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

OMB NO. 0938-0463

Expires: 12/31/2021

			EXPIT 03. 12/01/202
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315384	From 01/01/2022	Worksheet S Parts I, II & III Date/Time Prepared: 5/30/2023 12:34 pm

				37 307	2023 12.34 PIII
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically prepared cost rep	oort		Date: 5/30/2023	Time: 12:34 pr
use only	2. [ ] Manually prepared cost report				
	3. [ 0 ] If this is an amended report en	ter the numbe	r of times the provider	resubmitted this cos	t report
	3.01 [ ] No Medicare Utilization. Enter '	'Y" for yes o	r Leave blank for no.		
Contractor	4. [ 1 ] Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[ N ] Firs	t Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[ N ] Last	Cost Report for this F	Provider CCN	
	(3) Settled with audit	9. NPR Date:	•		
	(4) Reopened	10.[ 0 ]If I	ine 4, column 1 is "4":	 Enter number of time:	s reopened
	(5) Amended		r Vendor Code	4	•
	5. Date Received:	12.[ F ] Medi	care Utilization. Enterno utilization.	r "F" for full, "L" fo	or low, or "N"

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

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ROSE MOUNTAIN CARE CTR ( 315384 ) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX		
	1			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	-36, 385	743	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	-36, 385	743	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 ROSE MOUNTAIN CARE CTR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315384 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 12:34 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 27 US HIGHWAY 1 1.00 PO Box: 1.00 2.00 City: NEW BRUNSWICK State: NJ Zi p Code: 08901 2.00 3.00 County: MI DDLESEX CBSA Code: 35154 Urban/Rural: U 3.00 3. 01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF ROSE MOUNTAIN CARE CTR 315384 12/01/1997 N Р 0 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 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 12/31/2022 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 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 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 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. 19.01 20.00 Straight Line 17, 209 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 17 209 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) N 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (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 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 Υ 38.00 39.00 2 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 0 41 00

Heal th	Financial Systems	ial Systems ROSE MOUNTAIN CARE CTR In Lieu of				2540-10
SKI LLE	LED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315384   Period:   W					
COMPLE	X INDENTIFICATION DATA			From 01/01/2022	Part I	
				To 12/31/2022	Date/Time Pre	
					5/30/2023 12:	34 pm
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrativ	e and General cost	N	42. 00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing c	cost centers and		
	amounts.		_			
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addr	ess of the home		44. 00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address of t	the home office on the	lines	
	bel ow.	_				
45.00	Name:	Contractor's Name:	Con	tractor's Number:		45. 00
46.00	Street: PO Box:				46. 00	
47.00	Ci ty: Zi p Code:					47. 00

Health Financial Systems ROSE MOUNTAIN CARE CTR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315384 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2022 5/30/2023 12:34 pm Date 1. 00 2.00 General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary Is the provider involved in business transactions, including management 3.00 Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public C Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. 11.00 Ν Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 03/17/2023 Υ 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 Ν Ν 14 00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 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. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Health Fina	ancial Systems	ROSE MOUNTAII	N CARE CTR		In Lie	2540-10	
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provi der		Peri od: From 01/01/2022	Worksheet S-2 Part II		
					To 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 34 pm
			1	. 00	2.	00	
Cost	Report Preparer Contact Information						
19. 00 Ente	er the first name, last name and the title	e/position	CHARLES		REED		19. 00
held	d by the cost report preparer in columns 1	, 2, and 3,					
resp	pecti vel y.						
20. 00 Ente	er the employer/company name of the cost r	report	EXECUCARE ASS	OCI ATES			20. 00
prep	parer.						
	er the telephone number and email address		(609) 738-3200		CRWASSC@NETSCAF	PE. NET	21. 00
repo	ort preparer in columns 1 and 2, respectiv	∕el y.					

Health Financial Systems ROSE MOUNTAIN CARE CTR In Lieu of Form CMS-2540-10

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEX REIMBURSEMENT QUESTIONNAIRE

ROSE MOUNTAIN CARE CTR

Provider No.: 315384

Period:
From 01/01/2022
To 12/31/2022
To 12/31/2022
Part II
Date/Time Prepared:

Date/Time Prepared: 5/30/2023 12:34 pm Part B Date 4.00 PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to 03/17/2023 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 14.00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report 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? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 3.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position VI CE-PRESI DENT 19.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 20.00 20.00 preparer. 21.00 Enter the telephone number and email address of the cost 21.00

report preparer in columns 1 and 2, respectively.

In Lieu of Form CMS-2540-10 ROSE MOUNTAIN CARE CTR

Health Financial Systems ROSE MOUNTAIN SKILLED NURSING FACILITY HEALTH CARE

Provi der No.: 315384 Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/30/2023 12:34 pm COMPLEX STATISTICAL DATA

					12/31/2022	5/30/2023 12: 3	
				I np:	atient Days/Vis	its	
	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	112	40, 880	0	2, 405	24, 841	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC						6. 00
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	112	40, 880	0		24, 841	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	2, 596	29, 842	0		97	1. 00
2.00	NURSING FACILITY	o	0	0		0	2. 00
3.00	ICF/IID	o	0			0	3. 00
4.00	HOME HEALTH AGENCY COST	o	0				4. 00
5.00	Other Long Term Care	o	0				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)	2, 596	29, 842	0	36	97	8.00
		Di scha	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	The state of the s	11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	SKILLED NURSING FACILITY	54	187	0.00	66. 81	256. 09	1. 00
2.00	NURSING FACILITY	o	0	0.00		0.00	2.00
3.00	ICF/IID	o	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0.00		0.00	7. 00
8. 00	Total (Sum of lines 1-7)	54	187	0.00		256. 09	8. 00
		Average Length		Admi s	si ons		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
	Component	16. 00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	159. 58	17.00	18.00	77	59	1. 00
2.00	NURSING FACILITY	0.00	0	01	, ,	0	2. 00
3.00	ICF/IID	0.00	O		0	ol	3. 00
4.00	HOME HEALTH AGENCY COST	0.00			J	ĭ	4. 00
5.00	Other Long Term Care	0. 00				0	5. 00
6.00	SNF-Based CMHC	0.00					6. 00
7. 00	HOSPI CE	0.00	0	0	o	0	7. 00
8.00	Total (Sum of lines 1-7)	159. 58	0	61	77	59	8. 00
	, , , , , , , , , , , , , , , , , , ,	Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
	Component	Total	Payrol I	Workers			
		21.00	22. 00	23. 00			
1. 00	SKILLED NURSING FACILITY	197	74. 28	0.00			1. 00
2.00	NURSING FACILITY	o	0.00				2. 00
3.00	ICF/IID	o	0.00				3. 00
4.00	HOME HEALTH AGENCY COST		0.00	0.00			4. 00
5.00	Other Long Term Care	o	0.00				5. 00
6.00	SNF-Based CMHC		0.00	0.00			6.00
7.00	HOSPI CE	o	0.00				7. 00
8.00	Total (Sum of lines 1-7)	197	74. 28	0.00			8. 00

				T	0 12/31/2022	Date/Time Pre 5/30/2023 12:	
	·	Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
		· ·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
				,	3	,	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	3, 992, 100	0	3, 992, 100	154, 512. 00	25. 84	1. 00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2. 00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3. 00
4.00	Home office personnel	0	0	0	0.00	0.00	4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5. 00
6.00	Revised wages (line 1 minus line 5)	3, 992, 100	0	3, 992, 100	154, 512. 00	25. 84	6. 00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	3, 992, 100	0	3, 992, 100	154, 512. 00	25. 84	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1, 314, 216	0	1, 314, 216	32, 724. 00	40. 16	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00		15. 00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	607, 388	0	607, 388			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19.00	Wage related costs (excluded units)	0	0	0			19. 00
20.00	Physician Part A - WRC	0	0	0			20. 00
21.00	Physician Part B - WRC	0	0	0			21. 00
22.00	Total Adjusted Wage Related cost (see	607, 388	0	607, 388			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION ROSE MOUNTAIN CARE CTR

				1	o 12/31/2022	Date/lime Pre 5/30/2023 12:	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		Ropor tou	Worksheet A-6	,	Salary in col.		
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES			•			
1.00	Employee Benefits	0	O	0	0.00	0.00	1.00
2.00	Administrative & General	708, 241	0	708, 241	19, 746. 00	35. 87	2.00
3.00	Plant Operation, Maintenance & Repairs	84, 309	0	84, 309	2, 080. 00	40. 53	3. 00
4.00	Laundry & Li nen Servi ce	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	261, 253	0	261, 253	15, 460. 00	16. 90	5. 00
6.00	Di etary	374, 541	0	374, 541	23, 785. 00	15. 75	6. 00
7.00	Nursing Administration	265, 600	0	265, 600	8, 148. 00	32. 60	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	66, 437	0	66, 437	1, 880. 00	35. 34	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	210, 172	0	210, 172	12, 414. 00	16. 93	13. 00
14.00	Total (sum lines 1 thru 13)	1, 970, 553	0	1, 970, 553	83, 513. 00	23. 60	14.00

Health Financial Systems	ROSE MOUNTAIN CARE CTR	In Lieu	of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315384	From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared:

	To 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 34 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1.00
	Tax Shel tered Annuity (TSA) Employer Contribution	0	2.00
	Qualified and Non-Qualified Pension Plan Cost	0	
	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
	401K/TSA Plan Administration fees	0	5.00
	Legal/Accounting/Management Fees-Pension Plan	0	
	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		7.00
	Heal th Insurance (Purchased or Self Funded)	170, 683	8.00
	Prescription Drug Plan	170,003	
	Dental, Hearing and Vision Plan	0	
	Life Insurance (If employee is owner or beneficiary)	0	
	Accident Insurance (If employee is owner or beneficiary)	0	
	Disability Insurance (If employee is owner or beneficiary)	0	1
		1	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	
	Workers' Compensation Insurance	69, 080	
	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES	200 000	47.00
	FICA-Employers Portion Only	302, 989	
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	0	1
	State or Federal Unemployment Taxes	64, 636	20.00
	OTHER		
	Executive Deferred Compensation	0	
	Day Care Cost and Allowances	0	00
	Tuition Reimbursement	0	
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	607, 388	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No.: 315384 | Period: Worksheet S-3 From 01/01/2022 | Part V

12/31/2022 Date/Time Prepared: 5/30/2023 12:34 pm Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Sal ari es (col Related to Wage (col. 3 Reported col . 4) 1 + col. 2Salary in col 3.00 5. 00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 265, 320 41, 679 306, 999 6, 996. 00 43.88 1.00 Licensed Practical Nurses (LPNs) 639, 187 100, 411 739, 598 20, 575. 00 35.95 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 789, 845 124,078 913, 923 35, 197. 00 25.97 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 1, 694, 352 266, 168 1, 960, 520 62, 768. 00 31.23 4.00 5.00 3, 821. 00 43. 48 5.00 Physical Therapists 143, 596 22, 558 166, 154 Physical Therapy Assistants 0.00 6.00 0.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 24, 027 176, 978 3, 785. 00 46. 76 8.00 8.00 152 951 0.00 9.00 C 0.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 11.00 Speech Therapists 30,648 4,815 35, 463 626.00 56.65 11.00 Respiratory Therapists 12.00 0.00 12 00 0 00 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 265, 795 265, 795 3, 187. 00 83 40 14 00 15.00 Licensed Practical Nurses (LPNs) 273, 103 273, 103 4, 531. 00 60.27 15.00 Certified Nursing Assistant/Nursing 761, 928 761, 928 24, 800. 00 30.72 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 1, 300, 826 1, 300, 826 32, 518. 00 40.00 17.00 18.00 Physical Therapists 0.00 0.00 18.00  $\cap$ 19.00 Physical Therapy Assistants 0 0.00 0.00 19.00 0 Physical Therapy Aides 0 20.00 0 0.00 0.00 20.00 Occupational Therapists 0 0.00 21.00 0 0.00 21.00 Occupational Therapy Assistants 22.00 0 0 0.00 0.00 22.00 Occupational Therapy Aides 0 0.00 0.00 23.00 23.00 13, 390 24.00 Speech Therapists 13.390 206.00 65.00 24.00 Respiratory Therapists 0.00 25.00 25.00 0 0.00 26.00 Other Medical Staff 0 0.00 0.00 26.00 Peri od: Worksheet S-7
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared: 5/30/2023 12:34 pm

