12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"

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 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315525 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 11: 17 am PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 5/24/2024 Time: 11:17 am 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 ] 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

for no utilization.

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARBOUR VIEW SENIOR LIVING CENTER (315525) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Joe E	Blachorsky	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Joe Blachorsky			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	257, 585	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	257, 585	0	0	100.00

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

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

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315525 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:17 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 3161 KENNEDY BOULEVARD PO Box: 1.00 2.00 City: NORTH BERGEN State: NJ Zi p Code: 07047 2.00 3.00 County: HUDSON CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF HARBOUR VIEW SENIOR 315525 01/05/2018 N Р 0 4.00 LIVING CENTER 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 | SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related Υ 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 Straight Line 20.00 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits d 22.00 22.00 Sum of line 20 through 22 Q 23 00 23.00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility N 29.00 Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry mal practice insurance? (Y/N) Υ 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 2 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses:

0

0

41.00

Heal th	Ith Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu					
SKILLED NURSING FACILITY AND SKILLED NURSING COMPLEX INDENTIFICATION DATA		RSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE DENTIFICATION DATA Provider No.: 31552			Worksheet S- Part I Date/Time Pr 5/24/2024 11	epared:
					Y/N	. 17 diii
					1. 00	
	Are malpractice premiums and paid losse center? Enter Y or N. If yes, check boo amounts.		N	42. 00		
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?		N	43. 00
	If line 43 is yes, enter the home office of lines 45, 46 and 47.	ce chain number and enter	the name and address	of the home		44. 00
	1.00	2. 00		3. 00		
	If this facility is part of a chain org below.	ganization, enter the name	e and address of the h	nome office on the	lines	
45.00	Name:	Contractor's Name:	Contrac	tor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47. 00	ci ty:	State:	Zi p Cod	e:		47. 00

OMPLE	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	No.: 315525	Period: From 01/01/2023 To 12/31/2023		epared:
					1. 00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy)	ses enter in colum	n 1, "Y" fo	r Yes or "N"	for No. For all	the date	
	Completed by All Skilled Nursing Facilites						
. 00	Provider Organization and Operation  Has the provider changed ownership immediatel				N		1.00
	reporting period? If column 1 is "Y", enter instructions)	the date of the ch	ange in col	umn 2. (see			
	Thisti detroils)			Y/N	Date	V/I	
. 00	Has the provider terminated participation in	the Medicare Prod	ram? If	1. 00 N	2. 00	3. 00	2.00
	column 1 is yes, enter in column 2 the date of						
. 00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact	tions, including m	anagement	Υ			3.00
	contracts, with individuals or entities (e.g.						
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or trelationships? (see instructions)	family and other s	imilar				
	relationships: (see Histi uctions)			Y/N	Туре	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements prepa			Υ	С	10/31/2024	4.00
	Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complete						
	available in column 3. (see instructions) If	no, see instructi	ons.				
. 00	Are the cost report total expenses and total those on the filed financial statements? If of			N			5. 00
	reconciliation.		dom't				
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities						
00	Column 1: Were costs claimed for Nursing Schollegal operator of the program? (Y/N)	ool? (Y/N) Column	2: Is the	provider the	N	N	6.00
00	Were costs claimed for Allied Health Programs			Cara Novasias	N		7. 00
. 00	Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) se		ing period	ror Nursing	N		8. 00
						Y/N 1. 00	
	Bad Debts					1.00	
00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb				st reporting	N N	9.00
	period? If "Y", submit copy.		, ,	· ·		IN.	
1. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance w	aived? If "	Y", see instr	ructi ons.	N	11.00
2. 00	Have total beds available changed from prior	cost reporting pe	riod? If "Y			N	12. 00
		Descripti	on	Y/N	art A Date	Part B Y/N	
		0	OH	1.00	2. 00	3. 00	
3 00	PS&R Data Was the cost report prepared using the PS&R			Υ	02/01/2024	I Y	13 00
3. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter			Y	02/01/2024	Y	13. 0
. 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			Y	02/01/2024	Y	13. 00
	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)				02/01/2024		
	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			Y	02/01/2024	Y N	
	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y"				02/01/2024		
	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for				02/01/2024		
↓. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N	02/01/2024	N	14.00
. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that				02/01/2024		14.00
↓. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the			N	02/01/2024	N	14.00
i. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N N	02/01/2024	N N	14. 00
. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were			N	02/01/2024	N	14. 00
. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report			N N	02/01/2024	N N	14. 00
i. 00 i. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N N	02/01/2024	N N	13. 00 14. 00 15. 00 16. 00
i. 00 i. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			N N	02/01/2024	N N	14. 00
7. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were			N N	02/01/2024	N N	14. 00 15. 00 16. 00

Heal th	Financial Systems HARBOUR VIEW SENI	OR LIVING CENTER In Lieu of Form			u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE		Provi der No.: 315525	Peri od: From 01/01/2023	Worksheet S-2 Part II	!
COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023		pared: 17 am
	<u> </u>					
			1. 00	2.	00	
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position	CHAR	LES	REED		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
20.00	Enter the employer/company name of the cost report	EXEC	UCARE ASSOCIATES			20. 00
	preparer.					
21. 00	Enter the telephone number and email address of the cost	(609	)738-3200	CRWASSC@NETSCAI	PE. NET	21. 00
	report preparer in columns 1 and 2, respectively.					

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems HARBOUR VIEW SENIOR SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315525 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2023	Date/Time Prepared: 5/24/2024 11:17 am
		Part B			9,21,2921 111 17 4
		Date			
		4. 00			
	PS&R Data				
13. 00	Was the cost report prepared using the PS&R	02/01/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and 4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14. 00
11.00	for total and the provider's records for				11.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
	made to PS&R data for additional claims that				
	have been billed but are not included on the PS&R used to file this cost report? If "Y",				
	see Instructions.				
16. 00	1				16.00
. 0. 00	adjustments made to PS&R data for				10.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17.00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
40.00	Describe the other adjustments:				10.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18. 00
	provider s records? IT if see Histractions.				
			3.00		
	Cost Report Preparer Contact Information				
19. 00	Enter the first name, last name and the title		VI CE-PRESI DENT		19. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
00.00	respecti vel y.				00.00
20.00	Enter the employer/company name of the cost r	eport			20. 00
21. 00	preparer. Enter the telephone number and email address	of the cost			21. 00
21.00	report preparer in columns 1 and 2, respective				21.00
	1. 1-1. 1 - 1-1-1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	, , .	I .	1	I

Health Financial Systems HARBOUR VIEW SENIOR SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provi der No.: 315525

						5/24/2024 11:		
				I 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		
1.00	SKILLED NURSING FACILITY	60	21, 900	0	-,	11, 815	1. 00	
2.00	NURSING FACILITY	0	0	0		0	2.00	
3. 00 4. 00	HOME HEALTH AGENCY COST		U	0	0	0	3. 00 4. 00	
5. 00	Other Long Term Care	0	0			O ,	5. 00	
6.00	SNF-Based CMHC						6. 00	
7.00	HOSPI CE	o	0	0	0	0	7. 00	
8.00	Total (Sum of lines 1-7)	60	21, 900	0	-,	11, 815	8. 00	
		Inpatient D	ays/Vi si ts		Di scharges			
	Component	Other	Total	Title V	Title XVIII	Title XIX		
		6. 00	7. 00	8. 00	9. 00	10.00		
1.00	SKILLED NURSING FACILITY	4, 953	20, 735	0	81	57	1. 00	
2.00	NURSING FACILITY	0	0	0		0	2. 00	
3.00	ICF/IID	0	0			0	3. 00	
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0				4. 00 5. 00	
6. 00	SNF-Based CMHC		U				6. 00	
7. 00	HOSPI CE	o	0	О	0	0	7. 00	
8.00	Total (Sum of lines 1-7)	4, 953	20, 735	0	81	57	8. 00	
		Di sch	arges	Aver	Average Length of Stay			
	Component	Other	Total	Title V	Title XVIII	Title XIX		
1.00	CVILLED MUDCING FACILLETY	11.00	12. 00	13.00	14. 00	15. 00	1 00	
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	62	200	0. 00 0. 00		207. 28 0. 00	1. 00 2. 00	
3.00	ICF/IID	0	0	0.00		0.00	3. 00	
4.00	HOME HEALTH AGENCY COST						4. 00	
5.00	Other Long Term Care	o	0				5.00	
6.00	SNF-Based CMHC						6.00	
7.00	HOSPI CE	0	0	0.00		0.00	7. 00	
8. 00	Total (Sum of lines 1-7)	62 Average Length	200		48. 98 si ons	207. 28	8. 00	
		of Stay		/ talli c	31 0113			
	Component	Total	Title V	Title XVIII	Title XIX	Other		
1 00	TOWALLED ANDROLMO FACILITY	16.00	17. 00	18. 00	19. 00	20. 00	1 00	
1. 00 2. 00	SKILLED NURSING FACILITY	103. 68	0	105		59 0	1. 00 2. 00	
3. 00	NURSING FACILITY	0. 00 0. 00	U		0	0	3. 00	
4. 00	HOME HEALTH AGENCY COST	0.00				O	4. 00	
5.00	Other Long Term Care	0.00				0	5. 00	
6.00	SNF-Based CMHC						6. 00	
7.00	HOSPI CE	0.00	0	0	0	0	7. 00	
8. 00	Total (Sum of lines 1-7)	103.68 Admi ssi ons	Full Time	105 Equi val ent	41	59	8. 00	
	Component	Total	Employees an	Nonnai d				
	Component	Total	Employees on Payroll	Nonpai d Workers				
		21. 00	22. 00	23. 00				
1. 00	SKILLED NURSING FACILITY	205	109. 00	0. 00			1. 00	
2.00	NURSING FACILITY	0	0. 00				2. 00	
3.00	ICF/IID	0	0.00				3. 00	
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0. 00 0. 00				4. 00 5. 00	
6. 00	SNF-Based CMHC		0.00				6. 00	
7. 00	HOSPI CE	0	0.00				7. 00	
8.00	Total (Sum of lines 1-7)	205	109. 00				8. 00	
		·	·					

15.00

16.00

17.00

18.00

20.00

22.00

Home office salaries & wage related costs

Wage-related costs core (See Part IV)

Wage-related costs other (See Part IV)

Total Adjusted Wage Related cost (see

Wage related costs (excluded units)

WAGE-RELATED COSTS

21.00 Physician Part B - WRC

instructions)

Physician Part A - WRC

SNF WAGE INDEX INFORMATION Provi der No.: 315525 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/24/2024 11:17 am Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 Reported col . 4) Worksheet A-6  $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 4, 999, 444 4, 999, 444 227, 028. 00 22.02 1.00 Physician salaries-Part A 0.00 2.00 2.00 0 0 0 0.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 0.00 4.00 4.00 Sum of lines 2 through 4 0 0.00 5.00 0 0 0.00 5.00 4, 999, 444 227, 028. 00 22.02 6.00 Revised wages (line 1 minus line 5) 4, 999, 444 6.00 7.00 Other Long Term Care 0 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0.00 0.00 8.00 0.00 0 0 9.00 9.00 CMHC 0.00 0 10.00 HOSPI CE 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0.00 0.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 4, 999, 444 C 4, 999, 444 227, 028. 00 22.02 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 472, 950 0 472, 950 12, 307. 00 38. 43 14.00

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22.00

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315525

						072172021 11.	1 7 Giii
		Amount	Reclass. of			Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	296, 386	0	296, 386	9, 369. 00	31. 63	2.00
3.00	Plant Operation, Maintenance & Repairs	227, 933	0	227, 933	15, 173. 00	15. 02	3. 00
4.00	Laundry & Li nen Servi ce	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	308, 708	0	308, 708	17, 583. 00	17. 56	5.00
6.00	Di etary	568, 024	0	568, 024	40, 515. 00	14. 02	6.00
7.00	Nursing Administration	422, 203	0	422, 203	14, 287. 00	29. 55	7. 00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Soci al Servi ce	37, 706	0	37, 706	1, 048. 00	35. 98	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	186, 805	0	186, 805	10, 646. 00	17. 55	13.00
14.00	Total (sum lines 1 thru 13)	2, 047, 765	0	2, 047, 765	108, 621. 00	18. 85	14.00

	To 12/31/20		pared: 17 am
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	56, 906	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	6, 292	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	Workers' Compensation Insurance	76, 933	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	400, 986	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	169, 697	20. 00
	OTHER		
21.00	Executive Deferred Compensation	0	21. 00
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	710, 814	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COST	0	25. 00

