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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315263

Period:
From 01/01/2022
To 12/31/2022

Worksheet S
Parts I, II & III
Date/Time Prepared:
5/30/2023 12:35 pm

				3730	72023 1	2. 33 piii	
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically prepared cost re	port		Date: 5/30/2023	Time:	12:35 pm	
use only	2. [] Manually prepared cost report						
	3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report						
	3.01 [] No Medicare Utilization. Enter	"Y" for yes or	leave blank for no.				
Contractor	4. [1] Cost Report Status	6. Contractor	No.				
use only		7.[N] First Cost Report for this Provider CCN					
	(2) Settled without audit	8.[N] Last	Cost Report for this I	Provider CCN			
	(3) Settled with audit	9. NPR Date:	•				
	(4) Reopened	10.[0]If Ii	ne 4, column 1 is "4":	 Enter number of time	s reope	ened	
	(5) Amended	11.Contractor	Vendor Code	4			
	5. Date Received:	12.[F] Medi	care Utilization. Ente	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 THE PALACE REHAB. & CARE CTR (315263) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1		2	SI GNATURE STATEMENT	
1	Joe 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 Bl achorsky			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	-281, 837	8, 815	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	-281, 837	8, 815	0	100.00

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

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

Health Financial Systems THE PALACE REHAB. & CARE CTR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315263 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 12:35 pm 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 315 WEST MILL RD PO Box: 1.00 2.00 City: MAPLE SHADE State: NJ Zi p Code: 08052 2.00 3.00 County: BURLI NGTON CBSA Code: 15804 Urban/Rural: U 3.00 3.01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF THE PALACE REHAB. & 315263 06/24/1988 N Р 0 4.00 CARE CTR 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 136, 035 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 23.00 136, 035 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0

	THE PALACE REHAB. &	CARE CTR		In Lie	u of Form CMS-	2540-10
AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.:	315263 F	Peri od:	Worksheet S-2	
ATA					Part I	
			-	To 12/31/2022		
					5/30/2023 12:	35 pm
					Y/N	
					1.00	
emiums and paid loss	es reported in other than	the Administra	ative and	General cost	N	42. 00
N. If yes, check box	k, and submit supporting	schedule listin	ng cost ce	enters and		
-			_			
office costs as defi	ned in CMS Pub. 15-1, Ch.	apter 10?			N	43.00
enter the home office	ce chain number and enter	the name and a	ddress of	the home		44.00
46 and 47.						
. 00	2.00			3. 00		
s part of a chain or	ganization, enter the nam	e and address o	of the hor	me office on the	lines	
·						
			C	r's Number:		1 45 00
	Contractor's Name:	l l	Contracto	or s invulliber:		45.00
	Contractor's Name: PO Box:		Contracto	or s number:		46. 00
	emiums and paid losse N. If yes, check box office costs as defi enter the home offic , 46 and 47.	AND SKILLED NURSING FACILITY HEALTH CARE DATA emiums and paid losses reported in other than N. If yes, check box, and submit supporting so office costs as defined in CMS Pub. 15-1, Cha enter the home office chain number and enter 46 and 47.	emiums and paid losses reported in other than the Administra N. If yes, check box, and submit supporting schedule listin office costs as defined in CMS Pub. 15-1, Chapter 10? enter the home office chain number and enter the name and a 46 and 47.	AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315263 emiums and paid losses reported in other than the Administrative and N. If yes, check box, and submit supporting schedule listing cost confice costs as defined in CMS Pub. 15-1, Chapter 10? enter the home office chain number and enter the name and address of 46 and 47.	AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315263 Period: From 01/01/2022 To 12/31/2022 Pemiums and paid losses reported in other than the Administrative and General cost N. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? enter the home office chain number and enter the name and address of the home 46 and 47.	AND SKILLED NURSING FACILITY HEALTH CARE DATA AND SKILLED NURSING FACILITY HEALTH CARE DATA Provider No.: 315263 Period: From 01/01/2022 To 12/31/2022 Part I Date/Time Provider No. Y/N 1.00 Period: From 01/01/2022 To 12/31/2022 Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? Period: From 01/01/2022 Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? Period: From 01/01/2022 Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? Period: From 01/01/2022 Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? Period: From 01/01/2022 Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? Period: From 01/01/2022 Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? Part I Date/Time Provider No. No. If yes, check box, and submit supporting schedule listing cost centers and office costs as defined in CMS Pub. 15-1, Chapter 10? No. If yes, check box, and submit supporting schedule listing cost centers and office yes and yes a submit supporting schedule listing cost centers and yes a submit supporting yes a

Health Financial Systems THE PALACE REHAB. & CARE CTR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315263 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2022 5/30/2023 12:35 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?

N

Ν

18.00

Describe the other adjustments:

Was the cost report prepared only using the provider's records? If "Y" see Instructions.

Heal th	Financial Systems	THE PALACE REHA	AB. &	CARE CTR		In Lie	u of Form CMS	-2540-10
	D NURSING FACILITY AND SKILLED NURSING FACI	LITY HEALTH CARE		Provi der		Peri od:	Worksheet S-	2
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					From 01/01/2022 To 12/31/2022	Part II Date/Time Pr	enared·
						127 0 17 2022	5/30/2023 12	
				1.	00	2.	00	
	Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the tit	tle/position	CHAR	LES		REED		19. 00
	held by the cost report preparer in columns	s 1, 2, and 3,						
	respecti vel y.							
20.00	Enter the employer/company name of the cost	t report	EXEC	JCARE ASSO	CI ATES			20.00
	preparer.							
21.00	Enter the telephone number and email address	ss of the cost	(609	738-3200		CRWASSC@NETSCA	PE. NET	21.00
	report preparer in columns 1 and 2, respect	ti vel y.						

 Health Financial Systems
 THE PALACE REHAM

 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 THE PALACE REHAB. & CARE CTR

| Peri od: | Worksheet S-2 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315263 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2022	Date/Time Prep 5/30/2023 12:	
		Part B		· · ·		
		Date				
		4. 00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	03/17/2023				13. 00
	only? If either col. 1 or 3 is "Y", enter					
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and 4. (see Instructions.)					
14. 00	Was the cost report prepared using the PS&R					14. 00
14.00	for total and the provider's records for					14.00
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
	4.					
15. 00	If line 13 or 14 is "Y", were adjustments					15. 00
	made to PS&R data for additional claims that have been billed but are not included on the					
	PS&R used to file this cost report? If "Y",					
	see Instructions.					
16.00	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					18. 00
10.00	provider's records? If "Y" see Instructions.					10.00
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title		VI CE-PRESI DENT			19. 00
	held by the cost report preparer in columns 1 respectively.	i, 2, and 3,				
20. 00	Enter the employer/company name of the cost r	renort				20. 00
20.00	preparer.	opo. t				20.00
21. 00	Enter the telephone number and email address	of the cost				21. 00
	report preparer in columns 1 and 2, respective					

Health Financial Systems THE PALACE REHAET SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2540-10

						5/30/2023 12: 3	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	165	60, 225	0	1, 410	55, 034	1.00
2. 00 3. 00	NURSING FACILITY	0	0	0		0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	٩	0	0	0	0	4. 00
5.00	Other Long Term Care	O	0				5. 00
6.00	SNF-Based CMHC						6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	165	0 60, 225	0	0 1, 410	0 55, 034	7. 00 8. 00
0.00	Total (Sam of Titles 1 7)	Inpatient D		o _l	Di scharges	33, 034	0.00
	Commont	0+1	T-+-1	T: +1 - 1/	T: +1 - W/III	T: +1 - VIV	
	Component	0ther 6.00	Total 7.00	Title V 8.00	7itle XVIII 9.00	Title XIX 10.00	
1. 00	SKILLED NURSING FACILITY	1, 231	57, 675	0.00	13		1. 00
2.00	NURSING FACILITY	o	0	0		0	2.00
3.00	I CF/IID HOME HEALTH AGENCY COST	0	0			0	3. 00
4. 00 5. 00	Other Long Term Care		0				4. 00 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)	1, 231 Di scha	57, 675		age Length of	174 Stay	8. 00
		DI SCII		Avei		Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1.00	SKILLED NURSING FACILITY	11. 00	12. 00 212	13. 00 0. 00	14. 00 108. 46	15. 00 316. 29	1. 00
2. 00	NURSING FACILITY	0	0	0.00	100. 10	0.00	2. 00
3.00	ICF/IID	0	0			0. 00	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care		0				4. 00 5. 00
6.00	SNF-Based CMHC	J	Ü				6. 00
7. 00	HOSPI CE	O	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	25 Average Length	212	0.00 Admis		316. 29	8. 00
		of Stay		Adilii S	SI 0HS		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1 00	CVILLED MUDCING FACILLEY	16. 00	17. 00	18. 00	19. 00	20.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	272. 05 0. 00	0	55	130 0	22	1. 00 2. 00
3.00	ICF/IID	0. 00	· ·		0	Ö	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0. 00				0	5. 00
7. 00	HOSPI CE	0. 00	0	0	0	0	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	272. 05	0	55	130	22	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		24.00	Payrol I	Workers			
1.00	SKILLED NURSING FACILITY	21. 00	22. 00 38. 52	23. 00			1. 00
2. 00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	o	0.00				3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0. 00 0. 00				4. 00 5. 00
6.00	SNF-Based CMHC		0.00				6. 00
7. 00	HOSPI CE	О	0. 00	0. 00			7. 00
8. 00	Total (Sum of lines 1-7)	207	38. 52	0. 00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315263

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/202

					0 12/31/2022	5/30/2023 12:3	
		Amount	Reclass. of	Adjusted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	1, 711, 802	0	1, 711, 802	80, 132. 00	21. 36	1. 00
2.00	Physician salaries-Part A	0	0	C	0.00	0. 00	2. 00
3.00	Physician salaries-Part B	0	0	C	0.00	0. 00	3. 00
4.00	Home office personnel	0	0	C	0.00		4. 00
5.00	Sum of lines 2 through 4	0	0	C	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	1, 711, 802	0	1, 711, 802	80, 132. 00	21. 36	6. 00
7.00	Other Long Term Care	0	0	C	0.00		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	C	0.00		
9.00	CMHC	0	0	C	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	C	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	C	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	C	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	1, 711, 802	0	1, 711, 802	80, 132. 00	21. 36	13.00
	12)						
	OTHER WAGES & RELATED COSTS				,		
14. 00	Contract Labor: Patient Related & Mgmt	5, 711, 840	0	5, 711, 840	·		14. 00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		
16. 00	Home office salaries & wage related costs	0	0	C	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	308, 270	0	308, 270			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	C			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	308, 270	0	308, 270			22. 00
	instructions)			I	I		