	10	12/31/2022	5/30/2023 12:	34 pm
		Group	Days	
		1. 00	2. 00	1.00
1.00		RUX		1.00
2. 00 3. 00		RUL RVX		2. 00 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 13. 00		RUA RVC		12. 00 13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16.00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20.00		RMB		20.00
21.00		RMA		21. 00
22. 00 23. 00		RLB RLA		22. 00 23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30.00		HD1		30.00
31.00		HC2		31.00
32. 00 33. 00		HC1 HB2		32. 00 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 43. 00		LB1 CE2		42. 00 43. 00
44.00		CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50.00		CB1		50.00
51.00		CA2		51.00
52. 00 53. 00		CA1 SE3		52. 00 53. 00
54.00		SE2		54.00
55. 00		SE1		55. 00
56. 00		SSC		56.00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		I B2		59.00
60. 00   61. 00		I B1 I A2		60. 00 61. 00
62. 00		I A2		62.00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66. 00
67. 00		PE2		67. 00
68.00		PE1		68. 00
69. 00		PD2		69.00
70.00		PD1		70.00
71. 00 72. 00		PC2 PC1		71. 00 72. 00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00		PA2		75. 00
<del>-</del>				

Health Financial Systems	ROSE MOUNTAIN CAR	E CTR	In Lieu of Form CMS-2540-10				
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315384	Peri od:	Worksheet S-	7	
				From 01/01/2022 To 12/31/2022	Date/Time Pro 5/30/2023 12:		
				Group	Days 2, 00		
1.00							
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) 106.00 Total SNF revenue (Worksheet G-2, Part I, Lin	o 1 column 2)					105. 00 106. 00	
100.00 Total Sivi Teveride (WOLKSHeet G-2, Part I, IIII	e i, coruilli s)		l	1		1100.00	

Heal th	Financial Systems	ROSE MOUNTAIN	CARE CTR		In Lie	eu of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	pared·
						5/30/2023 12:	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col . 4)	
					A-6)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	T T			T		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		624, 132			624, 132	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		110			110	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	627, 124			627, 124	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	708, 241	1, 351, 670			2, 059, 911	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	84, 309	361, 057			445, 366	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	16, 768			16, 768	6. 00
7. 00	00700 HOUSEKEEPI NG	261, 253	30, 137			291, 390	7. 00
8. 00	00800 DI ETARY	374, 541	295, 702			670, 243	8. 00
9.00	00900 NURSING ADMINISTRATION	265, 600	26, 585			292, 185	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	116, 385			116, 385	1
11. 00	01100 PHARMACY	0	35, 674	35, 674	1 0	35, 674	
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	(	0	0	12.00
13. 00	01300 SOCIAL SERVICE	66, 437	0	66, 437	0	66, 437	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(	0	0	14. 00
15. 00	01500 ACTI VI TI ES	210, 172	19, 515	229, 687	7 0	229, 687	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	1, 694, 352	1, 334, 674	3, 029, 026	0	-,,	
31. 00	03100 NURSING FACILITY	0	0	(	0	0	31. 00
32. 00	03200   CF/IID	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	2, 569			2, 569	40. 00
41. 00	04100 LABORATORY	0	12, 761	12, 761		12, 761	•
42. 00	04200   NTRAVENOUS THERAPY	0	0	(	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	(	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	143, 596	0	143, 596		143, 596	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	152, 951	10.000	152, 951		152, 951	45. 00
46. 00	04600 SPEECH PATHOLOGY	30, 648	13, 390	44, 038	3	44, 038	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	(	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74 (50	74 (5	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	71, 653	71, 653	0	71, 653	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	l ol	0		0	0	51.00
60. 00	06000 CLINIC	O	0		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0			0	61.00
62. 00	06200 FQHC		U				62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0			0	70. 00
	07100 AMBULANCE		0			0	70.00
	07300 CMHC		0			0	1
73.00	SPECIAL PURPOSE COST CENTERS	l d			<u>)</u>	U	73.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0	0	80. 00
81. 00	08100 INTEREST EXPENSE		0				81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF		0				82. 00
83. 00	08300 H0SPI CE		0			0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	3, 992, 100	4, 939, 906	8, 932, 006		8, 932, 006	89. 00
07.00	NONREI MBURSABLE COST CENTERS	3, 772, 100	4, 737, 700	0, 732, 000	<u> </u>	0, 732, 000	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	n	(	) 0	0	90. 00
	09100 BARBER AND BEAUTY SHOP		n			Ö	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	ام	n		ol ő	o o	
	09300 NONPALD WORKERS		0		ol o	Ö	93. 00
	09400 PATIENTS LAUNDRY	o	0		ol o	0	94.00
100.00	1	3, 992, 100	4, 939, 906	8, 932, 006	0	8, 932, 006	
	•						

 
 Heal th Financial
 Systems
 ROSE MOU

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315384 

				То	12/31/2022	Date/Time Prep 5/30/2023 12:	
	Cost Center Description	Adjustments to	Net Expenses			, 3/30/2023 12.	54 pili
	<b>'</b>		For Allocation				
		Wkst A-8)	(col. 5 +-				
			col . 6)				
	CENEDAL CEDVICE COST CENTEDS	6. 00	7. 00				
1. 00	GENERAL SERVICE COST CENTERS    OO100   CAP REL COSTS - BLDGS & FIXTURES	-323, 607	300, 525				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	-323,007	110	ł .			2.00
3. 00	00300 EMPLOYEE BENEFITS	0	627, 124	•			3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	-642, 833		•			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	445, 366	•		ļ	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	16, 768	•			6. 00
7.00	00700 HOUSEKEEPI NG	0	291, 390			I	7. 00
8.00	00800 DI ETARY	0	670, 243			ļ	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	292, 185	•		ļ	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	116, 385	•		ļ	10.00
11. 00	01100 PHARMACY	0	35, 674	1		ļ	11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	l .		ļ	12. 00 13. 00
14. 00	01300   SOCIAL SERVICE   01400   NURSING AND ALLIED HEALTH EDUCATION	0	66, 437 0	1		ļ	14. 00
15. 00	01500 ACTIVITIES	0	229, 687	1			15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		227,007				13.00
30.00	03000 SKILLED NURSING FACILITY	-74, 762	2, 954, 264				30. 00
31.00	03100 NURSING FACILITY	0	0			l	31. 00
32.00	03200   CF/IID	0	0			ļ	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0				33. 00
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	0	2, 569	1		ļ	40. 00
41. 00	04100 LABORATORY	0	12, 761	1			41.00
42. 00 43. 00	04200   INTRAVENOUS THERAPY   04300   OXYGEN (INHALATION) THERAPY	0	0			ļ	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	143, 596				44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	152, 951	•			45. 00
46. 00	04600 SPEECH PATHOLOGY	0	44, 038	•			46. 00
47.00	04700 ELECTROCARDI OLOGY	0	O	1			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	71, 653			ļ	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		ļ	50. 00
51. 00	05100 SUPPORT SURFACES	0	0				51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS	0					(0.00
60. 00 61. 00	O6000   CLINIC   O6100   RURAL HEALTH CLINIC	0	0	1		ļ	60. 00 61. 00
62. 00	06200 FQHC	0	U				62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0				70. 00
71. 00	07100 AMBULANCE	0	0				71. 00
73.00	07300 CMHC	0	0				73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	1			ļ	80.00
	08100   INTEREST EXPENSE	0	0			ļ	81.00
82.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0				82.00
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 041, 202				l	83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	-1,041,202	1,070,004				0 7. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90. 00
	09100 BARBER AND BEAUTY SHOP	0	Ö	1		ļ	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0			ļ	92. 00
	09300 NONPAI D WORKERS	0	0			ļ	93. 00
	09400 PATIENTS LAUNDRY	0	0			ļ	94. 00
100.00	TOTAL	-1, 041, 202	7, 890, 804			ļ	100. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ROSE MOUNTAIN CARE CTR In Lieu of Form CMS-2540-10 Provi der No.: 315384 | Peri od: | Worksheet A-7 | From 01/01/2022 | To 12/31/2022 | Date/Time Prens

				Т	o 12/31/2022	Date/Time Prep 5/30/2023 12:3	
			'	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	3					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	522, 690	0	0	0	75, 655	4.00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	61, 786	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	584, 476	0	0	0	75, 655	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	584, 476	0	C	0	75, 655	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
	ANNUAL OF SUMMED AN OARLEST BALANCE	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
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	447, 035	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	61, 786	0				6. 00
7.00	Subtotal (sum of lines 1-6)	508, 821	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	508, 821	0				9. 00

Provi der No.: 315384

Peri od: Worksheet A-8 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				lo 12/31/2022	Date/lime Pre   5/30/2023 12:	
				Expense Classification on		34 pili
				To/From Which the Amount is		
				10/FI OIII WIII CII THE AIIIOUITT IS	to be Aujusteu	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
		Adjustment				
		1.00	2.00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-10, 981	ADMINISTRATIVE & GENERAL	4.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
2.00	(8)		· ·		0.00	2.00
3. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00			0		0.00	4. 00
4.00	Rental of provider space by suppliers		U	<b>'</b>	0.00	4.00
F 00	(chapter 8)		0		0.00	F 00
5.00	Tel ephone services (pay stations excluded)		0	,	0.00	5. 00
	(chapter 21)		_			
6.00	Television and radio service (chapter 21)		0	1	0.00	6. 00
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capital expenditures (chapter 24)					
12. 00	Adjustment resulting from transactions with	A-8-1	-397, 663	3		12. 00
	related organizations (chapter 10)		0777000			12.00
13. 00	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
					l .	
16. 00	Sale of medical supplies to other than		0	,	0.00	16. 00
47.00	patients		•		0.00	47.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vending machines		0		0.00	19. 00
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FIXTURES		
24.00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
			_	EQUI PMENT		
25. 00			0	1	0.00	25. 00
25. 00	P/R CONTROLLER	A	_46_900	ADMINISTRATIVE & GENERAL	4.00	25. 00
		1				
25. 02	MANAGEMENT FEES	A		ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	PROMOTIONAL ADS	A	· ·	ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	NJ CORP TAX	A		ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	NJ BAIT CORP TAX	A		ADMINISTRATIVE & GENERAL	4.00	25. 05
25. 06	MI SC EXPENSES	A	· ·	ADMINISTRATIVE & GENERAL	4.00	
25. 07	MI SC I NCOME	В	-6, 956	ADMINISTRATIVE & GENERAL	4.00	25. 07
25. 08	OTHER INCOME	В	-8, 459	ADMINISTRATIVE & GENERAL	4.00	25. 08
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 041, 202			100. 00
	to Worksheet A, col. 6, line 100)					
		'	0110 5 1 45 4	•	•	

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

Health Financial Systems ROSE MOUNTAIN
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME ROSE MOUNTAIN CARE CTR Provi der No.: 315384

OFFICE COSTS

71110E 00313			Т	o 12/31/2022	Date/Time Pr 5/30/2023 12	
·	Li ne No.	Cost C		Expense		
	1.00	2.		3. 0		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUICLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTION	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		AP REL COSTS	- BLDGS &	RENT		1.00
. 00	1 1	DMI NI STRATI VE	& GENERAL	REALTY ADMIN		2.00
. 00		KILLED NURSING		AI DES		3.00
. 00	30, 00	KILLED NURSING		LPNS AND RNS		4.00
. 00	0.00					5.00
. 00	0.00					6.00
. 00	0.00					7.0
3. 00	0.00					8.00
0.00	0.00					9.0
0.00 TOTALS (sum of lines 1-9). Transfer column						10.0
6, line 100 to Worksheet A-8, column 3, line	9					
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Nkst. A, col.	col. 5)			
		5				
DART I GOOTO LIVOURDER AND AR WOTHERTO REQUI	4.00	5. 00	6.00	D 0004411 7471 0410	0.0	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUICLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTION	NS WITH RELATE	D ORGANIZATIONS	OR	
. 00	156, 393	480, 000	-323, 607			1.0
2. 00	706	0	706	,		2. 0
. 00	124, 536	140, 431	-15, 895	i		3. 0
. 00	461, 230	520, 097	-58, 867	1		4. 0
. 00	0	0	C			5. 0
5. 00	0	0	C	)		6. 0
7. 00	0	0	C	)		7. 0
3. 00	0	0	C			8. 0
0.00	0	0	C			9. 0
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	742, 865	1, 140, 528	-397, 663			10.00

OFFICE COSTS

From 01/01/2022 Parts I-II Date/Time Prepared:

5/30/2023 12:34 pm

12/31/2022

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.