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES

Provi der No.: 315525

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

				T	o 12/31/2023	Date/Time Prep 5/24/2024 11:	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	.,
	, o j	Reported	Benefits	Salaries (col.	Related to	Wage (col. 3 ÷	
				1 + col . 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es						
1 00	Nursing Occupations Registered Nurses (RNs)	753, 103	110, 667	863, 770	31, 839. 00	27 12	1. 00
1. 00 2. 00	Licensed Practical Nurses (LPNs)	572, 612	84, 144				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 276, 636	187, 600				3. 00
3.00	Assi stants/Ai des	1, 270, 030	167,000	1, 404, 230	00, 407.00	21.40	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 602, 351	382, 411	2, 984, 762	111, 618. 00	26. 74	4. 00
5. 00	Physical Therapists	232, 883	34, 222				5. 00
6.00	Physical Therapy Assistants	0	0 .,	0	0.00		6. 00
7. 00	Physical Therapy Aides	o	0	ō	0.00		7. 00
8.00	Occupational Therapists	65, 304	9, 596	74, 900	1, 504. 00	49. 80	8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	O	0	0	0.00	0.00	10.00
11.00	Speech Therapists	51, 141	7, 515	58, 656	851.00	68. 93	11.00
12.00	Respiratory Therapists	O	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	5, 613		5, 613			14.00
15. 00	Licensed Practical Nurses (LPNs)	170, 179		170, 179			15. 00
16. 00	Certified Nursing Assistant/Nursing	290, 434		290, 434	9, 410. 00	30. 86	16. 00
17 00	Assistants/Aides	4// 22/		4// 22/	10 104 00	20. 22	17 00
17. 00 18. 00	Total Nursing (sum of lines 14 through 16)	466, 226 4, 919		466, 226 4, 919			17. 00 18. 00
19. 00	Physical Therapists Physical Therapy Assistants	4, 919		4, 919	0.00		19. 00
20. 00	Physical Therapy Aides			0	0.00		20.00
21. 00	Occupational Therapists	892		892			21. 00
21.00	Occupational Therapy Assistants	092		092	0.00		22.00
23. 00	Occupational Therapy Assistants  Occupational Therapy Aides				0.00		23. 00
24. 00	Speech Therapists	913		913			24. 00
25. 00	Respiratory Therapists	713		0			25. 00
26. 00		o		0			
	1	١		,	3.00		

12/31/2023 Date/Time Prepared: 5/24/2024 11:17 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE<sub>2</sub> 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB<sub>2</sub> 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75.00 PA<sub>2</sub>

Provi der No.: 315525

Peri od:

From 01/01/2023

Health Financial Systems	HARBOUR VIEW SENIOR LI	VING CENTE	TER In Lieu of Form CMS-2540-10				
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA				Peri od:	Worksheet S-	7	
				From 01/01/2023 To 12/31/2023			
				Group	Days		
				1. 00	2. 00		
76. 00				PA1		76. 00	
99. 00				AAA		99. 00	
100. 00 TOTAL			_	_		100. 00	
			Expenses	Percentage	Y/N		
			1.00	2. 00	3. 00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101. 00 Staffing						101. 00	
102.00 Recruitment						102.00	
103.00 Retention of employees						103. 00	
104. 00 Trai ni ng						104.00	
105.00 OTHER (SPECIFY)	line 1 column 2)					105.00	
106.00 Total SNF revenue (Worksheet G-2, Part I	, TITIE 1, COLUMN 3)		I			106. 00	

	Financial Systems HAR					eu of Form CMS-2	2340-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023		naradi
					10 12/31/2023	5/24/2024 11:	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	17 4111
	oust deliter beschiptron	Sul di i CS	Other	+ col . 2)	ons	Trial Balance	
				+ (01. 2)	Increase/Decre		
					ase (Fr Wkst	col . 4)	
					A-6)	COI. 4)	
		1 00	2.00	2 00	4. 00	5. 00	
	CENEDAL CEDVICE COCT CENTERS	1.00	2. 00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS		2 100 000	2 100 00		2 100 000	1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		2, 188, 000	1		2, 188, 000	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 053			1, 053	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	734, 660	1		734, 660	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	296, 386	1, 281, 337	l .		1, 577, 723	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	227, 933	1, 444, 635	1, 672, 56	8 0	1, 672, 568	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	3, 626	3, 62	6 0	3, 626	6. 00
7.00	00700 HOUSEKEEPI NG	308, 708	55, 148	363, 85	6 0	363, 856	7. 00
8.00	00800 DI ETARY	568, 024	223, 219	791, 24	3 0	791, 243	8. 00
9.00	00900 NURSING ADMINISTRATION	422, 203	23, 479	445, 68	2 0	445, 682	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	179, 637	179, 63	7 0	179, 637	10.00
11. 00	01100 PHARMACY	0	24, 310			24, 310	
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	2.,0.0		0	0	12.00
13. 00	01300 SOCI AL SERVI CE	37, 706	10, 000		-	47, 706	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	37,700	10,000	47,70	0	47,700	14. 00
		10/ 005	17.051	204 75	0		•
15. 00	01500 ACTIVITIES	186, 805	17, 951	204, 75	6 0	204, 756	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 (00 054	4// 00/	0.0/0.57	7	0.0(0.577	00.00
30.00	03000 SKILLED NURSING FACILITY	2, 602, 351	466, 226	3, 068, 57	7 0	-,,	30.00
31. 00	03100 NURSING FACILITY	0	0	)	0	0	31.00
32. 00	03200   I CF/I I D	0	0	)	0		32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	)	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				+		
40.00	04000 RADI OLOGY	0	13, 253	13, 25	3 0	13, 253	40.00
41.00	04100 LABORATORY	0	28, 248	28, 24	8 0	28, 248	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	869	86	9 0	869	43.00
44.00	04400 PHYSI CAL THERAPY	232, 883	38, 074	270, 95	7 0	270, 957	44.00
45.00	04500 OCCUPATI ONAL THERAPY	65, 304	892	66, 19	6 0	66, 196	45. 00
46. 00	04600 SPEECH PATHOLOGY	51, 141	913	1		52, 054	1
47. 00	04700 ELECTROCARDI OLOGY	0.7	0	1 02,00	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		86, 871	86, 87	1	86, 871	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		00, 071	00, 07		0 0	50.00
	05100 SUPPORT SURFACES		0		0 0	0	
51. 00		U U	0	<u>/ </u>	0	0	51.00
(0.00	OUTPATIENT SERVICE COST CENTERS			J			/ 0 00
60.00	06000 CLINIC	0	0	1	0	- 1	60.00
61.00	06100 RURAL HEALTH CLINIC	0	Ü	1	0	0	61.00
62. 00	06200 FQHC					<u> </u>	62. 00
	OTHER REIMBURSABLE COST CENTERS				_1	_	
70. 00	07000 HOME HEALTH AGENCY COST	0	0	1	0		70. 00
71. 00	07100 AMBULANCE	0	0	)	0		71. 00
73. 00	07300 CMHC	0	0	)	0 0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	)	0	0	80. 00
81.00	08100 I NTEREST EXPENSE		0		0	0	81. 00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	82. 00
83.00	08300 HOSPI CE	0	0		0	0	83. 00
89.00	SUBTOTALS (sum of lines 1-84)	4, 999, 444	6, 822, 401	11, 821, 84	5 0	11, 821, 845	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0		0 0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		0	ol	o o	Ö	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES		n	1	o o	Ö	92.00
	09300 NONPALD WORKERS	ام	0		o n	0	93. 00
	09400 PATIENTS LAUNDRY		0		م م	٥	94.00
100.00		4, 999, 444	6, 822, 401	, 11, 821, 84	5 0		1
100.00	ITOTAL	7, 777, 444	0, 022, 401	11,021,04	٠ <sub>ا</sub> ٥	11,021,045	1.00.00

Health Financial Systems

HARBOUR VIEW SENIOR LIVING CENTER

Provider No.: 315525

Period:
From 01/01/2023
To 12/31/2023

Cost Center Description

Adjustments to Expenses (Fr Wkst A-8)

General Service Cost Centers

	Cost Center Description	Adjustments to			
			For Allocation		
		Wkst A-8)	(col. 5 +-		
			col . 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				4
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-390, 119		•	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	1, 053	•	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	734, 660		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-315, 497	1, 262, 226		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	1, 672, 568		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	3, 626		6. 00
7.00	00700 HOUSEKEEPI NG	0	363, 856		7. 00
8.00	00800 DI ETARY	0	791, 243		8. 00
9.00	00900 NURSING ADMINISTRATION	0	445, 682		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	179, 637		10.00
11. 00		0	24, 310		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	l .	12.00
13.00		0	47, 706		13.00
14. 00		0	0	1	14.00
15. 00		0	204, 756		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		201,700		10.00
30.00		-1, 795	3, 066, 782		30.00
31. 00		0	0	1	31. 00
32. 00		0	0		32. 00
33. 00		0	•	1	33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS				33.00
40.00		0	13, 253		40. 00
41. 00	1	0	28, 248	•	41. 00
42. 00	1	0	0	•	42. 00
43. 00		0	869		43. 00
44. 00		-169		•	44. 00
45. 00	1 I	-107	66, 196	l .	45. 00
46. 00			52, 054	•	46.00
	1	0		•	1
47. 00	1	0	0	l .	47. 00
48. 00		0	0 071	l .	48. 00
49. 00		0	86, 871	•	49. 00
50.00		0	0	1	50.00
51. 00		] 0	0		51. 00
/ O OO	OUTPATIENT SERVICE COST CENTERS	0	1 0		(0.00
60.00	1	0		•	60.00
61.00	1	0	0		61.00
62. 00					62. 00
70.00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	1 0	0		70. 00
70.00		_		1	1
71. 00		0			71. 00
73. 00		1 0	0		73. 00
00.00	SPECIAL PURPOSE COST CENTERS	1 0	1 0		00.00
80.00		0	,	1	80.00
81.00		0	0	1	81. 00
82. 00		0	0	l .	82. 00
83.00		0	0	l .	83. 00
89. 00		-707, 580	11, 114, 265		89. 00
00.5-	NONREI MBURSABLE COST CENTERS				00.00
90.00		0			90.00
91. 00		0	0	1	91. 00
92.00	1	0	0	l .	92. 00
93. 00	1	0	0	l .	93. 00
94. 00	1	0	0	l .	94. 00
100.0	O TOTAL	-707, 580	11, 114, 265		100. 00

Health Financial Systems HAR	BOUR VIEW SENIOR LIVING CENTER			In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS		Provi der	No.: 315525	Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 17 am
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	0	100. 00
	of columns 4 and 5 must					
	equal sum of columns 8 and					
	9)					

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

Health Financial Systems HAR	BOUR VIEW SENIOR LI	VING CENTE	R	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	,
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 17 am
			Decreases			
	Cost Cente	-	Li ne #	Sal ary	Non Salary	
	6. 00		7.00	8. 00	9. 00	
TOTALS						
100.00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11:17 am Provi der No.: 315525

						3/24/2024 11.	17 alli
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	3					
1.00	Land	0	0	0		0 0	1. 00
2.00	Land Improvements	0	0	0		0 0	2. 00
3.00	Buildings and Fixtures	0	0	0		0 0	3. 00
4.00	Building Improvements	0	0	0		0 0	4. 00
5.00	Fixed Equipment	0	0	0		0 0	5. 00
6.00	Movable Equipment	0	0	0		0 0	6. 00
7.00	Subtotal (sum of lines 1-6)	0	0	0		0 0	7. 00
8.00	Reconciling Items	0	0	0		0 0	8. 00
9. 00	Total (line 7 minus line 8)	0	0	0		0 0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	3					
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	Subtotal (sum of lines 1-6)	0	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	0	0				9. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

Provi der No.: 315525

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

				10 12/31/2023	5/24/2024 11:	
				Expense Classification on		7, 4,
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1. 00	2.00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-1, 773	ADMINISTRATIVE & GENERAL	4.00	1. 00
0.00	(chapter 2)				0.00	0.00
2. 00	Trade, quantity, and time discounts (chapter		0	)	0.00	2. 00
3. 00	8)   Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)		_			
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)		_			
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7. 00 8. 00	Parking lot (chapter 21) Remuneration applicable to provider-based	A-8-2	0		0.00	7. 00 8. 00
8.00	physician adjustment	A-0-2	0	,		8.00
9. 00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
40.00	Capital expenditures (chapter 24)					40.00
12. 00	Adjustment resulting from transactions with	A-8-1	-653, 971			12. 00
13. 00	related organizations (chapter 10) Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0		0.00	14. 00
15. 00	Cost of meals - Guests		0		0.00	15. 00
16.00	Sale of medical supplies to other than		0		0.00	16.00
	patients		_			
17. 00 18. 00	Sale of drugs to other than patients Sale of medical records and abstracts		0		0. 00 0. 00	17. 00 18. 00
19. 00	Vendi ng machi nes		0		0.00	
20. 00	Income from imposition of interest, finance		0		0.00	20. 00
20.00	or penalty charges (chapter 21)		· ·		0.00	20.00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
22. 00	overpayments		0	NITH LZATION DEVIEW SNE	82.00	22. 00
22.00	Utilization reviewphysicians' compensation (chapter 21)		Ü	OUTILIZATION REVIEW - SNF	62.00	22.00
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2. 00	24. 00
25 00	MADVETING / DROMOTIONAL ADVEDTICING		40.007	EQUI PMENT	4.00	25 00
25. 00 25. 01	MARKETING / PROMOTIONAL ADVERTISING   PENALTIES	A A	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4. 00 4. 00	25. 00 25. 01
25. 01	STATE CORPORATE TAX	A		ADMINISTRATIVE & GENERAL	4.00	
25. 03	HMO WX	A	•	ADMI NI STRATI VE & GENERAL	4. 00	
25. 04	1	В		CAP REL COSTS - BLDGS &	1.00	
				FI XTURES		
25. 05			0		0.00	25. 05
25. 06			0		0.00	25. 06
25. 07 25. 08			0		0. 00 0. 00	25. 07 25. 08
25. 09			0		0.00	25. 09
25. 10			0		0.00	25. 10
25. 11			0		0.00	25. 11
25. 12			0		0.00	25. 12
25. 13			0		0.00	25. 13
25. 14			0	2	0.00	25. 14
25. 15 25. 16			0		0.00	25. 15 25. 16
	Total (sum of lines 1 through 99) (Transfer		-707, 580		0.00	25. 16 100. 00
100.00	to Worksheet A, col. 6, line 100)		707,300			. 55. 55
(1) Do	scription - all chapter references in this co	lumn nartain to	CMS Dub 15 1	· 1		

