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).

OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE	Provider CCN: 315036	Worksheet S
COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY		Parts I, II & III Date/Time Prepared:
		5/13/2024 9: 23 am

					0/10/2	.027 /.	20 am
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/13/	′2024	Time:	9: 23 aı
use only	2. [] Manually prepared cost report						
	3. [0] If this is an amended report ent	ter the number	of times the provider	resubmitted t	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	(1) As Submitted	7.[N] First	Cost Report for this	Provi der CCN			
	(2) Settled without audit	8.[N] Last	Cost Report for this P	rovider CCN			
	(3) Settled with audit	9. NPR Date:	·				
	(4) Reopened	10.[0]If Ii	ne 4, column 1 is "4":	 Enter number	of times	reoper	ied
	(5) Amended	11.Contractor	Vendor Code	4		•	
	5. Date Received:	12.[F] Medi d	are Utilization. Enter	F" for full	, "L" for	low, o	or "N"
		for r	no utilization.				

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY 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 ARBOR GLEN (315036) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Dia	ne Morris	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	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			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	5, 815	3, 077	0	1. 00
2.00 NURSING FACILITY	0			0	2. 00
3.00 ICF/IID				0	3. 00
4.00 SNF - BASED HHA I	0	0	0		4. 00
5. 00 SNF - BASED RHC I	0		0		5. 00
6.00 SNF - BASED FQHC I	0		0		6. 00
7.00 SNF - BASED CMHC I	0		0		7. 00
7. 10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	5, 815	3, 077	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.

Settled Mursing Facility and Settled Nursing Facility Complex Address: 1.00 1.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00	Heal th	Financial Systems		ARBOR GLEN			1	n Lieu	ı of Form CMS-	2540-10
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9.00 SNF-Bassed Cliffs										1
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12.00 SW-Based HOSPICE										1
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14.00 Cost Reporting Period (mm/dd/yyyy) 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 1.00 2.00 15.00 Type of Control (See Instructions) 01/01/2023 12/31/2023 14.00 15.00 Type of Control (See Instructions) 01/01/2023 12/31/2023 14.00 16.00 Sthis a distinct part skilled nursing facility 1.00 16.00 Sthis a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 17.00 Stock of the Section 48.35 1.00 1.00 17.00 Cost Section 48.35 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.										1
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30.00 Nursing Facility N 30.00 31.00 ICF/IID N 31.00 32.00 SNF-Based HHA N N N 32.00 33.00 SNF-Based RHC 33.00 SNF-Based FOHC N 34.00 35.00 SNF-Based CMHC N 35.00 36.00 SNF-Based OLTC N 35.00 36.00 SNF-Based OLTC N 36.00 SNF-Based OLTC N 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Y 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) N 38.00 Are you legally-required to carry malpractice insurance? (Y/N) N 38.00 SNF-Based OLTC SNF-	29. 00							N	N	29. 00
32.00 SNF-Based HHA 32.00 33.00 SNF-Based RHC 33.00 SNF-Based FOHC 35.00 SNF-Based CMHC 36.00 SNF-Based OLTC 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) 37.00 Is the mal practice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. N	30.00	Nursing Facility							l N	30.00
33.00 SNF-Based RHC 34.00 SNF-Based FOHC 35.00 SNF-Based CMHC 35.00 SNF-Based OLTC Ty/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) 37.00 Is the mal practice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance Premiums Paid Losses Pa								NI NI		1
34. 00 SNF-Based FQHC SNF-Based CMHC SNF-Based CMHC SNF-Based CMHC SNF-Based CMHC SNF-Based OLTC SNF-Based OLTC								I IN	I IN	
36.00 SNF-Based OLTC	34. 00	SNF-Based FQHC							N	
37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry malpractice insurance? (Y/N) 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance		1							N	1
37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry malpractice insurance? (Y/N) 38.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance	30.00	DINL-BASED OFIC					Y/N			36.00
regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance 1.00 2.00 3.00							1.00		2. 00	
38.00 Are you legally-required to carry malpractice insurance? (Y/N) 18 the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 inclaims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance	37. 00					vider as a SN	F Y			37. 00
39.00 Is the mal practice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insurance 1.00 2.00 3.00	38. 00				3: (I/N)		N			38.00
Premi ums Pai d Losses Sel f Insurance 1.00 2.00 3.00		Is the mal practice a "claims-made" or "occurr	rence" po	licy? If th	e policy i	is	1			39. 00
1.00 2.00 3.00		<u> "claims-made" enter 1. If the policy is "occu</u>	urrence",	enter 2.		Premiums	Paid Los	ses c	Self Insurance	2
41.00 List malpractice premiums and paid losses: 1 0 0 41.00							2. 00	303	3. 00	
	41. 00	List malpractice premiums and paid losses:				1	0		0	41.00

Health Financial Systems	ARBOR GLEN		In Lie	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 31503		Worksheet S-2	
COMPLEX INDENTIFICATION DATA			From 01/01/2023	Part I	
			To 12/31/2023	Date/Time Pre 5/13/2024 9: 2	pared:
	37				3 8111
				Y/N	
				1. 00	
42.00 Are malpractice premiums and paid loss				N	42.00
center? Enter Y or N. If yes, check bo	x, and submit supporting :	schedule listing cos	st centers and		
amounts.					
43.00 Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and enter	the name and address	s of the home	HB0067	44. 00
office on lines 45, 46 and 47.					
1.00	2. 00		3. 00		
If this facility is part of a chain or	ganization, enter the nam	e and address of the	e home office on the	lines	
below.					
45. 00 Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	S Contr	actor's Number: 1200	1	45. 00
46.00 Street: 101 EAST STATE STREET	PO Box:				46. 00
47.00 City: KENNETT SQUARE	State: PA	Zip C	ode: 1934	8	47. 00
47.00 City: KENNETT SQUARE	State: PA	Zi p C	ode: 1934	8	47. 00

Heal th	Financial Systems ARBOR	GLEN		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CACOMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der No.: 315036	Peri od: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/13/2024 9:2	pared: 3 am
			1.00	2.	00	
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position	JEAN		PRI CE		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
20.00	Enter the employer/company name of the cost report	GENE	SIS HEALTHCARE			20. 00
	preparer.					
21.00	Enter the telephone number and email address of the cost	4108	044481	JEAN. PRI CE@GENI	ESI SHCC. COM	21. 00
	report preparer in columns 1 and 2, respectively.					

 Health Financial
 Systems
 ARBOR

 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 ARBOR GLEN Provi der No.: 315036

COMPLEX REIMBURSEMENT QUESTIONNAIRE

OOMI EE	A RELIMBORGEMENT GOESTFORWATE			To 12/31/2023	Date/Time Pre 5/13/2024 9:2	
		Part B				
		Date				
		4. 00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R					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.)	00 /00 /000 /				
14. 00	Was the cost report prepared using the PS&R	03/09/2024				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					
	4.					
15. 00	If line 13 or 14 is "Y", were adjustments					15. 00
13.00	made to PS&R data for additional claims that					13.00
	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?					
40.00	Describe the other adjustments:					40.00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
	provider's records? IT Y See Instructions.					
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title		EIMBURSEMENT ANALYST			19. 00
	held by the cost report preparer in columns 1	, 2, and 3,				
	respecti vel y.					
20.00	Enter the employer/company name of the cost r	report				20. 00
21 00	preparer.	of the cost				21 00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21. 00
	Trebort brebarer in corumns rand 2, respectiv	reiy.		I		I

In Lieu of Form CMS-2540-10 ARBOR GLEN Provi der No.: 315036

Health Financial Systems ARBOR SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

				10	3 12/31/2023	5/13/2024 9: 23	
				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	122	44, 530	0	3, 328	24, 019	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	122	44, 530	0	3, 328	24, 019	8. 00
		Inpatient D	ays/visits		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	·	6.00	7. 00	8. 00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	12, 643	39, 990	0	62	72	1. 00
2.00	NURSING FACILITY	O	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST	0	0				4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	12, 643	39, 990		62	72	8. 00
		Di scha	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13. 00	14. 00	15. 00	
1. 00	SKILLED NURSING FACILITY	123	257	0.00	53. 68	333. 60	1. 00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	0	0.00			7. 00
8. 00	Total (Sum of lines 1-7)	123 Average Length	257	0.00 Admis	53. 68	333. 60	8. 00
		of Stay		Adiii 3	31 0113		
	Component	Total	Title V	Title XVIII	Title XIX	0ther	
		16.00	17. 00	18. 00	19. 00	20.00	
1. 00	SKILLED NURSING FACILITY	155. 60	0		32	164	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2. 00
3.00	ICF/IID	0. 00			0	0	3. 00
4.00	HOME HEALTH AGENCY COST	0.00					4. 00
5.00	Other Long Term Care SNF-Based CMHC	0. 00				0	5. 00
6. 00 6. 10	SNF-Based CORF						6. 00 6. 10
7. 00	HOSPI CE	0. 00	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	155. 60	0		32		8. 00
0.00	Total (Sum of Times 1 7)	Admi ssi ons	Full Time		32	104	0.00
		T					
	Component	Total	Employees on	Nonpai d			
		21. 00	Payrol I 22. 00	Workers 23.00			
1. 00	SKILLED NURSING FACILITY	27.00	88. 78				1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	o	0.00				3. 00
4. 00	HOME HEALTH AGENCY COST		0.00				4. 00
5. 00	Other Long Term Care	O	0.00				5. 00
6.00	SNF-Based CMHC		0.00				6. 00
6. 10	SNF-Based CORF		0.00				6. 10
7.00	HOSPI CE	0	0.00	0.00			7. 00
8.00	Total (Sum of lines 1-7)	270	88. 78	0. 00			8. 00

