIENT SERVICE COST CENTERS						
. 00	06000 CLI NI C	0	-				60. (
. 00	06100 RURAL HEALTH CLINIC	0	0	C	0 0	0	61. (
. 00							62. (
00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	) 0	0	70.
	07100 AMBULANCE	0			-	0	70.0
	07300 CMHC	0	0			0	73.0
	SPECIAL PURPOSE COST CENTERS		-	-	· <u> </u>	-	
. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. (
. 00	08100 INTEREST EXPENSE						81. (
. 00	08200 UTILIZATION REVIEW - SNF						82.
. 00	08300 HOSPI CE	0	0	C	0 0	0	83.
. 00	SUBTOTALS (sum of lines 1-84)	44, 310	44, 310	4, 877, 365	-2, 317, 157	9, 379, 624	89. (
	NONREI MBURSABLE COST CENTERS		0			0	
0. 00 . 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	162	140			0	90.
. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	102	162			2, 738 0	91. 92.
. 00	09300 NONPAI D WORKERS	0	0			0	93.
. 00	09400 PATIENTS LAUNDRY	0	0		0	0	94.
. 00	Cross Foot Adjustments						98.
	Negative Cost Centers	1					99.
. 00	0	728, 563	22, 947	826, 401		2, 317, 157	102. (
2.00 2.00		1					
2.00	Part I)				1	0 04/0/0	1400 4
02.00 03.00	Unit cost multiplier (Wkst. B, Part I)	16. 382510	0. 515988	0. 169436		0. 246969	
2.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	16. 382510	0. 515988	0. 169436 C	)	0. 246969 36, 484	
02.00 03.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	16. 382510	0. 515988	0. 169436 C 0. 000000			104. (

Health Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS-:	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2022	Worksheet B-1	
				o 12/31/2022		
Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/30/2023 12: NURSI NG	20 pm
	OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)		
	MAINT. & REPAIRS	(PATIENT DAYS)			(PATIENT DAYS)	
	(SQUARE FEET)					
	5.00	6.00	7.00	8.00	9.00	
1.00 OO100 CAP REL COSTS - BLDGS & FLXTURES	1				[	1.00
2.00 00200 CAP REL COSTS - BEDGS & FIXTURES						2.00
3. 00 00300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMINI STRATI VE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE	39, 144 1, 424					5.00 6.00
7. 00 00700 HOUSEKEEPI NG	167					7.00
8. 00 00800 DI ETARY	4, 482		1, 102			8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY	103		103		37, 830	
10. 00 01000 CENTRAL SERVI CES & SUPPLY 11. 00 01100 PHARMACY	2, 427		2,427		0	10.00
12.00 01200 MEDICAL RECORDS & LIBRARY	72		72		0	12.00
13. 00 01300 SOCI AL SERVI CE	64	C	) 64		0	13.00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	, s		, j		
15. 00 O1500 ACTI VI TI ES I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 517	0	1, 517	0	0	15.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	26, 460	37, 830	26, 460	113, 490	37, 830	30.00
31.00 03100 NURSING FACILITY	0	C	0 0	-	0	31.00
32.00 03200 I CF/I I D 33.00 03300 OTHER LONG TERM CARE	0					32.00 33.00
ANCI LLARY SERVI CE COST CENTERS	0		<u>л</u> С	<u> </u>	0	33.00
40. 00 04000 RADI OLOGY	0	C	C	0 0	0	40.00
41.00 04100 LABORATORY	0	0		-		
42.00 04200 I NTRAVENOUS THERAPY 43.00 04300 0XYGEN (I NHALATI ON) THERAPY	0			, j	0	42.00
44. 00 04400 PHYSI CAL THERAPY	2, 104		2, 104	, o	0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	0	C	C		0	45.00
46. 00 04600 SPEECH PATHOLOGY	0	0		0	0	46.00
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	162		162		0	47.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0				0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0					50.00
51.00 05100 SUPPORT SURFACES	0	0	) C	0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS	0	C		)	0	60,00
61. 00 06100 RURAL HEALTH CLINIC	0				-	
62.00 06200 FQHC						62.00
OTHER REI MBURSABLE COST CENTERS	0	C		0	0	70.00
71. 00 07100 AMBULANCE	0					71.00
73.00 07300 CMHC	0	C	) C	0	0	73.00
SPECIAL PURPOSE COST CENTERS	1					
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80.00 81.00
82. 00 08200 UTI LI ZATI ON REVIEW - SNF						82.00
83. 00 08300 HOSPI CE	0	C	C	0 0	0	
89.00 SUBTOTALS (sum of lines 1-84)	38, 982	37, 830	37, 391	113, 490	37, 830	89.00
NONREI MBURSABLE COST CENTERS           90.00         09000         GI FT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	162				0	
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	C	C	0 0	0	92.00
93. 00 09300 NONPAI D WORKERS 94. 00 09400 PATI ENTS LAUNDRY	0			0	0	
98.00 Cross Foot Adjustments				0	0	98.00
99.00 Negative Cost Centers						99.00
102.00 Cost to be allocated (per Wkst. B,	801, 082	73, 916	504, 118	1, 571, 689	481, 507	102.00
Part I) 103.00 Unit cost multiplier (Wkst. B, Part I)	20. 465001	1. 953899	13. 424174	13.848700	12. 728179	103 00
104.00 Cost to be allocated (per Wkst. B,	56, 049					104.00
Part II)						
105.00 Unit cost multiplier (Wkst. B, Part	1. 431867	0. 693709	0. 123106	0. 767795	0. 089638	105.00
	I	I	ļ.	ļ	I	I.