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315263

						5/30/2023 12:	35 pm
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	285, 609	0	285, 609	6, 187. 00	46. 16	2. 00
3.00	Plant Operation, Maintenance & Repairs	190, 603	0	190, 603	6, 847. 00	27. 84	3. 00
4.00	Laundry & Linen Service	0	0	C	0.00	0.00	4.00
5.00	Housekeepi ng	399, 859	0	399, 859	26, 568. 00	15. 05	5.00
6.00	Di etary	442, 411	0	442, 411	29, 983. 00	14. 76	6.00
7.00	Nursing Administration	0	0	C	0.00	0.00	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	C	0.00	0.00	10.00
11. 00	Soci al Servi ce	120, 282	0	120, 282	4, 216. 00	28. 53	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	0	0	C	0.00	0.00	13.00
14. 00	Total (sum lines 1 thru 13)	1, 438, 764	(o	1, 438, 764	73, 801. 00	19. 50	14. 00

Health Financial Systems	THE PALACE REHAB. & CAF	RE CTR	In Lieu	of Form CMS-2540-10
SNF WAGE RELATED COSTS	Pr	rovi der No. : 315263		Worksheet S-3
			From 01/01/2022	
			To 12/31/2022	Data/Time Dranarad

	To 12/31/2022		
		Amount	·
		Reported 1.00	
	PART IV - WAGE RELATED COSTS	1.00	
	Part A - Core List		
1 00	RETI REMENT COST	0	1 00
1.00	401K Employer Contributions	0	1.00
2.00	Tax Shel tered Annui ty (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6. 00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	-7, 739	
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	76, 561	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	Workers' Compensation Insurance	62, 139	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	129, 442	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	47, 867	20. 00
	OTHER		
21.00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	308, 270	24.00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25. 00

Occupational Therapy Assistants

Occupational Therapy Aides

Respiratory Therapists

Speech Therapists

26.00 Other Medical Staff

22.00

23.00

24.00

25.00

0.00

0.00

0.00

0.00

0.00

0

0

0.00

0.00

0.00

0.00

22.00

23.00

24.00

25.00

0.00 26.00

SNF REPORTING OF DIRECT CARE EXPENDITURES Provi der No.: 315263 Peri od: Worksheet S-3 From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/30/2023 12:35 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 1.00 2.00 5. 00 3.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 00 0.00 0.00 1.00 0 Licensed Practical Nurses (LPNs) 0.00 0.00 2.00 2.00 C 3.00 Certified Nursing Assistant/Nursing 0 0 0 0.00 0.00 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 0.00 0.00 4.00 5.00 Physical Therapists 100, 433 18, 094 2, 329. 00 50.89 5.00 118, 527 Physical Therapy Assistants 6.00 0.00 0.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 50. 91 8.00 146, 659 26, 422 3, 400.00 8.00 173, 081 0.00 9.00 0.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 Speech Therapists 11.00 25, 946 4,674 30, 620 602.00 50.86 11.00 Respiratory Therapists 12.00 12 00 0 00 0.00 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 1, 081, 171 1, 081, 171 12, 072. 00 89 56 14 00 15.00 Licensed Practical Nurses (LPNs) 2, 273, 044 2, 273, 044 45, 987. 00 49.43 15.00 Certified Nursing Assistant/Nursing 2, 357, 625 2, 357, 625 80, 945. 00 29. 13 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 5, 711, 840 5, 711, 840 139, 004. 00 41.09 17.00 18.00 Physical Therapists 0.00 0.00 18.00 0 19.00 Physical Therapy Assistants 0 0.00 0.00 19.00 00000000 Physical Therapy Aides 20.00 0 0.00 0.00 20.00 0 0.00 21.00 Occupational Therapists 0.00 21.00

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315263

l l	o 12/31/2022	Date/lime Prep 5/30/2023 12:3	
	Group	Days	•
1.00	1. 00 RUX	2. 00	1. 00
2.00	RUL		2. 00
3.00	RVX		3. 00
4.00	RVL		4. 00
5. 00	RHX		5. 00
6. 00 7. 00	RHL RMX		6. 00 7. 00
8.00	RML		8. 00
9.00	RLX		9. 00
10. 00	RUC		10.00
11. 00 12. 00	RUB RUA		11. 00 12. 00
13. 00	RVC		13. 00
14. 00	RVB		14.00
15. 00	RVA		15. 00
16. 00 17. 00	RHC RHB		16. 00 17. 00
18. 00	RHA		18. 00
19.00	RMC		19. 00
20. 00	RMB		20.00
21. 00 22. 00	RMA RLB		21. 00 22. 00
23. 00	RLA		23. 00
24.00	ES3		24. 00
25. 00	ES2		25. 00
26. 00	ES1		26. 00
27. 00 28. 00	HE2 HE1		27. 00 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 37. 00	LE1 LD2		36. 00 37. 00
38.00	LD2 LD1		38. 00
39.00	LC2		39. 00
40.00	LC1		40. 00
41. 00 42. 00	LB2 LB1		41. 00 42. 00
43. 00	CE2		43. 00
44.00	CE1		44.00
45. 00	CD2		45. 00
46. 00 47. 00	CD1 CC2		46. 00 47. 00
48.00	CC1		48. 00
49. 00	CB2		49. 00
50. 00	CB1		50.00
51. 00 52. 00	CA2 CA1		51. 00 52. 00
53. 00	SE3		53. 00
54. 00	SE2		54.00
55. 00	SE1		55. 00
56. 00 57. 00	SSC SSB		56. 00 57. 00
58. 00	SSA		58. 00
59. 00	I B2		59.00
60.00	I B1		60.00
61. 00 62. 00	I A2 I A1		61. 00 62. 00
63. 00	BB2		63. 00
64. 00	BB1		64.00
65. 00	BA2		65. 00
66. 00 67. 00	BA1 PE2		66. 00 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

Health Financial Systems	THE PALACE REHAB. & CARE CTR		In Lie	u of Form CMS	-2540-10			
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi dei	No.: 315263	Period: From 01/01/2022	Worksheet S-	7			
			To 12/31/2022	Date/Time Pr 5/30/2023 12				
			Group	Days				
			1. 00	2.00				
76. 00			PA1		76. 00			
99. 00			AAA		99. 00			
100. 00 TOTAL					100.00			
		Expenses	Percentage	Y/N				
		1. 00	2. 00	3. 00				
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)								
101. 00 Staffi ng					101. 00			
102.00 Recruitment					102.00			
103.00 Retention of employees					103.00			
104. 00 Trai ni ng					104. 00			
105. 00 OTHER (SPECIFY)					105. 00			
106.00 Total SNF revenue (Worksheet G-2, Part	I, line 1, column 3)				106. 00			

	THE PALACE REHAB.	& CARE CTR		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
				5	5/30/2023 12:	35 pm
Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Recl assi fi cati ons	Reclassified Trial Balance	
			+ (01. 2)	I ncrease/Decre		
				ase (Fr Wkst	col . 4)	
				A-6)		
OFNEDAL CERVILOE COCT OFNEDO	1.00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES		1, 677, 034	1, 677, 034	135, 248	1, 812, 282	1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT		136, 035			787	2. 00
3. 00 00300 EMPLOYEE BENEFITS	o	308, 392		·	308, 392	3. 00
4.00 OO400 ADMINISTRATIVE & GENERAL	285, 609	2, 623, 467			2, 909, 076	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	190, 603	720, 139	910, 742	0	910, 742	5.00
6.00 00600 LAUNDRY & LINEN SERVICE	0	39, 122			39, 122	6. 00
7. 00 00700 HOUSEKEEPI NG	399, 859	38, 566			438, 425	7. 00
8. 00 00800 DI ETARY	442, 411	486, 492			928, 903	8. 00
9.00 00900 NURSING ADMINISTRATION	0	54, 338			54, 338	9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY 11. 00 01100 PHARMACY	0	139, 764			139, 764	10. 00 11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	67, 111 0	67, 111	0	67, 111 0	12.00
13. 00 01300 SOCI AL SERVI CE	120, 282	15, 000	135, 282	0	135, 282	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	13, 000	133, 202	0	0	14. 00
15. 00 01500 ACTI VI TI ES	o	660, 885	660, 885	0	660, 885	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS		·			·	
30.00 03000 SKILLED NURSING FACILITY	0	5, 711, 840	5, 711, 840	0	5, 711, 840	30.00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00 03200 1 CF/I I D	0	0	0	0	0	32.00
33.00 O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l O	0	0	0	0	33. 00
40. 00 04000 RADI OLOGY	O	1, 162	1, 162	0	1, 162	40. 00
41. 00 04100 LABORATORY	o	2, 419			2, 419	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	O	0	0		0	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY	0	1, 776	1, 776	0	1, 776	43.00
44. 00 O4400 PHYSI CAL THERAPY	273, 038	48, 000	321, 038	-202, 949	118, 089	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	172, 442	172, 442	45.00
46.00 04600 SPEECH PATHOLOGY	0	0	0	30, 507	30, 507	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 32, 987	22.007	0	22.007	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS 50. 00 05000 DENTAL CARE - TITLE XIX ONLY		32, 987	32, 987 0		32, 987 0	49. 00 50. 00
51. 00 05100 SUPPORT SURFACES	0	0		0	0	51. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>					011.00
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 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST	O	0	0	0	0	70. 00
71. 00 07100 AMBULANCE		0			0	70.00
73. 00 07300 CMHC		0		0	0	73. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80. 00
81.00 08100 INTEREST EXPENSE		0	0	0	0	81. 00
82.00 08200 UTILIZATION REVIEW - SNF	0	0	0	0	0	82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	1, 711, 802	12, 764, 529	14, 476, 331	0	14, 476, 331	89. 00
NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	٥	0		0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP		0	1	0	0	91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	ا	0	ا م	0	Ö	92. 00
93. 00 09300 NONPALD WORKERS	o	0	O	0	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
100. 00 TOTAL	1, 711, 802	12, 764, 529	14, 476, 331	0	14, 476, 331	100. 00

Heal th FinancialSystemsTHE PALACERECLASSIFICATIONAND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provi der No.: 315263