SNF WAGE INDEX INFORMATION

instructions)

Provider No.: 315036 Peri od: From 01/01/2023 Part II

12/31/2023 Date/Time Prepared: 5/13/2024 9: 23 am Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Reported Wage (col. 3 col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 5, 833, 053 5, 833, 053 184, 665. 29 31. 59 1.00 Physician salaries-Part A 0.00 0.00 2.00 0 0 0 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 4.00 0.00 4.00 Sum of lines 2 through 4 0.00 5.00 0 0 0.00 5.00 0 31.59 6.00 Revised wages (line 1 minus line 5) 5, 833, 053 5, 833, 053 184, 665. 29 6.00 7.00 Other Long Term Care 0 0 0.00 0.00 7.00 HOME HEALTH AGENCY COST 8.00 0 0 0.00 0.00 8.00 0 9.00 9.00 CMHC 0 0.00 0.00 9.10 CORF 9. 10 10.00 HOSPI CE 0.00 0.00 10.00 Other excluded areas 0 0 0 0.00 0.00 11.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 12.00 0 0.00 0.00 12.00 through 11) 13.00 Total Adjusted Salaries (line 6 minus line 5, 833, 053 5, 833, 053 184, 665. 29 31.59 13.00 OTHER WAGES & RELATED COSTS 38. 77 14.00 Contract Labor: Patient Related & Mgmt 2, 152, 072 2, 152, 072 55, 505. 83 14.00 15.00 Contract Labor: Physician services-Part A 43, 122 0 43, 122 507.00 85.05 15.00 16.00 Home office salaries & wage related costs 346, 987 0 346, 987 7, 016. 00 49.46 16.00 WAGE-RELATED COSTS 1, 100, 182 17.00 17.00 Wage-related costs core (See Part IV) 1, 100, 182 Wage-related costs other (See Part IV) 0 18.00 0 19.00 Wage related costs (excluded units) 0 0 0 19.00 Physician Part A - WRC Physician Part B - WRC 20.00 0 0 0 20.00 21.00 0 0 0 21.00 Total Adjusted Wage Related cost (see 1, 100, 182 1, 100, 182 22.00 22.00 Health Financial Systems
SNF WAGE INDEX INFORMATION ARBOR GLEN

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315036

				ļ	0 12/31/2023	5/13/2024 9:23	
	·	Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		Nopol tou	Worksheet A-6	,	Salary in col.		
					3	.,	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES			•			
1.00	Employee Benefits	0	O	0	0.00	0.00	1. 00
2.00	Administrative & General	469, 848	0	469, 848	14, 090. 18	33. 35	2. 00
3.00	Plant Operation, Maintenance & Repairs	89, 082	0	89, 082	2, 952. 62	30. 17	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	0	0.00	0.00	5. 00
6.00	Di etary	0	0	0	0.00	0.00	6. 00
7.00	Nursing Administration	465, 112	-41, 888	423, 224	10, 231. 04	41. 37	7. 00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	41, 888	41, 888	2, 118. 74	19. 77	10.00
11. 00	Soci al Servi ce	164, 853	0	164, 853	5, 004. 64	32. 94	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	136, 868	0	136, 868	7, 100. 73	19. 28	13. 00
14. 00	Total (sum lines 1 thru 13)	1, 325, 763	0	1, 325, 763	41, 497. 95	31. 95	14. 00

Health Financial Systems	ARBOR GLEN	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 31503	From 01/01/2023	Worksheet S-3 Part IV Date/Time Prepared:

Amount Reported 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0		To 12/31/2023	Date/Time Prep 5/13/2024 9:23	
PART I V - WAGE RELATED COSTS			Amount	
PART I V - WAGE RELATED COSTS			Reported	
Part A - Core List RETIREMENT COST			1.00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00		RETI REMENT COST		
3. 00	1.00	401K Employer Contributions	91, 492	1.00
Prior Year Pension Service Cost 0	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Admin istration Fees 0 0 6.00	3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
5.00	4.00	Prior Year Pension Service Cost	0	4.00
Column C		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
To Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST	5.00	401K/TSA Plan Administration fees	0	5.00
HEALTH AND INSURANCE COST 390, 104 8. 00 Heal th Insurance (Purchased or Self Funded) 390, 104 8. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
8.00 Heal th Insurance (Purchased or Self Funded) 390, 104 8.00 9.00 Prescription Drug Plan 0 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 112,745 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 112,745 15.00 17.00 FICA-Employers Portion Only 433,608 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 53,164 20.00 OTHER 20.00 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 19,069 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported Part B - Other than Core Related Cost	8.00	Health Insurance (Purchased or Self Funded)	390, 104	8. 00
11. 00	9.00	Prescription Drug Plan	0	9. 00
12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 112,745 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 TAXES	10.00	Dental, Hearing and Vision Plan	0	10.00
13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 112,745 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15. 00 Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES TAX	15.00	Workers' Compensation Insurance	112, 745	15. 00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
17. 00 FICA-Employers Portion Only 433,608 17. 00 18. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00				
18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes Continuous Deferred Compensation 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost 18. 00 18. 00 19. 00 19. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 2		·		
19.00 Unemployment Insurance	17.00	FICA-Employers Portion Only	433, 608	17. 00
20.00 State or Federal Unemployment Taxes 53, 164 20.00 OTHER	18.00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 22.00 23.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00	19.00	Unempl oyment Insurance	0	19.00
21.00 Executive Deferred Compensation 0 21.00			53, 164	20.00
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 19, 069 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1, 100, 182 24. 00 Amount Reported 1. 00 1 Part B - Other than Core Related Cost		OTHER		
23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1, 100 Part B - Other than Core Related Cost	21.00	Executive Deferred Compensation	0	21.00
24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1,100,182 24.00 Amount Reported 1. 00 1.00	22.00	Day Care Cost and Allowances	0	22. 00
Amount Reported 1.00 Part B - Other than Core Related Cost	23.00	Tuition Reimbursement	19, 069	23.00
Part B - Other than Core Related Cost	24. 00	Total Wage Related cost (Sum of lines 1 - 23)	1, 100, 182	24. 00
Part B - Other than Core Related Cost			Amount	
Part B - Other than Core Related Cost				
			1. 00	
25. 00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

				17	12/31/2023		pared:
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	Jani
	oodpatrona. Satisgory	Reported		Sal ari es (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				,	3	ŕ	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations	,					
1.00	Registered Nurses (RNs)	1, 467, 654	231, 753		28, 337. 62		1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 047, 869	169, 334		·		2. 00
3.00	Certified Nursing Assistant/Nursing	1, 991, 767	555, 499	2, 547, 266	88, 754. 69	28. 70	3. 00
	Assi stants/Ai des	4 507 000	05/ 50/	o o	440 447 04		
4.00	Total Nursing (sum of lines 1 through 3)	4, 507, 290	956, 586	5, 463, 876	143, 167. 34		4. 00
5.00	Physical Therapists	0	0	0	0.00		5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		6. 00
7.00	Physical Therapy Aides	0	0	0	0.00	1	7. 00
8.00	Occupational Therapists	0	0	0	0.00	1	
9.00	Occupational Therapy Assistants	0	0	0	0.00		
10.00	Occupational Therapy Aides	0	0	0	0.00		
11. 00	Speech Therapists	0	0	_	0.00	1	
12.00	Respiratory Therapists	0	0		0.00		
13. 00	Other Medical Staff	U	0	0	0.00	0.00	13. 00
	Contract Labor Nursing Occupations						
14. 00	Registered Nurses (RNs)	0		0	0.00	0.00	14. 00
	Licensed Practical Nurses (LPNs)	3, 838		3, 838			
16. 00	Certified Nursing Assistant/Nursing	3, 595		3, 595	143. 79		
10.00	Assi stants/Ai des	3, 373		3, 373	143.77	23.00	10.00
17 00	Total Nursing (sum of lines 14 through 16)	7, 433		7, 433	220. 54	33. 70	17. 00
	Physical Therapists	246, 954		246, 954		1	
	Physical Therapy Assistants	121, 854		121, 854	2, 082. 00		
	Physical Therapy Aides	0		0	0.00		
21. 00	Occupational Therapists	161, 188		161, 188			
22. 00	Occupational Therapy Assistants	96, 847		96, 847	2, 081. 00		
23. 00	Occupational Therapy Aides	0		0	0.00		
24. 00		144, 617		144, 617	2, 363. 00	1	
25.00	Respiratory Therapists	19, 882		19, 882	414.00	48. 02	25. 00
26. 00	Other Medical Staff	43, 122		43, 122	507. 00	85. 05	26. 00