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

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

B. Amount Received - if cost cannot be determined.

6.00

7.00

8.00

9.00

10.00

TOTALS (sum of lines 1-9). Transfer column

6, line 100 to Worksheet A-8, column 3, line

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315525 Peri od: Worksheet A-8-1 From 01/01/2023 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2023 5/24/2024 11:17 am Line No. Cost Center Expense Items 1.00 2.00 3.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1.00 CAP REL COSTS - BLDGS & RENT 1.00 FI XTURES 2.00 4. 00 ADMINISTRATIVE & GENERAL MANAGEMENT FEE 2.00 3.00 30.00 SKILLED NURSING FACILITY RELATED NURSING 3.00 44.00 PHYSI CAL THERAPY RELATED THERAPY 4.00 4.00 5.00 0.00 5.00 6.00 0.00 6.00 7.00 0.00 7.00 8.00 0.00 8.00 9.00 0.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 10.00 6, line 100 to Worksheet A-8, column 3, line Amount Amount Adjustments Allowable In Included in (col. 4 minus Cost Wkst. A, col. col. 5) 4.00 5 00 6.00 PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1, 802, 889 2, 188, 000 -385, 111 1.00 2.00 397, 136 -266, 896 2.00 664, 032 3.00 -1, 795 177, 682 179, 477 3.00 4.00 16, 749 16, 918 -169 4.00 5.00 5.00 0 0 0

0

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2, 394, 456

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Ω

0

3, 048, 427

0

0

0

-653, 971

6.00

7.00

8.00

9.00

10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315525 Peri od: Worksheet A-8-1 From 01/01/2023 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2023 5/24/2024 11:17 am

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00 PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

1.00	F	JONATHAN ROSENBERG	0. 00	1.00
2.00	F	MOSHE ROSENBERG	0.00	2. 00
3.00	F	ZVI ROSENBERG	0. 00	3. 00
4.00	F	AVRAHAM ROSENBERG	0.00	4. 00
5. 00	F	JONATHAN ROSENBERG	0.00	5. 00
6.00	F	ESTHER ROSENBERG	0.00	6. 00
7. 00	F	MINDY ROSENBERG	0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

	Related Organization(s) and/or Home Office						
	Name	Percentage of	Type of Business	1			
		Ownershi p					
	4.00	5. 00	6. 00				
DART II INTERRE ATLANGUER TO BELATER ARABILT	ATLANIAN AND AND HOME OFFICE						

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

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

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

1.00		3161 KENNEY BLVD LLC	25. 00	REALTY	1.00
2.00		3161 KENNEY BLVD LLC	25. 00	REALTY	2.00
3.00		3161 KENNEY BLVD LLC	25. 00	REALTY	3. 00
4.00		3161 KENNEY BLVD LLC	25. 00	REALTY	4. 00
5.00		JER ROSE MANAGEMENT	50.00	MANAGEMENT	5. 00
6.00		JER ROSE MANAGEMENT	50.00	MANAGEMENT	6. 00
7.00		PEACE OF MIND STAFFING	100.00	STAFFING	7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0. 00		10.00
100.00	G. Other (financial or non-financial)		0. 00		100. 00
	speci fy:				

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

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

Provi der No.: 315525

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:17 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 ЗА GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1 00 1, 797, 881 1, 797, 881 1 00 2.00 1,053 1,053 2 00 3.00 00300 EMPLOYEE BENEFITS 734,660 734, 660 3.00 00400 ADMINISTRATIVE & GENERAL 1, 305, 779 4 00 1, 262, 226 O 43 553 4 00 Ω 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 1, 672, 568 C 0 33, 494 1, 706, 062 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 3, 626 3, 626 6.00 7.00 00700 HOUSEKEEPI NG 363, 856 0 45, 364 409, 220 7.00 00800 DI ETARY 791, 243 0 83.470 874.713 8 00 8 00 9.00 00900 NURSING ADMINISTRATION 445, 682 62,042 507, 724 9.00 01000 CENTRAL SERVICES & SUPPLY 179, 637 179, 637 10.00 10.00 01100 PHARMACY 11.00 24, 310 0 24, 310 11.00 0 01200 MEDICAL RECORDS & LIBRARY 0 12.00 0 Ω 0 12.00 13.00 01300 SOCIAL SERVICE 47, 706 0 0 5, 541 53, 247 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 0 14.00 01500 ACTI VI TI ES 15.00 0 27, 451 232, 207 15.00 204, 756 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 1, 797, 881 1, 053 382, 412 5, 248, 128 30.00 3,066,782 31.00 03100 NURSING FACILITY 0 0 31.00 0 03200 | CF/IID 32.00 0 32.00 0 0 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 13, 253 C 13, 253 40.00 04100 LABORATORY 41.00 0 0 0 28. 248 41.00 28.248 04200 I NTRAVENOUS THERAPY 42.00 0 0 0 Ω 42.00 04300 OXYGEN (INHALATION) THERAPY 43.00 869 869 43.00 44.00 04400 PHYSI CAL THERAPY 270, 788 0 34, 222 305, 010 44.00 04500 OCCUPATIONAL THERAPY 45.00 66, 196 Ω 0 9, 596 75, 792 45.00 52, 054 04600 SPEECH PATHOLOGY 7, 515 59, 569 46.00 46,00 04700 ELECTROCARDI OLOGY 47.00 0 0 0 0 Ω 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 Ω C 0 Λ 48 00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 86, 871 0 86, 871 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 0 0 05100 SUPPORT SURFACES 51.00 0 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 62 00 06200 FQHC 62 00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 n 70.00 07100 AMBULANCE 0 71.00 0 0 0 0 71.00 07300 CMHC 73.00 0 O 0 73 00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82 00 83.00 08300 H0SPI CE Λ 83.00 SUBTOTALS (sum of lines 1-84) 11, 114, 265 1, 797, 881 1,053 11, 114, 265 89.00 734, 660 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 0 0 09300 NONPALD WORKERS 0 93 00 0 0 93 00 Ω 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 98.00 Cross Foot Adjustments 0 0 98.00 0 0 99.00 99.00 Negative Cost Centers 0 0 0 0 11, 114, 265 TOTAL 1, 797, 881 1.053 11, 114, 265 100. 00 100.00 734, 660

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315525 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:17 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 1, 305, 779 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 227, 123 1, 933, 185 5.00 00600 LAUNDRY & LINEN SERVICE 4, 109 6.00 483 6.00 00700 HOUSEKEEPI NG 7.00 54.478 C 463, 698 7.00 8.00 00800 DI ETARY 116, 448 0 991, 161 8.00 9.00 00900 NURSING ADMINISTRATION 67, 592 0 9.00 0 0 23, 915 01000 CENTRAL SERVICES & SUPPLY 0 0 10.00 10.00 Ω 11.00 01100 PHARMACY 3, 236 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 01300 SOCIAL SERVICE o 7,089 0 13.00 13.00 C 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 0 14.00 15.00 01500 ACTI VI TI ES 30, 913 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 991, 161 30.00 698, 671 1 933 185 4 109 463 698 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 1,764 0 0 0 0 40.00 41.00 04100 LABORATORY 3, 761 0 0 41.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315525

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11:17 am

						5/24/2024 11:	<u>17 am</u>
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
		9. 00	SUPPLY 10. 00	11.00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						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	575, 316					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	203, 552				10.00
11. 00	01100 PHARMACY	0	0	27, 546			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0		12.00
13.00	01300 SOCIAL SERVICE	0	0	0	0	60, 336	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	o	0	o	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			<u>'</u>			
30.00	03000 SKILLED NURSING FACILITY	575, 316	203, 552	27, 546	0	60, 336	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0		31. 00
32. 00	03200   CF/IID	O	0	ام	0		32. 00
33. 00	03300 OTHER LONG TERM CARE		0		0		33. 00
00.00	ANCILLARY SERVICE COST CENTERS	٦		5			00.00
40. 00	04000 RADI OLOGY	0	0	O	0	0	40. 00
41. 00	04100 LABORATORY	0	0	Ö	0	Ö	41. 00
42. 00	04200 I NTRAVENOUS THERAPY		0		0	Ö	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0		0	Ö	43. 00
44. 00	04400 PHYSI CAL THERAPY		0		0		44. 00
45. 00	04500 OCCUPATIONAL THERAPY		0	0	0	0	45. 00
		0	0	0	0	0	
46. 00	04600 SPEECH PATHOLOGY	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	_			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					ı	
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
	SPECIAL PURPOSE COST CENTERS					,	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00		0	0	0	0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	575, 316	203, 552	27, 546	0	60, 336	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0	O	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	lol	0	o	0	0	94. 00
98. 00	Cross Foot Adjustments	0	0				98. 00
99. 00	Negative Cost Centers	0	0	o	0	0	99. 00
100.00		575, 316	203, 552	27, 546	0	1	
			,	, , , , , ,			

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315525

				'	0 12/31/2023	5/24/2024 11:	
			OTHER GENERAL				
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLIED HEALTH EDUCATION			Adjustments		
		14. 00	15. 00	16. 00	17. 00	18. 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 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE			•			6.00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION						9. 00
10. 00							10. 00
11. 00							11.00
12. 00 13. 00							12. 00 13. 00
14. 00				•			14. 00
15. 00			263, 120				15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		2007 120	1			
30.00		C	263, 120	10, 468, 822	. 0	10, 468, 822	30. 00
31. 00		C	0	1	_	0	31. 00
32. 00		C	0	1	_	0	
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS		0	0	0	0	33. 00
40. 00			0	15, 017	0	15, 017	40. 00
41. 00			Ö	1		32, 009	•
42. 00	1	C	0	1		0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	0	985	0	985	43. 00
44.00		C	0			345, 615	1
45. 00		C	0	,		85, 882	1
46. 00	l	C	0			67, 499	1
47. 00 48. 00	1		0	C	0	0	47. 00 48. 00
49. 00	1		0	98, 436	0	98, 436	1
50. 00	1	C	Ö	1		0	50.00
51.00	05100 SUPPORT SURFACES	C	0	C	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS	_	,				
60.00		C		l .		0	
61. 00 62. 00		C	0	C	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00		C	0	C	0	0	70. 00
71.00		C	0	C	0	0	71. 00
73.00		C	0	C	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS	_	ı	1			00.00
80. 00 81. 00	1						80. 00 81. 00
82. 00							82.00
83. 00	· ·	C	0		0	0	1
89. 00		C			_	11, 114, 265	•
	NONREI MBURSABLE COST CENTERS						
90.00		C	_			0	•
91.00	1 1		0		0	0	
92. 00 93. 00	l					0	
94. 00	l		0	0	0	0	
98. 00			Ö	ď	o o	Ö	ł
99. 00		C	0	C	0	0	99. 00
100.00	o TOTAL	C	263, 120	11, 114, 265	0	11, 114, 265	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315525

				'	12/31/2023	5/24/2024 11:	
			CAPITAL RE	LATED COSTS			
		D	DI DOC A	LIOVADI E	6 1 1 1 1	EMBL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	TIATURES	LQUIFWLINI		DENETITS	
		Related Costs					
		0	1.00	2.00	2A	3.00	
	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	0	0	0	0	1	3.00
4.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	0		0	0	4.00
5. 00 6. 00	00600 LAUNDRY & LINEN SERVICE		0		0	0	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	0	0		0	0	7. 00
8. 00	00800 DI ETARY	0	0		0	0	8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	o	0	o	0	Ō	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	O1500 ACTIVITIES	l 0		0	0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   SKILLED NURSING FACILITY	l ol	1, 797, 881	1, 053	1, 798, 934	0	30.00
31. 00	03100 NURSING FACILITY		1, 777, 001	.1	1, 770, 754	0	31.00
32. 00	03200   CF/IID	0	Ö	i	0		32. 00
33. 00	03300 OTHER LONG TERM CARE	o	0	i	0	1	33. 00
	ANCILLARY SERVICE COST CENTERS	'		'			
40. 00	04000 RADI OLOGY	0	C	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	44.00
45. 00 46. 00	04500   OCCUPATI ONAL THERAPY   04600   SPEECH PATHOLOGY	0	0		0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY		0		0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	l ő	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o	0	o o	0	Ö	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	O	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS						
60. 00	06000 CLI NI C	0	0		0	l	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	O6200   FQHC   OTHER REIMBURSABLE COST CENTERS						62.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	o	0	0	70.00
71. 00	07100 AMBULANCE	0	0		0	l .	71.00
73. 00	07300 CMHC	o	0		0	<b>l</b>	73. 00
	SPECIAL PURPOSE COST CENTERS	, -,	_	,			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 797, 881	1, 053	1, 798, 934	0	89. 00
00.00	NONREI MBURSABLE COST CENTERS			1	^	0	00 00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	1	0	l .	1
91.00	09200 PHYSI CLANS PRI VATE OFFICES		0		0		1
93. 00	09300 NONPAID WORKERS		0		0		
94. 00	09400 PATIENTS LAUNDRY		0	ol ol	0	l	94. 00
98. 00	Cross Foot Adjustments				0	]	98. 00
99. 00	Negative Cost Centers		0	0	0	0	
100.00	TOTAL	0	1, 797, 881	1, 053	1, 798, 934	0	100. 00