3		· ·		
1.00	Α	JONATHAN ROSENBERG	50.00	1.00
2.00	A	ESTHER ROSENBERG	50.00	2. 00
3.00	D	MINDY ROSENBERG	0.00	3. 00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6. 00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

	Rel ated Organi	Rel ated Organi zati on(s) and/or Home Office						
	Name	Percentage of	Type of Business	1				
		Ownershi p						
	4.00	5. 00	6. 00	1				
DART II INTERRELATIONOMER TO BELATER ORGANI	TATION (O) AND (OD HOME OFFI OF							

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		BRUNSWI CK MANOR	50.00	REALTY	1.00
2.00		BRUNSWI CK MANOR	50.00	REALTY	2. 00
3.00		PEACE OF MIND STAFFING	100.00	NURSING AGENCY	3. 00
4.00			0.00		4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	speci fy:				

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

COST Center Description					T	12/31/2022	Date/Time Pre	pared:
GENERAL SERVICE COST CENTERS				CAPI TAL REI	LATED COSTS		3/30/2023 12.	54 piii
SEMPRIAL SERVICE COSTS CENTERS   00   1.00   2.00   3.00   3.00		Cost Center Description	for Cost Allocation (from Wkst A				Subtotal	
1.00				1. 00	2.00	3. 00	3A	
0.0000   CAP PET, COSTS - MOVABLE FOULPMENT   1.10   1.10   2.00   0.0000   CMPLOYEE BETKET IS   3.00   0.0300   CMPLOYEE BETKET IS   3.00   0.0000   CMPLOYEE BETKET IS   3.00   C								
0.0300   EMPLOYEE BENEFITS			1 ' 1	300, 525				
4.00   0.0400   ADM IN STRATIVE & GENAL   1.417, 078   12, 274   4   112, 263   1.541, 161   4.00   6.00   0.0600   LANIDRY & LINEN SERVICE   16, 766   17, 311   6   0   34, 085   6.00   0.0600   LANIDRY & LINEN SERVICE   16, 766   17, 311   6   0   34, 085   6.00   0.0600   LANIDRY & LINEN SERVICE   16, 766   17, 311   6   0   34, 085   6.00   0.0600   LANIDRY & LINEN SERVICE   16, 766   17, 311   59, 366   760, 049   8.00   0.0600   DIETARY   7670, 243   31, 327   11   59, 366   760, 049   8.00   0.0600   DIETARY   7670, 243   31, 327   11   59, 366   760, 049   8.00   0.0600   DIETARY   7670, 243   31, 327   11   59, 366   760, 049   8.00   0.0600   DIETARY   7670, 243   31, 327   11   75, 366   760, 049   8.00   0.0600   DIETARY   7670, 243   31, 327   11   75, 366   760, 049   8.00   0.0600   DIETARY   7670, 243   31, 327   11   75, 366   760, 049   8.00   0.0600			1 I	E 4E0		422 704		
5,00   00500   PLANT OPERATION, MAINT & REPAIRS   445, 366   8, 723   3   13,364   447,456   5.00			1				1 5/1 610	
0.0000   LANDRY & LINEN SERVICE			1					
0.000   0.0000   URISTING ADMINISTRATION   272, 185   71, 184   3   42, 100   341, 472   9, 00   0.0000   URISTING ADMINISTRATION   272, 185   71, 184   3   42, 100   341, 472   9, 00   10.00   0.0000   CENTRAL SERVICES & SUPPLY   116, 385   72, 201   1   0   118, 587   10, 00   10, 00   10, 00   35, 674   11, 00   100   0   0   0   0   35, 674   11, 00   100   0   0   0   0   0   0   0			1					
9,00 000000 NURSING ADMINISTRATION 292, 185 7, 184 3 42, 100 341, 472 9, 00 11.0 00 10000 CENTRAL SERVICES & SUPPLY 116, 385 2, 201 1 1 0 118, 587 10. 00 11.0 00 11000 PHARMACY 35, 674 0 0 0 0 0 35, 674 11. 00 12.0 01.0 00 MEDICAL SERVICE 6 8, 1874 11. 00 10. 0 0 0 0 0 0 0 12. 00 13.0 00 1300 SOCIAL SERVICE 6 66, 437 2, 741 1 1 10, 531 79, 710 13. 00 1500 NURSING ADM ALLED HEALTH EDUCATION 0 0 0 0 0 0 14. 00 1500 ACTIVITIES 20 15. 00 1500 ACTIVITIES 20 1500 ACTIVITIES	7.00	00700 HOUSEKEEPI NG	291, 390	3, 646	1	41, 411	336, 448	7. 00
10. 00   10000   CENTRAL SERVICES & SUPPLY   116, 385   2, 201   1		l l	1					
11. 00   01100   PARAMACY   0   0   0   35, 674   0   0   0   0   35, 674   1. 00   12. 00   12. 00   12. 00   01300   MEDICAL SERVICE   66, 437   2, 741   1   10, 531   79, 710   13. 00   0   10, 10   10. 00   10, 10   10. 00   10, 10   10. 00   10, 10   10. 00   10, 10   10. 00   10, 10		l l	1					
12 00   01200   MEDICAL RECORDS & LIBRARY   0 0 0 0 0 0 0 0 1, 2 00 1, 30 0 1, 30 0 1, 30 0 0 1, 30 0 0 1, 30 0 0 1, 40 0 0 0 0 0 0 0 0 0 0 1, 40 00 1, 40 0 1, 40 0 1			1			0		
13. 00   01300   SOCIAL SERVICE   66, 437   2, 741   1   10, 531   79, 710   33, 00     14. 00   01400   NURSING AND ALLIED HEALTH EDUCATION   229, 687   42, 602   16   33, 314   305, 619     NORTHE TENT ROUTINE SERVICE COST CENTERS		l l	35, 674	0		0		
14. 00   01400   MURSING AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   0   0   0			66, 437	2. 741	1	10. 531	-	
INPATI ENT ROUTINE SERVICE COST CENTERS			0	0	0	0	•	
30.00   03000   03000   03000   0300   0300   03000	15. 00		229, 687	42, 602	16	33, 314	305, 619	15. 00
31.00   03100   NURSING FACILITY								
32.00   03200   ICFAT I D			2, 954, 264					
33.00   03300   O3300   O330			0			-	-	
ANCILLARY SERVICE COST CENTERS						-		
40.00   04000   RADIOLOGY	00.00		<u> </u>			<u> </u>		00.00
42.00   04200   04300   0   0   0   0   0   0   0   0   42.00	40.00		2, 569	0	0	0	2, 569	40. 00
43.00 04300   0xygen (Inhalatation) Therapy   0 0 0 0 0 0 0 0 0 43.00   44.00 04400   Physical Therapy   143,596   3,875   1 22, 761   170,233   44.00 04400   Physical Therapy   152,951   3,875   1 24,244   181,071   45.00 04600   0xygen (Inhalataterapy   152,951   3,875   1 24,244   181,071   45.00 04600   0xygen (Inhalataterapy   152,951   3,875   1 24,244   181,071   46.00 04600   0xygen (Inhalataterapy   143,096   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			12, 761	0		0	12, 761	
44. 00   04400   PHYSI CAL THERAPY			0	0	0	-	-	
45. 00   04500   OCCUPATIONAL THERAPY   152,951   3,875   1   24,244   181,071   45. 00   46. 00   04600   SPECH PATHOLOGY   44,038   0   0   0   4,858   48,896   46. 00   47. 00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0			142 504	2 075	0	-	-	
46. 00 04600 SPECH PATHOLOGY			1					
47. 00   04700   CLECTROCARDIOLOGY   0   0   0   0   0   0   47. 00   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   48. 00   04900   DRUGS CHARGED TO PATIENTS   71,653   0   0   0   0   71,653   49. 00   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   0100   SUPPORT SURFACES   0   0   0   0   0   0   00   00   00			1					
49. 00   04900   DRUGS CHARGED TO PATIENTS   71,653   0   0   0   71,653   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   0    OUTPATIENT SERVICE COST CENTERS    60. 00   06000   CLINIC   0   0   0   0   0   0   0   61. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   62. 00   06200   FOHC   0   0   0   0   0   0   0    OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   71. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   71. 00   07300   CMHC   SEPECIAL PURPOSE COST CENTERS    80. 00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   81. 00   81. 00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   81. 00   82. 00   08300   HOSPICE   0   0   0   0   0   0   0   83. 00   08300   HOSPICE   0   0   0   0   0   0   89. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   91. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   0   92. 00   09200   PATIENTS LAUNDRY   0   0   0   0   0   0   93. 00   09400   PATIENTS LAUNDRY   0   0   0   0   0   94. 00   Nonzeli Meurschaft   Cross Foot Adjustments   0   0   0   0   0   96. 00   Nogative Cost Centers   0   0   0   0   0   97. 00   Nogative Cost Centers   0   0   0   0   98. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   Nogative Cost Centers   0   0   0   0   99. 00   09. 00   09. 00   0   0   0   99. 00   09. 00   09. 00   0   0   0   99. 00   09. 00   09. 00   0   0   0   99. 00   09. 00   09. 00   09. 00   99. 00   09. 00   09. 00   09. 00   99. 00   09. 00   09. 00   09. 00   99. 00   09. 00   09. 00   09. 00   99.			0	0	0			
50.00     5000     DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   50.00	48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	0	0	0	48. 00
51.00   05100  SUPPORT SURFACES   0   0   0   0   0   0   0   0   0			71, 653	0	_	ĭ		
OUTPATIENT SERVICE COST CENTERS   O			0	0		-		
60. 00	51.00		l ol	0	0	U	0	51.00
61. 00	60.00		O	0	0	ol	0	60.00
OTHER REIMBURSABLE COST CENTERS   OTO00   OTO		l l	o				-	
70.00	62.00							62. 00
71. 00	70.00					ما		
73.00   07300   CMHC   0   0   0   0   0   0   0   0   0			0				-	
SPECIAL PURPOSE COST CENTERS   S0.00				-	_			
80. 00	73.00		<u> </u>			<u> </u>		73.00
82. 00   08200   UTILIZATION REVIEW - SNF   0 0 0 0 0 0 0 83. 00   83. 00	80.00							80. 00
83. 00   8300   HOSPICE   SUBTOTALS (sum of lines 1-84)   7,890,804   300,525   110   632,784   7,890,804   89.00   NONREI MBURSABLE COST CENTERS   90.00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   0   91.00   92.00   PHYSICI ANS PRI VATE OFFICES   0   0   0   0   0   92.00   9300   NONPAID WORKERS   0   0   0   0   0   0   93.00   94.00   94.00   98.00   99.00   Nongali ve Cost Centers   0   0   0   0   0   99.00   99.00   Nongali ve Cost Centers   0   0   0   0   0   0   99.00   99.00   Nongali ve Cost Centers   0   0   0   0   0   0   99.00   99.00   Nongali ve Cost Centers   0   0   0   0   0   0   99.00   99.00   Nongali ve Cost Centers   0   0   0   0   0   0   0   0   0	81. 00							
89. 00   SUBTOTALS (sum of lines 1-84)   7,890,804   300,525   110   632,784   7,890,804   89. 00								
NONREIMBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0			7 000 004	-	_	(22.704		
90. 00	89.00		7, 890, 804	300, 525	110	632, 784	7, 890, 804	89.00
91. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   0   93. 00   94. 00   94. 00   98. 00   99. 00   Negative Cost Centers   0   0   0   0   0   99. 00   0   0   99. 00   0   0   0   0   0   0   0   0   0	90.00		O	0	0	ol	0	90.00
92. 00   09200   PHYSICIANS PRIVATE OFFICES   0   0   0   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   93. 00   94. 00   09400   PATIENTS LAUNDRY   0   0   0   0   0   94. 00   98. 00   099. 00   098. 00   0   0   0   0   0   99. 00   099. 00   0   0   0   0   99. 00   099. 00   0   0   0   99. 00   099. 00   0   0   0   99. 00   099. 00   0   0   99. 00   0   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0   99. 00   0   0   99. 00   0   0   99. 00   0   99. 00   0   0			o			-		
94. 00   09400   PATIENTS LAUNDRY   0   0   0   0   94. 00   98. 00   99. 00   Negative Cost Centers   0   0   0   0   99. 00   0   0   0   0   0   0   0   0   0			0	0	0	O		
98.00   Cross Foot Adjustments			0	0		o		
99.00   Negative Cost Centers   0   0   0   99.00			0	0		0	-	
		1	0	0		0	-	
.55.55    1.52   7,575,557  550,525  110  552,757  7,570,504 100.50			7 890 804	300 525		-		
	. 55. 50	1.500	.,0,0,004	300, 323	, , , ,	302, 704	., 3,0, 304	1.00.00