From 01/01/2023 To 12/31/2023 Date/Time Prepar	
----------------------------------------------------	--

		o 12/31/2023	Date/lime Prep 5/13/2024 9:23	area: : am
		Group	Days	
	 	1. 00	2. 00	
1.00		RUX		1. 00
2. 00		RUL		2.00
3.00		RVX		3.00
4. 00 5. 00		RVL RHX		4. 00 5. 00
6. 00		RHL		6. 00
7. 00		RMX		7. 00
8. 00		RML		8. 00
9. 00		RLX		9.00
10. 00		RUC		10.00
11. 00		RUB		11.00
12.00		RUA		12.00
13. 00		RVC		13.00
14. 00 15. 00		RVB RVA		14. 00 15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18.00
19. 00		RMC		19.00
20. 00		RMB		20.00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00 24. 00		RLA ES3		23. 00 24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28.00
29. 00		HD2		29.00
30. 00		HD1		30.00
31. 00		HC2		31.00
32. 00		HC1		32. 00
33. 00 34. 00		HB2 HB1		33. 00 34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37.00
38. 00		LD1		38.00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41. 00		LB2		41.00
42.00		LB1		42. 00 43. 00
43. 00 44. 00		CE2 CE1		44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47.00
48. 00		CC1		48.00
49. 00		CB2		49. 00
50. 00		CB1		50.00
51. 00 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		SSC		56.00
57. 00		SSB		57.00
58. 00		SSA		58. 00
59. 00		I B2		59. 00
60.00		I B1		60. 00 61. 00
61. 00 62. 00		I A2 I A1		62. 00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65.00
66. 00		BA1		66.00
67. 00		PE2		67. 00
68. 00		PE1		68.00
69. 00		PD2		69. 00
70. 00 71. 00		PD1 PC2		70. 00 71. 00
72. 00		PC2 PC1		71.00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00	 	PA2		75. 00

Health Financial Systems	ARBOR GLEN			In Lie	u of Form CMS	5-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315036	Peri od:	Worksheet S	-7
				From 01/01/2023 To 12/31/2023	Date/Time Pi 5/13/2024 9	
				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 Vopayments beginning 10/01/2003. Congress expection expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fowith direct patient care and related expenses (See instructions)	cted this increase to a column 1 the amour areach category to ar yes or "N" for no	to be used nt of the total SNF o if the s	for direct expense for c revenue from pending refl	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
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, lir	ne 1, column 3)					106.00

Health Financial Systems	ARBOR G	LEN		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BAL	LANCE OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre	pared:
					5/13/2024 9: 2	3 am
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassified	
			+ col . 2)	ons Increase/Decre	Trial Balance (col. 3 +-	
				ase (Fr Wkst	col . 4)	
				A-6)	,	
	1.00	2.00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	6	1 470 5/7	1 470 57	7 0	1 470 5/7	1 00
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMEN		1, 478, 567 31, 222		1	1, 478, 567 31, 222	1. 00 2. 00
3. 00 00300 EMPLOYEE BENEFITS	0	1, 081, 877		1	1, 081, 877	3. 00
4. 00 00400 ADMINISTRATIVE & GENERAL	469, 848	1, 829, 414		1	2, 299, 262	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIL	RS 89, 082	349, 898		1	438, 980	5.00
6.00 00600 LAUNDRY & LINEN SERVICE	0	219, 640		1	219, 640	6. 00
7. 00 00700 HOUSEKEEPI NG	0	397, 328		1	397, 328	7. 00
8. 00 00800 DI ETARY	0 4/F 113	979, 601	979, 60	1	979, 601	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY	465, 112 0	29, 093 41, 586			452, 317 41, 586	9. 00 10. 00
11. 00 01100 PHARMACY		41, 300	41, 300		41, 300	11. 00
12. 00 01200 MEDICAL RECORDS & LIBRARY	o	0		41, 888	41, 888	12. 00
13.00 01300 SOCIAL SERVICE	164, 853	217	165, 070	0	165, 070	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCA	1	0	(0	0	14.00
15. 00 01500 ACTIVITIES	136, 868	26, 677	163, 54!	5 0	163, 545	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTER		210, 004	4 707 07	4 0	4 727 274	20.00
30.00 03000 SKILLED NURSING FACILITY 31.00 03100 NURSING FACILITY	4, 507, 290	219, 984	4, 727, 27	1 0	4, 727, 274 0	30. 00 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	16, 872	16, 872	1	16, 872	40.00
41. 00 04100 LABORATORY	0	15, 108			15, 108	41. 00
42.00 04200 INTRAVENOUS THERAPY 43.00 04300 0XYGEN (INHALATION) THERAPY	0	22, 503 31, 820			22, 503 31, 820	42. 00 43. 00
44. 00 04400 PHYSI CAL THERAPY		284, 454		1	284, 454	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY		301, 249		1	301, 249	45. 00
46. 00 04600 SPEECH PATHOLOGY	O	184, 832		1	184, 832	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATI	I ENTS 0	0	(0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	161, 539	161, 539	9 0	161, 539	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES		17, 777	17, 77	7 0	0 17, 777	50. 00 51. 00
52. 00 05200 OTHER ANCILLARY SERVICE COST CEI	1	17, 777	17,77		0	52. 00
OUTPATIENT SERVICE COST CENTERS	5			91		02.00
60. 00 06000 CLI NI C	0	0	(0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0	0	(0	0	61.00
62. 00 06200 FQHC	ENTED	0	,		0	62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CI	ENTER 0	0		<u>)</u>	0	63. 00
70. 00 07000 HOME HEALTH AGENCY COST	0	0		0	0	70. 00
71. 00 07100 AMBULANCE		0		o o	0	71. 00
72. 00 07200 CORF	О	0		0	0	72.00
73. 00 07300 CMHC	0	0	(0	0	73.00
74. 00 07400 OTHER REIMBURSABLE COST	0	0	(0	0	74. 00
SPECIAL PURPOSE COST CENTERS	CEC	0	,		0	90 00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSS 81.00 08100 INTEREST EXPENSE	SES	0			0	80. 00 81. 00
82. 00 08200 UTI LI ZATI ON REVI EW	o	0			Ö	82. 00
83. 00 08300 HOSPI CE	o	0	(o o	0	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTI	1	0	(o o	0	84.00
89.00 SUBTOTALS (sum of lines 1-84)	5, 833, 053	7, 721, 258	13, 554, 31	1 0	13, 554, 311	89. 00
NONREI MBURSABLE COST CENTERS	NITEEN				0	00.00
90.00 O9000 GIFT, FLOWER, COFFEE SHOPS & CAI 91.00 O9100 BARBER AND BEAUTY SHOP	NIEEN	0 8, 155	[8, 15!		0 8, 155	90. 00 91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES		0, 133 N	0, 13		0, 133	91.00
93. 00 09300 NONPALD WORKERS		0		ol ol	0	93. 00
94.00 09400 PATIENTS LAUNDRY	O	0		o o	0	94.00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTI		_ 0	(0	0	95. 00
100. 00 TOTAL	5, 833, 053	7, 729, 413	13, 562, 466	6 0	13, 562, 466	100. 00