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 12:35 pm

					23 12: 35 pm
	Cost Center Description	Adjustments to	Net Expenses		
			For Allocation		
		Wkst A-8)	(col. 5 +-		
			col . 6)		
	CENEDAL CEDVICE COCT CENTEDO	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	-1, 086, 784	725, 498	·	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	-1,080,784		•	2.00
3.00	00300 EMPLOYEE BENEFITS		308, 392	•	3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	-965, 938		•	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	703, 730	910, 742	•	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	39, 122	•	6. 00
7. 00	00700 HOUSEKEEPI NG	0	438, 425		7. 00
8. 00	00800 DI ETARY	0	928, 903	•	8. 00
9. 00	00900 NURSING ADMINISTRATION	0	54, 338	•	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	139, 764	•	10. 00
11. 00	01100 PHARMACY	0	67, 111		11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		12. 00
13.00	01300 SOCIAL SERVICE	0	135, 282		13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		14. 00
15. 00	01500 ACTI VI TI ES	0	660, 885		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	0	5, 711, 840		30. 00
31.00	03100 NURSING FACILITY	0	0		31. 00
32.00	03200 CF/IID	0	0		32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		33. 00
	ANCILLARY SERVICE COST CENTERS				
40. 00	04000 RADI OLOGY	0	.,	1	40. 00
41. 00	04100 LABORATORY	0	2, 419	1	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	l control of the cont	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	1, 776	•	43.00
44.00	04400 PHYSI CAL THERAPY	0	118, 089	•	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	172, 442	•	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	30, 507		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	·	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00 49. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	32, 987 0		50.00
51. 00	05100 SUPPORT SURFACES	0		l control of the cont	51.00
31.00	OUTPATIENT SERVICE COST CENTERS			/	31.00
60. 00	06000 CLINIC	1 0	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0	1	i de la companya de l	61. 00
62. 00	06200 FQHC		Ĭ		62. 00
02.00	OTHER REIMBURSABLE COST CENTERS				32.00
70. 00	07000 HOME HEALTH AGENCY COST	1 0	0		70. 00
71. 00	07100 AMBULANCE	0	•	•	71. 00
73. 00	07300 CMHC	0		•	73. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>	•		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80. 00
81.00	08100 I NTEREST EXPENSE	0	0		81. 00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		82. 00
83. 00	08300 H0SPI CE	0	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-2, 052, 722	12, 423, 609		89. 00
	NONREI MBURSABLE COST CENTERS				
90. 00		0	0	·	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	l control of the cont	91. 00
92.00	1	0	0	·	92. 00
93. 00		0	0	·	93. 00
	09400 PATIENTS LAUNDRY	0	0	I and the second	94.00
100.00	D TOTAL	-2, 052, 722	12, 423, 609	'	100. 00

Health Financial Systems	THE PALACE REHAB. & CARE CTR		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi der		Peri od: From 01/01/2022	Worksheet A-6	
			To 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 35 pm
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2. 00	3. 00	4. 00	5. 00	
(1) A - RECLASS OT					
1.00	OCCUPATI ONAL THERAPY	45. C	146, 659	25, 783	1. 00
2. 00	SPEECH PATHOLOGY	46.0	00 25, 946	4, 561	2. 00
(1) B - RECLASS LHI DEPRE					
3.00	CAP REL COSTS - BLDGS & FIXTURES	1.0	00 0	135, 248	3. 00
TOTALS					
100. 00	Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		172, 605	165, 592	100. 00

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

Heal th	Financial Systems	THE PALACE REHAB. & CARE CTR		In Lie	u of Form CMS-2	2540-10
RECLASS	SIFICATIONS	Provi der		Period: From 01/01/2022	Worksheet A-6	
				Γο 12/31/2022	Date/Time Pre 5/30/2023 12:	pared: 35 pm_
			Decreases			
		Cost Center	Li ne #	Sal ary	Non Salary	
		6.00	7. 00	8. 00	9. 00	
((1) A - RECLASS OT					
1.00		PHYSI CAL THERAPY	44.00	146, 659	25, 783	1. 00
2.00		PHYSI CAL THERAPY	44.00	25, 946	4, 561	2.00
	(1) B - RECLASS LHI DEPRE					
3. 00		CAP REL COSTS - MOVABLE	2.00	0	135, 248	3. 00
L		EQUI PMENT				
1	TOTALS					
100.00				172, 605	165, 592	100.00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS THE PALACE REHAB. & CARE CTR In Lieu of Form CMS-2540-10 Provi der No.: 315263

					10 12/31/2022	5/30/2023 12: 3	
				Acqui si ti ons	3		•
	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	5					
1.00	Land	0	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	0	0		0	0	3.00
4.00	Building Improvements	2, 797, 684	184, 357		0 184, 357	0	4.00
5.00	Fixed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	855, 567	0		0	23, 608	6.00
7.00	Subtotal (sum of lines 1-6)	3, 653, 251	184, 357		0 184, 357	23, 608	7.00
8.00	Reconciling Items	0	0		0	0	8.00
9.00	Total (line 7 minus line 8)	3, 653, 251	184, 357		0 184, 357	23, 608	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
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	2, 982, 041	0				4.00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	831, 959	0				6.00
7.00	Subtotal (sum of lines 1-6)	3, 814, 000	0				7.00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	3, 814, 000	0				9. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der No.: 315263 Peri od: Worksheet A-8

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

				lo 12/31/2022	Date/lime Prep 5/30/2023 12:	
				Expense Classification on		JJ pili
				To/From Which the Amount is		
				Toy I Tom Will cit the Amount 13	to be haj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	, ,	Adjustment				
		1.00	2.00	3. 00	4. 00	
1. 00	Investment income on restricted funds	В	-14, 626	ADMINISTRATIVE & GENERAL	4.00	1. 00
	(chapter 2)					
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4.00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			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	l control of the cont	0.00	
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	-1, 086, 558	3		12.00
	related organizations (chapter 10)					
13.00	Laundry and linen service		0		•	13. 00
14. 00	Revenue - Employee meals		0		0.00	
15. 00	Cost of meals - Guests		0	l .	0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients		_			
17. 00	Sale of drugs to other than patients		0		0.00	
18. 00	Sale of medical records and abstracts		0		0.00	
19. 00	Vending machines		0		0.00	
20. 00	Income from imposition of interest, finance		0)	0.00	20. 00
	or penal ty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
22.00	overpayments			HITLLI ZATLON DEVLEW CNE	02.00	22.00
22. 00	Utilization reviewphysicians' compensation		١	OUTILIZATION REVIEW - SNF	82.00	22. 00
23. 00	(chapter 21) Depreciationbuildings and fixtures		_	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	Depreciationburidings and fixtures		٦	FIXTURES	1.00	23.00
24. 00	Depreciationmovable equipment		_	CAP REL COSTS - MOVABLE	2.00	24. 00
24.00	beprecrationillovabre equipilient		١	EQUI PMENT	2.00	24.00
25. 00	MANAGEMENT FEE	Α	-750,000	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	ADVERTI SI NG	Ä		BADMINISTRATIVE & GENERAL	4.00	
25. 01	ADVERTISING PROMOTIONAL	Ä	1	ADMINISTRATIVE & GENERAL	4.00	
25. 02	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 03	BAD DEBT EXPENSE BAD DEBT EXP 30% NON MCD PART A	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	BAD DEBT EXP 30% NON MCD PART A	A		ADMINISTRATIVE & GENERAL	4.00	
25. 05	NJ FRANCHISE TAX EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 00	NJ CORPORATE TAX	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07	OTHER REV. MISC.	B		ADMINISTRATIVE & GENERAL	4.00	
25. 08	ASST ADMIN	A A		ADMINISTRATIVE & GENERAL	4.00	
	Total (sum of lines 1 through 99) (Transfer	, A	-2, 052, 722		4.00	100.00
100.00	to Worksheet A, col. 6, line 100)		-2,032,722			100.00
	TO WOLKSHOEL A, COL. U, TITLE 100)	I	I	I	1	I

to Worksheet A, col. 6, line 100)

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

Heal th Financial Systems THE PALACE REHAB.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME THE PALACE REHAB. & CARE CTR

| Peri od: | Worksheet A-8-1 | From 01/01/2022 | Parts I-I | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315263 OFFICE COSTS

			'	5/30/2023 12	
	Li ne No.	Cost (Center	Expense Items	
	1.00	2.	00	3. 00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUII	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:	11			L= ==	
1.00		CAP REL COSTS	- BLDGS &	RE TAXES	1. 00
2.00		FIXTURES CAP REL COSTS	DI DCC 0	RENT	2.00
2.00		FLXTURES	- DLDG3 &	KENI	2.00
3.00		ADMI NI STRATI VE	& GENERAL	REALTY ADMIN	3.00
4.00	0.00	, 1511111111111111111111111111111111111	a 021121012		4. 00
5. 00	0.00				5. 00
6. 00	0.00				6.00
7. 00	0.00				7.00
8. 00	0. 00				8. 00
9. 00	0.00				9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column					10.00
6, line 100 to Worksheet A-8, column 3, line					
12.					
	Amount	Amount	Adjustments		
	Allowable In Cost	Included in Wkst. A, col.	(col. 4 minus col. 5)		
	COST	5 5	COI . 5)		
	4. 00	5. 00	6, 00		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUII	1 1 1			D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:					
1.00	164, 325	164, 325	(1. 00
2. 00	413, 216	1, 500, 000	-1, 086, 784	1	2. 00
3. 00	226	0	226	5	3. 00
4. 00	0	0	(D	4. 00
5. 00	0	0	(5. 00
6.00	0	0	(6. 00
7. 00	0	0)	7. 00
8. 00 9. 00	0	0			8. 00 9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column	577, 767	1, 664, 325	-1, 086, 558) 5	10.00
6, line 100 to Worksheet A-8, column 3, line	3/1, /6/	1,004,325	- 1, 000, 558		10.00
12.					
1		l .	1	T.	1

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

Provi der No.: 315263

Worksheet A-8-1

From 01/01/2022 12/31/2022

Parts I-II Date/Time Prepared: 5/30/2023 12:35 pm

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

re- pa-pa-se er	1	i .	The state of the s	1
1. 00	Α	JONATHAN ROSENBERG	50.00	1.00
2.00	Α	ESTHER ROSENBERG	50. 00	2. 00
3.00			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	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDEL ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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

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

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

1.00	THE PALACE ASSOC LLC	50. 00 REALTY	1.00
2. 00	THE PALACE ASSOC LLC	50. 00 REALTY	2.00
3. 00		0.00	3.00
4. 00		0.00	4.00
5. 00		0.00	5.00
6. 00		0.00	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

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

CARE CTR In Lieu of Form CMS-2540-10
Provider No.: 315263 Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2022	Date/Time Pre 5/30/2023 12:	pared:
			CAPI TAL REI	LATED COSTS		373072023 12.	35 piii
	Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
		Allocation (from Wkst A					
		col. 7)	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	725, 498	725, 498				1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	787		787			2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	308, 392 1, 943, 138	0 10, 557	_	308, 392 51, 454	2, 005, 160	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	910, 742	2, 114		34, 338	947, 196	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	39, 122	23, 243		0 1,7 000	62, 390	•
7.00	00700 HOUSEKEEPI NG	438, 425	2, 012		72, 037	512, 476	7. 00
8.00	00800 DI ETARY	928, 903	46, 764		79, 704	1, 055, 422	8. 00
9. 00 10. 00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	54, 338	3, 098		0	57, 439	1
11. 00	01100 PHARMACY	139, 764 67, 111	2, 408 0	0	0	142, 175 67, 111	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	ő	Ö	0,,111	12. 00
13. 00	01300 SOCIAL SERVICE	135, 282	0	0	21, 670	156, 952	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITIES	660, 885	21, 613	23	0	682, 521	15. 00
30. 00	I NPATI ENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	5, 711, 840	577, 453	627	0	6, 289, 920	30.00
31. 00	03100 NURSING FACILITY	3, 711, 040	0,77,433	1	0	0, 207, 720	31.00
32. 00	03200 CF/IID	0	0		0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1 4.0		1 -	al		
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	1, 162 2, 419	0		0	1, 162 2, 419	40. 00 41. 00
42. 00	04200 NTRAVENOUS THERAPY	2,419	0	0	0	2, 417	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	1, 776	0	Ö	Ö	1, 776	43. 00
44.00	04400 PHYSI CAL THERAPY	118, 089	16, 180	18	18, 094	152, 381	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	172, 442	13, 948		26, 421	212, 826	1
46. 00	04600 SPEECH PATHOLOGY	30, 507	1, 586		4, 674	36, 769	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	32, 987	4, 522		o	37, 514	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
40.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	O	O	0	40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62. 00	06200 FQHC		O			O	62.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71.00	07100 AMBULANCE	0	0		0	0	71.00
73. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	U U	U	U	73. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00		0	705 400		0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	12, 423, 609	725, 498	787	308, 392	12, 423, 609	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		Ö	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	92. 00
93. 00	09300 NONPAI D WORKERS	0	0	0	0	0	93.00
94.00		0	0	0	0	0	94.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0	0	O N	0	98. 00 99. 00
100.00	3	12, 423, 609	725, 498		308, 392	12, 423, 609	
				•			