Provi der No.: 315384

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

				To	12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J4 piii
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS 5. 00	4.00	7. 00	0.00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 541, 619					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	113, 501	580, 957				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	8, 276	36, 722	79, 083			6. 00
7.00	00700 HOUSEKEEPI NG	81, 692	7, 734	1	425, 874		7. 00
8.00	00800 DI ETARY	184, 763	66, 454	1	52, 751	1, 064, 917	1
9.00	00900 NURSING ADMINISTRATION	82, 911	15, 239	1	12, 096	0	1
10. 00	01000 CENTRAL SERVICES & SUPPLY	28, 794	4, 669	0	3, 706	0	
11. 00	01100 PHARMACY	8, 662	0	0	0	0	
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	
13. 00	01300 SOCIAL SERVICE	19, 354	5, 815	0	4, 616	0	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	1
15. 00	01500 ACTIVITIES	74, 206	90, 372	0	71, 737	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	021 140	337, 510	79, 083	267, 916	1 044 017	30.00
30.00	03100 NURSING FACILITY	821, 169	337, 510		207, 910	1, 064, 917 0	1
32. 00	03200   CF/IID		0	0	0	0	1
33. 00	03300 OTHER LONG TERM CARE		0	0	0	0	
33.00	ANCILLARY SERVICE COST CENTERS	J		<u> </u>	<u> </u>	0	33.00
40. 00	04000 RADI OLOGY	624	0	0	0	0	40. 00
41. 00	04100 LABORATORY	3, 098	0		0	0	
42. 00	04200 I NTRAVENOUS THERAPY	3,070	0		0	0	1
43. 00	04300 OXYGEN (INHALATION) THERAPY		0		0	0	
44. 00	04400 PHYSI CAL THERAPY	41, 334	8, 221	l ő	6, 526	0	
45. 00	04500 OCCUPATI ONAL THERAPY	43, 965	8, 221	0	6, 526	0	
46. 00	04600 SPEECH PATHOLOGY	11, 872	0, == 1	o o	0	0	1
47. 00	04700 ELECTROCARDI OLOGY	O	0	0	0	0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	О	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	17, 398	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	o	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	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	
62. 00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS				ما		70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	1
71.00	07100 AMBULANCE	0	0		0	0	1
73. 00	07300 CMHC SPECI AL PURPOSE COST CENTERS	J U		ıj U	U	U	73. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100   INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	٥	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	1, 541, 619	580, 957	79, 083	425, 874	1, 064, 917	1
07.00	NONREI MBURSABLE COST CENTERS	1,011,017	000, 707	77,000	120, 07 1	1,001,717	07.00
90.00		0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	o	0	o	0	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0	o	0	0	
93. 00	09300 NONPALD WORKERS		0	o	o	0	
94.00	09400 PATIENTS LAUNDRY	0	0	o	o	0	1
98. 00	Cross Foot Adjustments	0	0	0	o	0	
99. 00	Negative Cost Centers	0	0	0	o	0	99. 00
100.00	TOTAL	1, 541, 619	580, 957	79, 083	425, 874	1, 064, 917	100.00

Provi der No.: 315384

				'	3 12/31/2022	5/30/2023 12:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
	JOENEDAL OFFICE OF CONT. OFFITTEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6. 00 7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	451, 718					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	431, 716	155, 756				10.00
11. 00	01100 PHARMACY		133, 730	44, 336			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0	44, 330 O	0		12. 00
	01300 SOCIAL SERVICE		0	0	0	109, 495	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		o	0	0	0	1
15. 00	01500 ACTIVITIES		Ö	0	0	1	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	٩	٥			<u> </u>	10.00
30.00	03000 SKILLED NURSING FACILITY	451, 718	155, 756	44, 336	0	109, 495	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	l	31. 00
32.00	03200   CF/IID	o	o	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	o	o	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41.00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES	l 0	0	0	0	0	51.00
60. 00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC	l ol	ol	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	o	0	0	1	61. 00
62. 00	06200 FQHC		Ĭ	O	Ü	Ĭ	62. 00
	OTHER REIMBURSABLE COST CENTERS		l			l .	
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	o	o	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 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	I I	0	0	0	0	1	
89. 00	SUBTOTALS (sum of lines 1-84)	451, 718	155, 756	44, 336	0	109, 495	89. 00
00.00	NONREI MBURSABLE COST CENTERS		٥				00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	· -	
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0		
92. 00 93. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	
93.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0	0	0	0	1
98. 00	Cross Foot Adjustments		0	U	U		98.00
98.00	Negative Cost Centers		0	^	0	0	1
100.00		451, 718	155, 756	44, 336	-		
100.00	/	751,710	155, 750	44, 330	O	107,473	1.00.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315384

					-	Γο 12/31/2022	Date/Time Pre 5/30/2023 12:	
				OTHER GENERAL			07 307 2023 12.	о <del>ч</del> рііі
				SERVI CE				
		Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
			ALLIED HEALTH EDUCATION			Adjustments		
			14.00	15. 00	16. 00	17. 00	18. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	1	ADMINISTRATIVE & GENERAL						4. 00
5. 00	1	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00		LAUNDRY & LINEN SERVICE						6. 00
7.00	1	HOUSEKEEPI NG						7.00
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY						10.00
11. 00		PHARMACY						11. 00
12.00	01200	MEDICAL RECORDS & LIBRARY						12.00
13. 00	1	SOCIAL SERVICE	_					13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0	E41 024				14. 00
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS	0	541, 934				15. 00
30. 00		SKILLED NURSING FACILITY	0	541, 934	7, 255, 83	6 0	7, 255, 836	30.00
31. 00		NURSING FACILITY	O	0		o o	0	31.00
32. 00		ICF/IID	0	0		0 0	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0		0	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	O	O	3, 19	3 0	3, 193	40. 00
41. 00	1	LABORATORY	0	0	· ·		15, 859	1
42. 00	1	INTRAVENOUS THERAPY	o	o			0	1
43.00		OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43. 00
44. 00		PHYSI CAL THERAPY	0	0	226, 31	1	226, 314	1
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	239, 78	1	239, 783	1
47. 00		ELECTROCARDI OLOGY	0	0	60, 76		60, 768 0	47.00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	ő	Ö		o o	0	48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0	0	89, 05 <sup>-</sup>	1 0	89, 051	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0	0	
51. 00		SUPPORT SURFACES	0	0		0	0	51. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	O	0		o lo	0	60.00
61. 00	1	RURAL HEALTH CLINIC	o	0			0	61.00
62.00	06200							62. 00
		REI MBURSABLE COST CENTERS		_		-1 -1		
70.00	1	HOME HEALTH AGENCY COST	0	0		0	0	
71. 00 73. 00	07100	AMBULANCE CMHC	0	0		0 0	0	
73.00		AL PURPOSE COST CENTERS	<u> </u>	U		9		73.00
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82.00	1	UTILIZATION REVIEW - SNF						82.00
83. 00 89. 00	08300	HOSPICE SUBTOTALS (sum of lines 1-84)	0	541, 934	7, 890, 80	0 4	0 7, 890, 804	•
07.00	NONRE	IMBURSABLE COST CENTERS	<u> </u>	341, 734	7, 070, 00	+  0	7, 070, 004	0 7. 00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91. 00		BARBER AND BEAUTY SHOP	0	0	(	0	0	
92.00		PHYSICIANS PRIVATE OFFICES	0	0	!	0	0	1
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0	0	'		0	
98. 00	07400	Cross Foot Adjustments		0			0	ł
99. 00		Negative Cost Centers	Ö	ő		o o	0	99. 00
100.00	)	TOTAL	o	541, 934	7, 890, 80	4 o	7, 890, 804	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

			To	12/31/2022	Date/Time Prep 5/30/2023 12:	pared:
		CAPI TAL REL	ATED COSTS		5/30/2023 12.	54 PIII
Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	Assigned New Capital	FI XTURES	EQUI PMENT		BENEFI TS	
	Related Costs					
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	3. 00	
1. 00 O0100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 00300 EMPLOYEE BENEFITS	0	5, 658	2	5, 660	5, 660	3. 00
4.00   00400 ADMINISTRATIVE & GENERAL 5.00   00500 PLANT OPERATION, MAINT. & REPAIRS	0	12, 274 8, 723	4	12, 278 8, 726	1, 004 120	4. 00 5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE		17, 311	6	17, 317	0	6. 00
7. 00   00700   HOUSEKEEPI NG	O	3, 646	1	3, 647	370	7. 00
8. 00   00800   DI ETARY	0	31, 327	11	31, 338	531	8. 00
9.00 O0900 NURSING ADMINISTRATION	0	7, 184	3	7, 187	377	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0	2, 201	1	2, 202	0	10.00
11. 00   01100   PHARMACY 12. 00   01200   MEDI CAL RECORDS & LI BRARY	0	0	0	U O	0	11. 00 12. 00
13. 00   01200   MEDICAL RECORDS & LIBRARY		2, 741	1	2, 742	94	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION		2, , 11	0	0	0	14. 00
15. 00 01500 ACTIVITIES	0	42, 602	16	42, 618	298	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 SKI LLED NURSI NG FACILITY	0	159, 108	60	159, 168	2, 402	30.00
31. 00   03100   NURSING FACILITY 32. 00   03200   CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00   03300 OTHER LONG TERM CARE		0	0	0	0	33. 00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		00.00
40. 00   04000   RADI OLOGY	0	0	0	0	0	40.00
41. 00   04100   LABORATORY	0	0	0	0	0	41. 00
42. 00 04200 INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00   04300   0XYGEN (I NHALATI ON) THERAPY 44. 00   04400   PHYSI CAL THERAPY		3, 875	1	3, 876	204	43. 00 44. 00
45. 00 04500 OCCUPATI ONAL THERAPY		3, 875	1	3, 876	217	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	0	0	43	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00   04900   DRUGS CHARGED TO PATIENTS 50.00   05000   DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	49. 00 50. 00
51. 00   05100   SUPPORT SURFACES		0	0	0	0	51. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	O <sub>1</sub>	<u> </u>	0	31.00
60. 00 06000 CLI NI C	0	0	0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00 06200 FOHC						62. 00
OTHER REIMBURSABLE COST CENTERS  70. 00 07000 HOME HEALTH AGENCY COST	O	ol	0	ol	0	70. 00
71. 00 07100 AMBULANCE		ő	Ö	Ö	0	71.00
73. 00 07300 CMHC	0	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   INTEREST EXPENSE 82.00   08200   UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00   08300   HOSPI CE	o	0	0	0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)		300, 525	110	300, 635	5, 660	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 93. 00   09300   NONPAID WORKERS	0	0	0	0	0	92. 00 93. 00
94. 00   09400   PATI ENTS LAUNDRY		0	0	0	0	94. 00
98.00 Cross Foot Adjustments		Ĭ		Ö		98. 00
99.00 Negative Cost Centers		O	0	o	0	99. 00
100. 00 TOTAL	0	300, 525	110	300, 635	5, 660	100. 00