Health Financial Systems ARCLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Cost Center Description					To 12/31/2023	Date/Time Prepared: 5/13/2024 9:23 am
		Cost Center Description				37 137 2024 7. 23 aiii
COLOR COLO						
SERIEBAL SERVICE COST CENTERS			Wkst A-8)			
ENFERIN SERVICE COST CENTERS 1,00 0000 CAP REL COSTS - BLOSS & FITURES 0 1,478 567 1,00 0000 0000 CAP REL COSTS - BLOSS & FITURES 0 1,478 567 2,00 0000 0000 CAP REL COSTS - BLOSS & FITURES 0 3,00 0000 0000 CAP REL COSTS - BLOSS & FITURES 0 3,00 0000 0000 CAP REL COSTS - BLOSS & FITURES 0 0,00 0000 CAP REL COSTS - BLOSS & FITURES 0 0,00 0000 CAP REL COSTS - BLOSS & FITURES 0 0,00 0000 CAP REL COSTS - CAP REL COSTS			6. 00			
2.00 00000 (CAP REIL COSTS - MOVABLE FOULDMENT 0 31,222 3.00 0.0000 (BUILOVE ERBRETS 22,726 1.104,603 3.00 0.0000 (BUILOVE ERBRETS 22,726 1.537,309 4.00 0.000 0.0000 (BUILOVE ERBRETS 22,726 1.537,309 4.00 0.0000 (BUILOVE ERBRETS 2.0000 0.0000 (BUILOVE ERBRETS 2.00000 0.0000 (BUILOVE ERBRETS 2.00000 0.00000 (BUILOVE ERBRETS 2.00000 0.00000 (BUILO		GENERAL SERVICE COST CENTERS				
0.000 0.000 DEMPLOYEE ENDERITS			0			•
4.00 0.0400 ADMIN INSTRATIVE & CEREBAL -761, 903 1,537, 309 4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00			-		•	•
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0.000 LAUNDRY & LINEN SERVICE			-701, 755		•	•
8.00 0.0000 DIETARY 0 979, 601 8.00 0.00 0.000 DIESTARY 9.00 0.0000 DIESTARY 9.00 0.000 0.0000 DIESTARY 9.00 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000			0		•	•
9.00 0.0900 NURSI INC ADMINISTRATION 0 452,317 9.00 11.00 0 0100 CENTRAL SERVICE CSS & SUPPLY 0 41,566 10.00 11.00 0 0 0 11.00 13.00 0 1300 BECAL RECORDS & LIBRARY 0 41,888 12.00 13.00 0 1300 SOCIAL SERVICE 0 16,6070 13.00 15.00 0 1500 ACTIVITIES -20,795 142,750 142,750 15.00 1500 ACTIVITIES 5.00 142,750 30.00 31.00 31.00 313.00 MIRSI MARIA BELLIEV 485 4,727,759 30.00 31.00 33.00 330.00 MIRSI MERIOR FACILITY 485 4,727,759 31.00 31.00 33.00 330.00 MIRSI MERIOR FACILITY 485 4,727,759 31.00 31.00 33.00 330.00 MIRSI MERIOR FACILITY 485 4,722,759 31.00 31.00 33.00 330.00 MIRSI MERIOR FACILITY 0 0 0 31.00	7.00	00700 HOUSEKEEPI NG	0	397, 328		7. 00
10.00 01000 CENTRAL SERVICES & SUPPLY 0 41,586 11.00 10.00 11.100 10.00 10.00 11.100 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 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 11.00 11.00 1		l l	0		•	
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82. 00 83. 00 83. 00 83. 00 84. 00 84. 00 89. 00 SUBTOTALS (sum of lines 1-84) -759, 537 12, 794, 774 89. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 90. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 90. 00 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 92. 00 P3. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 P4. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 00	80.00		0	0		80. 00
83. 00		l l	0	0		
84. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 90. 00 91. 00 91. 00 92. 00 92. 00 93. 00 93. 00 94. 00 94. 00 95. 00 95. 00 95. 00 95. 00 96. 00 97. 00 97. 00 98. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00			0	0		
89. 00 SUBTOTALS (sum of lines 1-84)			0	0		
NONREL MBURSABLE COST CENTERS		i i	-759 537	12.794 774		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0	57.00		, , , , , , , , , , , , , , , , , , , ,			37.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 93. 00 93. 00 94. 00 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	_		
93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		l .	
94. 00 09400 PATI ENTS LAUNDRY 0 0 94. 00 95. 00 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400 07400			0	-		
95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95. 00				0		
		l l		0		
		l l	-759, 537	12, 802, 929		

Health Financial Systems	ARBOR GLEN			In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
					5/13/2024 9: 2	3 am
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
(1) A - DEFAULT						
1.00	MEDICAL RECORDS & LI	BRARY	12.0	0 41, 888	0	1.00
TOTALS						
100. 00	Total Reclassifications			41, 888	0	100.00
	of columns 4 and 5 must					
	equal sum of columns	s 8 and				
	9)					

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

Health Financial Systems	ARBOR GLEN		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi de		Peri od:	Worksheet A-6	
			From 01/01/2023 To 12/31/2023		narod:
			10 12/31/2023	5/13/2024 9: 2	3 am
		Decreases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	6. 00	7.00	8. 00	9. 00	
(1) A - DEFAULT					
1. 00	NURSING ADMINISTRATION	9. 0	0 41, 888	0	1. 00
TOTALS					
100. 00			41, 888	0	100. 00

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

Heal th Financial Systems ARBOR GLEN In Lieu of Form CMS-2540-10
RECONCILIATION OF CAPITAL COSTS CENTERS Provider No.: 315036 Period: Worksheet A-7

From 01/01/2023 To 12/31/2023

						5/13/2024 9: 23	3 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	\$					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	79, 858	0	0	0	0	2. 00
3.00	Buildings and Fixtures	4, 472, 259	0	0	0	0	3. 00
4.00	Building Improvements	298, 226	0	0	0	0	4. 00
5.00	Fixed Equipment	99, 166	0	0	0	0	5. 00
6.00	Movable Equipment	492, 126	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	5, 441, 635	0	0	0	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	5, 441, 635	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	ANNUAL OF SUMMORS AND AND THE ASSET BALANCE	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	70.050	0				1.00
2.00	Land Improvements	79, 858	0				2.00
3.00	Buildings and Fixtures	4, 472, 259	0				3. 00
4.00	Building Improvements	298, 226	0				4. 00
5.00	Fi xed Equi pment	99, 166	0				5. 00
6.00	Movable Equipment	492, 126	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	5, 441, 635	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	5, 441, 635	0			I	9. 00

Provi der No.: 315036

Peri od:

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

				10 12/31/2023	5/13/2024 9: 2	
				Expense Classification on		
				To/From Which the Amount is		
					,	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	200011 p 21 cm (1)	Adjustment	7 1110 01110		21110 1101	
		1.00	2, 00	3.00	4, 00	
1. 00	Investment income on restricted funds	1.00	2.00		0.00	1. 00
1.00	(chapter 2)				0.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
2.00	8)					2.00
3.00	Refunds and rebates of expenses (chapter 8)		Ō		0.00	3. 00
4. 00	Rental of provider space by suppliers		Ô		0.00	4. 00
1.00	(chapter 8)				0.00	1. 00
5.00	Telephone services (pay stations excluded)		o		0.00	5. 00
0.00	(chapter 21)					0.00
6.00	Television and radio service (chapter 21)	A	-20 795	ACTI VI TI ES	15.00	6. 00
7. 00	Parking lot (chapter 21)	1	20,770		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	Ö		0.00	8. 00
0.00	physician adjustment	7 0 2				0.00
9. 00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)				0.00	10. 00
11. 00	Nonal lowable costs related to certain				0.00	11. 00
11.00	Capital expenditures (chapter 24)				0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	63, 772			12. 00
12.00	related organizations (chapter 10)	7 0 1	03,772			12.00
13. 00	Laundry and Linen service		O		0.00	13. 00
14. 00	Revenue - Employee meals		0			14. 00
15. 00	Cost of meals - Guests				0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
10.00	pati ents				0.00	10.00
17. 00	Sale of drugs to other than patients	•	o.		0.00	17. 00
18. 00	Sale of medical records and abstracts				0.00	
19. 00	Vending machines		0		0.00	
20. 00	Income from imposition of interest, finance	•			0.00	20.00
20.00	or penalty charges (chapter 21)				0.00	20.00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
21.00	and borrowings to repay Medicare				0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW	82.00	22. 00
22.00	(chapter 21)			DOTTET ZATTON KEVTEW	02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	bepreer at ron barraings and rextares			FI XTURES	1.00	23.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
24.00	bepreer at ronmovabre equi pinent			EQUI PMENT	2.00	24.00
25. 00	MISC INCOME	В	_// //12	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	UNALLOWED A & G	A		ADMINISTRATIVE & GENERAL	4.00	
25. 01	WORKERS COMPENSATION	A		EMPLOYEE BENEFITS	3.00	25. 01
25. 02		A		SKILLED NURSING FACILITY	30.00	25. 02
		A			30.00	25. 03 100. 00
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-759, 537			100.00
(1) D-	to worksheet A, Cor. 6, Title 100)	 	 CMC Dub	1	I	l

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

⁽²⁾ Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

ARBOR GLEN

Health Financial Systems ARBOR G
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS

OFFI C	E COSTS				rom 01/01/2023 o 12/31/2023	Parts I-II Date/Time P 5/13/2024 9	
		Li ne No.	Cost (Center	Expense		25 8111
		1. 00	2.		3. (
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	4. 00 44. 00 45. 00 46. 00 30. 00 43. 00	ADMI NI STRATI VE ADMI NI STRATI VE PHYSI CAL THERA OCCUPATI ONAL T SPEECH PATHOLO SKI LLED NURSI N OXYGEN (I NHALA ADMI NI STRATI VE	& GENERAL PY HERAPY GY G FACILITY TION) THERAPY	HOME OFFICE A&G HOME OFFICE CAF PT OT ST NURSING PURCHAS RT MEDICAL DIRECTO	PITAL SED SERVICES	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
	12.	Amount Allowable In Cost	Amount Included in Wkst. A, col.	Adjustments (col. 4 minus col. 5)			
		4. 00	5 5. 00	6.00			
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	588, 253 66, 199 283, 384 300, 600 184, 832 7, 432 19, 882 43, 122 0 1, 493, 704	0 283, 384 300, 600 184, 832 7, 432 19, 882 43, 122	66, 199 C C C C C C			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315036 Peri od: Worksheet A-8-1 From 01/01/2023 OFFICE COSTS Parts I-II 12/31/2023 Date/Time Prepared:

				5/13/2024 9: 2	3 am
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
DART II INTERRE ATLANGUER TO BELATER ORGANIE	7.4.T.L. ONL (O)	D HOME OFFICE			

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

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

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

1.00	В	0.00 1.00
2. 00	В	0.00 2.00
3.00	В	0.00 3.00
4.00	В	0.00 4.00
5. 00	В	5. 00
6.00		0.00 6.00
7. 00		0.00 7.00
8.00		0.00
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	Type of Business	1
		Ownershi p		
	4.00	5. 00	6. 00	
DART II INTERRE ATLANGUER TO BELATER ARABILT	ATLANIAN AND AND HOME OFFICE			

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2. 00		GRS	100.00	PT OT ST	2.00
3.00		CSU	100.00	NURSING PURCHASED SERVICES	3.00
4. 00		RHS	100.00	RT	4. 00
5. 00		GPS	100.00	MEDICAL DIRECTOR	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 (financi	al or non-financial)		0.00		100. 00
speci fy:					

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						o 12/31/2023	Date/Time Pre	
				CAPI TAL REL	ATED COSTS		5/13/2024 9: 2	3 alli
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
			for Cost Allocation	FI XTURES	EQUI PMENT	BENEFI TS		
			(from Wkst A					
			col . 7) 0	1.00	2.00	3. 00	3A	
1 00		AL SERVICE COST CENTERS	1 470 5/7	1 470 5/7		1		1 00
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	1, 478, 567 31, 222	1, 478, 567	31, 222			1. 00 2. 00
3.00		EMPLOYEE BENEFITS	1, 104, 603	0	O	,		3. 00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	1, 537, 309 438, 980	0	C	88, 975 16, 869	1, 626, 284 455, 849	4. 00 5. 00
6. 00	00600	LAUNDRY & LINEN SERVICE	219, 640	ő	C	0	219, 640	
7. 00 8. 00	1	HOUSEKEEPI NG DI ETARY	397, 328 979, 601	0	0	0	397, 328 979, 601	7. 00 8. 00
9. 00		NURSING ADMINISTRATION	452, 317	0	C	80, 146	532, 463	9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	41, 586	O	0	0	41, 586	10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	41, 888	0	0	7, 932	0 49, 820	11. 00 12. 00
13.00	01300	SOCIAL SERVICE	165, 070	o	C	31, 218	196, 288	13. 00
14. 00 15. 00	1	NURSING AND ALLIED HEALTH EDUCATION ACTIVITIES	0 142, 750	0	0		0 168, 669	14. 00 15. 00
13.00		IENT ROUTINE SERVICE COST CENTERS	142, 730	<u> </u>		25, 717	100, 007	13.00
30.00		SKILLED NURSING FACILITY	4, 727, 759	1, 478, 567	31, 222	853, 544	7, 091, 092	30.00
31. 00 32. 00		NURSING FACILITY ICF/ D	0	0	C	0	0	31. 00 32. 00
33.00	03300	OTHER LONG TERM CARE	0	0	C		0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	16, 872	ol	C	O	16, 872	40. 00
41.00	04100	LABORATORY	15, 108	0	C		15, 108	41. 00
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	22, 503 31, 820	0	0	0	22, 503 31, 820	42. 00 43. 00
44. 00		PHYSI CAL THERAPY	284, 454	0	C	0	284, 454	44. 00
45. 00	1	OCCUPATI ONAL THERAPY	301, 249	0	O	0	301, 249	
46. 00 47. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	184, 832	0	C	0	184, 832 0	46. 00 47. 00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o	C	0	0	48. 00
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	161, 539	0	0	0	161, 539 0	49. 00 50. 00
51. 00		SUPPORT SURFACES	17, 777	0	C	0	17, 777	51. 00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	52. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	0	C	0	0	60. 00
61. 00		RURAL HEALTH CLINIC	0	o	C	0	0	61.00
62. 00 63. 00	06200	OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0	0	62. 00 63. 00
	OTHER	REIMBURSABLE COST CENTERS	-			-		
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0	0	C	_	0	
72. 00	07200			ő	C	_	0	72. 00
73. 00 74. 00	07300	CMHC OTHER REIMBURSABLE COST	0	0	C	_	0	73. 00 74. 00
74.00		AL PURPOSE COST CENTERS	<u> </u>	<u> </u>		ı o	0	74.00
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00		INTEREST EXPENSE UTILIZATION REVIEW						81. 00 82. 00
83. 00		HOSPI CE	0	0	C	0	0	83. 00
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	12, 794, 774	0 1, 478, 567	31, 222	1, 104, 603	0 12, 794, 774	84. 00 89. 00
		MBURSABLE COST CENTERS	, , , , , , , , ,		0.7222	.,,		
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0 8, 155	0	0	0	0 8, 155	90. 00 91. 00
92. 00		PHYSICIANS PRIVATE OFFICES	0, 133	o	C	o	0, 133	92.00
93.00		NONPALD WORKERS PATIENTS LAUNDRY	0	0	0	0	0	93. 00 94. 00
94. 00 95. 00		OTHER NONREIMBURSABLE COST CENTERS		ol	C	0	0	94. 00 95. 00
98. 00		Cross Foot Adjustments	0	o	C	0	0	98. 00
99. 00 100. 00		Negative Cost Centers TOTAL	12, 802, 929	0) 1, 478, 567	31, 222	0 1, 104, 603	0 12, 802, 929	99. 00 100. 00
	1		, , , , - , - , - ,	=, ==,	,		= /	

Provi der No.: 315036

					o 12/31/2023		
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/13/2024 9: 2 DI ETARY	3 am
	cost denter bescription	& GENERAL	OPERATION, MAINT. &	LI NEN SERVI CE	HOOSEKEETTING	DIETAKI	
			REPAI RS				
	T	4.00	5. 00	6. 00	7. 00	8. 00	
1 00	GENERAL SERVICE COST CENTERS						4 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	1, 626, 284					4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	66, 329	522, 178	3			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	31, 959	0	251, 599	·		6. 00
7.00	00700 HOUSEKEEPI NG	57, 814	0) c	455, 142		7. 00
8.00	00800 DI ETARY	142, 539	0	0	0	1, 122, 140	
9.00	00900 NURSI NG ADMI NI STRATI ON	77, 477	0	0	0	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	6, 051	0		0	0	10. 00 11. 00
	01200 MEDI CAL RECORDS & LI BRARY	7, 249	0		0	0	12.00
13. 00	1	28, 561	0		Ö	0	13. 00
14. 00		0	0		o	0	14. 00
15.00	01500 ACTI VI TI ES	24, 543	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		1, 031, 808	522, 178			1, 122, 140	
31.00	03100 NURSING FACILITY	0	0		-	0	31.00
	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0	Ί "	1	0	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	j oj		ή	<u> </u>	0	33.00
40. 00		2, 455	0		0	0	40. 00
41. 00		2, 198	0		1	0	
42.00	04200 I NTRAVENOUS THERAPY	3, 274	0) c	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	4, 630	0) c	0	0	43. 00
	04400 PHYSI CAL THERAPY	41, 390	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	43, 834	0	0	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY	26, 894	0			0	46.00
	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	47. 00 48. 00
49. 00		23, 505	0		Ö	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		o	0	50.00
51.00	05100 SUPPORT SURFACES	2, 587	0) c	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS				l al		
60.00	06000 CLINIC	0	0		1	0	
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	٩	U		U	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		o	0	
00.00	OTHER REIMBURSABLE COST CENTERS			,1	<u> </u>		00.00
70.00		0	O) C	0	0	70. 00
	07100 AMBULANCE	0	0	0	0	0	
72. 00	07200 CORF	0	0	0	0	0	72. 00
	07300 CMHC	0	0		0	0	
74.00	O7400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0) <u> </u>	0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83.00	08300 HOSPI CE	0	0) c	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	1, 625, 097	522, 178	251, 599	455, 142	1, 122, 140	89. 00
00.00	NONREI MBURSABLE COST CENTERS					0	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 1, 187	0		1	0	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	1, 187	0		1	0	
93. 00	09300 NONPALD WORKERS		n		ol ol	0	1
94. 00	09400 PATIENTS LAUNDRY	0	0) c	o	0	1
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0) C	o	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0	0	0	
99.00	Negative Cost Centers	0	500 470	0	0	1 122 140	99. 00
100.00	D TOTAL	1, 626, 284	522, 178	251, 599	455, 142	1, 122, 140	100.00

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/13/2024 9: 23 am Provi der No.: 315036