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS HARBOUR VIEW SENIOR LIVING CENTER Provi der No.: 315525

					0 12/31/2023	5/24/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	T
	•	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
	CENEDAL CEDALCE COCT CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	•					2.00
3.00	00300 EMPLOYEE BENEFITS	1					3.00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS		(				5.00
6.00	00600 LAUNDRY & LINEN SERVICE			o l			6.00
7. 00	00700 HOUSEKEEPI NG		Č		0		7. 00
8.00	00800 DI ETARY	0	C		0	0	1
9. 00	00900 NURSING ADMINISTRATION	o	C		0	0	
10. 00	01000 CENTRAL SERVICES & SUPPLY	o	C		0	0	
11. 00	01100 PHARMACY	o	C	ol c	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	o	C	ol c	0	0	12.00
13.00	01300 SOCIAL SERVICE	0	C	o	0	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C	o	0	0	14.00
15.00	01500 ACTI VI TI ES	0	C	o	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	C	0	0	0	30. 00
31. 00	03100 NURSING FACILITY	0	C	0	0	0	31. 00
32.00	03200   CF/IID	0	C	0	0	0	
33.00	03300 OTHER LONG TERM CARE	0	C	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	C	0	0	0	1
41. 00	04100 LABORATORY	0	C	0	0	0	
42. 00	04200 I NTRAVENOUS THERAPY	0	C	0	0	0	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	C	0	0	0	
44. 00	04400 PHYSI CAL THERAPY	0	C	0	0	0	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	C		0	0	
46. 00	04600 SPEECH PATHOLOGY	0	C		0	0	
47. 00	04700 ELECTROCARDI OLOGY	0	C		0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	0	
49. 00	04900 DRUGS CHARGED TO PATIENTS				0	0	1
50. 00 51. 00	05000   DENTAL CARE - TITLE XIX ONLY   05100   SUPPORT SURFACES				0	0	
31.00	OUTPATIENT SERVICE COST CENTERS	J O		7	0	0	31.00
60. 00	06000 CLINIC	0	C		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		Č		0	0	
62. 00	06200 FQHC			1		Ĭ	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	C	0	0	0	70. 00
71. 00	07100 AMBULANCE	O	C	ol c	0	0	71.00
73.00	07300 CMHC	0	C	ol c	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	0	C	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	C	0	0	0	89. 00
	NONRE MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C			0	
91. 00	09100 BARBER AND BEAUTY SHOP	0	C	0	_	0	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	C	0	_	0	
93. 00	09300 NONPALD WORKERS	0	C	0	0	0	
94.00	09400 PATIENTS LAUNDRY		C	<u>0</u>	0	0	
98.00	Cross Foot Adjustments		-	1 2	0	0	
99.00	Negative Cost Centers TOTAL	0			0	0	99. 00 100. 00
100.00	DI LIGIAL	١	C	ין י	ı U	1 0	1100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315525

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11:17 am

NURSING   CENTRAL   PHARMACY   MEDICAL   RECORDS & LI BRARY   PROPERTIES   PROPERT   PROPERTIES   PROPERTIES   PROPERTIES   PROPERTIES   PROPERTIE		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
SUPPLY   LI BRARY   9.00   10.00   11.00   12.00   13.00		2. 00 3. 00 4. 00 5. 00
9. 00 10. 00 11. 00 12. 00 13. 00    GENERAL SERVICE COST CENTERS		2. 00 3. 00 4. 00 5. 00
1. 00		2. 00 3. 00 4. 00 5. 00
2. 00   00200   CAP REL COSTS - MOVABLE EQUI PMENT   3. 00   00300   EMPLOYEE BENEFITS   4. 00   00400   ADMINI STRATI VE & GENERAL		2. 00 3. 00 4. 00 5. 00
3.00   00300   EMPLOYEE BENEFITS   4.00   00400   ADMINISTRATIVE & GENERAL		3. 00 4. 00 5. 00
4. 00   00400   ADMINISTRATIVE & GENERAL		4. 00 5. 00
		5. 00
		5. 00
of the second service of the service		•
6.00 00600 LAUNDRY & LINEN SERVICE		
7. 00   00700  HOUSEKEEPI NG		7. 00
8. 00   00800  DI ETARY		8.00
9. 00   00900  NURSI NG ADMI NI STRATI ON 0		9. 00
10. 00   01000  CENTRAL SERVI CES & SUPPLY 0 0		10.00
		•
11. 00   01100   PHARMACY		11.00
12. 00   01200   MEDI CAL RECORDS & LI BRARY   0   0   0   0   0		12.00
13. 00   01300   SOCIAL SERVI CE   0   0   0	0	13.00
14.00 O1400 NURSING AND ALLIED HEALTH EDUCATION O O O	0	14. 00
15. 00   01500 ACTIVITIES   0  0  0  0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS		
30.00   03000   SKILLED NURSING FACILITY   0   0   0   0	0	30. 00
31.00   03100   NURSING FACILITY   0   0   0   0	0	31. 00
32. 00   03200   1 CF/1 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 0LOGY   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   0XYGEN (I NHALATI ON) 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	46. 00
47. 00   04700   ELECTROCARDI OLOGY   0   0   0	0	47. 00
48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0 0 0 0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0	0	49. 00
50. 00   05000   DENTAL CARE - TITLE XIX ONLY 0 0 0	0	50.00
51. 00   05100   SUPPORT SURFACES   0   0   0   0	0	51.00
OUTPATIENT SERVICE COST CENTERS		
60. 00 06000 CLI NI C 0 0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC 0 0 0	0	61.00
62. 00   06200   FOHC		62.00
OTHER REIMBURSABLE COST CENTERS		
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	73. 00
SPECIAL PURPOSE COST CENTERS		
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		80. 00
81. 00 08100 I NTEREST EXPENSE		81. 00
82. 00   08200   UTI LI ZATI ON REVI EW - SNF		82. 00
83. 00   08300  HOSPI CE   0   0   0	0	83. 00
89. 00 SUBTOTALS (sum of lines 1-84) 0 0 0	0	89. 00
NONREI MBURSABLE COST CENTERS		07.00
90. 00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0	0	90. 00
91. 00   09100  BARBER AND BEAUTY SHOP   0   0   0	0	91.00
92. 00   09200  PHYSI CI ANS PRI VATE OFFI CES   0   0   0	0	92.00
93. 00   09300  NONPAI D WORKERS   0 0 0 0	0	93.00
93. 00   09300   NONPALD WORKERS   0 0 0 0 0 0 0 0 0	0	
	U	
98.00   Cross Foot Adjustments	^	98.00
	0	
100. 00   TOTAL   0  0  0	U	100. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315525 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/24/2024 11:17 am OTHER GENERAL SERVI CE Cost Center Description NURSING AND ACTI VI TI ES Subtotal Post Step-Down Total ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9.00 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TI ES 15.00 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 1, 798, 934 1, 798, 934 30.00 31.00 03100 NURSING FACILITY 0 0 0 0 31.00 0 32.00 03200 | CF/IID 0 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 0 o 33.00 Ω 0 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 40.00 0 41.00 04100 LABORATORY 0000000000 0 0 0 0 0 0 0 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 0 0 45.00 45.00 0 04600 SPEECH PATHOLOGY 0 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48 00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50.00 C 0 51.00 05100 SUPPORT SURFACES 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 60.00 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 0 C 0 61.00 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CF 83 00 83.00 0 Λ SUBTOTALS (sum of lines 1-84) 89.00 0 0 1, 798, 934 1, 798, 934 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 00000 0 0 0 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00

0

0

0

0

0

0

1, 798, 934

0 93.00

0 98.00

0 99.00

1, 798, 934 100. 00

0

94.00 0

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

TOTAL

Cross Foot Adjustments

Negative Cost Centers

93.00

94.00

98.00

99.00

100.00

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315525

					o 12/31/2023	Date/Time Pre 5/24/2024 11:	
		CAPITAL REI	LATED COSTS			372472024 11.	17 alli
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1. 00	2.00	3. 00	4A	4. 00	
1 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES	22 520	I	T	T	T	1 00
1. 00 2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES	22, 530	22, 530				1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	1			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	0	2,0,000			1
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	0	227, 933		1, 706, 062 3, 626	1
7. 00	00700 HOUSEKEEPI NG	O	Ö	308, 708		409, 220	1
8. 00	00800 DI ETARY	0	0	568, 024		874, 713	1
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON	0	0	422, 203		507, 724	1
11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY				_	179, 637 24, 310	1
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	Ö	d	Ö	0	1
13. 00	01300 SOCI AL SERVI CE	0	0	37, 706		53, 247	1
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0	186, 805	0	1	14. 00 15. 00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS			180,800	0	232, 207	15.00
30. 00	03000 SKILLED NURSING FACILITY	22, 530	22, 530	2, 602, 351	0	5, 248, 128	30. 00
31.00	03100 NURSING FACILITY	0	0				1
32. 00 33. 00	03200   CF/IID 03300   OTHER LONG TERM CARE	0	0				
33. 00	ANCI LLARY SERVI CE COST CENTERS						33.00
40. 00	04000 RADI OLOGY	0	0	-			1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	C		28, 248 0	1
43. 00	04300 OXYGEN (INHALATION) THERAPY					869	1
44. 00	04400 PHYSI CAL THERAPY	0	0	232, 883	0	305, 010	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	65, 304		75, 792	1
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	51, 141 C		59, 569 0	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	Ö			0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	C	0	86, 871	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	C			
31.00	OUTPATIENT SERVICE COST CENTERS			1	<u>,                                     </u>	0	31.00
60.00	06000 CLI NI C	0	0	C			60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	
62. 00	06200 F0HC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71. 00	07100 AMBULANCE	0	0				
73. 00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	73. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00 83. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE				o	0	82.00
89. 00	SUBTOTALS (sum of lines 1-84)	22, 530	0 22, 530				
	NONREI MBURSABLE COST CENTERS		,	., ,	1,000,111	.,	
90.00		0	0	1			1
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	1			
93. 00	09300 NONPALD WORKERS				_	-	1
94.00	09400 PATIENTS LAUNDRY	0	0	c	0	0	94. 00
98.00	Cross Foot Adjustments						98. 00
99. 00 102. 00	Negative Cost Centers   Cost to be allocated (per Wkst. B,	1, 797, 881	1, 053	734, 660		1, 305, 779	99. 00 102. 00
.02.00	Part I)	1, 777, 001	1,053	, 54, 000		1, 303, 779	102.00
103.00		79. 799423	0. 046738	0. 146948		0. 133127	1
104.00	Cost to be allocated (per Wkst. B, Part II)			_ c		0	104. 00
105.00				0. 000000		0. 000000	105. 00
		1	l	l		l	I

Provi der No.: 315525

Period: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 17 am

							5/24/2024 11:	17 am
		Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
			OPERATION,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
			MAINT. &	(PATIENT DAYS)			(DATIENT DAVE)	
			REPAIRS (SQUARE FEET)				(PATIENT DAYS)	
			5. 00	6.00	7. 00	8. 00	9. 00	
	GENER	AL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300	EMPLOYEE BENEFITS						3. 00
4.00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS	22, 530					5. 00
6.00		LAUNDRY & LINEN SERVICE	0	20, 735				6.00
7.00		HOUSEKEEPI NG	0	0	l ==,;	(2.205		7. 00
8. 00 9. 00		DI ETARY NURSI NG ADMINI STRATI ON			0	62, 205	20, 735	8. 00 9. 00
10. 00		CENTRAL SERVICES & SUPPLY	0		0	0	20, 733	10.00
11. 00		PHARMACY	0	0	0	0	Ö	11. 00
12. 00		MEDICAL RECORDS & LIBRARY	0	Ö	Ō	0	Ō	12. 00
13.00		SOCIAL SERVICE	0	0	0	0	0	13. 00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00		ACTI VI TI ES	0	0	0	0	0	15. 00
		IENT ROUTINE SERVICE COST CENTERS		l				
30.00		SKILLED NURSING FACILITY	22, 530		1		20, 735	30.00
31.00	1	NURSING FACILITY	0	0		0	0	31.00
32. 00 33. 00		ICF/IID   OTHER LONG TERM CARE	0	0		0	0	32. 00 33. 00
33.00		LARY SERVICE COST CENTERS				U	0	33.00
40. 00		RADI OLOGY	0	0	0	0	0	40. 00
41. 00	1	LABORATORY	Ö	Ö		o O	o o	41. 00
42.00	1	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00		PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	45. 00
46. 00	1	SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	1	ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	48. 00 49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0		0	0		50.00
51. 00		SUPPORT SURFACES	0	٥	1	0		51.00
		TIENT SERVICE COST CENTERS	_	_				
60.00		CLI NI C	0	0	0		0	60. 00
61.00		RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200	l.						62. 00
70.00		REI MBURSABLE COST CENTERS			_			70.00
70.00	1	HOME HEALTH AGENCY COST	0	1		0	0	
71. 00 73. 00	07100	AMBULANCE	0	0		0	0	71. 00 73. 00
73.00		AL PURPOSE COST CENTERS	0				0	73.00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
		INTEREST EXPENSE						81. 00
82.00	08200	UTILIZATION REVIEW - SNF						82. 00
83. 00	08300	HOSPI CE	0	0		0	0	
89. 00		SUBTOTALS (sum of lines 1-84)	22, 530	20, 735	22, 530	62, 205	20, 735	89. 00
00.00		I MBURSABLE COST CENTERS						00.00
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0		0	l .	90. 00 91. 00
91.00		PHYSICIANS PRIVATE OFFICES	0			0	0	91.00
93. 00	1	NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00		PATIENTS LAUNDRY	Ö	Ö	o o	o O	Ö	94. 00
98. 00		Cross Foot Adjustments	_	_	_			98. 00
99. 00		Negative Cost Centers						99. 00
102.00	)	Cost to be allocated (per Wkst. B,	1, 933, 185	4, 109	463, 698	991, 161	575, 316	102. 00
40		Part I)	05					
103.00	1	Unit cost multiplier (Wkst. B, Part I)	85. 804927	0. 198167	20. 581358	15. 933783	l e	•
104.00	,	Cost to be allocated (per Wkst. B, Part II)	0	0	0	O	l 0	104. 00
105.00		Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105 00
100.00			5. 000000	3.000000	0.00000	3. 000000	3.000000	. 55. 66
		,	1	•	•		•	•