	Financial Systems LLOCATION - STATISTICAL BASIS	COUNTRY ARCH	CARE CENTER	No.: 315433 P	Period:	u of Form CMS-2 Worksheet B-1	
	LLUGATION - STATISTICAL BASIS		Provider	F	rom 01/01/2022 o 12/31/2022		
	Cost Center Description	CENTRAL	PHARMACY	MEDICAL	SOCI AL SERVI CE	5/30/2023 12:	
		SERVICES & SUPPLY (PATIENT DAYS)	(PATIENT DAYS)		(PATI ENT DAYS)	ALLI ED HEALTH EDUCATI ON (ASSI GNED	
		10.00	11.00	12.00	13.00	TIME) 14.00	
	GENERAL SERVICE COST CENTERS	1	1	I	1	Γ	
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	37, 830 C C C C C C C C C	37, 830 0 0 0 0 0	37, 830 C C C	37, 830 0 0	0	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	37, 830	37, 830	37, 830	37, 830	0	30.00
	03100 NURSING FACILITY	37,830 0		37,830 C		0	
	03200 I CF/I I D	C		C		0	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C	0	C	0 0	0	33.00
40.00	04000 RADI OLOGY	C	0	C	0 0	0	40.00
	04100 LABORATORY	C	0		-	0	
42.00 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY				, s	0	
	04400 PHYSI CAL THERAPY						
	04500 OCCUPATI ONAL THERAPY	C	0	C C	0	0	
	04600 SPEECH PATHOLOGY	C	0	C	0 0	0	
		C	0	C	0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS				0 0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY		0		0 0	0	
	05100 SUPPORT SURFACES	C	0	C	0		
	OUTPATIENT SERVICE COST CENTERS	1	1	1	1	1	
	06000 CLINIC 06100 RURAL HEALTH CLINIC			0			
	06200 FQHC		0		0	0	62.00
	OTHER REIMBURSABLE COST CENTERS			-		-	
	07000 HOME HEALTH AGENCY COST	C					70.00
	07100 AMBULANCE 07300 CMHC		e e e e e e e e e e e e e e e e e e e	, s		Ű	71.00
73.00	SPECIAL PURPOSE COST CENTERS		<u>ı</u> 0		<u> </u>	0	1 / 3. 00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	37,830	-	37, 830	37,830	0	
07.00	NONREI MBURSABLE COST CENTERS	57,000	<u> </u>	37,030	, 37,030		07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	C	0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	C				-	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	C			0	0	
	09400 PATIENTS LAUNDRY		0	c c	0 0	0	
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers	000 7				-	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	390, 709	38, 377	3, 958	164, 754	0	102.00
103.00	-	10. 328020	1. 014459	0. 104626	4. 355115	0.000000	103.00
		45, 748					104.00
104.00							
104.00 105.00	Part II)	1. 209305	0. 003172	0.035263	0. 044621	0.000000	105 00