Provider No.: 315384 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				T	o 12/31/2022	Date/Time Pre	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/30/2023 12: DI ETARY	34 pili
	p	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS 5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS	12 202					3. 00 4. 00
5. 00	OO4OO  ADMINISTRATIVE & GENERAL   OO5OO  PLANT OPERATION, MAINT. & REPAIRS	13, 282 978	9, 824				5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	71	621				6. 00
7.00	00700 HOUSEKEEPI NG	704	131				7. 00
8.00	00800 DI ETARY	1, 592	1, 124	1	601	35, 186	8. 00
9.00	00900 NURSING ADMINISTRATION	714	258		138	0	9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	248 75	79 0		42	0	10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	75	0		0	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	167	98	_		0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			0	14.00
15. 00	01500 ACTI VI TI ES	639	1, 528	0	817	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	7, 075	5, 707		· ·	35, 186	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200   CF/IID	0	0			0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0			0	33. 00
	ANCILLARY SERVICE COST CENTERS	-1	-				
40.00	04000 RADI OLOGY	5	0	0	0	0	40. 00
41. 00	04100 LABORATORY	27	0	_	· ·	0	41. 00
42.00	04200   NTRAVENOUS THERAPY	0	0	_	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	356	0 139		74	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	379	139			0	45. 00
46. 00	04600 SPEECH PATHOLOGY	102	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	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	150	0	0	· · · · · · · · · · · · · · · · · · ·	0	49. 00
50. 00 51. 00	O5000   DENTAL CARE - TITLE XIX ONLY   O5100   SUPPORT SURFACES	0	0	0	· ·	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>		31.00
60.00	06000 CLINI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS				٥	0	70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			0	70. 00 71. 00
73.00	07300 CMHC	0	0			0	73.00
	SPECIAL PURPOSE COST CENTERS	-1	-	_	-1		
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
	08100   I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF		0			0	82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	13, 282	9, 824			0 35, 186	
07.00	NONREI MBURSABLE COST CENTERS	13, 282	9, 624	10,009	4, 052	30, 180	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0			0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	· ·	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	· ·	0	93.00
94. 00 98. 00	09400 PATIENTS LAUNDRY	0	0	0	_	0	94. 00 98. 00
98.00	Cross Foot Adjustments Negative Cost Centers		0	0	· ·	0	98.00
100.00		13, 282	9, 824		· ·		100.00

Provi der No.: 315384

				10	) 12/31/2022	5/30/2023 12:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	<u> у р</u>
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11.00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & 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 NURSING ADMINISTRATION	8, 674					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	2, 571				10.00
11.00	01100 PHARMACY	0	0	75			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	o	0	o	o		12.00
13.00	01300 SOCIAL SERVICE	o	0	0	0	3, 154	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	o	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		,				
30.00	03000 SKILLED NURSING FACILITY	8, 674	2, 571	75	0	3, 154	30.00
31.00	03100 NURSING FACILITY	o	0	0	0	0	31.00
32.00	03200   CF/IID	o	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	o	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
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	o	0	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	О	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	o	0	О	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	o	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	o	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	0	O	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	0	70.00
71.00	07100 AMBULANCE	0	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	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	8, 674	2, 571	75	0	3, 154	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	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98. 00	Cross Foot Adjustments	0	0	0			98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	8, 674	2, 571	75	0	3, 154	100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315384

						To 12/31/2022	Date/Time Pre 5/30/2023 12:	
				OTHER GENERAL			3/30/2023 12.	J4 piii
				SERVI CE				
		Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
			ALLI ED HEALTH EDUCATI ON			Adjustments		
			14. 00	15. 00	16. 00	17. 00	18. 00	
	GENER.	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	1	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL						3. 00 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		DI ETARY						8. 00
9. 00 10. 00		NURSI NG ADMINISTRATION CENTRAL SERVICES & SUPPLY						9. 00 10. 00
11. 00		PHARMACY						11. 00
12. 00		MEDICAL RECORDS & LIBRARY						12. 00
13.00	01300	SOCIAL SERVICE						13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTIVITIES	0	45, 900				15. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	0	45, 900	290, 97	4 0	290, 974	30. 00
31. 00		NURSING FACILITY	0	43, 700	1	0 0	270, 774	31. 00
32. 00		ICF/IID	0	0		o o	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0		0 0	0	33. 00
10.00		LARY SERVICE COST CENTERS	1		ı	-l ol		40.00
40. 00 41. 00	1	RADI OLOGY LABORATORY	0	0	•	5 O	5 27	40. 00 41. 00
42. 00	1	INTRAVENOUS THERAPY	0	0	1	0	0	
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	1	o o	0	43. 00
44. 00		PHYSI CAL THERAPY	0	0	4, 64	9 0	4, 649	
45. 00		OCCUPATIONAL THERAPY	0	0	4, 68		4, 685	
46. 00 47. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	14	0 0	145 0	46. 00 47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		0	48.00
49. 00	1	DRUGS CHARGED TO PATIENTS	0	Ö			150	
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50. 00
51.00		SUPPORT SURFACES	0	0		0 0	0	51. 00
40.00		TIENT SERVICE COST CENTERS  CLINIC	0	0			0	40.00
60. 00 61. 00		RURAL HEALTH CLINIC	0	0		0 0	0	60. 00 61. 00
62. 00	06200			J			ŭ	62. 00
		REIMBURSABLE COST CENTERS						
70. 00	1	HOME HEALTH AGENCY COST	0	0	•	0 0	0	
71.00		AMBULANCE	0	0		0 0	0	
73. 00	07300 SPECI	AL PURPOSE COST CENTERS	0	U		<u>U</u>	0	73. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF	_	_			_	82. 00
83.00	08300	HOSPICE	0	0 4F 000		0 5 0	300 (35	
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	0	45, 900	300, 63	<u>ગ</u> ળ	300, 635	89. 00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		o o	0	90. 00
91.00	09100	BARBER AND BEAUTY SHOP	0	0		o o	0	91. 00
92. 00	1	PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
93.00		NONPALD WORKERS	0	0		0	0	93. 00
94. 00 98. 00	09400	PATIENTS LAUNDRY Cross Foot Adjustments	0	0			0	94. 00 98. 00
99. 00		Negative Cost Centers		0		ŏ ol	0	99. 00
100.00	)	TOTAL	0	45, 900	300, 63	5 0	300, 635	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Cost Center Description						o 12/31/2022	Date/Time Pre 5/30/2023 12:	
TEXTURES   CONTENT   CON			CAPITAL REI	LATED COSTS			37 307 2023 12.	<del>у рііі</del>
SHEWLY SHAVE COST CHITES		Cost Center Description	FIXTURES	EQUI PMENT	BENEFITS (GROSS	Reconciliation	& GENERAL	
0.00   0.00   CAP REL COSTS - BLOSS & FIXTURES   22,256   22,256   22,256   22,256   22,256   22,256   22,256   22,256   22,256   23,300   20,300			1. 00	2.00		4A	4. 00	
2.00			20.05/	T	T	T	Г	
3.00   0.0000 EMPLOYER BENEFITS   4.19			22, 256	l .				1
0.00500   PLANT OPERATION, MAINT: & REPAIRS			419					
6.00 O OCODO (LAUNDRY & LINEN SERVICE         1,282 1,282 0         0         34,685 6         0           7.00 O OTODO (DUSEKEPING)         270 270 220 241,253 0         336,448 7 0         0         760,949 8         0           8.00 O 0900 (DIETARY)         2,320 2,320 374,541 0         0         0,541,772 9         0           10.00 O 1000 (SENIRAL SERVICES & SUPPLY)         163 163 0         0         0         118,587 10 10           11.00 O 1000 (SENIRAL SERVICES & SUPPLY)         163 163 0         0         0         33,74 11 00           13.00 O 1000 (SENIRAL SERVICES & SUPPLY)         163 163 0         0         0         118,587 10 10           13.00 O 1000 (SENIRAL SERVICES & SUPPLY)         163 163 0         0         0         77,710 13 00           13.00 O 1300 SCI AL SERVICE         203 203 0         6,437 0         79,710 13 00           15.00 D 1900 ACTIVITIES         3,155 3,155 210,172 0         305,619 15 00           15.00 D 1900 ACTIVITIES         3,155 3,155 210,172 0         30,5619 15 00           20.00 0300 SKILLED MURSING FACILITY         1,783 11,893 11,694,352 0         3,382,002 30         30           20.00 0300 SKILLED MURSING FACILITY         1,80 0 0         0         0         3,250 00         30         32           20.00 0300 SKILLED MURSING FACI			1					1
0.000   0.00								1
8.00   0.0800   DIETARY   2, 320   2, 320   374, 541   0   760, 949   8.00   10.00   0.0800   UNISNIN SIMBATION   5.35   5.32   256, 560   0   341, 472   9.00   10.0								
10.00   01000   CENTRAL SERVICES & SUPPLY			1					
11.00   01100   PHARMACY   0   0   0   0   0   35,674   11.00								1
12.00   01200   MEDICAL RECORDS & LIBRARY   0   0   0   0   0   0   12.00			1		1	_		
13.00   01300   SOCIAL SERVICE   203   203   66, 437   0   79, 710   13.00				1		0	l	1
15. 00		01300 SOCIAL SERVICE	203	203	66, 437	0	79, 710	
INPATI ENT ROUTINE SERVICE COST CENTERS			0	0	210 173	_	0	
30.00   30000   SKILLED NURSING FACILITY	15.00		3, 155	3, 155	210, 172	0	305, 619	] 15.00
32.00   03200   CF/I I D	30. 00		11, 783	11, 783	1, 694, 352	0	3, 382, 002	30. 00
33.00   OTHER LONG TERNI CARE   0   0   0   0   0   3.00		· ·	1	_	•			
MOCILLARY SERVICE COST CENTERS		· ·						
40. 00   04000   RADIOLOGY	33.00			0	1	0	<u> </u>	33.00
42 00   04200   INTRAVENOUS THERAPY	40.00		0	0	C	0	2, 569	40. 00
43.00   04300   04500   0.0			0	0		_		1
A4 00   04400   PHYSI CAL THERAPY   287   287   143,596   0   170,233   44.00		1	0	0		_		1
46.00   04600   SPEECH PATHOLOGY   0   0   0   30,648   0   48,896   46.00   47.00   48.00   48.00   49.00			287	_	1	_		1
47.00			287					1
48. 00 04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   48. 00   49. 00 04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   71,653   49. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   60. 00 05000   DRABER AND BEAUTY SERVENS   0   0   0   0   0   60. 00 05000   DANAPAL DRABER AND BEAUTY SHOP   0   0   0   0   0   60. 00 05000   DANAPAL DRABER AND BEAUTY SHOP   0   0   0   0   0   60. 00 05000   DANAPAL DRABER AND BEAUTY SHOP   0   0   0   0   0   60. 00 05000   DANAPAL DRABER AND BEAUTY SHOP   0   0   0   0   0   60. 00 05000   DANAPAL DRABER AND BEAUTY SHOP   0   0   0   0   0			0	0				1
49.00   04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00				0		_	1	1
51.00			0	Ö	d	0		1
OUTPATI ENT SERVICE COST CENTERS			0	0		_		1
60.00	51. 00		0	0	<u> </u>	0	0	51.00
62. 00	60. 00		0	0	C	0	0	60.00
OTHER REIMBURSABLE COST CENTERS   O			0	0	C	0	0	
70. 00	62. 00							62. 00
71. 00   07100   AMBULANCE   0   0   0   0   0   0   71. 00   73. 00   07300   CMHC   0   0   0   0   0   0   0    SPECIAL PURPOSE COST CENTERS  80. 00   08100   INTEREST EXPENSE   81. 00   82. 00   08200   UTILIZATION REVIEW - SNF   82. 00   83. 00   08300   HOSPI CE   0   0   0   0   0   0   89. 00   NONREI MBURSABLE COST CENTERS   89. 00    NONREI MBURSABLE COST CENTERS   89. 00   90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   91. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0   93. 00   09300   NONPAID WORKERS   0   0   0   0   0   94. 00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   95. 00   Negative Cost Centers   99. 00   102. 00   Cost to be allocated (per Wkst. B, Part I)   13. 503100   0. 004942   0. 158509   0. 242806   103. 00   104. 00   Unit cost multiplier (Wkst. B, Part II)   105. 00   Unit cost multiplier (Wkst. B, Part II)   0. 001418   0. 002092   105. 00    105. 00   Unit cost multiplier (Wkst. B, Part II)   105. 00   Unit cost multiplier (Wkst. B, Part II)   0. 001418   0. 002092   105. 00    105. 00   Unit cost multiplier (Wkst. B, Part II)   105. 00   Unit cost multiplier (Wkst. B, Part II)   0. 001418   0. 002092   105. 00    106. 00   071. 00   0   0   0   0   0   0   0   0    107. 00   071. 00   0   0   0   0   0   0   0    108. 00   072. 00   0   0   0   0   0   0   0    109. 00   09000	70. 00		0	0		0	0	70.00
SPECIAL PURPOSE COST CENTERS   80.00   80000   MALPRACTI CE PREMI UMS & PAI D LOSSES   81.00   82.00   82.00   82.00   82.00   82.00   82.00   82.00   82.00   82.00   82.00   82.00   82.00   83.00			0		•		l .	
80. 00	73. 00		0	0	C	0	0	73. 00
81.00	80 00		1		I			80 00
83. 00   08300   HOSPICE   0   0   0   0   0   0   83. 00   89. 00     SUBTOTALS (sum of lines 1-84)   22,256   22,256   3,992,100   -1,541,619   6,349,185   89. 00     NONREI MBURSABLE COST CENTERS		1						1
89. 00   SUBTOTALS (sum of lines 1-84)   22,256   22,256   3,992,100   -1,541,619   6,349,185   89.00		· ·						1
NONREI MBURSABLE COST CENTERS   NONREI MBURSABLE COST CENTER			0					
90. 00	89.00		22, 250	22, 250	3, 992, 100	-1, 541, 619	0, 349, 185	89.00
92. 00	90.00		0	0	C	0	0	90. 00
93. 00			0	-				
94. 00			0	_	1	_		
99.00   Negative Cost Centers   99.00   102.00   Cost to be allocated (per Wkst. B, Part I)   13.503100   104.00   Cost to be allocated (per Wkst. B, Part II)   13.503100   105.00   Unit cost multiplier (Wkst. B, Part II)   0.002092   105.00   105.0			0	Ö		_		
102.00   Cost to be allocated (per Wkst. B, Part I)   103.00   Unit cost multiplier (Wkst. B, Part I)   13.503100   Cost to be allocated (per Wkst. B, Part II)   13.503100   Cost to be allocated (per Wkst. B, Part II)   105.00   Unit cost multiplier (Wkst. B, Part II)   Unit cost multiplier (Wkst. B, Part II)   0.002092   105.00   104.00   105								
Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part III) 105.00 Unit cost multiplier (Wkst. B, Part IIII) 105.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			200 525	110	(22.704		1 541 /10	
103.00     Unit cost multiplier (Wkst. B, Part I)     13.503100     0.004942     0.158509     0.242806     103.00       104.00     Cost to be allocated (per Wkst. B, Part II)     5,660     13,282     104.00       105.00     Unit cost multiplier (Wkst. B, Part     0.001418     0.002092     105.00	102.00		300, 525	110	032, /84		1, 541, 619	102.00
Part II)     105.00     Unit cost multiplier (Wkst. B, Part	103.00	Unit cost multiplier (Wkst. B, Part I)	13. 503100	0. 004942	0. 158509			
105.00 Unit cost multiplier (Wkst. B, Part 0.001418 0.002092 105.00	104.00				5, 660		13, 282	104. 00
	105 00				0 001418		0 002092	105, 00