						5/13/2024 9: 2	3 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
		0.00	SUPPLY	11.00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE 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	609, 940					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	47, 637				10.00
11. 00	01100 PHARMACY	0	0	0			11. 00
12.00		0	0	0	57, 069		12. 00
13.00	•	0	0	0	0	224, 849	13. 00
14. 00	•	0	0	0	0	0	
15. 00		0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		47.69	1	50.000		
30.00		609, 940	47, 637		50, 888	224, 849	30.00
31. 00		0	0		0	0	31.00
32. 00 33. 00		0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	U	U	33. 00
40. 00		0	0	0	74	0	40. 00
41. 00		0	0		94	0	•
42. 00	• • • • • • • • • • • • • • • • • • •	0	0	0	59	Ö	
43. 00		o	0	Ö	19	0	43. 00
44. 00	, ,	O	0	0	2, 115	0	44.00
45.00		0	0	0	2, 169	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	О	1, 189	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	461	0	49. 00
50.00		0	0	0	0	0	50.00
51. 00	•	0	0	0	1	0	•
52. 00		0	0	0	0	0	52. 00
(0.00	OUTPATIENT SERVICE COST CENTERS		0		0	0	/ 0 00
60.00		0	0		0	0 0	60.00
61. 00 62. 00	•		U	٥	U	U	61. 00 62. 00
63. 00	l l	0	0	0	0	0	1
03.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	03.00
70. 00		0	0	0	0	0	70. 00
71. 00	•	o	0	Ö	0	Ō	
72. 00		o	0	0	0	0	72. 00
73.00		0	0	О	0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
							80. 00
81. 00							81. 00
82. 00			_	_	_	_	82. 00
83. 00		0	0	0	0	0	1
84.00		0 (00 040	47 (27	0	F7 0/0	0	
89. 00	,	609, 940	47, 637	0	57, 069	224, 849	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	О	0	0	90. 00
91.00			0		0	0	1
92. 00	• • • • • • • • • • • • • • • • • • •		0	Ö	0	0	•
93. 00			n	ő	n	ő	1
94. 00			Ö	Ö	Ō	0	
95.00		ol	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	o	0				98. 00
99. 00	1 9	0	0	0	0	0	
100.00	0 TOTAL	609, 940	47, 637	0	57, 069	224, 849	100. 00

					To 12/31/2023	Date/Time Pre 5/13/2024 9:2	
			OTHER GENERAL			37 137 2024 9. 2	3 alli
	Cost Center Description	NURSING AND ALLIED HEALTH	SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION 14.00	15. 00	16.00	17.00	18. 00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	16.00	
	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0000		2			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	193, 212	2 11, 600, 48	5 0	11, 600, 485	30. 00
	03100 NURSING FACILITY	0		-	0	0	31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	l .	1	0 0	0	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS			9	0 0	0	33.00
40.00	04000 RADI OLOGY	0	(19, 401	•
41. 00	04100 LABORATORY	0		- ,		17, 400	1
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	(25, 836 36, 469	
44. 00	04400 PHYSI CAL THERAPY			1		327, 959	1
45. 00	04500 OCCUPATI ONAL THERAPY			1		347, 252	1
46.00	04600 SPEECH PATHOLOGY	0	(1		212, 915	1
47.00	04700 ELECTROCARDI OLOGY	0	(O	0 0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(O	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0		-1,	5 0	185, 505	1
	05000 DENTAL CARE - TITLE XIX ONLY	0	(- I	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0		1	5 0 0	20, 365 0	1
32.00	OUTPATIENT SERVICE COST CENTERS			J	0	U	32.00
60.00	06000 CLINIC	0	(O	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	(O	0 0	0	61. 00
62.00	06200 FQHC						62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	(0	0 0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0		1	0 0	0	70. 00
71. 00	107100 AMBULANCE			-	0 0	0	71.00
	07200 CORF			Ö	o o	0	72.00
	07300 CMHC	0		o	0	0	1
74. 00	07400 OTHER REIMBURSABLE COST	0	()	0 0	0	74. 00
	SPECIAL PURPOSE COST CENTERS		1				
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW						81. 00 82. 00
	108300 HOSPI CE	0			0	0	1
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS			Ö	o o	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	193, 212	12, 793, 58	7 0	12, 793, 587	•
	NONREI MBURSABLE COST CENTERS	_					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	•	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0		9, 34	2 0	9, 342	
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0				0	
93.00	09400 PATI ENTS LAUNDRY			ol .		0	1
	09500 OTHER NONREIMBURSABLE COST CENTERS			ol .	o o	0	1
98. 00	Cross Foot Adjustments				o o	0	1
99. 00	Negative Cost Centers	0	(o l	0 0	0	99. 00
100.00	TOTAL	0	193, 212	2 12, 802, 92	9 0	12, 802, 929	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315036

				10	12/31/2023	Date/IIme Pre 5/13/2024 9:2	
			CAPI TAL REL	ATED COSTS		37 137 2024 7. 2	J dill
	Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	FIXIURES	EQUIPMENT		DENEFITS	
		Related Costs					
		0	1. 00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS		0	0	0	0	2.00
3. 00 4. 00	00400 ADMINISTRATIVE & GENERAL		0	0	0	0	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	o	0	0	Ö	0	6. 00
7.00	00700 HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	00800 DI ETARY	0	0	0	0	0	8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100 PHARMACY	0	0	0	0	0	11.00
12. 00 13. 00	O1200 MEDICAL RECORDS & LIBRARY O1300 SOCIAL SERVICE	0	0	0	0	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITIES	O	0	0	Ö	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1, 478, 567	31, 222	1, 509, 789	0	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	33. 00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00 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 PATTENTS	0	0	0	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	O	0	0	Ö	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	0	0	0	61.00
62. 00 63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	O _I	<u> </u>	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
	07200 CORF	0	0	0	0	0	
	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
90 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						00.00
80. 00 81. 00	08100 NTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW						82.00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 478, 567	31, 222	1, 509, 789	0	89. 00
00.05	NONREI MBURSABLE COST CENTERS		=1	_1	_1	-	00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0	0	0	0	91. 00 92. 00
93.00	09300 NONPALD WORKERS		0	0	O O	0	92.00
94. 00	09400 PATIENTS LAUNDRY		0	0	n	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0	Ö	ő	0	95. 00
98.00	Cross Foot Adjustments				o		98. 00
99. 00	Negative Cost Centers		0	0	0	0	
100.00	TOTAL	0	1, 478, 567	31, 222	1, 509, 789	0	100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315036 Peri

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/13/2024 9:23 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 4.00 6.00 7.00 8.00 5.00 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 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 0000000000 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 00700 HOUSEKEEPI NG 0 7.00 7.00 8.00 00800 DI ETARY 0 0 0 0 0 0 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 Λ 11.00 01100 PHARMACY 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 01300 SOCIAL SERVICE 0 0 13.00 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 C 0 14.00 15.00 01500 ACTI VI TI ES 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 SKILLED NURSING FACILITY 30.00 n O 0 0 0 03100 NURSING FACILITY 31.00 0 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 41.00 04100 LABORATORY 0000000000 0 0 0 0 0 0 0 0 0 0 41.00 0 42 00 04200 I NTRAVENOUS THERAPY 0 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 44. 00 04400 PHYSI CAL THERAPY 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 0 45.00 04600 SPEECH PATHOLOGY 0 46 00 Ω 46 00 0 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 0 51.00 05100 SUPPORT SURFACES C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 ol 52.00 0 52.00 OUTPATIENT SERVICE COST CENTERS 0 60.00 60.00 06000 CLI NI C 0 0 0 0 06100 RURAL HEALTH CLINIC 61.00 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 0 71.00 07100 AMBULANCE 0 0 0 71.00 07200 CORF 0 72.00 0 0 72.00 0 0 0 73.00 07300 CMHC 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 C 0 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 0 0 0 0 0 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 Ω 0 0 Λ 90.00 0 91.00 09100 BARBER AND BEAUTY SHOP 0 C 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 0 0 0 92.00 09300 NONPALD WORKERS 0 93.00 93.00 0 0 09400 PATIENTS LAUNDRY 0 94.00 94.00 0 0 95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 0 0 99 00 Negative Cost Centers 0 0 99 00 100.00 **TOTAL** 0 100.00

Provi der No.: 315036

						5/13/2024 9: 2	3 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & 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 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6. 00 7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION	0					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0			•	10.00
11. 00	01100 PHARMACY	0	0	0			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0		12. 00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	0	0	0	0	30.00
31. 00	03100 NURSING FACILITY	0	0		0	0	31.00
32. 00	03200 CF/IID	0	0	1	0	0	ł
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	,					
40. 00	04000 RADI OLOGY	0	0		0	0	40. 00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0	0	0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	l o	0	U U	U	0	52. 00
60. 00	06000 CLINIC	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	1	0	0	
62.00	06200 FQHC						62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	0	0	
71. 00 72. 00	07100 AMBULANCE 07200 CORF	0	0	0	0	0	
73. 00	07300 CMHC	0	0	0	0	0	ł
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	ł
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW		0		0		82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	•
89. 00	SUBTOTALS (sum of lines 1-84)	0	0		0		1
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	•
94. 00 95. 00	09400 PATIENTS LAUNDRY		0	0	0	0	
98.00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments		0	-	U	0	95. 00 98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	•
100.00		Ö	0	-	0		100.00
		'		'	'		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315036