Health Financial Systems

HARBOUR VIEW SENIOR LIVING CENTER

ONLY OF Period:
From 01/01/2023
To 12/31/2023

Cost Center Description

CENTRAL
PHARMACY
PHARMA

						5/24/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
			(PATIENT DAYS)		(DATI ENT DAYE)	ALLI ED HEALTH	
		SUPPLY (PATIENT DAYS)		LI BRARY (PATI ENT DAYS)	(PATIENT DAYS)	EDUCATION (ASSIGNED	
		(PATTENT DATS)		(PATTENT DATS)		TIME)	
		10.00	11.00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			•			6.00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	20, 735					10. 00
11. 00	01100 PHARMACY	0	20, 735	l .			11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	0	20, 735 0			12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION					0	14. 00
15. 00	01500 ACTIVITIES	0	0			0	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		10.00
30.00	03000 SKILLED NURSING FACILITY	20, 735	20, 735	20, 735	20, 735	0	30. 00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200   CF/IID	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			-	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0			_	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	Ö	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 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	_	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0			_	-	51.00
01.00	OUTPATIENT SERVICE COST CENTERS						0 00
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							62. 00
70.00	OTHER REIMBURSABLE COST CENTERS			J		0	70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0				70. 00 71. 00
71.00	07300 CMHC			1			73.00
73.00	SPECIAL PURPOSE COST CENTERS						73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	· -		0	
89. 00	SUBTOTALS (sum of lines 1-84)	20, 735	20, 735	20, 735	20, 735	0	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		•			91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	Ö	_	0	
93. 00	09300 NONPALD WORKERS	Ö	Ö	Ö	0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	1 1 9						99. 00
102.00		203, 552	27, 546	0	60, 336	0	102. 00
103. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	9. 816831	1. 328478	0. 000000	2. 909863	0. 000000	103 00
103.00		7. 810831	1. 3284/8	0.000000	2. 909863		103.00
104.00	Part II)			1			1.04.00
105.00		0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2540-10 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der No.: 315525

				5/24/2024	
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
			(PATIENT DAYS) 15.00		
	GENER	AL SERVICE COST CENTERS	15.00		
1.00		CAP REL COSTS - BLDGS & FIXTURES			1, 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300	EMPLOYEE BENEFITS			3. 00
4.00	00400	ADMINISTRATIVE & GENERAL			4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	1	LAUNDRY & LINEN SERVICE			6. 00
7.00		HOUSEKEEPI NG			7. 00
8. 00 9. 00		DI ETARY NURSI NG ADMINI STRATI ON			8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY			10.00
11. 00	1	PHARMACY			11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY			12. 00
13.00	1	SOCIAL SERVICE			13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00		ACTI VI TI ES	20, 735		15. 00
		IENT ROUTINE SERVICE COST CENTERS			
30.00	1	SKILLED NURSING FACILITY	20, 735		30.00
31.00	1	NURSING FACILITY	O O		31.00
32. 00 33. 00			0		32. 00 33. 00
33.00		LARY SERVICE COST CENTERS	0		33.00
40. 00		RADI OLOGY	0		40. 00
41.00	1	LABORATORY	O		41.00
42.00	04200	INTRAVENOUS THERAPY	0		42. 00
43.00		OXYGEN (INHALATION) THERAPY	0		43.00
44. 00	1	PHYSI CAL THERAPY	0		44. 00
45. 00	1	OCCUPATIONAL THERAPY	0		45. 00
46. 00	1	SPEECH PATHOLOGY	0		46.00
47. 00 48. 00	1	ELECTROCARDIOLOGY	0		47. 00 48. 00
48.00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0		48.00
50.00	1	DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	1	SUPPORT SURFACES	o		51.00
		TIENT SERVICE COST CENTERS	-		
60.00	06000	CLI NI C	0		60.00
61. 00		RURAL HEALTH CLINIC	0		61. 00
62. 00	06200				62. 00
70.00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0		70.00
70. 00 71. 00		AMBULANCE	0		70. 00 71. 00
	07300		o		73. 00
70.00		AL PURPOSE COST CENTERS	<u> </u>		70.00
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
		INTEREST EXPENSE			81. 00
		UTILIZATION REVIEW - SNF	_		82. 00
83. 00	08300	HOSPI CE	0		83.00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	20, 735		89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00		BARBER AND BEAUTY SHOP	0		91. 00
92. 00		PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00		NONPALD WORKERS	ő		93. 00
94. 00		PATI ENTS LAUNDRY	o		94. 00
98. 00		Cross Foot Adjustments			98. 00
99. 00		Negative Cost Centers			99. 00
102.00		Cost to be allocated (per Wkst. B,	263, 120		102. 00
103.00		Part I)	12 400455		103. 00
103.00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	12. 689655 0		103.00
104.00	1	Part II)			104.00
105.00	)	Unit cost multiplier (Wkst. B, Part	0. 000000		105. 00
		11)			

71. 00 07100 AMBULANCE

Total

100.00

0. 000000

71.00

100.00

0

738, 703

645, 443

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315525 Peri od: Worksheet C From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11:17 am Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 2 col . 18 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 15, 017 13, 253 1. 133102 40.00 41. 00 | 04100 | LABORATORY 32,009 28, 248 1.133142 41.00 42. 00 04200 I NTRAVENOUS THERAPY 0 0.000000 42.00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 985 869 1.133487 43.00 44. 00 04400 PHYSI CAL THERAPY 345, 615 294, 747 1. 172582 44.00 04500 OCCUPATIONAL THERAPY 45.00 85, 882 249, 858 0.343723 45.00 46. 00 04600 SPEECH PATHOLOGY 1.012814 67, 499 66, 645 46.00 47. 00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 98, 436 49.00 85, 083 1. 156941 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 0 51.00 05100 SUPPORT SURFACES 0 0.000000 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0.000000 60.00 60.00 0 0 61.00 06100 RURAL HEALTH CLINIC 61.00 62. 00 06200 FQHC 62.00

Heal th	Financial Systems HA	ARBOUR VIEW SENI	OR LIVING CENTE	:R	In Lie	eu of Form CMS-:	2540-10
APPORT	TIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315525	Peri od: From 01/01/2023 To 12/31/2023		
			Title	XVIII (1)	Skilled Nursing Facility		
			Health Care Pr	rogram Charge		Program Cost	
		Ratio of Cost	Part A	Part B	Part A (col 1	Part B (col. 1	
		to Charges	I di t A	Tart D	x col. 2)	x col. 3)	
		(Fr. Wkst. C			,	,	
		Column 3)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	1. 133102			0	0	
41.00	04100 LABORATORY	1. 133142			0	0	41.00
	04200 I NTRAVENOUS THERAPY	0. 000000				0	42. 00
	04300 OXYGEN (INHALATION) THERAPY	1. 133487			0 1/0 100	0	43. 00
	04400 PHYSI CAL THERAPY	1. 172582			0 168, 423		44. 00
		0. 343723			0 47, 188		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	1. 012814 0. 000000			0 27, 496	0	46. 00 47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000					47.00
	04900 DRUGS CHARGED TO PATTENTS	1. 156941				1	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0. 000000				íl o	50.00
	05100 SUPPORT SURFACES	0. 000000				o o	
31.00	OUTPATIENT SERVICE COST CENTERS	0.00000	<u> </u>		0	<u>'</u>	31.00
60.00	06000 CLI NI C	0. 000000	0		0 0	0	60.00
	06100 RURAL HEALTH CLINIC						61. 00
	06200 FQHC						62.00
71.00	07100 AMBULANCE (2)	0. 000000			0	0	71. 00
100.00	Total (Sum of lines 40 - 71)		308, 066		0 243, 107	'  o	100. 00
(1) Fo	s title V and VIV use columns 1 2 and 4 an	Lv					

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

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

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lieu of Form CMS-2540-10							
	TIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315525	Peri od: From 01/01/2023 To 12/31/2023		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST						
1.00	Drugs charged to patients - ratio of cos	st to charges	(From Workshee	t C. column 3	. line 49)	1. 156941	1.00
2.00	Program vaccine charges (From your reco			•	,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title )	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health		Cost (From	& Allied	
		·	(From Wkst. B,			Heal th Costs	
		18		Costs to Tota Costs - Part		for Pass Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		3 X 001. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	15, 017	0			0	40. 00
	04100 LABORATORY	32, 009	0	0.00000		0	41. 00
	04200 I NTRAVENOUS THERAPY	0	0	0. 00000		0	
43. 00	04300 OXYGEN (INHALATION) THERAPY	985		0. 00000		0	
44. 00	04400 PHYSI CAL THERAPY	345, 615		0.00000		l e	
45. 00	04500 OCCUPATI ONAL THERAPY	85, 882		0.00000	· ·	<b>l</b>	
46. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	67, 499	0	0. 00000 0. 00000		l e	
47. 00 48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.00000		0	
49. 00	04900 DRUGS CHARGED TO PATTENTS	98, 436		0.00000		0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	70, 430 O		0.00000		0	
51. 00	05100 SUPPORT SURFACES	0		0.00000		0	
100.00		645, 443	Ö	1	243, 107		100.00
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	Financial Systems HARBOUR VIEW SENIOR ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315525	In Lie Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 5/24/2024 11:	pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			20, 735	
00	Private room days			0	2
00	Inpatient days including private room days applicable to the			3, 967 0	3
00 00	Medically necessary private room days applicable to the Progr Total general inpatient routine service cost	alli		10, 468, 822	
,0	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			10, 400, 622	٦
0	General inpatient routine service charges			7, 844, 379	1 6
00	General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		1. 334564	
0	Enter private room charges from your records	,		0	8
0	Average private room per diem charge (Private room charges li 2)	ne 8 divided by private	room days, line	0. 00	(
00 Enter semi-private room charges from your records					
00	Average semi-private room per diem charge (Semi-private room semi-private room days)	n charges line 10, divide	d by	0. 00	11
00	Average per diem private room charge differential (Line 9 mir	,		0. 00	
00	Average per diem private room cost differential (Line 7 times			0.00	13
00					
00		ost differential (Line 5	minus line 14)	10, 468, 822	15
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 di	vided by Line 1)		504.89	1
00	Program routine service cost (Line 3 times line 16)	vided by Title 1)		2, 002, 899	
00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0 2,002,077	
00	Total program general inpatient routine service cost (Line 1			2, 002, 899	
00	Capital related cost allocated to inpatient routine service of line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	1, 798, 934	20
00	Per diem capital related costs (Line 20 divided by line 1)			86. 76	21
00	Program capital related cost (Line 3 times line 21)			344, 177	22
00	Inpatient routine service cost (Line 19 minus line 22)			1, 658, 722	
00	Aggregate charges to beneficiaries for excess costs (From pr			0	24
00	Total program routine service costs for comparison to the cos	st limitation (Line 23 mi	nus line 24)	1, 658, 722	
00	Enter the per diem limitation (1)		0() (4)		26
00	Inpatient routine service cost limitation (Line 3 times the p		, , ,		27
. 00	Reimbursable inpatient routine service costs (Line 22 plus to (Transfer to Worksheet E, Part II, line 4) (See instructions)		Tine 27)		28