Provi der No.: 315384

				Т	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	O I PIII
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(PATIENT DAYS)			(PATIENT DAYS)	
		REPAIRS (SQUARE FEET)				(PATTENT DAYS)	
		5. 00	6. 00	7.00	8. 00	9. 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	OO4OO   ADMINISTRATIVE & GENERAL   OO5OO   PLANT OPERATION, MAINT. & REPAIRS	20, 282					4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 282	l e				6.00
7. 00	00700 HOUSEKEEPING	270		18, 730			7.00
8. 00	00800 DI ETARY	2, 320		2, 320			8. 00
9.00	00900 NURSING ADMINISTRATION	532	0	532	0	29, 842	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	163	0	163	0	0	10.00
11. 00	01100 PHARMACY	0	0	C	0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	12.00
13. 00 14. 00	01300   SOCIAL SERVICE   01400   NURSING AND ALLIED HEALTH EDUCATION	203	•	203	0	0	13. 00 14. 00
15. 00	01500 ACTIVITIES	3, 155	1	3, 155	0	0	15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 133		3, 133	1		13.00
30.00	03000 SKILLED NURSING FACILITY	11, 783	29, 842	11, 783	89, 526	29, 842	30.00
31. 00	03100 NURSING FACILITY	0	0	· c	0	0	31.00
32. 00	03200   CF/IID	0	0	C	0	"	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	<u>C</u>	0	0	33. 00
40.00	ANCILLARY SERVICE COST CENTERS						40.00
40. 00	04000 RADI OLOGY	0		C		0 1 0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	1		-		41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0		0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	287	Ö	287	0	Ö	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	287	0	287	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	C	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	O C	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00 50. 00	04900   DRUGS CHARGED TO PATIENTS   05000   DENTAL CARE - TITLE XIX ONLY		0		0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		1		0		51.00
01.00	OUTPATIENT SERVICE COST CENTERS						01.00
60.00	06000 CLI NI C	0	0	C		0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	o c	0	0	61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	•				70. 00 71. 00
71.00	07300 CMHC	0		C		0	73.00
73.00	SPECIAL PURPOSE COST CENTERS				,		73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	20, 282	29, 842	18, 730	89, 526	29, 842	89. 00
00.00	NONREI MBURSABLE COST CENTERS		1 0	J	0	0	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0		O	0	l	90. 00 91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0		0	0	92.00
93. 00	09300 NONPALD WORKERS		0	Ö	Ö	Ö	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	C	0	0	94.00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00		580, 957	79, 083	425, 874	1, 064, 917	451, 718	102. 00
102.00	Part I)	20 442070	2 450057	22 727522	11 005050	15 124000	102 00
103.00 104.00		28. 643970 9, 824	1	1		l e	103.00
104.00	Part II)	7, 024	10,009	4, 002	. 35, 160	0,074	104.00
105.00		0. 484370	0. 603478	0. 259050	0. 393025	0. 290664	105. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315384

Peri od: Worksheet B-1 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/30/2023 12:34 pm Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & ALLI ED HEALTH SERVICES & (PATIENT DAYS) **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (ASSI GNED (PATLENT DAYS) (PATLENT DAYS) TIME) 12.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 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 10.00 01000 CENTRAL SERVICES & SUPPLY 29,842 10.00 11.00 01100 PHARMACY 29, 842 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 29,842 12.00 01300 SOCIAL SERVICE 0 29, 842 13 00 13 00 C C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 29,842 29,842 29, 842 29,842 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 0 41.00 04100 LABORATORY 0000000000 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 43.00 04400 PHYSI CAL THERAPY 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 r 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 61.00 0 Ω 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 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 Λ 83.00 89.00 SUBTOTALS (sum of lines 1-84) 29,842 29,842 29,842 29,842 0 89.00 NONREI MBURSABLE COST CENTERS 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP C 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 0 93.00 09300 NONPALD WORKERS 0 0 93.00 0 94 00 09400 PATIENTS LAUNDRY 0 O ol 94 00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 109, 495 0 102.00 102.00 155, 756 44, 336 0 Part I) 0.000000 0.000000 103.00 103 00 Unit cost multiplier (Wkst. B, Part I) 3.669158 5 219355 1. 485691 104.00 Cost to be allocated (per Wkst. B, 0 104.00 2,571 3, 154 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.086154 0.002513 0.000000 0.105690 11)

ROSE MOUNTAIN CARE CTR In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315384

				10 12/31/2022 Date/Time Pre   5/30/2023 12:	
			OTHER GENERAL	0,00,202	J
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
			(PATIENT DAYS)		
			15. 00		
		AL SERVICE COST CENTERS			
1. 00	1	CAP REL COSTS - BLDGS & FIXTURES			1. 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	1	EMPLOYEE BENEFITS			3. 00
4.00	1	ADMINISTRATIVE & GENERAL			4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	1	LAUNDRY & LINEN SERVICE			6.00
7.00	1	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		PHARMACY			11.00
12. 00	1	MEDICAL RECORDS & LIBRARY			12. 00
13. 00	1	SOCIAL SERVICE			13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION			14. 00
15.00	1	ACTI VI TI ES	29, 842		15. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS			
30.00	03000	SKILLED NURSING FACILITY	29, 842		30. 00
31.00	03100	NURSING FACILITY	0		31. 00
32.00	03200	I CF/I I D	0		32. 00
33.00		OTHER LONG TERM CARE	0		33. 00
		LARY SERVICE COST CENTERS			
40. 00	1	RADI OLOGY	0		40. 00
41. 00		LABORATORY	0		41. 00
42.00	1	I NTRAVENOUS 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 47. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0		46. 00 47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48.00
49. 00		DRUGS CHARGED TO PATIENTS	0		49. 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	CLINIC	0		60.00
61.00	06100	RURAL HEALTH CLINIC	0		61. 00
62.00	06200	FQHC			62. 00
		REIMBURSABLE COST CENTERS			
70. 00		HOME HEALTH AGENCY COST	0		70. 00
71. 00		AMBULANCE	0		71. 00
73. 00	07300		0		73. 00
80. 00		AL PURPOSE COST CENTERS			80. 00
	1	MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE			81.00
		UTILIZATION REVIEW - SNF			82.00
83. 00		HOSPICE	0		83.00
89. 00	00300	SUBTOTALS (sum of lines 1-84)	29, 842		89. 00
07.00	NONRE	IMBURSABLE COST CENTERS	27,042		07.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00		BARBER AND BEAUTY SHOP	o		91.00
92. 00		PHYSICIANS PRIVATE OFFICES	Ö		92.00
93.00		NONPALD WORKERS	О		93. 00
94.00		PATIENTS LAUNDRY	0		94. 00
98. 00		Cross Foot Adjustments			98. 00
99. 00		Negative Cost Centers			99. 00
102.00	P	Cost to be allocated (per Wkst. B,	541, 934		102. 00
400 5		Part I)	40 4/044		400 00
103.00		Unit cost multiplier (Wkst. B, Part I)	18. 160110		103. 00
104.00	ן	Cost to be allocated (per Wkst. B,	45, 900		104. 00
105. 00		Part II) Unit cost multiplier (Wkst. B, Part	1. 538101		105. 00
100.00	1		1. 536101		100.00
	1	1	ı I		ı