	Financial Systems LLOCATION - STATISTICAL BASIS	COUNTRY ARCH CA	Provi der No. : 315433	Peri od:	u of Form CMS-2540 Worksheet B-1
0017				From 01/01/2022	
				To 12/31/2022	Date/Time Prepare 5/30/2023 12:20 p
		OTHER GENERAL			
	Cost Center Description	SERVICE ACTIVITIES			
	cost center bescription	(PATIENT DAYS)			
		15.00			
~~	GENERAL SERVICE COST CENTERS	1			
. 00 . 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT				1.
. 00	00300 EMPLOYEE BENEFITS				3.
. 00	00400 ADMI NI STRATI VE & GENERAL				4.
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.
. 00	00600 LAUNDRY & LINEN SERVICE				6.
. 00	00700 HOUSEKEEPI NG				7.
. 00 . 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON				8.
0.00	01000 CENTRAL SERVICES & SUPPLY				10.
1.00	01100 PHARMACY				11.
	01200 MEDI CAL RECORDS & LI BRARY				12.
3.00	01300 SOCIAL SERVICE				13.
	01400 NURSING AND ALLIED HEALTH EDUCATION				14.
5.00	01500 ACTIVITIES	37,830			15.
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	37, 830			30.
	03100 NURSING FACILITY	0			31.
	03200 I CF/I I D	0			32.
	03300 OTHER LONG TERM CARE	0			33.
	ANCILLARY SERVICE COST CENTERS				
0. 00	04000 RADI OLOGY	0			40.
1.00	04100 LABORATORY	0			41.
2.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0			42. 43.
4.00	04400 PHYSI CAL THERAPY	0			43.
	04500 OCCUPATI ONAL THERAPY	0			45.
6. 00	04600 SPEECH PATHOLOGY	0			46.
7.00	04700 ELECTROCARDI OLOGY	0			47.
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48.
9.00 0.00	04900 DRUGS CHARGED TO PATIENTS	0			49. 50.
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0			50.
1.00	OUTPATIENT SERVICE COST CENTERS	9			
0. 00	06000 CLI NI C	0			60.
1. 00	06100 RURAL HEALTH CLINIC	0			61.
2.00					62.
0 00	OTHER REIMBURSABLE COST CENTERS	0			70.
	07100 AMBULANCE	0			70.
	07300 CMHC	0			73.
	SPECIAL PURPOSE COST CENTERS				
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				80.
1.00	08100 I NTEREST EXPENSE				81.
2.00	08200 UTI LI ZATI ON REVI EW - SNF				82.
3.00 9.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 37, 830			83. 89.
,. 00	NONREI MBURSABLE COST CENTERS	57,030			
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.
	09100 BARBER AND BEAUTY SHOP	0			91.
2.00	09200 PHYSI CLANS PRI VATE OFFI CES	0			92.
3.00	09300 NONPALD WORKERS	0			93.
4.00	09400 PATIENTS LAUNDRY	0			94. 98.
8.00 9.00	Cross Foot Adjustments Negative Cost Centers				98.
9.00 02.00		452, 413			102.
00	Part I)				<sup>102.</sup>
03.00	Unit cost multiplier (Wkst. B, Part I)	11. 959107			103.
04.00		29, 245			104.
05.00	Part II)	0 7700/1			405
	Unit cost multiplier (Wkst. B, Part	0. 773064			105.

Health Financial Systems COUNTRY ARCH CA	ARE CENTER		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der		Period:	Worksheet C	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	nared
				5/30/2023 12:	20 pm
Cost Center Description		Total (from	Total Charges		
		Wkst. B, Pt I	,	di vi ded by	
		col . 18)		col. 2	
		1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS		40.05		1.04/004	40.00
40. 00 04000 RADI OLOGY		12, 35			
41. 00 O4100 LABORATORY		9, 42	7 7, 560		
42. 00 04200 I NTRAVENOUS THERAPY			0 0	0.00000	
43.00 04300 0XYGEN (INHALATION) THERAPY		(07.00	0 0	0.00000	
44. 00 04400 PHYSI CAL THERAPY		637, 32			•
45. 00 04500 OCCUPATI ONAL THERAPY		178, 72			•
46.00 04600 SPEECH PATHOLOGY		161, 88	4 306, 496		•
47. 00 04700 ELECTROCARDI OLOGY		00.70	0 0	0.000000	•
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		32, 72			•
49. 00 04900 DRUGS CHARGED TO PATIENTS		303, 50	7 243, 396		
50.00 05000 DENTAL CARE - TITLE XIX ONLY			0 0	0.00000	
51.00 05100 SUPPORT SURFACES			0 0	0. 000000	51.00
		1	0 0	0,000000	1 ( 0 . 00
			0 0	0. 000000	•
61. 00 06100 RURAL HEALTH CLINIC					61.00
62. 00 06200 FQHC				0,00000	62.00
71.00 07100 AMBULANCE		1 225 04		0. 000000	
100. 00   Total		1, 335, 94	4 1, 597, 124		100.00