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	20, 735	1. 00
2.00	Program inpatient days (see instructions)	3, 967	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. 191319	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Interpretation of the Program of the Prog		ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315525	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/24/2024 11:	pare
PART I CALCULATION OF INPATIENT ROUTINE COSTS  INPATIENT DAYS  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient days including private room days applicable to the Program  Inpatient routine service cost  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Ceneral inpatient routine service cost / Charges  General inpatient routine service cost/charge ratio (Line 5 divided by line 6)  Enter private room charges from your records  Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)  Enter semi-private room per diem charge (Semi-private room charges line 10, divided by			Title XIX	9	Cost	
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Average per diem private room cost differential (Line 7 times line 12)  O Private room cost differential adjustment (Line 2 times line 13)  General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related cost (Line 20 divided by line 1)  Per diem capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)			snarges inne ie, aivide	u 2)	0.00	
Private room cost differential adjustment (Line 2 times line 13)  General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related cost (Line 20 divided by line 1)  Program capital related cost (Line 20 divided by line 1)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service cost for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)  S, 965, 275  Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)  Aggregate charges to volume the cost limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)	. 00	Average per diem private room charge differential (Line 9 minus	s line 11)		0.00	12
General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)  PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Aggregate routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  South Program capital related cost necess costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)  Aggregate charges to worksheet E, Part II, line 4) (See instructions)	00	Average per diem private room cost differential (Line 7 times I	ine 12)		0.00	13
PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  September 10 de divided by line 1)  Solution 18, pert II column 18, pert II p	00	Private room cost differential adjustment (Line 2 times line 13	3)		0	14
Adjusted general inpatient service cost per diem (Line 15 divided by line 1)  Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICE/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related costs (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service cost (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Enter to Worksheet E, Part II, line 4) (See instructions)	. 00	General inpatient routine service cost net of private room cost	t differential (Line 5	minus line 14)	10, 468, 822	15
Program routine service cost (Line 3 times line 16)  Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)						
Medically necessary private room cost applicable to program (line 4 times line 13)  Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)  Total program routine service costs (Line 22 plus the lesser of line 25 or line 27)	00	, , , , , , , , , , , , , , , , , , , ,	ded by line 1)			
Total program general inpatient routine service cost (Line 17 plus line 18)  Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)						
Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)					- 1	
line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)  Per diem capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)						
Per diem capital related costs (Line 20 divided by line 1)  Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service costs limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)	00		StS (From WKSt. B, Par	t II column 18,	1, 798, 934	20
Program capital related cost (Line 3 times line 21)  Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service costs limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)	$\cap \cap$				86.76	21
On Inpatient routine service cost (Line 19 minus line 22)  Aggregate charges to beneficiaries for excess costs (From provider records)  Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)						
Aggregate charges to beneficiaries for excess costs (From provider records)  O Aggregate charges to beneficiaries for excess costs (From provider records)  O Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  Enter the per diem limitation (1)  Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)		, ,				
Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)  4,940,206 29  Enter the per diem limitation (1)  1 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)  Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)  (Transfer to Worksheet E, Part II, line 4) (See instructions)			vider records)			
00 Enter the per diem limitation (1) 01 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 02 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 03 (Transfer to Worksheet E, Part II, line 4) (See instructions)				nus Line 24)	- 1	
00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) 01 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 5,965,275 28 (Transfer to Worksheet E, Part II, line 4) (See instructions)						
00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 5,965,275 29 (Transfer to Worksheet E, Part II, line 4) (See instructions)			diem limitation line	26) (1)		
(Transfer to Worksheet E, Part II, line 4) (See instructions)	. 00				5, 965, 275	
				ŕ		
Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	Li	nes 26 and 27 are not applicable for title XVIII, but may be use	ed for title V and or t	itle XIX		
						1

(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	1	
( ) =	,		
		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	20, 735	1.00
2.00	Program inpatient days (see instructions)	11, 815	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. 569810	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	HARBOUR V	IEW SENIOR LIV	VING CENTER	In Lieu	of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SE	ETTLEMENT FOR TITLE XVIII			From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/24/2024 11:17 am
			Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			_	1.00	
	DART A LINDATION OF DELINDINGS	EMENT		1. 00	
1. 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSI Inpatient PPS amount (See Instructions)	EMENI		3, 239, 800	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	vmonts)		3, 239, 600 0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	ymerits)		3, 239, 800	3. 00
4.00	Primary payor amounts			3, 234, 600	4. 00
5.00	Coi nsurance			561, 200	5. 00
6.00	Allowable bad debts (From your records)			404, 372	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		15, 600	
8. 00	Adjusted reimbursable bad debts. (See instructions)	ctions)		262, 842	
9. 00	Recovery of bad debts - for statistical records only			202, 042	
10. 00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			2, 941, 442	
12. 00	Interim payments (See instructions)			2, 625, 028	
13. 00	Tentati ve adjustment			2, 023, 020	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	Seguestration for non-claims based amounts (see instructions)			5, 257	
14. 99				53, 572	14. 99
15. 00					15. 00
16, 00	16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)				16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER				
17.00	Ancillary services Part B			0	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22.00	Primary payor amounts			0	22. 00
23. 00	3.00 Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24.00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	02 Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00				0	25. 00
26. 00				0	26. 00
27. 00				0	27. 00
28. 00				0	28. 00
28. 50				0	28. 50
28. 55				0	28. 55
28. 99	Sequestration amount (see instructions)			0	
29. 00	Balance due provider/program (see instructions)			0	
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30. 00

Health Financial Systems	HARBOUR VIEW SENIOR LI	VING CENTER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT	SETTLEMENT TITLE V and TITLE XIX ONLY	Provi der No.: 315525	From 01/01/2023	Worksheet E Part II Date/Time Prepared: 5/24/2024 11:17 am
		Title XIX	Skilled Nursing	Cost

1.00			Title XIX	Skilled Nursing Facility	Cost	
COMPUTATION OF NET COST OF COVERED SERVICES						
1.00		PONUMENTATION OF MET COOT OF COMPRED OFFICE			1. 00	
2.00	1 00				0	1 00
3.00			<b>5</b> )			
Inpatient routine services (see instructions)			5)			
1.00					-	
Cost of covered services (Sum of lines 1 - 5)   5,965,275   6.00   7.00   10   10   10   10   10   10   10			1.3			
7.00			oras)		-	
SUBTOTAL (Line 6 minus line 7)   S. 965, 275   8. 00   9. 00						
9.00   Primary payor amounts   5, 965, 275   10.00   Total Reasonable Cost (Line 8 minus line 9)   7, 965, 275   10.00   REASONABLE CHARGES   11.00   1			less than semi private	accommodations		
10.00   Total Reasonable Cost (Line 8 minus line 9)   5,965,275   10.00		,				
REASONABLE CHARGES Inpatient ancillary service charges Outpatient service charges Outpatient routine service charges Oitferential in charges between semiprivate accommodations and less than semiprivate accommodations Oitferential in charges between semiprivate accommodations and less than semiprivate accommodations Oitferential in charges between semiprivate accommodations and less than semiprivate accommodations Oitoal reasonable charges Oitoal Charges Oitoal Charges Oitoal Charges Oitoal Charges Oitoal Ch					-	
11.00 Inpatient ancillary service charges 0 11.00 12.00 Outpatient service charges 0 12.00 14.00 Inpatient routine service charges 0 13.00 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 15.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis nad such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 19.00 Total customary charges (see instructions) 0 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 20.00 20.00 Cost of covered services (see Instructions) 0 22.00 21.00 Deductibles 0 22.00 22.00 Subtotal (Line 20 minus line 21) 0 22.00 23.00 Coinsurance 0 23.00 24.00 Subtotal (Line 22 minus line 23) 0 24.00 24.00 Subtotal (Line 22 minus line 23) 0 25.00 25.00 Allowable bad debts (from your records) 0 25.00 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit t 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 0 29.00 29.00 Other Adjustments (see instructions) Specify 0 29.00 30.00 Inrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit finus, enter amount in parentheses) 0 31.00 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 0 31.00 31.00 Interim payments	10.00				5, 965, 275	10.00
12.00 Outpatient service charges 0 12.00 Inpatient routine service charges 0 13.00 Inpatient routine service charges 0 13.00 Inpatient routine service charges 0 13.00 Ifferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 Interest of Interest	11 00			1		11 00
13.00 Inpatient routine service charges 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Total reasonable charges  CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 24.00 Subtotal (Line 22 minus line 23) 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 25.00 Allowable bad debts (from your records) 26.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 30.00 Interfundable charges (be instructions) Specify 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 31.00 Interim payments 31.00 Subtotal (Line 26 proyregram (Line 31 minus lines 32) (indicate overpayments in parentheses) (see						
14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14.00 Total reasonable charges 0 15.00 CUSTOMARY CHARGES  16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been seeing the form payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 17.00 had such payment been services (see instructions) 17.00 had such payment services (see Instructions) 17.00 had such payment services (see Instructions) 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payment services on a charge basis of 17.00 had such payme		, ,				
15.00 Total reasonable charges CUSTOMARY CHARGES  16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected from patients liable for payment for services on a charge basis on the collected base on charge basis on the collected from patients liable for payment for services on a charge basis on the collected liable services on a charge basis on the collected base on carge basis on the collected from patients liable for payment for services on a charge basis on the collected based on carge basis on the collected based on carge basis on the collected from patients liable for payment for services on a charge basis on the collected based on carge bas					-	
CUSTOMARY CHARGES  16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Anounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e)  18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 Total customary charges (see instructions) 0 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions) 0 21.00 Deductibles 0 21.00 Deductibles 0 22.00 Subtotal (Line 20 minus line 21) 0 22.00 23.00 Coinsurance 0 24.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Sum of lines 24 and 25) 0 25.00 Allowable bad debts (from your records) 0 25.00 26.00 Subtotal (Sum of lines 24 and 25) 0 26.00 Cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( if minus, enter amount in parentheses) 30.00 Interim payments 0 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 33.00 Bal ance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see			less than semiprivate	accommodations	-	
16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e)  18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 Total customary charges (see instructions) 0 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions) 0 20.00 21.00 Deductibles 0 22.00 Subtotal (Line 20 minus line 21) 0 22.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Line 22 minus line 23) 0 25.00 Allowable bad debts (from your records) 0 25.00 Subtotal (sum of lines 24 and 25) 0 25.00 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 0 28.00 Excovery of excess depreciation resulting from provider termination or a decrease in program 0 28.00 utilization 0 29.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (	15.00				0	15.00
17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000)  19. 00 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20. 00 Eductibles  Subtotal (Line 20 minus line 21)  Coinsurance  4. 00 Subtotal (Line 22 minus line 23)  25. 00 Allowable bad debts (from your records)  26. 00 Subtotal (sum of lines 24 and 25)  27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29. 00 Other Adjustments (see instructions) Specify  30. 00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (	1/ 00		umant for condition on	a abarras basis	0	1/ 00
had such payment been made in accordance with 42 CFR 413.13(e)  Ratio of line 16 to line 17 (not to exceed 1.00000)  18.00  19.00  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00  Cost of covered services (see Instructions)  Deductibles  Subtotal (Line 20 minus line 21)  Coinsurance  24.00  24.00  24.00  Allowable bad debts (from your records)  Subtotal (sum of lines 24 and 25)  Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  Recovery of excess depreciation resulting from provider termination or a decrease in program  Deduction of the Adjustments (see instructions)  28.00  18.00  19.00  20.00  20.00  21.00  22.00  22.00  23.00  24.00  24.00  25.00  Allowable bad debts (from your records)  Defuction of the 20 minus line 23)  Defuction of the 20 minus line 23 of 22.00  26.00  27.00  28.00  29.00  10.00  20.						
18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 Total customary charges (see instructions)  20.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Cost of covered services (see Instructions)  21.00 Deductibles  22.00 Subtotal (Line 20 minus line 21)  23.00 Coinsurance  24.00 Subtotal (Line 22 minus line 23)  25.00 Allowable bad debts (from your records)  26.00 Subtotal (sum of lines 24 and 25)  27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29.00 Other Adjustments (see instructions) Specify  30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  31.01 Interim payments  31.02 Balance due provider/program (Line 31 minus lines 32) (indicate overpayments in parentheses) (see	17.00		payment for services c	ii a ciiai ye basi s	U	17.00
Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  Cost of covered services (see Instructions)  Deductibles  Subtotal (Line 20 minus line 21)  Coinsurance  Subtotal (Line 22 minus line 23)  Allowable bad debts (from your records)  Subtotal (sum of lines 24 and 25)  Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  Recovery of excess depreciation resulting from provider termination or a decrease in program  utilization  29.00  Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31.00  Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	18 00				0 000000	18 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT  20. 00 Cost of covered services (see Instructions)  Deductibles  Subtotal (Line 20 minus line 21)  Coinsurance  Subtotal (Line 22 minus line 23)  Allowable bad debts (from your records)  Subtotal (sum of lines 24 and 25)  To Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  Recovery of excess depreciation resulting from provider termination or a decrease in program  Unitization  Page 10  Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31. 00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32. 00 Interim payments  Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
20.00 Cost of covered services (see Instructions)  21.00 Deductibles  22.00 Subtotal (Line 20 minus line 21)  23.00 Coinsurance  24.00 Subtotal (Line 22 minus line 23)  25.00 Allowable bad debts (from your records)  26.00 Subtotal (sum of lines 24 and 25)  27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29.00 Other Adjustments (see instructions) Specify  30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	17.00					17.00
21.00 Deductibles Subtotal (Line 20 minus line 21) Coinsurance 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 31.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	20.00				0	20 00
22. 00 Subtotal (Line 20 minus line 21)  23. 00 Coinsurance  24. 00 Subtotal (Line 22 minus line 23)  25. 00 Allowable bad debts (from your records)  26. 00 Subtotal (sum of lines 24 and 25)  27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29. 00 Other Adjustments (see instructions) Specify  30. 00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31. 00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32. 00 Interim payments  33. 00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see		,				
23.00 Coinsurance 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29.00 Other Adjustments (see instructions) Specify 30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32.00 Interim payments 33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see					-	
24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29.00 Other Adjustments (see instructions) Specify 30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32.00 Interim payments 33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
25. 00 Allowable bad debts (from your records) 26. 00 Subtotal (sum of lines 24 and 25) 27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29. 00 Other Adjustments (see instructions) Specify 30. 00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses) 31. 00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32. 00 Interim payments 33. 00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
26.00 Subtotal (sum of lines 24 and 25)  27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29.00 Other Adjustments (see instructions) Specify  30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization  29. 00 Other Adjustments (see instructions) Specify  30. 00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)  31. 00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32. 00 Interim payments  33. 00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see						
cost limit  28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program  29.00 Other Adjustments (see instructions) Specify  30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (  if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see			v collected based on c	orrection of	-	
utilization  29.00 Other Adjustments (see instructions) Specify  30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (  if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  32.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	27.00		<i>y</i> 20.1.20124 24224 2.1. 2		Ü	27.00
utilization  29.00 Other Adjustments (see instructions) Specify  30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (  if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see	28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28. 00
30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( if minus, enter amount in parentheses) 31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28) 32.00 Interim payments 33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00				' '		
if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  32.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00	29.00	Other Adjustments (see instructions) Specify			0	29. 00
if minus, enter amount in parentheses)  31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32.00 Interim payments  32.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00	30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	eciable assets (	0	30.00
32.00 Interim payments 0 32.00 33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00						
33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00	31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31.00
	32.00	Interim payments			0	32.00
Instructions)	33.00		overpayments in parent	heses) (see	0	33. 00
		Instructions)				