Heal th Finar	ncial Systems				ROSE	MOUNTAIN (	CAR	RE CTR		In Lie	u of Form CMS-2540-10
RATIO OF CO	ST TO CHARGES	FOR ANCI	LLARY AN	ID OUTPATIENT	COST	CENTERS		Provider No.: 3	15384		Worksheet C
										From 01/01/2022 To 12/31/2022	Date/Time Prenared

			o 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	Total (from	Total Charges	Ratio (col. 1	
		Wkst. B, Pt I,		di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS				
	04000 RADI OLOGY	3, 193	·		•
41. 00	04100 LABORATORY	15, 859	12, 761	1. 242771	41. 00
42.00	04200 I NTRAVENOUS THERAPY		0	0. 000000	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY		0	0.000000	43. 00
44.00	04400 PHYSI CAL THERAPY	226, 314	143, 596	1. 576047	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	239, 783	232, 561	1. 031054	45. 00
46.00	04600 SPEECH PATHOLOGY	60, 768	44, 038	1. 379899	46. 00
47.00	04700 ELECTROCARDI OLOGY		0	0.000000	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0.000000	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	89, 051	71, 653	1. 242809	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		0	0.000000	50.00
51.00	05100 SUPPORT SURFACES	(	0	0.000000	51. 00
	OUTPATIENT SERVICE COST CENTERS				
60.00	06000 CLI NI C		0	0.000000	60.00
61.00	06100 RURAL HEALTH CLINIC				61. 00
62.00	06200 FQHC				62. 00
71.00	07100 AMBULANCE		0	0. 000000	71. 00
100.00	Total	634, 968	507, 178		100. 00

Health Financial Systems	ROSE MOUNTAI	N CARE CTR		In Lieu of Form CMS-2540-10			
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315384	Peri od:	Worksheet D		
				From 01/01/2022			
				To 12/31/2022	Date/Time Pre 5/30/2023 12:		
		Title	XVIII (1)	Skilled Nursing		от рііі	
				Facility			
		Health Care Pr	rogram Charge	s Health Care	Program Cost		
	Ratio of Cost	Part A	Part B	,	Part B (col. 1		
	to Charges			x col. 2)	x col. 3)		
	(Fr. Wkst. C						
	1.00	2.00	3.00	4. 00	5. 00		
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	3.00		
ANCI LLARY SERVI CE COST CENTERS						1	
40. 00 04000 RADI OLOGY	1. 242896	0		0 0	0	40.00	
41. 00   04100   LABORATORY	1. 242771	0		0 0	0	41.00	
42.00 04200 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	42.00	
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.00	
44. 00   04400 PHYSI CAL THERAPY	1. 576047	76, 868		0 121, 148	0	44. 00	
45. 00   04500 OCCUPATI ONAL THERAPY	1. 031054	103, 798		0 107, 021	0	45. 00	
46. 00 04600 SPEECH PATHOLOGY	1. 379899			0 57, 643	0		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0		
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l .		0	0		
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 242809	l		0	0	1	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	l		0		50.00	
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00	
OUTPATIENT SERVICE COST CENTERS	0.000000		1	0			
60. 00   06000   CLI NI C	0. 000000	0		0 0	0	00.00	
61. 00   06100   RURAL HEALTH CLINIC 62. 00   06200   FOHC						61. 00 62. 00	
62. 00   06200   FQHC 71. 00   07100   AMBULANCE (2)	0. 000000				0		
100.00 Total (Sum of Lines 40 - 71)	0.000000	222, 439		0 285, 812		100.00	
100.00    10tal (3uii 01 111ies 40 - 71)	1	222, 437	I	0 200,012	,	1100.00	

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

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

Heal th	Financial Systems	ROSE MOUNTAI	N CARE CTR		In Lie	eu of Form CMS-2	2540-10			
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315384	Period: From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 12:3				
			Ti tl	e XVIII	Skilled Nursing Facility	PPS				
	Cost Center Description									
	PART II - APPORTIONMENT OF VACCINE COST					1. 00				
1.00	Drugs charged to patients - ratio of co	, line 49)	1. 242809	1.00						
2.00	Program vaccine charges (From your reco				,	7, 050	2. 00			
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	8, 762	3. 00			
	E, Part I, line 18)									
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A					
		(From Wkst. B,			Cost (From	& Allied				
			(From Wkst. B,			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									
40.00	04000 RADI OLOGY	3, 193		0.0000		0	40. 00			
41.00	04100 LABORATORY	15, 859	0	0.00000		0	41. 00			
42.00	04200 I NTRAVENOUS THERAPY	0	0	0.0000		0	42. 00			
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.0000		0	43. 00			
44. 00	04400 PHYSI CAL THERAPY	226, 314	0	0.0000		1	44. 00			
45. 00	04500 OCCUPATI ONAL THERAPY	239, 783		0.00000	· ·	0	45. 00			
46. 00	04600 SPEECH PATHOLOGY	60, 768	0	0.00000		1	46. 00 47. 00			
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000		0	47.00			
49. 00	04900 DRUGS CHARGED TO PATTENTS	89, 051	0	0.0000			49.00			
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0 <del>7</del> , 031	0	0.0000		0	50.00			
	05100 SUPPORT SURFACES	0		0.00000		0				
100.00		634, 968	Ö	•	285, 812		100. 00			
	, , , , , , , , , , , , , , , , , , ,	•	•	•			•			

<u> </u>	MOUNTAIN CAR	E CTR	In Lie	u of Form CMS-2	2540-
MPUTATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315384	Peri od:	Worksheet D-1 Parts I-II	
From 01/01/2022   Parts   To 12/31/2022   Date/					pare
			12, 01, 2022	5/30/2023 12:	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS					
I NPATI ENT DAYS					
On Inpatient days including private room days				29, 842	
OO Private room days				0	l
Inpatient days including private room days applicabl Medically necessary private room days applicable to		gram		2, 405 0	
Total general inpatient routine service cost	the Program			7, 255, 836	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				7, 255, 650	3.
OO General inpatient routine service charges				8, 211, 015	6.
General inpatient routine service cost/charge ratio	(Line 5 div	ided by line 6)		0. 883671	
OD Enter private room charges from your records				0	8
OO Average private room per diem charge (Private room c	charges line	8 divided by private	room days, line	0.00	9
					100
00   Enter semi-private room charges from your records 00   Average semi-private room per diem charge (Semi-private room charges line 10, divided by					10
00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)				0. 00	' '
00 Average per diem private room charge differential (L	ine 9 minus	line 11)		0.00	12
00 Average per diem private room cost differential (Lin				0.00	
00 Private room cost differential adjustment (Line 2 ti	mes line 13)	•		0	14
00 General inpatient routine service cost net of privat	e room cost	differential (Line 5	minus line 14)	7, 255, 836	15
PROGRAM INPATIENT ROUTINE SERVICE COSTS					
OO Adjusted general inpatient service cost per diem (Li		ed by line 1)		243. 14	
OO Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to		no 4 timos lino 12)		584, 752 0	
00 Total program general inpatient routine service cost				584. 752	
OD Capital related cost allocated to inpatient routine	, ,	,	t II column 18	290, 974	
line 30 for SNF; line 31 for NF, or line 32 for ICF/		_ (		,	
00 Per diem capital related costs (Line 20 divided by				9. 75	21
00 Program capital related cost (Line 3 times line 21)				23, 449	
00 Inpatient routine service cost (Line 19 minus line				561, 303	
OO Aggregate charges to beneficiaries for excess costs			1: 24)	0	
00   Total program routine service costs for comparison t 00   Enter the per diem limitation (1)	to the cost I	imitation (Line 23 mi	nus IIne 24)	561, 303	25 26
00 Inpatient routine service cost limitation (Line 3 ti	mes the ner	diem limitation line	26) (1)		27
00 Reimbursable inpatient routine service costs (Line 2					28
(Transfer to Worksheet E, Part II, line 4) (See inst					-0
Lines 26 and 27 are not applicable for title XVIII, but	,	l for title V and or t	itle XIX		

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	29, 842	1.00
2.00	Program inpatient days (see instructions)	2, 405	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. 080591	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems ROSE MOUNTAIN CA ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315384	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2023 12:3	pare
		Title XIX	Skilled Nursing Facility	Cost	
			raciiity		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
0	Inpatient days including private room days			29, 842	1
0	Private room days			0	2
0	Inpatient days including private room days applicable to the Pr			24, 841	3
0	Medically necessary private room days applicable to the Program	1		0	4
0	Total general inpatient routine service cost			7, 255, 836	5
^	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			0 011 015	1 6
0 0	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 di	vided by Line 4)		8, 211, 015 0. 883671	7
0	Enter private room charges from your records	vided by Title 6)		0. 863671	
0	Average private room per diem charge (Private room charges line	8 divided by private	room days line	0. 00	
U	2)	o divided by private	Toom days, Time	0.00	'
00	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private room c	harges line 10, divide	d by	0.00	11
	semi -pri vate room days)	3	,		
00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12
00	Average per diem private room cost differential (Line 7 times I	ine 12)		0.00	13
00	Private room cost differential adjustment (Line 2 times line 13			0	14
00	General inpatient routine service cost net of private room cost	differential (Line 5	minus line 14)	7, 255, 836	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				١
00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		243. 14	
00	Program routine service cost (Line 3 times line 16)			6, 039, 841	
00	Medically necessary private room cost applicable to program (I			0 0 0 0 0 1	18
00	Total program general inpatient routine service cost (Line 17 Capital related cost allocated to inpatient routine service cos		t II column 10	6, 039, 841 290, 974	
UU	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	Sts (110111 WKSt. B, Fal	t II Corullii 16,	270, 774	20
00	Per diem capital related costs (Line 20 divided by line 1)			9. 75	21
00	Program capital related cost (Line 3 times line 21)			242, 200	
00	Inpatient routine service cost (Line 19 minus line 22)			5, 797, 641	
00	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		0	24
00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	5, 797, 641	25
00	Enter the per diem limitation (1)			0.00	26
00	Inpatient routine service cost limitation (Line 3 times the per			0	
00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	elesser of line 25 or	line 27)	6, 039, 841	28
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. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH			
0	Total SNF inpatient days			29, 842	
	Drogram inputiont days (see instructions)			24 041	l م

24, 841

2. 00 3. 00 4. 00

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

2.00

4.00 5.00

Health Financial Systems	ROSE MOUNTAIN CA	RE CTR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	FOR TITLE XVIII	Provi der No.: 315384	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 12:34 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			_	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMENT		1.00	
1. 00	Inpatient PPS amount (See Instructions)	LIVILIAI		1, 614, 603	1. 00
2. 00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	ymerres)		1, 614, 603	3. 00
4. 00	Primary payor amounts			0	4. 00
5. 00	Coinsurance			294, 668	5. 00
6. 00	Allowable bad debts (From your records)			241, 801	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		1, 167	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)			157, 171	8. 00
9. 00	Recovery of bad debts - for statistical records only			0	9. 00
10. 00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			1, 477, 106	11. 00
12. 00	Interim payments (See instructions)			1, 495, 542	12. 00
13. 00	Tentati ve adjustment			0	13. 00
14. 00	OTHER adjustment (See instructions)			o	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			o	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 980	14. 75
14. 99	Sequestration amount (see instructions)			15, 969	14. 99
15.00	Balance due provider/program (see Instructions)		-36, 385	15.00	
16.00	0.00 Protested amounts (Nonal Lowable cost report items in accordance with CMS Pub. 15-2, section 115.2)				16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (	OF COST OR CHARGES - T	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17.00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			8, 762	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			8, 762	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			7, 050	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			7, 050	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			7, 050	
26. 00	Interim payments (See instructions)			6, 218	26. 00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			89	28. 99
29. 00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	a with CMS Dub 1E 3	costion 11E 2	743 0	
30.00	Triotested amounts (Nonarrowable cost report items) in accordance	e with two rub. 10-2, S	SECTION 113. Z	υĮ	30.00