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315263 Peri d

Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/30/2023 12:35 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 2,005,160 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 1, 129, 495 5.00 182, 299 5.00 00600 LAUNDRY & LINEN SERVICE 12.008 36, 829 111, 227 6.00 6.00 00700 HOUSEKEEPI NG 7.00 98, 632 3, 187 C 614, 295 7.00 8.00 00800 DI ETARY 203, 129 74, 099 0 41, 780 1, 374, 430 8.00 9.00 00900 NURSING ADMINISTRATION 11,055 4, 909 0 2, 768 9.00 0 27, 363 2, 151 01000 CENTRAL SERVICES & SUPPLY 3, 815 0 10.00 10.00 Ω 11.00 01100 PHARMACY 12, 916 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 01300 SOCIAL SERVICE 30, 207 0 0 13.00 13.00 C 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 ACTI VI TI ES 131, 359 34, 246 19, 309 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 111, 227 515, 912 30.00 03000 SKILLED NURSING FACILITY 1, 374, 430 30.00 1, 210, 574 914, 991 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 224 0 0 0 0 40.00 41.00 04100 LABORATORY 466 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY Ω 0 0 42 00 0 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 342 C 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 29, 328 25, 638 14, 456 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 40, 961 22, 102 0 12, 462 0 45.00 04600 SPEECH PATHOLOGY 46 00 7.077 0 46 00 2, 513 1, 417 0 04700 ELECTROCARDI OLOGY 47.00 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48.00 0 C 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 7.220 7. 166 0 4.040 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 50.00 0 C 0 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C О 0 0 0 60.00 0 06100 RURAL HEALTH CLINIC 0 61.00 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 70.00 0 0 0 07100 AMBULANCE O 71.00 0 r 0 Λ 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 2,005,160 1, 129, 495 111, 227 614, 295 1, 374, 430 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 n 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 0 0 98.00 Cross Foot Adjustments 0 C 0 0 Λ 98 00 99.00 Negative Cost Centers 0 0 0 0 99.00 100.00 TOTAL 2,005,160 1, 129, 495 111, 227 614, 295 1, 374, 430 100. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315263 Peri od:

5/30/2023 12:35 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE RECORDS & ADMI NI STRATI ON SERVICES & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9.00 00900 NURSING ADMINISTRATION 76, 171 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 175, 504 0 01100 PHARMACY 80, 027 11.00 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 13.00 01300 SOCIAL SERVICE 0 0 0 187, 159 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 0 14.00 C 0 01500 ACTI VI TI ES 15.00 C 0 0 Ω 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 76, 171 175, 504 80, 027 0 187, 159 30.00 03100 NURSING FACILITY 0 31.00 31.00 C Ω 32.00 03200 | CF/IID 0 C 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 0 0 33.00 0 33.00 ANCILLARY SERVICE COST CENTERS 04000 RADI OLOGY 40.00 0 0 0 Λ 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000 0 0 0 0 0 0 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 04400 PHYSI CAL THERAPY 0 44.00 0 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 C 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 0 0 04900 DRUGS CHARGED TO PATIENTS 0 49.00 0 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 50 00 Ω 0 0 50.00 05100 SUPPORT SURFACES 51.00 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 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 0 07100 AMBULANCE 0 71.00 Ω 0 71 00 73.00 07300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 83.00 SUBTOTALS (sum of lines 1-84)
NONREIMBURSABLE COST CENTERS 187, 159 89. 00 89.00 76. 171 175, 504 80,027 0 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 C 0 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 Cross Foot Adjustments 98.00 98.00 0 C

76, 171

175, 504

In Lieu of Form CMS-2540-10

Date/Time Prepared:

Worksheet B

Part I

From 01/01/2022

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80, 027

0

Λ 99 00

187, 159 100. 00

12/31/2022

99.00

100.00

Negative Cost Centers

TOTAL

| 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.: 315263

				Τ	To 12/31/2022	Date/Time Pre 5/30/2023 12:	
			OTHER GENERAL			3/30/2023 12.	35 piii
			SERVI CE				
	Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH EDUCATI ON			Adjustments		
		14. 00	15. 00	16. 00	17.00	18. 00	
	GENERAL SERVICE COST CENTERS				1		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPING						7.00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0.7.405				14. 00
15. 00	01500 ACTIVITIES	0	867, 435				15. 00
30. 00	O3000 SKILLED NURSING FACILITY	0	867, 435	11, 803, 350	ol lo	11, 803, 350	30.00
31. 00	03100 NURSING FACILITY	0	007, 433	11, 603, 330	. 1	11, 603, 330	
32. 00	03200 CF/IID	0	0	(1	0	1
33. 00	03300 OTHER LONG TERM CARE	o o	o	(1	0	1
	ANCILLARY SERVICE COST CENTERS		-1		-1		
40.00	04000 RADI OLOGY	0	0	1, 386	5 0	1, 386	40. 00
41. 00	04100 LABORATORY	0	0	2, 885	5 0	2, 885	1
42. 00	04200 I NTRAVENOUS THERAPY	0	0	C	- 1	0	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	2, 118		2, 118	1
44. 00	04400 PHYSI CAL THERAPY	0	0	221, 803		221, 803	1
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0		288, 351 47, 77 <i>6</i>		288, 351 47, 776	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	47, 770		47, 770	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	o	(0	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	o	55, 940	ol ol	55, 940	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(o	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	C	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	(1	0	1
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	C	이	0	
62. 00	OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	ol	(ol ol	0	70. 00
71. 00	07100 AMBULANCE	0	l o	(0	1
73. 00	07300 CMHC	0	o	Ċ		0	
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
							81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	_	_	_		_	82. 00
83. 00	08300 H0SPI CE	0	0 0 7 405	10 100 (0	0	0	
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	867, 435	12, 423, 609	위 이	12, 423, 609	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	٥	(ا ما	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	(0	1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	i o	o	Č	1	0	
93. 00	09300 NONPALD WORKERS	0	o	C	ol ol	0	1
94.00	09400 PATIENTS LAUNDRY	0	0	(o o	0	94. 00
98. 00	Cross Foot Adjustments	0	0	C	이	0	
99. 00	Negative Cost Centers	0	0	(이	0	
100.00) TOTAL	0	867, 435	12, 423, 609	위 이	12, 423, 609	100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315263

			To	12/31/2022	Date/Time Pre 5/30/2023 12:	
		CAPI TAL REL	ATED COSTS		3/30/2023 12.	35 piii
Cost Center Description	Di rectly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	Assigned New	FI XTURES	EQUI PMENT		BENEFITS	
	Capi tal Related Costs					
	0	1. 00	2.00	2A	3. 00	
GENERAL SERVICE COST CENTERS						4 00
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00 00300 EMPLOYEE BENEFITS	0	О	0	0	0	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	0	10, 557	11	10, 568	0	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	0	2, 114	2	2, 116	0	5. 00
6. 00 00600 LAUNDRY & LI NEN SERVI CE 7. 00 00700 HOUSEKEEPI NG	0	23, 243 2, 012	25 2	23, 268 2, 014	0	6. 00 7. 00
8. 00 00800 DI ETARY		46, 764	51	46, 815	0	8. 00
9. 00 00900 NURSING ADMINISTRATION	0	3, 098	3	3, 101	0	9. 00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	0	2, 408	3	2, 411	0	10.00
11. 00 01100 PHARMACY 12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	11.00
13. 00 01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12. 00 13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	o	0	o	0	14. 00
15. 00 01500 ACTI VI TI ES	0	21, 613	23	21, 636	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS		E77 4E0	(27	F70, 000		1 20 00
30.00 03000 SKILLED NURSING FACILITY 31.00 03100 NURSING FACILITY	0	577, 453	627 0	578, 080	0	30. 00 31. 00
32. 00 03200 CF/IID		o	0	o	0	32. 00
33.00 O3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS	1	ام		al a		
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	0	0	0	O O	0	40. 00 41. 00
42. 00 04200 NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	ō	0	O	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	0	16, 180	18	16, 198	0	44. 00
45. 00 04500 OCCUPATIONAL THERAPY	0	13, 948	15	13, 963	0	45. 00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0	1, 586 0	2	1, 588 0	0	46. 00 47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	o	0	o	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	4, 522	5	4, 527	0	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	0	O[0	51.00
60. 00 06000 CLINIC	0	o	0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	О	0	0	0	61. 00
62. 00 06200 FQHC						62.00
OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST	0	ol	0	ol	0	70.00
71. 00 07100 AMBULANCE		o	0	o	0	71.00
73. 00 07300 CMHC	0	o	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS	1					
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF						82.00
83. 00 08300 HOSPI CE	0	o	0	0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	0	725, 498	787	726, 285	0	89. 00
NONREI MBURSABLE COST CENTERS		ما		ما	0	00.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	90. 00 91. 00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES		o	0	Ö	0	92.00
93.00 09300 NONPALD WORKERS		ō	0	ō	0	93. 00
94. 00 09400 PATIENTS LAUNDRY	0	0	0	O	0	94.00
98.00 Cross Foot Adjustments 99.00 Negative Cost Centers				0	0	98. 00 99. 00
100.00 TOTAL	0	725, 498	787	726, 285		100.00
The state of the s	, 9	==, ., 0		, -001	· ·	

Health Financial Systems

THE PALACE REHAB. & CARE CTR

In Lieu of Form CMS-2540-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315263
Period:
From 01/01/2022
To 12/31/2022
Date/Time Prepared:
5/30/2023 12: 35 pm