HARBOUR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315525 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11:17 am Title XVIII Skilled Nursing PPS

				Facility		
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 625, 028		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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		Г		Т	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03			0		0	
3.04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program				Г	
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	0.00
3.54			0		0	
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		0		0	3. 99
4 00	- 3.98)		0 (05 000			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 625, 028		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTITIVE TO TROVIDER		Ö		Ö	
5. 03			Ö		Ö	
0.00	Provider to Program		<u> </u>			0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			o		0	
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)		_		_	
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		257, 585		0	6. 01
6.02	PROVI DER TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 882, 613		0	7. 00
			Contract	or Name	Contractor	
					Number	
			1.	00	2. 00	
8.00	Name of Contractor					8. 00
(1) On	lines 3 5 and 6 where an amount is due provider to progr.	am show the a	mount and date	on which the r	nrovi der	

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

Health Financial Systems

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

Provi der No.: 315525

| Peri od: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 17 am

oni y)		Conoral Fund	Specific [	Endowment Fund	5/24/2024 11:	17 am
		General Fund	Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					1
1.00	Cash on hand and in banks	172, 355	0	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	2, 040, 191	0	0	0	
4. 00 5. 00	Other recei vables	2,040,191	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	l ő	0	Ö	0	
	recei vabl e				_	
7. 00	Inventory	o	0	0	0	7.0
8. 00	Prepai d expenses	64, 102	0	0	0	
9.00	Other current assets	-5, 713, 016	0	0	0	
10. 00 11. 00	Due from other funds TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	-3, 436, 368	0	0	0	
11.00	FIXED ASSETS	-3, 430, 300	U	<u> </u>	0	11.0
12. 00	Land	l ol	0	ol	0	12.0
13. 00	Land improvements	O	0	o	0	
14. 00	Less: Accumulated depreciation	o	0	0	0	14.0
15. 00	Bui I di ngs	O	0	0	0	15.0
16. 00	Less Accumulated depreciation	0	0	0	0	
17. 00	Leasehold improvements	0	0	0	0	1
18. 00	Less: Accumulated Amortization	0	0	0	0	
19.00	Fixed equipment	0	0	0	0	1
20.00	Less: Accumulated depreciation	0	0	0	0	
21. 00 22. 00	Automobiles and trucks	0	0	U O	0	
23. 00	Less: Accumulated depreciation Major movable equipment		0	0	0	
24. 00	Less: Accumulated depreciation		0	0	0	
25. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	
26. 00	Mi nor equipment nondepreciable	o	0	o	0	
27. 00	Other fixed assets	o	0	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0	0	0	0	28.0
	OTHER ASSETS					
29. 00	Investments	0	0	0	0	1
30. 00	Deposits on Leases	0	0	0	0	
31. 00	Due from owners/officers	0	0	0	0	
32. 00 33. 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	77, 330	0	U O	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	77, 330 -3, 359, 038	0	0	0	
34.00	Liabilities and Fund Balances	3, 337, 030	O <sub>I</sub>	<u> </u>		34.0
	CURRENT LI ABI LI TI ES					1
35. 00	Accounts payable	0	0	0	0	35.0
36. 00	Salaries, wages, and fees payable	291, 747	0	0	0	1
37. 00	Payroll taxes payable	22, 319	0	0	0	
38. 00	Notes & Loans payable (Short term)	0	0	0	0	
39. 00	Deferred income	0	0	O	0	
40. 00 41. 00	Accel erated payments Due to other funds	0	0		0	40. C
42.00	Other current liabilities	2, 648, 185	0	0	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 962, 251	0	o	0	
10.00	LONG TERM LIABILITIES	2,702,201	<u> </u>	<u> </u>		1
44. 00	Mortgage payable	0	0	0	0	44.0
45. 00	Notes payable	o	0	0	0	45.0
46. 00	Unsecured Loans	0	0	0	0	46.0
47. 00	Loans from owners:	0	0	0	0	
	Other long term liabilities	0	0	0	0	
			0	0	0	•
49. 00	OTHER (SPECIFY)	0				
19. 00 50. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	0	
49. 00 50. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	0 2, 962, 251		0	0	
49. 00 50. 00 51. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS		0	0 0		51. (
49. 00 50. 00 51. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	-6, 321, 289	0	0 0		51. ( 52. (
49. 00 50. 00 51. 00 52. 00 53. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS General fund balance		0 0	0 0		51. ( 52. ( 53. (
49. 00 50. 00 51. 00 52. 00 53. 00 54. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund		0 0	0 0 0 0		51. ( 52. ( 53. ( 54. (
19. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund Donor created - endowment fund balance - restricted		0 0	0 0 0 0 0 0	0	51. 52. 53. 54. 55.
49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant		0 0	0 0 0 0 0	0	51. ( 52. ( 53. ( 54. ( 55. ( 56. ( 57. (
49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)  CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		0 0	0 0 0 0 0	0	51. 0 52. 0 53. 0 54. 0 55. 0 56. 0
49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)  CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	-6, 321, 289	0 0	0 0 0 0 0	0	51. ( 52. ( 53. ( 54. ( 55. ( 56. ( 57. ( 58. (
48. 00 49. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)  CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		0 0	0 0 0 0 0	0	51. 0 52. 0 53. 0 54. 0 55. 0 57. 0 58. 0

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315525

				'	0 12/31/2023	5/24/2024 11:	
		Genera	l Fund	Special Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-2, 442, 162		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-3, 879, 128	1			2. 00
3. 00	Total (sum of line 1 and line 2)		-6, 321, 290	1	0		3. 00
4. 00 5. 00	Additions (credit adjustments) ROUNDING	1		0		0	4. 00 5. 00
6.00	ROUNDING						6. 00
7. 00		0				0	7. 00
8.00		0		Ö		Ö	8. 00
9.00		0		0		0	9. 00
10. 00	Total additions (sum of line 5 - 9)		1		0		10. 00
11. 00	Subtotal (line 3 plus line 10)		-6, 321, 289		0		11. 00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13.00
14. 00 15. 00		0					14. 00 15. 00
16. 00		0				0	16. 00
17. 00		0		l o		Ö	17. 00
18.00	Total deductions (sum of lines 13 - 17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		-6, 321, 289		0		19. 00
	sheet (Line 11 - line 18)	F F	DI	- Frank			
		Endowment Fund	Prant	Fund			
		6. 00	7. 00	8.00			
1.00	Fund balances at beginning of period	0		0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)	_		_			2. 00
3.00	Total (sum of line 1 and line 2)	0		0			3. 00
4. 00 5. 00	Additions (credit adjustments) ROUNDING		0				4. 00 5. 00
6.00	ROUNDI NG		0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 5 - 9)	0		0			10. 00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12. 00 13. 00	Deductions (debit adjustments)		0				12. 00 13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0		0			18. 00
19. 00	Fund balance at end of period per balance	0		0			19. 00
	sheet (Line 11 - line 18)	I		I	l	ļ	

Health Financial Systems	HARBOUR VIEW SENIOR L	VING CENTER	In Lie	u of Form CMS-2540-10

Heal th	Financial Systems HARBOUR VIEW SENIOR LI	VING CENT	ER	In Li€	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		7, 844, 37	9	7, 844, 379	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		7, 844, 37	9	7, 844, 379	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		738, 70	0	738, 703	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	CMHC			0	0	11. 00
12.00	HOSPI CE			0 0	0	12. 00
13.00	OTHER (SPECIFY)			0 0	0	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	8, 583, 08	2 0	8, 583, 082	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)				11, 821, 845	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
14.00	Total Deductions (Sum of lines 9 - 13)				0	14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				11, 821, 845	15. 00

Health Financial Systems HARBOUR VIEW SENIOR LIVING CENTER In Lie	eu of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES   Provider No.: 315525   Period:	Worksheet G-3	
From 01/01/2023		
To 12/31/2023		
	5/24/2024 11:	1/ am
	1. 00	
1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	8, 583, 082	1. 00
2.00 Less: contractual allowances and discounts on patients accounts	647, 146	2. 00
3.00 Net patient revenues (Line 1 minus line 2)	7, 935, 936	3.00
4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)	11, 821, 845	4.00
5.00 Net income from service to patients (Line 3 minus 4)	-3, 885, 909	5. 00
Other income:		
6.00 Contributions, donations, bequests, etc	0	6. 00
7.00 Income from investments	1, 773	7. 00
8.00 Revenues from communications (Telephone and Internet service)	0	8. 00
9.00 Revenue from television and radio service	0	
10.00 Purchase discounts	0	10.00
11.00 Rebates and refunds of expenses	0	11. 00
12.00 Parking lot receipts	0	12. 00
13.00 Revenue from Laundry and Linen service	0	13. 00
14.00 Revenue from meals sold to employees and guests	0	14. 00
15.00 Revenue from rental of living quarters	0	15. 00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17.00 Revenue from sale of drugs to other than patients	0	17. 00
18.00 Revenue from sale of medical records and abstracts	0	18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00 Revenue from gifts, flower, coffee shops, canteen	0	20. 00
21.00 Rental of vending machines	0	21. 00 22. 00
22.00 Rental of skilled nursing space 23.00 Governmental appropriations	0	23. 00
23.00   Governmental appropriations 24.00   CELL TOWER RENT	5, 008	
24. 01 OTHER I NCOME	5,008	24. 00
24. 50 COVI D-19 PHE Funding		24. 01
25.00 Total other income (Sum of lines 6 - 24)	6, 781	25. 00
26. 00   Total (Line 5 plus line 25)	-3, 879, 128	
27. 00 Other expenses (specify)	-3, 6/9, 126	27. 00
28. 00		
29. 00		
30.00 Total other expenses (Sum of lines 27 - 29)		30.00
31.00 Net income (or loss) for the period (Line 26 minus line 30)	-3, 879, 128	



### HARBOUR VIEW SENIOR LIVING CORP

Financial Statements

Year Ended December 31, 2023

#### **Harbour View Senior Living Corp**

#### Year Ended December 31, 2023

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#### INDEPENDENT AUDITOR'S REPORT

To the Members, Harbour View Senior Living Corp:

#### Opinion

We have audited the accompanying financial statements of Harbour View Senior Living Corp, which comprise the balance sheet as of December 31, 2023, and the related statement of income, members' equity, and cash flow for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Harbour View Senior Living Corp as of December 31, 2023, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

#### **Basis for Opinion**

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Harbour View Senior Living Corp and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

#### **Responsibilities of Management for the Financial Statements**

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Harbour View Senior Living Corp's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

#### Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.