					To 12/31/2023	B Date/Time Pre 5/13/2024 9:2	
			OTHER GENERAL			37 137 2024 7.2	J diii
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Dowr	Total	
		ALLIED HEALTH EDUCATION			Adjustments		
		14. 00	15. 00	16.00	17. 00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	OO300						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						10. 00 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					14. 00
15. 00	01500 ACTI VI TI ES	0	0				15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			4 500 7	00	4 500 700	00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	0		89 (1
32. 00	03200 CF/IID	0		1		1	1
33. 00	03300 OTHER LONG TERM CARE	0	•	1	0	1	1
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	1	1	0	1	1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0		0 0		
43. 00	04300 OXYGEN (INHALATION) THERAPY	0			0		1
44. 00	04400 PHYSI CAL THERAPY	0	Ö	6	0		
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	o c	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0		0		1
47. 00	04700 ELECTROCARDI OLOGY	0	0		0 0		
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0				
50. 00	05000 DENTAL CARE - TITLE XIX ONLY			ó	0	1	1
51.00	05100 SUPPORT SURFACES	0	0		0	o c	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 (o c	52. 00
	OUTPATIENT SERVICE COST CENTERS		1	,		J .	
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0		0 0		
62. 00	06200 FQHC		Ĭ	1		1	62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 (o c	63. 00
	OTHER REIMBURSABLE COST CENTERS	_	I -		-1	.1	
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0 0		
	07200 CORF				-		
	07300 CMHC	0	Ō		0		73.00
74.00	07400 OTHER REIMBURSABLE COST	0	0		0 (o c	74. 00
00.00	SPECIAL PURPOSE COST CENTERS		I			1	00.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	0	О		0	ol c	1
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	o c	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	0	1, 509, 7	89 (1, 509, 789	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1	0		0 (90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	6			1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0		1
93.00	09300 NONPALD WORKERS	0	0)	0 0	o c	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	2	0		
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0			0 0		
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0	S)) C	
100.00		0	Ö	1, 509, 7			
		•		•	*	•	-

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315036

				Т	o 12/31/2023	Date/Time Pre 5/13/2024 9:2	
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	33, 587	I			I	1. 00
	00200 CAP REL COSTS - BLDGS & FIXTURES	33, 307	33, 587				2.00
	00300 EMPLOYEE BENEFITS	0	0				3. 00
	00400 ADMINISTRATIVE & GENERAL	0	0	469, 848			4. 00
1	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	0	89, 082		455, 849 219, 640	5. 00 6. 00
	00700 HOUSEKEEPI NG	0	0		_	397, 328	7. 00
	00800 DI ETARY	0	0	C	0	979, 601	8. 00
1	00900 NURSI NG ADMI NI STRATI ON	0	0	423, 224		532, 463	9.00
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0			41, 586 0	10. 00 11. 00
	01200 MEDICAL RECORDS & LIBRARY	0	Ö	41, 888	_	49, 820	•
4	01300 SOCI AL SERVI CE	0	0	164, 853		196, 288	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0	136, 868	_		14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			130,000		100,007	13.00
30. 00	03000 SKILLED NURSING FACILITY	33, 587	33, 587	4, 507, 290	0	7, 091, 092	30. 00
	03100 NURSING FACILITY	0	0			-	31.00
	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0				32. 00 33. 00
	ANCI LLARY SERVICE COST CENTERS						00.00
	04000 RADI OLOGY	0	0				40.00
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0			15, 108 22, 503	1
	04300 OXYGEN (INHALATION) THERAPY	0	Ö	Ö	0	31, 820	1
	04400 PHYSI CAL THERAPY	0	0	C	0	284, 454	44. 00
	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0	301, 249	1
	04700 ELECTROCARDI OLOGY					184, 832 0	46. 00 47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	C	0	0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	0	C	_	161, 539	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		_	0 17, 777	50. 00 51. 00
1	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö				52. 00
	OUTPATIENT SERVICE COST CENTERS	1					
	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0				60. 00 61. 00
62. 00	06200 FQHC		_	_	_		62. 00
	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	63. 00
	07000 HOME HEALTH AGENCY COST	0	0	С	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	C		-	71. 00
1	07200 CORF 07300 CMHC	0	0		0	0	
	07400 OTHER REIMBURSABLE COST	0	0			0	1
	SPECIAL PURPOSE COST CENTERS				I		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	0	0	C	0	0	83. 00
84. 00 89. 00	O8400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	33, 587	0 33, 587	5, 833, 053	0 -1, 626, 284	0 11, 168, 490	84. 00 89. 00
	NONREI MBURSABLE COST CENTERS	33, 367	33, 367	J, 655, 055	-1, 020, 204	11, 100, 490	09.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90. 00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	8, 155 0	91. 00 92. 00
	09300 NONPALD WORKERS	0	0		0	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	C	0	0	94. 00
	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	95. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00	Cost to be allocated (per Wkst. B,	1, 478, 567	31, 222	1, 104, 603		1, 626, 284	
103. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	44. 022003	0. 929586	0. 189370		0. 145507	
103.00	Cost to be allocated (per Wkst. B,	44. 022003	0. 929386	0. 1893/0			103.00
	Part II)						
105. 00	Unit cost multiplier (Wkst. B, Part			0.000000		0. 000000	105. 00
ı	1	1	1	1	1	1	1

Provi der No.: 315036

				1	0 12/31/2023	Date/lime Pre 5/13/2024 9: 2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(TOTAL PATIENT			CTOTAL DATIENT	
		(SQUARE FEET)	DAYS)			(TOTAL PATIENT DAYS)	
		5. 00	6.00	7. 00	8. 00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	33, 587					4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	33, 367	39, 990	1			6. 00
7. 00	00700 HOUSEKEEPING		37, 770	33, 587			7. 00
8. 00	00800 DI ETARY	l c	Ö	0	119, 970		8. 00
9.00	00900 NURSING ADMINISTRATION	C	0	0	0	39, 990	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	C	0	0	0	0	10. 00
11. 00	01100 PHARMACY	C	0	0	0	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	C	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE		0		0	0	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES		0		0	0	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	ή	0	0	13.00
30. 00	03000 SKILLED NURSING FACILITY	33, 587	39, 990	33, 587	119, 970	39, 990	30. 00
31.00	03100 NURSING FACILITY	C		0	0	0	31. 00
32.00	03200 CF/IID	C	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	C	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	_	1	1	_		
40.00	04000 RADI OLOGY	C	0	0	0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	C	0	0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY				0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY		0		0	Ö	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		Ö	o o	0	Ö	45. 00
46.00	04600 SPEECH PATHOLOGY	C	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	C	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	C	0	0	0	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES		0		0	0	50.00
51.00	05200 OTHER ANCILLARY SERVICE COST CENTERS		0		0		51. 00 52. 00
02.00	OUTPATIENT SERVICE COST CENTERS			,			02.00
60.00	06000 CLI NI C	C	0	0		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61. 00
62. 00	06200 FOHC				_		62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS		0	0		0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	C	0) 0	0	0	70. 00
71. 00	07100 AMBULANCE	C	0	0	0	0	71. 00
	07200 CORF	C	0	0	0	0	72. 00
	07300 CMHC	C	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	C	0) 0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		1			I	80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	C	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS		0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	33, 587	39, 990	33, 587	119, 970	39, 990	89. 00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		0		0	0	90. 00 91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES				0	0	92.00
93. 00	09300 NONPALD WORKERS		Ö		0	Ö	93. 00
94.00	09400 PATIENTS LAUNDRY	C	0	0	0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	C	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers	F00 1==	051 5		4 400 4:-	/00 0:-	99.00
102.00		522, 178	251, 599	455, 142	1, 122, 140	609, 940	102.00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	15. 547027	6. 291548	13. 551136	9. 353505	15. 252313	103 00
104.00		13. 347327	0. 271340	0	7. 555505		104. 00
- // 50	Part II)						50
105.00	i i i i i i i i i i i i i i i i i i i	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	105. 00
	11)	1	I	I		I	