Health Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315433	Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		
				To 12/31/2022	Date/Time Pre 5/30/2023 12:	20 nm
		Title	XVIII (1)	Skilled Nursing	PPS	20 pm
				Facility		
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	•	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	<u>Column 3)</u> 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	
ANCI LLARY SERVICE COST CENTERS	TENT COST					-
40. 00 04000 RADI OLOGY	1. 246921	0		0 0	0	40.00
41. 00 04100 LABORATORY	1. 246958	0		0 0	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0 0	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 319633			0 245, 307	0	
45.00 04500 OCCUPATIONAL THERAPY	0. 338679			0 75, 255	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 528177			0 77, 830	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 713022	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 246968	0		0 0	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
OUTPATIENT SERVICE COST CENTERS			_			
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00   Total (Sum of lines 40 - 71)		555, 447		0 398, 392	0	100.00

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

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

Health Financial Systems	COUNTRY ARCH	CARE CENTER		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315433	Period: From 01/01/2022 To 12/31/2022		pared: 20 pm
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	1. 246968	1.00
2.00 Program vacci ne charges (From your reco	ords, or the PS&	&R)			18, 075	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	er this amoun	t to Worksheet	22, 539	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,			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 &	ALLI ED HEALTH				
ANCI LLARY SERVI CE COST CENTERS						1
40. 00 04000 RADI OLOGY	12, 352	C	0.0000	0 00	0	40.00
41.00 04100 LABORATORY	9, 427	C	0.0000	0 0	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	C	0.0000	0 0	0	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY	0	C	0.0000	0 0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	637, 322	C	0.0000	245, 307	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	178, 723	C	0.0000	0 75, 255	0	45.00
46.00 04600 SPEECH PATHOLOGY	161, 884	C	0.0000	0 77, 830	0	46.00
47.00 04700 ELECTROCARDI OLOGY	0	C	0.0000	0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 729	C	0.0000		0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	303, 507	C	0.0000		0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C	0.0000		0	50.00
51.00 05100 SUPPORT SURFACES	0	C	0.0000		0	51.00
100.00  Total (Sum of lines 40 - 52)	1, 335, 944	C		398, 392	0	100. 00

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315433	Period: From 01/01/2022 To 12/31/2022		pared:
		Title XVIII	Skilled Nursing Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			37, 830	1.0
2.00	Private room days			0	
. 00	Inpatient days including private room days applicable to the			6, 225	•
. 00	Medically necessary private room days applicable to the Prog	ram		0	
. 00	Total general inpatient routine service cost			10, 354, 671	5.0
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			12 012 445	
o. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5	divided by line ()		13, 813, 445 0. 749608	
7.00 8.00	Enter private room charges from your records	divided by Tine 6)		0.749608	
9.00 9.00	Average private room per diem charge (Private room charges I	ing & divided by private	room dave lino	0.00	
. 00	2)	The a divided by private	room days, rrne	0.00	9.0
0.00	Enter semi-private room charges from your records			0	10.0
1.00	Average semi-private room per diem charge (Semi-private roo	m charges line 10. divide	d bv	0.00	
	semi-private room days)	<u> </u>			
2.00	Average per diem private room charge differential (Line 9 mi	nus line 11)		0.00	12.0
3.00	Average per diem private room cost differential (Line 7 time	s line 12)		0.00	13.0
	Private room cost differential adjustment (Line 2 times line			0	1
5.00	General inpatient routine service cost net of private room c	ost differential (Line 5	minus line 14)	10, 354, 671	15.0
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
	Adjusted general inpatient service cost per diem (Line 15 d	ivided by line 1)		273.72	
	Program routine service cost (Line 3 times line 16)			1, 703, 907	
	Medically necessary private room cost applicable to program			0	
9.00	Total program general inpatient routine service cost (Line Capital related cost allocated to inpatient routine service		t II oolumn 10	1, 703, 907	
0.00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	COSIS (FIONI WKSL. B, PAI	L II COLUMIT 18,	702, 765	20.
1. 00	Per diem capital related costs (Line 20 divided by line 1)			18. 58	21. (
	Program capital related costs (Line 3 times line 21)			115, 661	
	Inpatient routine service cost (Line 19 minus line 22)			1, 588, 246	
	Aggregate charges to beneficiaries for excess costs (From p	rovider records)		0	
	Total program routine service costs for comparison to the co		nus line 24)	1, 588, 246	
	Enter the per diem limitation (1)		,		26.
7.00	Inpatient routine service cost limitation (Line 3 times the	per diem limitation line	26) (1)	1	27.0
	Reimbursable inpatient routine service costs (Line 22 plus				28. (
	(Transfer to Worksheet E, Part II, line 4) (See instructions	۱ ۱			1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	37, 830	1.00
2.00	Program inpatient days (see instructions)	6, 225	2.00
3.00	Total nursing & allied health costs. (see instructions) (Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 164552	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00
			,