#### Independent Auditors' Report Continued

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Harbour View Senior Living Corp's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Harbour View Senior Living Corp's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

MARTIN FRIEDMAN, C.P.A. P.C. Certified Public Accountants

Martin Friedman CHA, PC

Brooklyn, NY

December 16, 2024

## Harbour View Senior Living Corp Balance Sheet December 31, 2023

#### **Assets**

Total Liabilities & Members' Equity			\$_	34,366,597
members Equity				1, 4,500
Members' Equity				174,988
Total Long Term Liabilities				20,077,104
Total Long Term Liabilities	_	37,010		28,677,184
Patients' Trust Fund Payable		37,010		
Lease Liability		28,640,174		
Total Current Liabilities			\$	5,514,425
Loans Payable - Related Parties		94,091		
Due To Third Party Payors		945,538		
Exchanges		180,476		
Accrued Expenses & Taxes		2,502,511		
Accrued Payroll		291,747		
Lease Liability		996,846		
Accounts Payable		503,216		
Liabilities and Equity				
Total Assets			\$_	34,366,597
Total Other Assets			_	29,674,030
Patients' Trust Fund	_	37,010		
Right-of-Use Asset		29,637,020		
Total Current Assets			\$	4,692,567
Other Current Assets		173,435		
Loans Receivable - Related Parties		234,507		
Prepaid Expenses		68,065		
Accounts Receivable (Net)		2,650,923		
Cash	\$	1,565,637		

### Harbour View Senior Living Corp Statement of Operations For the year ended December 31, 2023

Total Revenue From Patients		\$	13,216,118
Operating Expenses:			
Payroll	\$ 5,305,852		
Employee Benefits	825,429		
Professional Care	892,198		
Dietary & Housekeeping	342,518		
Plant & Maintenance	4,250,657		
General & Administrative	1,433,568		
Total Operating Expenses		_	13,050,222
Income From Operations			165,896
Other Income		_	64,245
Income Before Taxes			230,141
Less: Pass-Through Entity Taxes		_	1,549
Net Income		\$	228,592

# Harbour View Senior Living Corp Statement of Members' Equity For the year ended December 31, 2023

Members' Equity:		
Balance as of Beginning of Period	\$	(53,604)
Net Income for the Period		228,592
Total Members' Equity - End of Period	Ś	174.988

#### Harbour View Senior Living Corp Statement of Cash Flows For the year ended December 31, 2023

#### Cash Flows From Operating Activities:

Net Income Adjustments to reconcile Net Income to Net Cash Provided by Operating Activities:		\$	228,592
(Increase) Decrease In: Accounts Receivable Prepaid Expenses	\$ (1,061,727) (393)		
Increase (Decrease) In: Accounts Payable Accrued Payroll & Withholding Taxes Accrued Expenses & Taxes	230,247 74,672 756,574		
Due to Third Party Payors  Exchanges  Due to Prior Owner	710,143 265,771 58,466		4 022 752
Total Adjustments  Net Cash Provided By Operating Activities		_	1,033,753 1,262,345
Cash Flows From Investing Activities:  Loans Receivable - Related Parties Other Assets  Net Cash Used In Investing Activities	(234,507) (36,191)		(270,698)
Cash Flows From Financing Activities Decrease In Long-Term Debt Other Liabilities Loans Payable - Related Parties Net Cash Provided By Financing Activities	(77,330) 28,823 94,091	_	45,584
Net Change In Cash Cash - Beginning of Period		_	1,037,231 528,406
Cash - End of Period		\$_	1,565,637
Supplemental Disclosures: Income Taxes Paid		\$	1,549

#### 1) Organization:

Harbour View Senior Living Corp, an "S" Corporation, is licensed by the New Jersey State Department of Health to run and operate a 60 bed skilled nursing bed, 54 unit independent living apartment and 116 comprehensive personal care bed facility located in North Bergen, New Jersey. The facility began operations July 1, 2022.

#### 2) Summary of Significant Accounting Policies:

The accounting policies that affect the significant elements of the financial statements are summarized below.

#### **Method of Accounting -**

The Facility maintains its books and prepares its financial statements on the accrual basis of accounting.

#### Cash -

For purposes of the statement of cash flows, cash includes time deposits, certificates of deposits, and all highly liquid debt instruments with original maturities of six months or less. The Facility maintains cash at financial institutions which periodically exceeds federally insured amounts during the year.

#### **Fixed Assets -**

Fixed assets are stated at cost. Depreciation and amortization for assets are computed using the straight-line method over the estimated useful lives of the assets.

Leasehold Improvements	10 years
Furniture & Equipment	5 years

#### Use of Estimates -

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

#### Advertising -

Advertising costs are expensed as incurred and included in general and administrative expenses. Advertising expense for the year was \$46,299.

#### **Income Taxes -**

The Facility has elected to be taxed under the provisions of the Internal Revenue Code as a tax-option corporation (an "S" corporation). Accordingly, any resulting tax liabilities or tax benefits resulting from operations are those of the individual shareholders. New Jersey State Corporation taxes are calculated based on income as defined by New Jersey State statute.

#### 3) Accounts Receivable:

The Facility grants credit, without collateral, to its patients, the majority of whom are insured under the third-party payor agreements. The amount of receivables from patients and third-party payors at December 31, 2023 was as follows:

Total	\$ 2,650,923
Less: Allowance For Bad Debt	(180,000)
Private Patients and Other	627,197
HMO Patients	653,087
Medicare Patients	374,846
Medicaid Patients	\$ 1,175,793

Management periodically reviews accounts receivable and all receivables deemed uncollectible are charged to income when that determination is made. Management considers accounts receivable as stated to be collectible.

#### 4) Uncertainty in Income Taxes:

Management has determined that there are no material uncertain tax positions that require recognition or disclosure in the financial statements. Periods ended December 31, 2022 and subsequent remain subject to examination by applicable taxing authorities.

#### 5) Compensated Absences:

The Facility recognizes a liability for compensated absences when the employees have earned the right to the leave through their service, the leave is expected to be used in the future, and the amount can be reasonably estimated. Compensated absences include accrued vacation, sick leave and personal time off. The liability is calculated based on the employee's current pay rate and number of remaining unused days. As of December 31, 2023, the liability for compensated absences amounted to \$43,313, which is included in the total accrued payroll liability of \$291,747.

#### 6) Right-of-Use Asset and Lease Liability:

The Facility's operating lease right-of-use assets and lease liabilities were for a building lease.

The Facility occupies premises pursuant to a 25 year lease from 3161 Kennedy Blvd LLC expiring in June 2047. The lease provides for monthly rental payments equal to the lessor's principal and interest payments plus 95% of the net earnings of the lessee. Rent expense for the year ended December 31, 2023 was \$2,700,000.

#### 6) Right-of-Use Asset and Lease Liability (cont.):

The Facility determines the present value of the remaining lease payments using the US Treasury risk-free rate at the time of adoption of the Standard, which was 2.01%.

The Facility has not recognized any material impairments of its operating lease right-of-use asset as of December 31, 2023. As of December 31, 2023, the Facility's operating lease liability and corresponding asset was \$29,637,020 of which \$996,846 of the liability was considered short term.

The Facility's future minimum lease payments for the next five years and thereafter, as of December 31, 2023, were as follows:

2024	\$ 1,583,400
2025	1,583,400
2026	1,583,400
2027	1,583,400
2028	1,583,400
Thereafter	30,084,600

The future minimum lease payments include only the remaining non-cancelable lease payments under the operating leases with a term of more than 12 months as of December 31, 2023.

#### 7) Patient Care Revenue Recognition:

Resident services revenue is recognized at the amount the Facility expects to receive in exchange for providing care to residents. This revenue includes amounts due from residents, third-party payors (such as health insurers and government programs), and incorporates variable considerations for potential retroactive adjustments resulting from audits and reviews. Typically, the Facility bills residents and third-party payors a few days after services are provided or when the resident no longer requires care. Revenue is recognized as performance obligations are fulfilled.

Resident services revenue is recognized at the amount the Facility expects to receive in exchange for providing care to residents. This revenue includes amounts due from residents, third-party payors (such as health insurers and government programs), and incorporates variable considerations for potential retroactive adjustments resulting from audits and reviews. Typically, the Facility bills residents and third-party payors a few days after services are provided or when the resident no longer requires care. Revenue is recognized as performance obligations are fulfilled.

Performance obligations are identified based on the nature of the services provided. For obligations satisfied over time, revenue is recognized based on the Percentage of Completion method actual charges incurred relative to the total expected charges. This approach is believed to accurately reflect the transfer of services throughout the performance obligation period, particularly for residents receiving post-acute care services in our Facility.

#### 8) Patient Care Revenue Recognition (cont.):

Revenue for performance obligations fulfilled at a specific point in time is generally recognized when goods are provided to residents in a retail setting (e.g., personal care services and additional meals not included in the resident contract) and when no further goods or services are required.

The transaction price is determined based on standard charges for services rendered, adjusted for contractual allowances given to third-party payors, discounts for uninsured residents per the Facility's charity care policy, and implicit price concessions for uninsured residents. Estimates for contractual adjustments and discounts are based on contractual agreements, Facility policies, and historical data.

Agreements with major third-party payors typically stipulate payments at amounts lower than established charges. A summary of the payment arrangements with key payors includes:

- Medicare: Certain in-resident post-acute care services are reimbursed at predetermined rates per service, influenced by clinical and diagnostic factors. Other services are reimbursed based on cost-reimbursement methodologies, with physician services paid according to established fee schedules. Medicare revenue primarily consists of fixed regional rates adjusted for patient acuity, subject to audit verification.
- Medicaid: Under the current statewide pricing methodology, Medicaid revenue is based on the rate in effect as of July 1, 2014. The State has made statewide adjustments in some years, but the rates are not subject to audit.
  - New Jersey implemented a managed care Medicaid formula in January 2014, requiring Medicaid patients to enroll in managed long-term care plans. The state's executive budget mandates that managed care companies pay rates no less than the current Medicaid methodology, with New Jersey Department of Health calculating these rates annually.
- Other: Payment agreements with various commercial insurance carriers, health maintenance organizations, and preferred provider organizations typically provide for payment based on predetermined rates per service, discounts from standard charges, and daily rates.

Compliance with government regulations, particularly concerning Medicare and Medicaid, is complex and can be subject to interpretation. Facilities may receive requests for information and notices of alleged noncompliance, leading to potential settlement agreements. Future regulatory reviews may result in fines, penalties, or exclusion from programs. The Facility believes they are currently in compliance with all applicable laws and regulations.

Settlements for retroactive adjustments due to audits or investigations are considered variable considerations and are included in the transaction price estimation for resident services. These settlements are estimated based on agreements with payors, relevant correspondence, and historical settlement activities. Adjustments are made in subsequent periods as new information becomes available or when cases are settled.

#### 9) Patient Care Revenue Recognition (cont.):

Residents covered by third-party payors are generally responsible for deductibles and coinsurance, which can vary. The Facility also serves uninsured residents and offers discounts as required by policy or law. Estimates of transaction prices for these residents are based on historical data and market conditions. Initial transaction price estimates are calculated by reducing standard charges by contractual adjustments, discounts, and implicit price concessions.

Changes to transaction price estimates are recorded as adjustments to resident service revenue in the period of change. Adverse changes in residents' ability to pay are recorded as bad debt expense.

Revenue from resident's deductibles and coinsurance are included in the preceding categories based on the primary payor.

Revenues are recorded based on current billings of the estimated net realizable amounts from patients, third-party payers and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Certain adjustments may be made in subsequent periods as a result of audits or appeals. Such adjustments, if any, will be reflected in revenues in the period in which they are received.

#### 8) Subsequent Events:

The Facility has evaluated subsequent events through December 16, 2024, the date which the financial statements were available to be issued. No significant subsequent events have been identified by management.



### INDEPENDENT AUDITOR'S REPORT ON ADDITIONAL INFORMATION

To the Members, Harbour View Senior Living Corp:

Our report on our audit of the basic financial statements of Harbour View Senior Living Corp for 2023 appears on page 1. That audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information on pages 13 through 15 is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Martin Friedman CPA, PC

MARTIN FRIEDMAN C.P.A. P.C. Certified Public Accountants

Brooklyn, NY

December 16, 2024

# Harbour View Senior Living Corp Supplementary Schedules For the year ended December 31, 2023

#### Revenue From Patients:

Private - SNF	\$	1,491,020		
Medicaid - SNF		3,097,874		
Medicare - SNF		3,539,496		
Private - ALF		3,170,581		
Medicaid - ALF	_	1,917,147		
Total Revenue From Patients			\$	13,216,118
Other Income:				
Interest		59,237		
Rental		5,008		
Total Other Income			_	64,245
Total Revenue			\$	13,280,363

## Harbour View Senior Living Corp Supplementary Schedules For the year ended December 31, 2023

Administrative & Office	\$ 369,302		
Nursing	3,017,300		
Therapies	349,328		
Social Services	37,706		
Recreation	196,637		
Dietary	757,365		
Housekeeping	324,956		
Maintenance	 253,258		
Total Payroll		\$ <u>_</u>	5,305,852
Employee Benefits:			
Payroll Taxes	570,684		
Workmen's Compensation	167,061		
Employee Benefits	 87,684		
Total Employee Benefits		\$ <u>_</u>	825,429
Professional Care:			
Prescription Drugs	86,870		
Medical Supplies	218,070		
Contracted Nursing Service	466,226		
Fees & Expenses	 121,032		
Total Professional Care		\$	892,198

### Harbour View Senior Living Corp Supplementary Schedules For the year ended December 31, 2023

Total General & Administrative		\$	1,433,568
iviiscellatieous	 124,413		
Credit Losses Miscellaneous	109,461		
Advertising	46,299		
Insurance	142,969		
Professional Fees	113,238		
Auto & Travel	3,350		
Telephone	5,283		
Computer Services	23,216		
Management Fees	664,032		
Contracted Office Services	144,017		
Office	57,290		
General & Administrative:			
Total Plant & Maintenance		\$_	4,250,657
Water & Sewer Charges	 22,261		
Security	18,090		
Contracted Maintenance Services	158,100		
Maintenance	926,169		
Light, Heat & Power	424,984		
Equipment Rentals	1,053		
Rent	2,700,000		
Plant & Maintenance:			
Total Dietary & Housekeeping		\$_	342,518
Contracted Dietary Services	 55,189		
Housekeeping	58,051		
Laundry	5,239		
Other Dietary Expenses	39,045		
Food	\$ 184,994		
Dietary & Housekeeping:			