				11	o 12/31/2022	Date/Time Pre 5/30/2023 12:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	эо рііі
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	4 00	7.00	9 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 EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	10, 568					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	960	3, 076				5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	63	100	·			6. 00
7.00	00700 HOUSEKEEPI NG	520	9		2, 543	40.040	7. 00
8.00	00800 DI ETARY	1, 070	202		173	48, 260	8. 00
9. 00 10. 00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	58 144	13 10		11	0	9. 00 10. 00
11. 00	l i	68	0		0	0	11. 00
12. 00	l i	0	0		Ö	0	12. 00
13. 00	1	159	0	0	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	O	0	0	0	0	14. 00
15.00		692	93	0	80	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		6, 383	2, 492	·	2, 135	48, 260	30. 00
31.00		0	0		0	0	31. 00
32.00		0	0		0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	U U	0	0	0	0	33. 00
40. 00		1	0	0	O	0	40. 00
41. 00		2	0		0	0	41. 00
42. 00	l i	0	0		Ö	0	42. 00
43. 00	l i	2	0	Ō	0	0	43. 00
44.00		155	70	0	60	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	216	60	0	52	0	45.00
46. 00	l i	37	7	0	6	0	46.00
47. 00		0	0		0	0	47. 00
48. 00		0	0		0	0	48. 00
49.00		38	20		17	0	49.00
50. 00 51. 00	l i	0	0		0	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	<u> </u>	0	31.00
60. 00		0	0	0	0	0	60. 00
61.00	l l	0	0		0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00		0	0		0	0	70. 00
71. 00		0	0		0	0	71. 00
73. 00	07300 CMHC SPECIAL PURPOSE COST CENTERS	l O	0	0	0	0	73. 00
80. 00							80. 00
81. 00							81. 00
	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00		0	0	0	0	0	
89. 00		10, 568	3, 076	23, 431	2, 543	48, 260	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00		0	0	0	0	0	90. 00
91.00		0	0	0	이	0	91.00
92.00	1	0	0	0	0	0	92.00
93.00		0	0	0		0	93. 00
94. 00 98. 00		۱	Ü			0	94. 00 98. 00
98.00	1		0			0	
100.00		10, 568	3, 076	23, 431	2, 543	48, 260	
			2,370		_, _, _,	,	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315263

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/30/2023 | 12: 35 pm

						5/30/2023 12:	35 pm_
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9. 00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	3, 183					9. 00
10.00		o	2, 574				10.00
11. 00	01100 PHARMACY	o	0	68			11. 00
12. 00		o	0	0	0		12.00
13. 00		o	0	0	0	159	13. 00
14. 00	1	0	0	0	0	0	14. 00
15. 00		o	0	0	0	0	15. 00
.0.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>			
30. 00		3, 183	2, 574	68	0	159	30. 00
31. 00	1	0	2, 0, 1	0	0		31. 00
32. 00	1	l o	0	o o	0	1	32. 00
33. 00			0	o o	0	0	33. 00
00.00	ANCI LLARY SERVICE COST CENTERS	٩	J	<u> </u>	<u> </u>		00.00
40. 00		0	0	0	0	0	40. 00
41. 00			0	0	0	l ő	41. 00
42. 00	1		0	o o	0	Ö	42. 00
43. 00	I I		0	0	0	Ö	43. 00
44. 00			0	0	0	Ö	44. 00
45. 00	I I		0	0	0	Ö	45. 00
46. 00			0	0	0	Ö	46. 00
47. 00			0	0	0	0	47. 00
48. 00		0	0	0	0	0	48. 00
49. 00			0	0	0	0	49. 00
50. 00	1		0	0	0	0	50.00
		0	0	0	0	0	51. 00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	l o	U	U	0	0	51.00
(0.00			0	0	0		(0.00
60.00		0	0		0	0	60.00
61.00		٩	U	0	Ü	0	61.00
62. 00							62. 00
70.00	OTHER REIMBURSABLE COST CENTERS		0	0	0		70.00
70.00		0	0	0	0	-	70.00
71. 00		0	0		0		71. 00
73. 00		0	0	0	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS					ı	00.00
80.00							80.00
81. 00							81. 00
82. 00							82. 00
83. 00	1	0		0	0	0	83. 00
89. 00		3, 183	2, 574	68	0	159	89. 00
	NONREI MBURSABLE COST CENTERS		_			_	
90. 00		0	0	0	0		90. 00
91. 00		0	0	0	0		91. 00
92. 00		0	0	0	0		92.00
93. 00		0	0	0	0	1	93. 00
94. 00		0	0	0	0	0	94. 00
98. 00		0	0	0			98. 00
99. 00		0	0	0	0	0	99. 00
100.0	O TOTAL	3, 183	2, 574	68	0	159	100. 00

83 00

89.00

90.00

94.00 0

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726, 285 100. 00

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Health Financial Systems THE PALACE REHAB. & CARE CTR In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315263 Peri od: Worksheet B From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/30/2023 12:35 pm OTHER GENERAL SERVI CE Cost Center Description NURSING AND ACTI VI TI ES Subtotal Post Step-Down Total ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9.00 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TI ES 15.00 0 22, 501 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 22, 501 689, 266 0 689, 266 30.00 31.00 03100 NURSING FACILITY 0 0 0 31.00 0 32.00 03200 | CF/IID 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 0 0 33.00 0 33.00 Ω ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 41.00 04100 LABORATORY 0000000000 0 2 0 2 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 16, 483 44.00 16, 483 0 44.00 04500 OCCUPATIONAL THERAPY 14, 291 45.00 14, 291 45.00 04600 SPEECH PATHOLOGY 46.00 1,638 1, 638 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 C 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 4, 602 49.00 4,602 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 C C 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 51.00 0 OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 60.00 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 0 C 0 61.00 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00

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22, 501

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22, 501

726, 285

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726, 285

08300 H0SPI CE

SUBTOTALS (sum of lines 1-84)

09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN

NONREIMBURSABLE COST CENTERS

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

TOTAL

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

83.00

89.00

90.00

91.00

92.00

93.00

94.00

98.00

99. 00

100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider No.: 315263 | Period: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Preparent

					o 12/31/2022	Date/Time Pre 5/30/2023 12:	pared:
		CAPITAL REL	ATED COSTS			5/30/2023 12.	35 piii
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM COST)	
		1.00	2. 00	3. 00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	49, 412		I			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	47, 412	49, 412				2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0			10 410 440	3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	719 144	719 144				4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 583	1, 583	, c	0	62, 390	6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	137 3, 185	137 3, 185			512, 476 1, 055, 422	7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	211	211			57, 439	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	164	164		_	142, 175	1
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0	C	_	67, 111 0	11. 00 12. 00
13. 00	01300 SOCI AL SERVI CE	0	Ö	120, 282	_	156, 952	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C		0	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	1, 472	1, 472	<u> </u>	0	682, 521	15. 00
30. 00	03000 SKILLED NURSING FACILITY	39, 329	39, 329				30. 00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0 0	1		-	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0				33. 00
	ANCILLARY SERVICE COST CENTERS			1			
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0				40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	Ö	Č	-	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	1 103	1 102	1		1, 776	1
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	1, 102 950	1, 102 950			152, 381 212, 826	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	108		25, 946	0	36, 769	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	· ·	-	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	308	308	_	_		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0				50.00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	51. 00
60.00	06000 CLI NI C	0	0			-	60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	C	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS			L			02.00
70.00	07000 HOME HEALTH AGENCY COST	0	_				70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0	•			71. 00 73. 00
70.00	SPECIAL PURPOSE COST CENTERS						70.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
82. 00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83.00	08300 H0SPI CE	0	0				83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	49, 412	49, 412	1, 711, 802	-2, 005, 160	10, 418, 449	89. 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	С	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	1			91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0		C	_	0	92. 00 93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	C	0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00		725, 498	787	308, 392	2	2, 005, 160	•
	Part I)	44 (00/00	0.045005				
103. 00 104. 00	1	14. 682628	0. 015927	0. 180156		0. 192462 10. 568	103. 00 104. 00
	Part II)						
105.00	Unit cost multiplier (Wkst. B, Part			0.000000		0. 001014	105. 00
	1 1117	1	ı	I	I	ı	ı

Provi der No.: 315263

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

						5/30/2023 12:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(PATIENT DAYS)			(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	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	48, 549	l .				5. 00
6. 00 7. 00	O0600 LAUNDRY & LINEN SERVICE O0700 HOUSEKEEPING	1, 583					6. 00 7. 00
8. 00	00800 DI ETARY	137 3, 185	 	46, 829 3, 185			8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	211	l .	211	171, 307	57, 675	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	164	 	164	0	0,,0,0	10.00
11. 00	01100 PHARMACY		ol o	0	0	Ö	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY		o	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	C	0	0	0	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	1, 472	2 0	1, 472	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	39, 329	1	39, 329	171, 987	57, 675	30. 00
31. 00	03100 NURSING FACILITY		1	0	0	0	31.00
32.00	03200 1 CF/1 D	C		0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	C)[0	0	0	0	33. 00
40. 00	04000 RADIOLOGY		0	0	0	0	40. 00
41. 00	04100 LABORATORY		1	0	_	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY				0	Ö	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		ol o	Ö	0	o o	43. 00
44.00	04400 PHYSI CAL THERAPY	1, 102	0	1, 102	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	950	0	950	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	108	0	108	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	C	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	308	l .	308	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	-	0	0	0	50.00
51. 00	O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	C) 0	0	0	0	51. 00
60. 00	06000 CLINIC) 0	0		0	60.00
61. 00	06100 RURAL HEALTH CLINIC		1			1	61. 00
62. 00	06200 FQHC			Ī	_		62. 00
	OTHER REIMBURSABLE COST CENTERS	•		•	<u>'</u>	•	
70.00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70. 00
71. 00	07100 AMBULANCE		0	0	0	0	71. 00
73. 00	07300 CMHC		0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS			1	I		
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00
82. 00 83. 00	08300 HOSPI CE		0		0	0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	48, 549	1	46, 829	171, 987	57, 675	89. 00
07.00	NONREI MBURSABLE COST CENTERS	10,547	37,073	40,027	171, 707	37,073	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP		0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES		0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	C	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers	4 400 405	444 007	(44.005	4 074 400	7, 474	99. 00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 129, 495	111, 227	614, 295	1, 374, 430	76, 171	102.00
103.00	1 1 -	23. 265052	1. 928513	13. 117833	7. 991476	1. 320694	103 00
103.00		3, 076				l	103.00
. 5 1. 50	Part II)	3,576	25, 151	2, 545	10, 200] 3, 103	
105.00		0. 063359	0. 406259	0. 054304	0. 280603	0. 055189	105. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315263

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

5/30/2023 12:35 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) (PATIENT 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 57, 675 10.00 11.00 01100 PHARMACY 57, 675 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 57, 675 12.00 01300 SOCIAL SERVICE 0 57, 675 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 30.00 03000 SKILLED NURSING FACILITY 57,675 57, 675 57, 675 57, 675 0 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 0 40.00 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 0 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 0 61.00 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) 57,675 57, 675 57,675 57, 675 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 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 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, 175, 504 80,027 187, 159 0 102.00 102.00 Part I) 0.000000 0.000000 103.00 103 00 Unit cost multiplier (Wkst. B, Part I) 1.387551 3 042982 3. 245063 104.00 Cost to be allocated (per Wkst. B, 0 104.00 2,574 68 159 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.044629 0.001179 0.000000 0.002757 11)