Health Financial Systems	ROSE MOUNTAIN CAF	RE CTR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315384	From 01/01/2022	Worksheet E Part II Date/Time Prepared: 5/30/2023 12:34 pm
		Title XIX	Skilled Nursing	Cost

		litte xix	Facility	COST	
			1 40		
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	1. 00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	3. 00
4.00	Inpatient routine services (see instructions)			6, 039, 841	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			6, 039, 841	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)			6, 039, 841	8. 00
9.00	Primary payor amounts			0	
10.00	Total Reasonable Cost (Line 8 minus line 9)			6, 039, 841	10. 00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges				11. 00
12. 00	Outpatient service charges			0	12.00
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa				16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services o	on a charge basis	0	17. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	40.00
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	
19. 00	Total customary charges (see instructions)			0	19. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				20.00
20. 00	Cost of covered services (see Instructions)			0	
21. 00	Deductibles			0	
22. 00 23. 00	Subtotal (Line 20 minus line 21)			0	22. 00 23. 00
	Coinsurance			-	
24. 00	Subtotal (Line 22 minus line 23) Allowable bad debts (from your records)			0	
25. 00 26. 00	Subtotal (sum of lines 24 and 25)			0	
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	v callested based on a	correction of	0	
27.00	cost limit	y corrected based on c	LOTT ECTION OF	٥	27.00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	nrogram	0	28. 00
20.00	lutilization	tron or a decrease in	pi ogi alli	٥	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	reciable assets (	0	
00.00	if minus, enter amount in parentheses)	o a. opoo. t. o o. aop.	00. 40. 0 400010 (	١	00.00
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	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	theses) (see	0	33. 00
	Instructions)	. 3	´ `		
			·	·	

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

Date/Time Prepared: 5/30/2023 12:34 pm Title XVIII Skilled Nursing PPS

		11 (1	e Aviii	Facility	FFS	
		Inpatien	t Part A		t B	
		/ 1 1 /		/ 1 1 /		
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	1, 303, 966	3.00	6, 218	1. 00
2.00	Interim payments payable on individual bills, either		181, 589		0, 218	2. 00
2.00	submitted or to be submitted to the contractor for		101, 307		١	2.00
	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)					
0.01	Program to Provider	07 (40 (0000	0.007			0.04
3. 01 3. 02	ADJUSTMENTS TO PROVIDER	07/19/2022	9, 987		0	3. 01 3. 02
3.02			0			3. 02
3. 03			0			3. 03
3. 05			o			3. 05
0.00	Provider to Program		o <sub>l</sub>		Ü	0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		9, 987		0	3. 99
4 00	- 3.98)		1 405 540		4 210	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line		1, 495, 542		6, 218	4. 00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		1			
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5.03	Provider to Program		U		U	5. 03
5. 50	TENTATI VE TO PROGRAM		O		0	5. 50
5. 51	TENTATI VE TO TROGRAM		Ö		0	5. 51
5. 52			o		l ol	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		o	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		0		743	6. 01
6. 02 7. 00	PROVIDER TO PROGRAM Total Medicare program liability (see instructions)		36, 385 1, 459, 157		0 6, 961	6. 02 7. 00
7.00	Total medicale program frability (see instructions)		Contract	or Name	Contractor	7.00
			Contract	.O. Name	Number	
			1. (	00	2. 00	
8. 00	Name of Contractor					8. 00
					-	

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

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

Provider No.: 315384 | Period: From 01/01/

| Period: | Worksheet G | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 12: 34 pm |

oni y)		General Fund	Specific I	Endowment Fund	5/30/2023 12: Plant Fund	34 pm
			Purpose Fund	Endowment Fund		
	Assets	1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	3, 067, 423	0	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	972, 944	0	0	0	
+. 00 5. 00	Other receivables	972, 944	0	0	0	
5. 00	Less: allowances for uncollectible notes and accounts	0	0	0	0	
	recei vabl e					
7. 00	Inventory	0	0	0	0	
3. 00	Prepai d expenses	130, 678	0	0	0	
9.00	Other current assets	0	0	0	0	
10. 00 11. 00	Due from other funds TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	4, 171, 045	0	ol Ol	0	
11.00	FIXED ASSETS	4, 171, 043	U U	υ	0	11.0
12. 00	Land	T 0	0	ol	0	12. C
13. 00	Land improvements	0	O	ō	0	
14.00	Less: Accumulated depreciation	0	0	o	0	14.0
15. 00	Bui I di ngs	0	0	0	0	
16. 00	Less Accumulated depreciation	0	0	0	0	
17.00	Leasehold improvements	447, 035	0	0	0	1
18.00	Less: Accumulated Amortization Fixed equipment	-406, 427	0	0	0	
19. 00 20. 00	Less: Accumulated depreciation	0	0	0	0	
21. 00	Automobiles and trucks	0	0	0	0	
22. 00	Less: Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	61, 786	0	o	0	1
24. 00	Less: Accumulated depreciation	-61, 786	Ö	o	0	
25. 00	Mi nor equi pment - Depreci abl e	0	0	o	0	
26. 00	Mi nor equi pment nondepreci abl e	0	0	o	0	26.0
27. 00	Other fixed assets	0	0	0	0	27.0
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	40, 608	0	0	0	28. C
	OTHER ASSETS	1				
29. 00	Investments	0	0	0	0	
30. 00 31. 00	Deposits on leases	0	0	0	0	
32. 00	Due from owners/officers Other assets		0	0	0	
33. 00	TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	0	0	0	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	4, 211, 653	Ö	o	0	
	Liabilities and Fund Balances	•		'		
	CURRENT LIABILITIES	_				
35. 00	Accounts payable	1, 844, 209	0	0	0	
36.00	Sal ari es, wages, and fees payable	205, 365	0	0	0	1
37. 00	Payroll taxes payable (Short tarm)	23, 018	0	0	0	
38. 00 39. 00	Notes & Loans payable (Short term) Deferred income	0	0	0	0	
40. 00	Accel erated payments	0	J	o o	O	40.0
41. 00	Due to other funds	0	0	0	0	
42. 00	Other current liabilities	484, 216	Ö	o	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 556, 808		О	0	
	LONG TERM LIABILITIES					
44. 00	Mortgage payable	0	0	0	0	1
45. 00	Notes payable	0	0	0	0	
46. 00	Unsecured Loans	0	0	0	0	
47. 00	Loans from owners:	0	0	0	0	
48. 00	Other long term liabilities	0	0	0	0	
49. 00 50. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	O O	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	2, 556, 808	0	0	0	
71.00	CAPITAL ACCOUNTS	2,000,000	<u> </u>	<u> </u>		3
52. 00	General fund balance	1, 654, 845				52.0
53. 00	Specific purpose fund		0			53.0
54. 00	Donor created - endowment fund balance - restricted			0		54.0
55. 00	Donor created - endowment fund balance - unrestricted			0		55. (
56. 00	Governing body created - endowment fund balance			0		56. (
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58. 0
	ronl coment and evaporation					1
58. 00	replacement, and expansion	1 454 045	0	ما	^	50 /
57. 00 58. 00 59. 00 50. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	1, 654, 845 4, 211, 653		0	0	

ROSE MOUNTAIN CARE CTR

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					То	12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 34 pm
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1. 00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		1, 976, 658			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		-321, 820 1, 654, 838			0		2. 00 3. 00
4. 00	Additions (credit adjustments)		1, 054, 050			O		4. 00
5.00	ROUNDI NG	7			0		0	5. 00
6.00		0			0		0	6. 00
7. 00 8. 00		0			0		0	7. 00 8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 5 - 9)		7		Ĭ	0		10. 00
11. 00	Subtotal (line 3 plus line 10)		1, 654, 845			0		11. 00
12. 00	Deductions (debit adjustments)							12. 00
13.00		0			0		0	13.00
14. 00 15. 00		0			0		0 0	14. 00 15. 00
16. 00					0		0	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		1, 654, 845			0		19. 00
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund				
1.00	le i i i e i e i e	6. 00	7. 00	8. 00				1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	0			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00	Additions (credit adjustments)	1						4. 00
5.00	ROUNDI NG		0					5. 00
6.00			0					6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 5 - 9)	o			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments)							12.00
13. 00 14. 00			0					13. 00 14. 00
15. 00			0					15. 00
16. 00			O					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 sheet (Line 11 - line 18)	0			0			19. 00
	Sheet (Line II - Iine IO)	1	l	I	I			l

Health Financial Systems	ROSE MOUNTAIN CARE CTR		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315384	From 01/01/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/30/2023 12:	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		8, 211, 0	15	8, 211, 015	1.00

		T T	0 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	OT PIII
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	8, 211, 015		8, 211, 015	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)	8, 211, 015		8, 211, 015	5. 00
	All Other Care Services				
6.00	ANCI LLARY SERVI CES	507, 178	0	507, 178	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, 718, 193	0	8, 718, 193	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)			8, 932, 006	1. 00
2.00	Add (Specify)		0		2. 00
3.00			0		3. 00
4.00			0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7. 00			0	_	7. 00
8.00	Total Additions (Sum of lines 2 - 7)		_	0	8. 00
9.00	Deduct (Specify)		0		9. 00
10.00			0		10.00
11. 00			0		11. 00
12.00			0		12.00
13.00			0	_	13.00
	Total Deductions (Sum of lines 9 - 13)			0	
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			8, 932, 006	15.00

Heal th	Financial Systems R	OSE MOUNTAIN CARE CTR	In Lie	u of Form CMS-2	2540-10
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315384	Peri od: From 01/01/2022	Worksheet G-3	
				Date/Time Prep 5/30/2023 12:3	oared: 34 pm
				1. 00	
	Total notions revenues (From What C.) Don't I	col 2 lino 14)		8, 718, 193	1 00
1.00	Total patient revenues (From Wkst. G-2, Part I,	cor. 3, True 14)		0, 710, 173	1.00
	Less: contractual allowances and discounts on pa			163, 605	2. 00
2.00					2. 00
1. 00 2. 00 3. 00 4. 00	Less: contractual allowances and discounts on pa	tients accounts		163, 605	2. 00 3. 00

		3/30/2023 12.	34 PIII
		1.00	
4 00	T. I.	1.00	1 00
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	8, 718, 193	1.00
2.00	Less: contractual allowances and discounts on patients accounts	163, 605	2.00
3.00	Net patient revenues (Line 1 minus line 2)	8, 554, 588	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	8, 932, 006	
5.00	Net income from service to patients (Line 3 minus 4)	-377, 418	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6. 00
7. 00	Income from investments	10, 981	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 di scounts	0	10. 00
11. 00	Rebates and refunds of expenses	0	11. 00
12. 00	Parking lot receipts	0	12.00
13. 00	Revenue from laundry and linen service	0	13.00
14. 00	Revenue from meals sold to employees and guests	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	Rental of skilled nursing space	l ol	22. 00
23. 00	Governmental appropriations	o	23. 00
24.00	MISC INCOME	6, 956	24. 00
24. 01	OTHER I NCOME	8, 459	24. 01
24. 50	COVI D-19 PHE Funding	29, 202	24. 50
25. 00	Total other income (Sum of lines 6 - 24)	55, 598	25. 00
26.00	Total (Line 5 plus line 25)	-321, 820	26. 00
27. 00	Other expenses (specify)	l ol	27. 00
28. 00		l ol	28. 00
29. 00		l ol	29. 00
	Total other expenses (Sum of lines 27 - 29)	l ol	30. 00
	Net income (or loss) for the period (Line 26 minus line 30)	-321, 820	
550	1	32., 320	300