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315433	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2023 12:	pared:
		Title XIX	Skilled Nursing Facility	Cost	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	INPATI ENT DAYS				İ
1.00	Inpatient days including private room days			37, 830	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicable to the I	Program		24, 454	3.00
4.00	Medically necessary private room days applicable to the Progra	am		0	4.00
5.00	Total general inpatient routine service cost			10, 354, 671	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges			13, 813, 445	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 d	divided by line 6)		0.749608	7.00
8.00	Enter private room charges from your records			0	8.00
9.00	Average private room per diem charge (Private room charges lin 2)	ne 8 divided by private	room days, line	0.00	9.00
10.00	Énter semi-private room charges from your records			0	10.00
11.00	Average semi-private room per diem charge (Semi-private room semi-private room days)	charges line 10, divide	d by	0.00	11.00
12.00	Average per diem private room charge differential (Line 9 min	us line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times	line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line	13)		0	14.00
15.00	General inpatient routine service cost net of private room cos PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Line 5	minus line 14)	10, 354, 671	15.00
16.00	Adjusted general inpatient service cost per diem (Line 15 div	vided by line 1)		273.72	16.00
17.00	Program routine service cost (Line 3 times line 16)			6, 693, 549	17.00
18.00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 1	7 plus line 18)		6, 693, 549	19.00
20. 00	Capital related cost allocated to inpatient routine service co line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	702, 765	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)			18.58	21.00
	Program capital related cost (Line 3 times line 21)			454, 355	
	Inpatient routine service cost (Line 19 minus line 22)			6, 239, 194	23.00
	Aggregate charges to beneficiaries for excess costs (From pro			0	24.00
25.00	Total program routine service costs for comparison to the cos	t limitation (Line 23 mi	nus line 24)	6, 239, 194	
	Enter the per diem limitation (1)			0.00	
	Inpatient routine service cost limitation (Line 3 times the pe			0	27.00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus th (Transfer to Worksheet E, Part II, line 4) (See instructions)	ne lesser of line 25 or	line 27)	6, 693, 549	28.00

		1.00	
PART II CALCUL	ATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00 Total SNF inpa	tient days	37, 830	1.00
2.00 Program inpati	ent days (see instructions)	24, 454	2.00
3.00 Total nursing	& allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00 Nursing & alli	ed health ratio. (line 2 divided by line 1)	0. 646418	4.00
5.00 Program nursir	g & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

Heal th	Financial Systems COUNTRY ARCH CA	ARE CENTER	In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315433	Period: From 01/01/2022	Worksheet E Part I	
			To 12/31/2022	Date/Time Pre 5/30/2023 12:2	
		Title XVIII	Skilled Nursing		
			Facility		
				1 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBI	UDSEMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	URSEMENT		4, 370, 499	1.00
2.00	Nursing and Allied Health Education Activities (pass through	navments)		4, 370, 477	2.00
3.00	Subtotal (Sum of Lines 1 and 2)	paymentesy		4, 370, 499	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coinsurance			588, 168	5.00
6.00	Allowable bad debts (From your records)			639, 091	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See ins	tructions)		83, 739	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	,		415, 409	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			4, 197, 740	11.00
12.00	Interim payments (See instructions)			3, 841, 794	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestration			0	14.50
14.55	Demonstration payment adjustment amount after sequestration			0	
14.75	Sequestration for non-claims based amounts (see instructions	)		5, 235	
14.99	Sequestration amount (see instructions)			44, 574	
15.00	Balance due provider/program (see Instructions)			306, 137	15.00
16.00	Protested amounts (Nonallowable cost report items in accorda			0	16.00
17 00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESS	ER OF COST OR CHARGES - I	IILE XVIII UNLY	0	17 00
17.00 18.00	Ancillary services Part B			0 22, 539	17.00 18.00
18.00	Vaccine cost (From Wkst D, Part II, line 3) Total reasonable costs (Sum of lines 17 and 18)			22, 539	
20.00	Medicare Part B ancillary charges (See instructions)			18,075	
20.00	Cost of covered services (Lesser of line 19 or line 20)			18, 075	
22.00	Primary payor amounts			0,075	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 ins	tructions)		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)			18, 075	25.00
26.00	Interim payments (See instructions)			13, 465	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestration			0	28.50
28.55	Demonstration payment adjustment amount after sequestration			0	28.55
28.99	Sequestration amount (see instructions)			228	
29.00	Balance due provider/program (see instructions)			4, 382	
30.00	Protested amounts (Nonallowable cost report items) in accord	ance with CMS Pub.15-2, s	ection 115.2	0	30.00