THE PALACE REHAB. & CARE CTR In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315263

			To 12/31/2022 Date/Time Pre	
		OTHER GENERAL	07 007 2020 12.	Jo piii
		SERVI CE		
	Cost Center Description	ACTI VI TI ES		
		(PATIENT DAYS)		
	CENEDAL CEDVICE COST CENTEDS	15. 00		
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6. 00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY			10. 00
11. 00	01100 PHARMACY			11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY			12. 00
13.00	01300 SOCIAL SERVICE			13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	E7 47E		14. 00 15. 00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	57, 675		13.00
30. 00	03000 SKILLED NURSING FACILITY	57, 675		30.00
	03100 NURSING FACILITY	0		31.00
32. 00	03200 CF/11D			32. 00
	03300 OTHER LONG TERM CARE	0		33. 00
	ANCILLARY SERVICE COST CENTERS	<u> </u>		
40.00	04000 RADI OLOGY	0		40.00
	04100 LABORATORY	0		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0		42. 00
	04300 OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00	04400 PHYSI CAL THERAPY	0		44. 00
	04500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY			46. 00 47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS			49. 00
	05000 DENTAL CARE - TITLE XIX ONLY			50.00
	05100 SUPPORT SURFACES	0		51.00
	OUTPATIENT SERVICE COST CENTERS			
	06000 CLI NI C	0		60.00
	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FOHC			62. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST			70.00
	07100 AMBULANCE	0		70. 00 71. 00
	07300 CMHC			73.00
, 5. 55	SPECIAL PURPOSE COST CENTERS	<u> </u>		1 , 5. 50
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			80. 00
81.00	08100 I NTEREST EXPENSE			81.00
82.00	08200 UTILIZATION REVIEW - SNF			82. 00
83.00	08300 H0SPI CE	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	57, 675		89. 00
	NONREI MBURSABLE COST CENTERS			4
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0		91.00
92.00	1	0		92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY			93. 00 94. 00
98. 00	Cross Foot Adjustments			98.00
99. 00	Negative Cost Centers			99. 00
102.00		867, 435		102.00
	Part I)			
103.00		15. 040052		103. 00
104.00	"	22, 501		104. 00
40	Part II)			
105.00		0. 390134		105. 00
	1)	į l		1

Health Financial Systems	THE PALACE REHAB. & CARE CTR	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FO	R ANCLILARY AND OUTPATIENT COST CENTERS Provider No : 315263	Period: Worksheet C

From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 12:35 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 2 col . 18 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 1, 386 1, 162 1. 192771 41.00 04100 LABORATORY 2,885 325 8.876923 42.00 04200 I NTRAVENOUS THERAPY 0 0.000000 0 43.00 04300 OXYGEN (INHALATION) THERAPY 2, 118 1, 776 1. 192568 44. 00 04400 PHYSI CAL THERAPY 221, 803 214, 484 1.034124 04500 OCCUPATIONAL THERAPY 0. 920646 45.00 288, 351 313, 205 04600 SPEECH PATHOLOGY 46.00 47, 776 0.862227 55, 410

Health Financial Systems	THE PALACE REHA	.B. & CARE CTR		In Li∈	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2022	Worksheet D Part I	
				To 12/31/2022	Date/Time Pre 5/30/2023 12:	
		Title	XVIII (1)	Skilled Nursing	PPS	•
		Heal th Care Pr	rogram Charge	Facility Health Care	Program Cost	
		l loar en oar e ri	ogram onarge	near throan c	Trogram oost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part R (col 1	
	to Charges	rait A	rait b	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X COI. 2)	X COI. 3)	
	Col umn 3)					
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
ANCILLARY SERVICE COST CENTERS	_					
40. 00 04000 RADI OLOGY	1. 192771			0	0	
41. 00 04100 LABORATORY	8. 876923			0	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 192568			0	0	
44. 00 O4400 PHYSI CAL THERAPY	1. 034124			0 44, 566		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 920646			0 38, 305	l .	
46. 00 04600 SPEECH PATHOLOGY	0. 862227			0 12, 952		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	1. 695820			0	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0. 000000	0		0 0	0	51.00
60, 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.00000	0				61.00
62. 00 06200 FOHC						62.00
71. 00 07100 AMBULANCE (2)	0. 000000			0		
100.00 Total (Sum of Lines 40 - 71)	0.00000	99, 724		0 95, 823		100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	I V	1 ,,,,2	ı	75, 025	1	1.00.00
(1) FOR CITIE V and ALA use corunnis 1, 2, and 4 on	у.					

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

Heal th	Financial Systems T	HE PALACE REHA	.B. & CARE CTR		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315263	Period: From 01/01/2022 To 12/31/2022		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	•
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	1. 695820	1.00
2.00	Program vaccine charges (From your reco			•	,	11, 138	2. 00
3.00	Program costs (Line 1 x line 2) (Title 1	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	18, 888	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col. 18	(From Wkst. B,			Health Costs	
		18	Part I, Col. 14)	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 &	ALLI ED HEALTH	•			
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	1, 386		0.00000		0	40. 00
41.00	04100 LABORATORY	2, 885	C	0.00000		0	
42.00	04200 I NTRAVENOUS THERAPY	0	C	0. 00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	2, 118		0.00000		0	43. 00
44. 00	04400 PHYSI CAL THERAPY	221, 803	C	0.00000		0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	288, 351	C	0.00000		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	47, 776		0.00000		0	46.00
47. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0.00000		0 0	47. 00 48. 00
	04900 DRUGS CHARGED TO PATIENTS	55, 940		0.00000		0	
	05000 DENTAL CARE - TITLE XIX ONLY	33, 940 0		0.00000		0	
	05100 SUPPORT SURFACES	0	٦	0.00000		0	
100.00		620, 259		1	95, 823	-	100.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	020,20,	٦ -	T	, , , , , , ,	ı	1.22.00

	Financial Systems THE PALACE REHAB. &			u of Form CMS-2		
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No. : 315263	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Prep 5/30/2023 12:3	pared:	
		Title XVIII	Skilled Nursing Facility	PPS	33 piii	
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00		
	INPATIENT DAYS					
1.00	Inpatient days including private room days			57, 675	1.00	
2.00	Private room days			0	2. 00	
3.00	Inpatient days including private room days applicable to the Pr	ogram		1, 410		
4.00	Medically necessary private room days applicable to the Program			0	4.00	
5. 00	Total general inpatient routine service cost			11, 803, 350	5. 00	
6. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			14, 316, 971	6. 00	
7. 00	General impatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 824431	7. 00	
8.00	Enter private room charges from your records	,		0	8. 00	
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 0.00					
10.00	Enter semi-private room charges from your records	0 0. 00	10.00			
11. 00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)				11. 00	
12. 00						
13. 00	Average per diem private room cost differential (Line 7 times I			0. 00 0. 00		
14.00	Private room cost differential adjustment (Line 2 times line 13			0	14. 00	
15.00	General inpatient routine service cost net of private room cost	differential (Line 5	minus line 14)	11, 803, 350	15. 00	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS					
16.00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		204. 65		
17. 00 18. 00	Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (I	no 4 timos lino 12)		288, 557 0	17. 00 18. 00	
19. 00	Total program general inpatient routine service cost (Line 17)			288, 557	19.00	
20.00	Capital related cost allocated to inpatient routine service cos		t II column 18.	689, 266		
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			55.7, 255		
21. 00	Per diem capital related costs (Line 20 divided by line 1)			11. 95	21. 00	
22. 00	Program capital related cost (Line 3 times line 21)			16, 850		
23. 00	Inpatient routine service cost (Line 19 minus line 22)			271, 707		
24.00	Aggregate charges to beneficiaries for excess costs (From prov Total program routine service costs for comparison to the cost		nuc Line 24)	0	24. 00 25. 00	
25. 00 26. 00	Enter the per diem limitation (1)	THE LATION (LINE 23 MI	nus IIIle 24)	271, 707	26.00	
27. 00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27. 00	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the				28. 00	
	(Transfer to Worksheet E, Part II, line 4) (See instructions)					
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX			

		1. 00			
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH					
1.00	Total SNF inpatient days	57, 675	1.00		
2.00	Program inpatient days (see instructions)	1, 410	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. 024447	4. 00		
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00		

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315263	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	
			racitity		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
0	I NPATI ENT DAYS			F7 /7F	1
0 0	Inpatient days including private room days Private room days			57, 675 0	1 2
00	Inpatient days including private room days applicable to the Pr	coaram		55, 034	3
00	Medically necessary private room days applicable to the Program			33, 034	4
0	Total general inpatient routine service cost	'		11, 803, 350	5
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			117 0007 000	~
0	General inpatient routine service charges			14, 316, 971	1
0	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 824431	7
0	Enter private room charges from your records			0	8
0	Average private room per diem charge (Private room charges line 2)	e 8 divided by private	room days, line	0. 00	ç
00	Énter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private room c semi-private room days)	charges line 10, divide	d by	0. 00	11
00 Average per diem private room charge differential (Line 9 minus line 11)					12
00 Average per diem private room cost differential (Line 7 times line 12)					13
00 Private room cost differential adjustment (Line 2 times line 13)					14
00	General inpatient routine service cost net of private room cost PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus line 14)	11, 803, 350	15
00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		204. 65	16
00	Program routine service cost (Line 3 times line 16)			11, 262, 708	
00	Medically necessary private room cost applicable to program (I			0	18
00	Total program general inpatient routine service cost (Line 17			11, 262, 708	
00	Capital related cost allocated to inpatient routine service cosline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	sts (From Wkst. B, Par	t II column 18,	689, 266	20
00	Per diem capital related costs (Line 20 divided by line 1)			11. 95	
00	Program capital related cost (Line 3 times line 21)			657, 656	
00	Inpatient routine service cost (Line 19 minus line 22)	:		10, 605, 052	
00	Aggregate charges to beneficiaries for excess costs (From prov Total program routine service costs for comparison to the cost	,	nuc line 24)	0 10, 605, 052	24
00	Enter the per diem limitation (1)	Timitation (Line 23 III	iius IIIIe 24)	0.00	
00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)	0.00	27
00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)			11, 262, 708	
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		1. 00	
0	Total SNF inpatient days			57, 675	1
	Program innations days (see instructions)			55 034	

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)

55, 034

2.00 3. 00 4. 00

2.00

4.00 5.00

Health Financial Systems	THE PALACE REHAB.	& CARE CTR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	OR TITLE XVIII	Provi der No.: 315263	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 12:35 pm
		Title XVIII	Skilled Nursing	PPS

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REINBURSEMENT 1,00			II LIE AVIII	Facility	PPS	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT 937,990 1.0						
1.00					1. 00	
Nursing and Allied Heal th Education Activities (pass through payments)			MENT			
Subtotal (Sum of lines 1 and 2)			_			
A. 0.0		1 3 1	yments)			
5.00 Coinsurance 131,871 5.00 6.00 All lowable bad debts (From your records) 121,670 6.00 7.00 All lowable bad debts (From your records) 121,670 6.00 8.00 All justed relimbursable bad debts. (See instructions) 79,086 8.00 9.00 Recovery of bad debts - For statistical records only 0 9,000 10.00 Utilization review 0 10.00 12.00 Interim payments (See instructions) 885,205 11.00 12.00 Interim payments (See instructions) 1,155,524 12.00 14.00 Interim payments (See instructions) 0 1,555,24 12.00 14.00 Interim payments (See instructions) 0 14.00 14.50 Demonstration payment adjustment amount after sequestration 0 14.50 14.55 Sequestration for non-claims based amounts (See instructions) 997 14.75 14.50 Balance due provider/program (see Instructions) 99.22 281,837 15.00 15.00 Parts et amounts (Monall owable cost report items in accordance w						
Allowable Bad debts (From your records) 121,670 6.00 16,682 7.00 10,000 16						
1.0						
R. 00						
Pool Recovery of bad debts - for statistical records only 0 0 0 0 0 0 0 0 0			ctions)			
10. 00 Utilization review 0 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 155. 524 12. 00 12. 00 11. 00 12. 00 11. 00 12. 00		, ,				
11.00 Subtotal (See instructions) 11.00 1.155.24 12.00 1.155.24 12.00 1.155.24 12.00 1.155.24 12.00 1.155.24 12.00					- 1	
1, 155, 524 12, 00 1						
13. 00		,				
14.00 OTHER adjustment (See instructions) 0 14.00 14.50 Demonstration payment adjustment amount before sequestration 0 14.55 14.55 Demonstration payment adjustment amount after sequestration 0 14.55 14.55 Sequestration for non-claims based amounts (see instructions) 997 14.75 14.99 Sequestration amount (see instructions) -281,837 15.00 Balance due provider/program (see Instructions) -281,837 15.00 PORTOSE PROVIDER PRO					1, 155, 524	
14.50						
14. 55 Demonstration payment adjustment amount after sequestration 9	14. 00				0	
14. 75 Sequestration for non-claims based amounts (see instructions) 997 14. 75 14. 99 Sequestration amount (see instructions) 10, 521 14. 99 15. 00 Bal ance due provider/program (see Instructions) -281,837 15. 00 16. 00 Protested amounts (Nonall owable cost report items in accordance with CMS Pub. 15-2, section 115. 2) 0 16. 00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 0 17. 00 18. 00 Vacci ne cost (From Wkst D, Part II, line 3) 18, 888 18. 00 19. 00 Total reasonable costs (Sum of lines 17 and 18) 18, 888 19. 00 20. 00 Medicare Part B ancillary charges (See instructions) 11, 138 20. 00 21. 00 Cost of covered services (Lesser of line 19 or line 20) 11, 138 21. 00 22. 00 Primary payor amounts 0 22. 00 23. 00 Allowable bad debts (From your records) 0 24. 01 24. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 0 24. 01 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 02 25. 00 In					0	
14. 99 Sequestration amount (see instructions) 10, 521 14. 99 15. 00 15. 00 16. 00 17.						
15. 00 Bal ance due provider/program (see Instructions) Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16. 00						
16. 00 Protested amounts (Nonal wable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16. 00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 1						
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 17. 00 Ancillary services Part B 18. 00 Vaccine cost (From Wkst D, Part II, line 3) 19. 00 Total reasonable costs (Sum of lines 17 and 18) 19. 00 Medicare Part B ancillary charges (See instructions) 11. 138 20. 00 11. 138 20. 00 12. 00 Cost of covered services (Lesser of line 19 or line 20) 11. 138 21. 00 12. 00 Primary payor amounts 10. 02. 00 Primary payor amounts 11. 138 21. 00 120. 00 Allowable bad debts (From your records) 11. 138 21. 00 124. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 124. 01 Adjusted reimbursable bad debts (see instructions) 125. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11. 138 25. 00 11. 10 Terim payments (See instructions) 12. 10 Tentative adjustment 12. 10 Demonstration payment adjustment amount before sequestration 12. 28. 50 12. 50 Sequestration amount (see instructions) 12. 60 Pemonstration payment adjustment amount after sequestration 12. 62. 69 13. 60 Pemonstration payment adjustment amount after sequestration 14. 62. 69 14. 60 Pemonstration payment adjustment amount after sequestration 15. 60 Pemonstration payment adjustment amount after sequestration 16. 28. 50 17. 60 Pemonstration payment adjustment amount after sequestration 18. 888 18. 00 18. 888 18. 00 18. 888 18. 00 11. 138 25. 00 12. 0						
17. 00 Ancillary services Part B 0 17. 00 18. 00 Vaccine cost (From Wkst D, Part II, line 3) 18,888 18.00 19. 00 Total reasonable costs (Sum of lines 17 and 18) 18,888 19.00 20. 00 Medicare Part B ancillary charges (See instructions) 11,138 20.00 21. 00 Cost of covered services (Lesser of line 19 or line 20) 11,138 21.00 22. 00 Primary payor amounts 0 22.00 23. 00 Coinsurance and deductibles 0 23.00 24. 01 Allowable bad debts (From your records) 0 24.00 24. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 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) 11,138 25.00 26. 00 Interim payments (See instructions) 2,183 26.00 27. 00 Tentative adjustment 0 24.00 28. 50 Demonstration payment adjustment amount before sequestration 0 28.50 28. 50 Demonstration payment adjustment amount after sequestration 0 28.50	16. 00				0	16. 00
18.00 Vaccine cost (From Wkst D, Part II, line 3) 18,888 18.00 19.00 Total reasonable costs (Sum of lines 17 and 18) 18,888 19.00 20.00 Medicare Part B ancillary charges (See instructions) 11,138 20.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 11,138 21.00 22.00 Primary payor amounts 0 22.00 23.00 Coinsurance and deductibles 0 23.00 24.01 Allowable bad debts (From your records) 0 24.00 24.02 Allowable Bad debts for dual eligible beneficiaries (see instructions) 0 24.01 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11,138 25.00 26.00 Interim payments (See instructions) 2,183 26.00 27.00 Tentative adjustment 0 27.00 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) 8,815 29.00			OF COST OR CHARGES - T	TITLE XVIII ONLY		
19.00 Total reasonable costs (Sum of lines 17 and 18) 18,888 19.00 20.00 Medicare Part B ancillary charges (See instructions) 11,138 20.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 11,138 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 instructions) 0 24.01 24.02 Adjusted reimbursable bad debts (see instructions) 0 24.01 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11,138 26.00 Interim payments (See instructions) 21,183 26.00 27.00 Tentative adjustment 0 27.00 28.50 Demonstration payment adjustment amount before sequestration 0 28.00 28.55 Demonstration payment adjustment amount after sequestration 0 28.55 28.99 Sequestration amount (see instructions) 8,815 29.00 29.00 Balance due provider/program (see instructions) 8,815 29.00						
20.00 Medicare Part B ancillary charges (See instructions) 21.00 Cost of covered services (Lesser of line 19 or line 20) 22.00 Primary payor amounts 23.00 Coinsurance and deductibles 24.00 Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 29.00 Balance due provider/program (see instructions) 30.00 31., 138 20.00 22.00 23.00 24.01 24.01 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11, 138 25.00 11, 138 25.00 12, 00 24.00 24.00 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11, 138 25.00 12, 00 24.00 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11, 138 25.00 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 30.00 31.00 32.						
21.00 Cost of covered services (Lesser of line 19 or line 20) 22.00 Primary payor amounts Coinsurance and deductibles Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11, 138 25.00 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 29.00 Balance due provider/program (see instructions) 31, 138 21.00 22.00 23.00 24.00 24.00 24.00 24.00 24.00 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 11, 138 25.00 24.00 25.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 38.50 Demonstration payment adjustment amount after sequestration 39.80 Sequestration amount (see instructions) 89.815 29.00						
22.00 Primary payor amounts Coi nsurance and deductibles Allowable bad debts (From your records) Allowable Bad debts for dual eligible beneficiaries (see instructions) Adjusted reimbursable bad debts (see instructions) Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) Interim payments (See instructions) Interim payments (See instructions) Tentative adjustment See instructions) Primary payor amounts O 22.00 24.00 24.00 24.01 24.01 24.01 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) Interim payments (See instructions) 2, 183 25.00 27.00 Tentative adjustment O 27.00 Other Adjustments (See instructions) Specify Demonstration payment adjustment amount before sequestration Demonstration payment adjustment amount after sequestration O 28.50 28.50 Sequestration amount (see instructions) 140 28.99 29.00 Balance due provider/program (see instructions) 8,815 29.00		,				
23.00 Coinsurance and deductibles 24.00 Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.00 Demonstration payment adjustment amount before sequestration 28.50 Demonstration payment adjustment amount after sequestration 28.50 Demonstration payment adjustment amount fere sequestration 28.50 Demonstration payment adjustment amount see instructions) 29.50 Bal ance due provider/program (see instructions) 30 23.00 24.01 24.02 25.00 24.02 26.00 Interim payments (See instructions) 27.00 Other Adjustments (See instructions) Specify 30 28.00 31, 138 32, 26.00 32, 183 32, 26.00 32, 183 32, 26.00 32, 183 32, 26.00 32, 183 32, 26.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 183 32, 27.00 32, 283 32, 283 32, 283 33, 283 34, 283						
24.00 Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 29.00 Balance due provider/program (see instructions) 30 24.00 24.01 24.02 25.00 24.02 26.00 27.00 28.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50 29.50						
24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.50 Demonstration payment adjustment amount after sequestration 28.50 Sequestration amount (see instructions) 29.00 Bal ance due provider/program (see instructions) 30 24.01 24.02 24.02 25.00 24.02 26.00 27.00 28.50 29.50 29.50 29.50 29.50 29.00 20.50						
24. 02 Adj usted reimbursable bad debts (see instructions) 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26. 00 Interim payments (See instructions) 27. 00 Tentative adj ustment 28. 00 Other Adj ustments (See instructions) Specify 28. 50 Demonstration payment adj ustment amount before sequestration 28. 55 Demonstration payment adj ustment amount after sequestration 28. 99 Sequestration amount (see instructions) 29. 00 Bal ance due provider/program (see instructions) 24. 02 25. 00 27. 00 27. 00 28. 00 28. 00 28. 00 28. 90 28. 99 29. 00 Bal ance due provider/program (see instructions) 8, 815 29. 00						
25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 29.00 Balance due provider/program (see instructions) 21.1,138 25.00 27.00 27.00 28.00 28.50 28.50 28.50 29.00 20.20 20.			ctions)			
26.00 Interim payments (See instructions) 27.00 Tentative adjustment 28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 28.99 Sequestration amount (see instructions) 29.00 Balance due provider/program (see instructions) 30.00 Other Adjustments 30.00 Other Adjustments 30.00 Other Adjustments 30.00 Other Adjustment amount before sequestration 30.28.50 Other Adjustment amount after sequestration 30.28.50 Other Adjustments 30.00 Other Adjustments 30.0						
27.00Tentative adjustment027.0028.00Other Adjustments (See instructions) Specify028.0028.50Demonstration payment adjustment amount before sequestration028.5028.55Demonstration payment adjustment amount after sequestration028.5528.99Sequestration amount (see instructions)14028.9929.00Balance due provider/program (see instructions)8,81529.00						
28.00 Other Adjustments (See instructions) Specify 28.50 Demonstration payment adjustment amount before sequestration 28.55 Demonstration payment adjustment amount after sequestration 28.55 Sequestration amount (see instructions) 28.50 Demonstration payment adjustment amount after sequestration 30 28.50 28.59 Sequestration amount (see instructions) 3140 28.99 Bal ance due provider/program (see instructions) 32.00 29.00						
28.50Demonstration payment adjustment amount before sequestration028.5028.55Demonstration payment adjustment amount after sequestration028.5528.99Sequestration amount (see instructions)14028.9929.00Balance due provider/program (see instructions)8,81529.00						
28.55Demonstration payment adjustment amount after sequestration028.5528.99Sequestration amount (see instructions)14028.9929.00Balance due provider/program (see instructions)8,81529.00						
28. 99 Sequestration amount (see instructions) 140 28. 99 29. 00 Balance due provider/program (see instructions) 8, 815 29. 00						
29.00 Balance due provider/program (see instructions) 8,815 29.00						
30.00 Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2 0 30.00			' II ONG D I 45 G	445.0		
	30.00	protested amounts (Nonallowable cost report Items) in accordance	e with CMS Pub. 15-2, s	section 115.2	0	30.00