Health Financial System:		COUNTRY ARCH CAR			u of Form CMS-2	2540-1
CALCULATION OF REIMBURS	EMENT SETTLEMENT TITLE V	and TITLE XIX ONLY	Provider No.: 315433	Peri od:	Worksheet E	
				From 01/01/2022 To 12/31/2022	Part II	narad
				10 12/31/2022	Date/Time Pre 5/30/2023 12:	20 nm
			Title XIX	Skilled Nursing		20 pm
				Facility	0001	
			•			
					1.00	
COMPUTATION OF NE	T COST OF COVERED SERVIC	ES				
1.00 Inpatient ancilla	nry services (see Instruc	tions)			0	1.0
2.00 Nursing & Allied	Health Cost (From Works	heet D-1, Pt. II, lir	ie 5)		0	2.0
3.00 Outpatient servi	es				0	
	e services (see instructi				6, 693, 549	4.0
	ewphysicians' compensat		cords)		0	
6.00 Cost of covered	services (Sum of lines 1	- 5)			6, 693, 549	6.0
	charges between semipriva	te accommodations and	lless than semiprivate	accommodations	0	7.0
8.00 SUBTOTAL (Line 6	minus line 7)				6, 693, 549	
9.00 Primary payor am	ounts				0	9.0
	Cost (Line 8 minus line	9)			6, 693, 549	10.0
REASONABLE CHARC						
11.00 Inpatient ancilla					0	
12.00 Outpatient servi					0	
13.00 Inpatient routine	5				0	
	charges between semipriva	te accommodations and	lless than semiprivate	accommodations	0	
15.00 Total reasonable					0	15.0
CUSTOMARY CHARGE						
	actually collected from				0	
	d have been realized fro			n a charge basis	0	17.0
	been made in accordance				0,00000	18.0
	to line 17 (not to excee				0.000000	
	harges (see instructions IMBURSEMENT SETTLEMENT	.)			0	19.0
	services (see Instruction				0	20.0
21.00 Deductibles	services (see instruction	5)			0	
22.00 Subtotal (Line 20	minus line 21)				0	
23. 00 Coi nsurance	minus inne 21)				0	
24.00 Subtotal (Line 2	minus lino 22)				0	
25.00 Allowable bad del					0	
26.00 Subtotal (sum of					0	
	es to beneficiaries for e	vers costs arronadus	ly collected based on c	orrection of	0	
cost limit	is to beneficialles for e		i y corrected based on c		0	27.0
	s depreciation resulting	from provider termin	ation or a decrease in	program	0	28.0
utilization		····· p·····		P 9	-	
	s (see instructions) Spe	cifv			0	29.0
	e to prior cost reportin		rom disposition of depr	eciable assets (	0	
	amount in parentheses)	a reneration of the second string i			0	
-	plus or minus lines 29	, and 30, minus lines	27 and 28)		0	31.0
32.00 Interim payments			/		0	
1 1 2	der/program (Line 31 min	us line 32) (indicate	e overpayments in parent	heses) (see	0	
Instructions)		, ,		<i>,</i> ,		