Health Financial Systems	THE PALACE REHAB. &	CARE CTR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315263	From 01/01/2022	Worksheet E Part II Date/Time Prepared: 5/30/2023 12:35 pm
		Title XIX	Skilled Nursing	Cost

		litte xix	Facility	COST	
			raciiity		
				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)			11, 262, 708	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	
6.00	Cost of covered services (Sum of lines 1 - 5)			11, 262, 708	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			11, 262, 708	
9.00	Primary payor amounts			0	
10.00	Total Reasonable Cost (Line 8 minus line 9)			11, 262, 708	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	accommodati ons	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			0	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 callocted based on a	correction of	0	
27.00	cost limit	y corrected based on c	Join ection of	U	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 um	J	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00					30.00
	if minus, enter amount in parentheses)				
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments	•		0	32.00
33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	theses) (see	0	33. 00
	Instructions)		, ,		

Health Financial Systems THE PARALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315263 Peri od: Worksheet E-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 12:35 pm Title XVIII Skilled Nursing PPS

		11 (1	e Aviii	Facility	FFS	
		Inpatien	t Part A		t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		795, 598		2, 183	1. 00
2.00	Interim payments payable on individual bills, either		291, 148		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
5. 00	amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/16/2022	68, 778		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provi der to Program		_1		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0	3. 53 3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		68, 778			3. 99
3. 77	- 3.98)		00, 770			3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 155, 524		2, 183	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line		.,,		_,	
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider					F 01
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0			5. 02
5.05	Provider to Program		O _I		0	5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		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		8, 815	6. 01
6. 02	PROVI DER TO PROGRAM		281, 837		0	6. 02
7. 00	Total Medicare program liability (see instructions)		873, 687	N	10, 998	7. 00
			Contract	or Name	Contractor Number	
			1. (20	2. 00	
8. 00	Name of Contractor		1.	30	2.00	8. 00
3. 00	Thems of contractor		l		ı 1	0.00

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

Health Financial Systems

THE PALACE REH.

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

| Period: | Worksheet G | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 12: 35 pm | Provi der No.: 315263

oni y)		General Fund	Specific I	Endowment Fund	5/30/2023 12: Plant Fund	35 pm
			Purpose Fund	Endowment Fund		
	Assets	1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	1, 201, 375	0	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	1, 045, 647	0	0	0	
i. 00 5. 00	Other recei vables	1,045,647	0	0	0	
5. 00	Less: allowances for uncollectible notes and accounts	-120, 000	-	ő	0	
	recei vabl e	,,				
7. 00	Inventory	3, 693	0	0	0	
3. 00	Prepaid expenses	227, 708	0	0	0	
9.00	Other current assets	2, 274, 341	0	0	0	
10.00	Due from other funds TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	4, 632, 764	0	ol Ol	0	
11.00	FIXED ASSETS	4,032,704	<u> </u>	<u> </u>		1
12. 00	Land	0	0	0	0	12.0
13.00	Land improvements	0	0	0	0	13.0
14.00	Less: Accumulated depreciation	0	0	0	0	14. C
15. 00	Bui I di ngs	0	0	0	0	
16.00	Less Accumulated depreciation	0	0	0	0	
17. 00 18. 00	Leasehold improvements	2, 982, 041	0	0	0	1
19.00	Less: Accumulated Amortization Fixed equipment	-1, 899, 572	0	0	0	
20. 00	Less: Accumulated depreciation		0	0	0	
21. 00	Automobiles and trucks	l o	0	ol	0	
22. 00	Less: Accumulated depreciation	Ö	O	ō	0	
23. 00	Maj or movable equipment	831, 959	0	o	0	23.0
24. 00	Less: Accumulated depreciation	-831, 958	0	0	0	
25. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	
26. 00	Mi nor equi pment nondepreci abl e	0	0	0	0	1
27. 00 28. 00	Other fixed assets	1 092 470	0	O O	0	
20. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	1, 082, 470	J O	U	0	20.0
29. 00	Investments	1 0	0	ol	0	29.0
30. 00	Deposits on Leases	0	0	o	0	30. C
31. 00	Due from owners/officers	0	0	o	0	31.0
32. 00	Other assets	183	0	0	0	1
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	183	0	0	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5, 715, 417	0	0	0	34.0
	Liabilities and Fund Balances CURRENT LIABILITIES					+
35. 00	Accounts payable	4, 676, 711	0	ol	0	35. 0
36. 00	Sal ari es, wages, and fees payable	0	0	O	0	
37. 00	Payroll taxes payable	17, 368	0	o	0	37.0
38. 00	Notes & Loans payable (Short term)	0	0	0	0	
39. 00	Deferred income	0	0	0	0	
10.00	Accel erated payments	0			•	40.0
11.00	Due to other funds	049 221	0	0	0	1
12. 00 13. 00	Other current liabilities TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	948, 331 5, 642, 410		ol	0	
13. 00	LONG TERM LIABILITIES	3,042,410	<u> </u>	<u> </u>		75.0
14. 00	Mortgage payable	0	0	0	0	44. 0
15. 00	Notes payable	0	0	ō	0	1
16. 00	Unsecured Loans	0	0	О	0	
17. 00	Loans from owners:	0	0	0	0	1
18.00	Other long term liabilities	0	0	0	0	
19.00	OTHER (SPECIFY)	0	0	0	0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	5, 642, 410	0	ol Ol	0	
71.00	CAPITAL ACCOUNTS	3,042,410	<u> </u>	<u> </u>		31.0
52. 00	General fund balance	73, 007				52.0
53. 00	Specific purpose fund		0			53. (
4. 00	Donor created - endowment fund balance - restricted			o		54. (
5.00	Donor created - endowment fund balance - unrestricted			0		55.
6. 00	Governing body created - endowment fund balance			0	_	56. (
7.00	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement,				0	58. (
-0.00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	73, 007	0		0	59. (
	LIVING LUND DAGNICES COUNT OF LITTES OF LITTUS OF	1 /3,00/	ı U	Ų	U	」 ンプ・し
59. 00 50. 00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	5, 715, 417	n	n	0	60.0

14.00

15.00

16.00

17.00

18.00

19.00

In Lieu of Form CMS-2540-10 Health Financial Systems THE PALACE REHAB. & CARE CTR STATEMENT OF CHANGES IN FUND BALANCES Provi der No.: 315263 Peri od: Worksheet G-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 12:35 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 1, 852, 802 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) 187, 828 2.00 3.00 Total (sum of line 1 and line 2) 2,040,630 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0000 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 2,040,630 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 1, 967, 623 0 13.00 14.00 0 0 0 14.00 0 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 1, 967, 623 18.00 Fund balance at end of period per balance 19.00 73,007 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00

0

0

0

0

0

14.00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 13 - 17)

sheet (Line 11 - line 18)

Fund balance at end of period per balance

Health Financial Systems	THE PALACE REHAB. &	CARE CTR		In	n Lieu	u of Form CMS-2540-10
CTATEMENT OF DATIENT DEVENUES	AND ODEDATING EVERNOES	D ' I N	045040	D . I		W I I I O O

Heal th	Financial Systems TH	E PALACE REHAB. &	CARE CTR		In Lie	eu of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der		Period: From 01/01/2022 To 12/31/2022		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			14, 316, 97	1	14, 316, 971	1.00
2.00	NURSING FACILITY				0	0	2.00
3.00	ICF/IID				0	0	3. 00
4.00	OTHER LONG TERM CARE				0	0	4. 00
5.00	Total general inpatient care services (Sum of	lines 1 - 4)		14, 316, 97	1	14, 316, 971	5. 00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES			619, 34	9 0	619, 349	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	12. 00
13.00	OTHER (SPECIFY)				0	0	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	14, 936, 32	0 0	14, 936, 320	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, L	ine 100)				14, 476, 331	1.00
2.00	Add (Specify)				0		2.00
3.00					0		3. 00
4.00					0		4. 00
5.00					0		5. 00
6.00					0		6.00
7.00					0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)					0	8. 00
9.00	Deduct (Specify)				0		9. 00
10.00					0		10. 00
11. 00					0		11. 00
12.00					0		12. 00
13.00					0		13. 00
14.00	Total Deductions (Sum of lines 9 - 13)					0	14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8	, minus line 14)				14, 476, 331	15. 00

Heal th	Financial Systems THE PALACE REHAB.	& CARE CTR	In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315263	Peri od:	Worksheet G-3	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/30/2023 12:	
			L .	3/30/2023 12.	33 PIII
				1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		14, 936, 320	1. 00
2. 00	Less: contractual allowances and discounts on patients account			295, 287	2.00
3.00	Net patient revenues (Line 1 minus line 2)	.5		14, 641, 033	3. 00
4. 00	Less: total operating expenses (From Worksheet G-2, Part II, I	ine 15)		14, 476, 331	4. 00
5. 00	Net income from service to patients (Line 3 minus 4)	1116 13)		164, 702	5. 00
3.00	Other income:			104, 702	3.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			14, 626	7. 00
8.00	Revenues from communications (Telephone and Internet service)	1		0	8.00
9. 00	Revenue from television and radio service			0	9. 00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11. 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 th	nan 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			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	REV MISC			8, 500	24. 00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (Sum of lines 6 - 24)			23, 126	25. 00
26.00	Total (Line 5 plus line 25)			187, 828	26. 00
27. 00	Other expenses (specify)			0	27. 00
28. 00				0	28. 00
29. 00				0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)			0	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)			187, 828	31. 00