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315433	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Date/Time Prep 5/30/2023 12:2	pare
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	20 μ
		Inpatien	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		3, 737, 7 122, 9		13, 465 0	1
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3
)1	ADJUSTMENTS TO PROVIDER		1	0	0	3
)2				0	0	3
03				0	Ő	
)4				0	0	1
)5				0	0	
	Provider to Program		1			
0	ADJUSTMENTS TO PROGRAM	07/21/2022	18, 8		0	1
1				0	0	
52				0	0	
3				0	0	
54			10.0	0	0	3
9	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-18, 8	85	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		3, 841, 7	94	13, 465	4
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	5
)2				0	ō	5
)3				0	0	5
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
9	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5
00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					é
)1	PROGRAM TO PROVIDER		306, 1	37	4, 382	6
)2	PROVIDER TO PROGRAM		300, 1	0	4, 302	6
00	Total Medicare program liability (see instructions)		4, 147, 9	31	17, 847	7
-				actor Name	Contractor	Í
					Number	

 8.00
 Name of Contractor

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

d-type	HEET (If you are nonproprietary and do not maintain accounting records, complete the "General Fund" column	Provi der	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet G Date/Time Pre	
y)		Canaral Fund		Endowment Fund	5/30/2023 12:	
		General Fund	Purpose Fund		Plant Fund	
Ass	sets	1.00	2.00	3.00	4.00	+
	RRENT ASSETS	•				1
	sh on hand and in banks	844, 896		0	0	
	mporary investments	0	0	0	0	
	tes recei vable counts recei vable	3, 050, 497		0	0	
	her receivables	0	0	0	0	
0 Les	ss: allowances for uncollectible notes and accounts	0	0	0	0	
	cei vabl e					
	ventory	0	0	0	0	
	epaid expenses her current assets	169, 661		0	0	
	e from other funds	0	0	0	0	
	TAL CURRENT ASSETS (Sum of lines 1 - 10)	4,065,054	0		0	
FIX	KED ASSETS		-			
00 Lar		0			0	
	nd improvements	0	0		0	
	ss: Accumulated depreciation ildings			0	0	
	ss Accumulated depreciation	0		0	0	
	asehold improvements	1, 480, 200		0	0	
	ss: Accumulated Amortization	-1, 320, 347	0	0	0	1
	xed equipment	0	0	0	0	
	ss: Accumulated depreciation	0	0		0	
	tomobiles and trucks ss: Accumulated depreciation	0	0	0	0	
	jor movable equipment	216, 923	-	0	0	
1 3	ss: Accumulated depreciation	-216, 923	0	0	0	
00 Mir	nor equipment - Depreciable	0	0	0	0	2
1	nor equipment nondepreciable	0	0	0	0	
	her fixed assets	0	0		0	
	TAL FIXED ASSETS (Sum of lines 12 - 27) HER ASSETS	159, 853	0	0	0	) 2
	vestments	0	0	0	0	0 2
	posits on leases	0	0		0	
	e from owners/officers	0	0	0	0	
	her assets	0	0	0	0	
1	TAL OTHER ASSETS (Sum of Lines 29 - 32)	0	0		0	
	TAL ASSETS (Sum of lines 11, 28, and 33) abilities and Fund Balances	4, 224, 907	0	0	0	) 3
	RENT LI ABI LI TI ES					1
	counts payable	1, 662, 661	0	0	0	3
	laries, wages, and fees payable	144, 741	0		0	
	yroll taxes payable	7,644		0	0	
	tes & loans payable (Short term)	0	0	0	0	
	ferred income celerated payments	0	0	0	0	4
	e to other funds	0	0	0	0	
	her current liabilities	824, 031	0	0	0	
оо тот	TAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 639, 077	0	0	0	4
	IG TERM LI ABI LI TI ES	1				4
	rtgage payable	0	0		0	
	tes payable secured Loans	0	0	-	0	
1	secured Loans ans from owners:			0	0	
	her long term liabilities	0	0	0	0	
	HER (SPECIFY)	0	0	Ő	0	
оо  тот	TAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	0	5
	TAL LIABILITIES (Sum of lines 43 and 50)	2, 639, 077	0	0	0	<u>)</u> 5
	PITAL ACCOUNTS	1 505 020		1		٩.,
	neral fund balance ecific purpose fund	1, 585, 830	0			5
	nor created - endowment fund balance - restricted			0		5
	nor created - endowment fund balance - unrestricted			0		5
	verning body created - endowment fund balance			0		5
00   PI a	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	5
	placement, and expansion	4 505 055	-	_	-	
	TAL FUND BALANCES (Sum of Lines 52 thru 58)	1, 585, 830		0	0	
	TAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	4, 224, 907	0	1 U	0	6  0

Heal th	Financial Systems	COUNTRY ARCH CA	RE CENTER		In Li	eu of Form CMS-2	2540-10
	IENT OF CHANGES IN FUND BALANCES		Provi der 1	No.: 315433	Period: From 01/01/2022 To 12/31/2022	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) BREAKAGE Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 585, 830 1, 585, 827 1, 585, 827 3 1, 585, 830 0 1, 585, 830	0.00			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) BREAKAGE	0	0 0 0 0 0		0		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 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0 0	0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems	COUNTRY ARCH CARE	CENTER			Inlie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSE			No.: 315433		riod: om 01/01/2022	Worksheet G-2 Parts I-II Date/Time Prep 5/30/2023 12:3	pared:
	Cost Center Description			I npati ent		Outpati ent	Total	
	·			1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			13, 813, 44	45		13, 813, 445	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE				0		0	4.00
5.00	Total general inpatient care services (Sum c	oflines 1 - 4)		13, 813, 44	45		13, 813, 445	5.00
	All Other Care Services			1		1		
6.00	ANCI LLARY SERVI CES			1, 597, 12	24	0	1, 597, 124	6.00
7.00	CLINIC					0	0	7.00
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9.00
10.00	RURAL HEALTH CLINIC					0	0	10.00
10. 10	FQHC					0	0	10. 10
11.00	СМНС					0	0	11.00
12.00	HOSPI CE				0	0	0	12.00
	OTHER (SPECIFY)				0	0	0	13.00
	Total Patient Revenues (Sum of lines 5 - 13)	(Transfer column 3	to	15, 410, 50	69	0	15, 410, 569	14.00
	Worksheet G-3, Line 1)							
	Cost Center Description							
						1.00	2.00	
	PART II - OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3,	Line 100)					14, 100, 348	1.00
2.00	Add (Specify)					0		2.00
3.00						0		3.00
4.00						0		4.00
5.00						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and	18, minus line 14)					14, 100, 348	15.00

Heal th	Financial Systems	ancial Systems COUNTRY ARCH CARE CENTER In Lie				u of Form CMS-2540-10		
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSE		S	Provider No.: 315433	Peri od:	Worksheet G-3			
				From 01/01/2022	5 . <i>(</i> <b>7</b> ) 5			
				To 12/31/2022	Date/Time Prep 5/30/2023 12:2			
					5/ 50/ 2025 12.2	<u>20 pm</u>		
					1.00			
1.00	Total patient revenues (From Wkst. G-2, Par	t I, col. 3, line 1	4)		15, 410, 569	1.00		
2.00	Less: contractual allowances and discounts o	1, 513, 306	2.00					
3.00	Net patient revenues (Line 1 minus line 2)		13, 897, 263	3.00				
4.00	Less: total operating expenses (From Workshe	14, 100, 348	4.00					
5.00	Net income from service to patients (Line 3	minus 4)			-203, 085	5.00		
	Other income:							
6.00	Contributions, donations, bequests, etc				0	6.00		
7.00	Income from investments				2, 078			
8.00	Revenues from communications ( Telephone and	Internet service)			0	8.00		
9.00	Revenue from television and radio service				0	9.00		
10.00	Purchase di scounts				0	10.00		
11.00	Rebates and refunds of expenses				0	11.00		
12.00	Parking lot receipts				0	12.00		
13.00	Revenue from laundry and linen service				0	13.00		
14.00	Revenue from meals sold to employees and gue	sts			0	14.00		
15.00	Revenue from rental of living quarters				0	15.00		
16.00	Revenue from sale of medical and surgical su	pplies to other tha	n patients		0	16.00		
17.00	Revenue from sale of drugs to other than pat	ients			0	17.00		
18.00	Revenue from sale of medical records and abs	tracts			0	18.00		
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00		
20.00	Revenue from gifts, flower, coffee shops, ca	nteen			0	20.00		
21.00	Rental of vending machines				0	21.00		
22.00	Rental of skilled nursing space				0	22.00		
23.00	Governmental appropriations				0	23.00		
24.00	OTHER INCOME				8, 608	24.00		
24.50	COVID-19 PHE Funding				42, 042	24.50		
25.00	Total other income (Sum of lines 6 - 24)				52, 728	25.00		
26.00	Total (Line 5 plus line 25)				-150, 357	26.00		
27.00	Other expenses (specify)				0	27.00		
28.00					0	28.00		
29.00					0	29.00		
30.00	Total other expenses (Sum of lines 27 - 29)				0	30.00		
31.00	Net income (or loss) for the period (Line 26	minus line 30)			-150, 357	31.00		
					•			