	Financial Systems LLOCATION - STATISTICAL BASIS	ARBOR G		No . 21502/	In Lie	u of Form CMS-2 Worksheet B-1	2540-10
CU31 P	LLUCATION - STATISTICAL DASIS		Provider	F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	nared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	5/13/2024 9: 2	
	cost center bescription	SERVICES &	(COSTED	RECORDS &		ALLI ED HEALTH	
		SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(TOTAL PATIENT DAYS)	EDUCATION (ASSI GNED	
		REQUI S.) 10. 00	11. 00	CHARGES) 12.00	13. 00	TI ME) 14. 00	
4 00	GENERAL SERVICE COST CENTERS	1		I	1 1		1 00
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FIXTURES OO200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00 5. 00	OO400 ADMI NI STRATI VE & GENERAL OO500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6. 00 7. 00
8. 00	00800 DI ETARY						8. 00
9. 00 10. 00	00900 NURSI NG ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	68, 272					9. 00 10. 00
11. 00	01100 PHARMACY	00,272	0				11. 00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	0	23, 647, 786	39, 990		12. 00 13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	O	0		0	0	14. 00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	68, 272	0			0	30. 00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0		0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	O	0	<u> </u>	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	30, 508	O	0	40. 00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	1	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	7, 676		0	43. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	876, 496 898, 783		0	44. 00 45. 00
46.00	04600 SPEECH PATHOLOGY	Ö	Ö	492, 721	Ö	0	46. 00
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	O	0	190, 913		0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0 337	0	0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	<u> </u>	0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0		С	0	0	60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	C	0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	О	0	C	0	0	
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0			0	70. 00
71. 00	07100 AMBULANCE	Ö	Ö	· ·	Ö	0	71. 00
72. 00 73. 00	07200 CORF 07300 CMHC	0	0		0	0	72. 00 73. 00
74. 00	07400 OTHER REIMBURSABLE COST	o	0		0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW						81. 00 82. 00
83. 00	08300 HOSPI CE	o	0	С	0	0	
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0 68, 272	0		0 39, 990	0	84. 00 89. 00
	NONREI MBURSABLE COST CENTERS	00, 272					
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0		0	0	90. 00 91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92.00
93. 00 94. 00	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY	0	0		0	0	93. 00 94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	С	0	0	95.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00	Cost to be allocated (per Wkst. B, Part I)	47, 637	0	57, 069	224, 849	0	102. 00
103.00	Unit cost multiplier (Wkst. B, Part I)	0. 697753	0. 000000	0. 002413	5. 622631	0. 000000	•
104.00	Cost to be allocated (per Wkst. B, Part II)	0	0	C	0	0	104. 00
105.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105. 00
)	ı I		I	ı I		I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/13/2024 9: 23 am Provi der No.: 315036

				5/13/2024 9: 2	3 am
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
			(TOTAL PATIENT		
			DAYS)		
			15. 00		
		AL SERVICE COST CENTERS			
1. 00	1	CAP REL COSTS - BLDGS & FLXTURES			1. 00
2.00		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	DIETARY			8. 00
9.00	00900	NURSING ADMINISTRATION			9. 00
10.00		CENTRAL SERVICES & SUPPLY			10.00
11.00	1	PHARMACY			11. 00
12.00	1	MEDICAL RECORDS & LIBRARY			12. 00
13.00	1	SOCIAL SERVICE			13. 00
14.00		NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	1	ACTIVITIES	39, 990		15. 00
		IENT ROUTINE SERVICE COST CENTERS			
30.00		SKILLED NURSING FACILITY	39, 990		30.00
31. 00		NURSING FACILITY	0		31. 00
32.00		ICF/IID	0		32. 00
33. 00	1	OTHER LONG TERM CARE	o		33. 00
		LARY SERVICE COST CENTERS	-1		1
40.00		RADI OLOGY	0		40.00
41.00		LABORATORY	o		41.00
42.00		I NTRAVENOUS THERAPY	o		42.00
43.00		OXYGEN (INHALATION) THERAPY	o		43.00
44.00	04400	PHYSI CAL THERAPY	0		44. 00
45.00	04500	OCCUPATI ONAL THERAPY	0		45. 00
46.00	04600	SPEECH PATHOLOGY	O		46. 00
47.00	04700	ELECTROCARDI OLOGY	O		47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	O		48. 00
49.00	04900	DRUGS CHARGED TO PATIENTS	O		49. 00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	О		50.00
51.00	05100	SUPPORT SURFACES	0		51. 00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0		52.00
	OUTPA	TIENT SERVICE COST CENTERS			
60.00	06000	CLINIC	0		60.00
61. 00		RURAL HEALTH CLINIC	0		61. 00
62.00	06200				62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
		REIMBURSABLE COST CENTERS			
		HOME HEALTH AGENCY COST	0		70. 00
		AMBULANCE	0		71. 00
72. 00	07200		0		72. 00
73. 00	07300	l .	0		73. 00
74. 00		OTHER REIMBURSABLE COST	0		74. 00
		AL PURPOSE COST CENTERS			
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00		I NTEREST EXPENSE			81. 00
82. 00		UTILIZATION REVIEW	_		82. 00
83. 00		HOSPI CE	0		83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0		84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	39, 990		89. 00
00 00		IMBURSABLE COST CENTERS	0		00.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0		90.00
91. 00 92. 00		PHYSICIANS PRIVATE OFFICES	0		91.00
	1	•	0		92.00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0		93. 00 94. 00
94. 00 95. 00		OTHER NONREIMBURSABLE COST CENTERS	0		95.00
98. 00 98. 00	0 7500	Cross Foot Adjustments	۷		98.00
99. 00		Negative Cost Centers			99.00
102.00		Cost to be allocated (per Wkst. B,	193, 212		102. 00
102. UL	Ί	Part I)	173, 212		102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	4. 831508		103. 00
104.00	1	Cost to be allocated (per Wkst. B,	n		104. 00
	1	Part II)			
105.00		Unit cost multiplier (Wkst. B, Part	0. 000000		105. 00
		II)			

Health Financial Systems		ARBOR GLEN		_	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR	ANCILLARY AND OUTPATIENT COST	CENTERS	Provider No · 315036	Peri od:	Worksheet C

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/13/2024 9:23 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col . 2 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 19, 401 30, 508 0. 635932 40.00 41.00 04100 LABORATORY 17, 400 38, 771 0.448789 41.00 24, 305 42.00 04200 I NTRAVENOUS THERAPY 25, 836 1.062991 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 36, 469 7, 676 4.751042 43.00 44. 00 04400 PHYSI CAL THERAPY 327, 959 876, 496 0.374171 44.00 04500 OCCUPATIONAL THERAPY 898, 783 45.00 347, 252 0. 386358 45.00 04600 SPEECH PATHOLOGY 212, 915 492, 721 0.432121 46.00 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 185, 505 0. 971673 49.00 49.00 190, 913 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 51.00 05100 SUPPORT SURFACES 20, 365 337 60. 430267 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 63.00 63.00 0.000000 0 0 71. 00 | 07100 | AMBULANCE 0.000000 71.00

1, 193, 102

2, 560, 510

100.00

100.00

Total

Health Financial Systems	ARBOR	GLEN		In lie	eu of Form CMS-:	2540_10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	ANDON			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I	pared:
		Title	XVIII (1)	Skilled Nursing Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	ENT COST					4
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	0. 635932	2 220	I	0 2,054	. 0	40. 00
41. 00 04100 LABORATORY	0. 635932			2,054	0	
42. 00 04200 NTRAVENOUS THERAPY	1. 062991	6, 575		0 6, 989	1	
43. 00 04300 0XYGEN (I NHALATION) THERAPY	4. 751042			0 16, 804		
44. 00 04400 PHYSI CAL THERAPY	0. 374171			0 103, 818		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 386358			0 120, 561	1	
46. 00 04600 SPEECH PATHOLOGY	0. 432121			0 87, 965		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0. 971673	47, 168		0 45, 832	2	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0	,	50.00
51. 00 05100 SUPPORT SURFACES	60. 430267	40		0 2, 417	0	51.00
52.00 O5200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52. 00
OUTPATIENT SERVICE COST CENTERS						4
60. 00 06000 CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61. 00
62. 00 06200 FQHC						62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0	0	
71. 00 07100 AMBULANCE (2)	0. 000000	ł .		0 307 440	0	
100.00 Total (Sum of Lines 40 - 71)	1	853, 622	I	0 386, 440	1 0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	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 Financ		ARBOR			In Lie	u of Form CMS-2	2540-10
APPORTI ONMENT	OF ANCILLARY AND OUTPATIENT COSTS			No.: 315036	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/13/2024 9:2	pared: 3 am
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
(Cost Center Description					1. 00	
	I - APPORTIONMENT OF VACCINE COST					1.00	
	Orugs charged to patients - ratio of c			t C, column 3	, line 49)	0. 971673	
	Program vaccine charges (From your rec					8, 446	
	Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	/iders, transf	er this amoun	t to Worksheet	8, 207	3. 00
	E, Part I, line 18)	1		1 5 6			
(Cost Center Description	Total Cost (From Wkst. B.	Nursing &	Ratio of	Program Part A Cost (From	Part A Nursing & Allied	
			(From Wkst. B,			Health Costs	
		18		Costs to Total		for Pass	
		10	14)	Costs - Part		Through (Col.	
			,	(Col . 2 / Co		3 x Col . 4)	
				1)			
		1.00	2.00	3.00	4. 00	5. 00	
PART II	II - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ARY SERVICE COST CENTERS						
	RADI OLOGY	19, 401	0	0.0000		0	
	_ABORATORY	17, 400	0	0.0000		0	41.00
	NTRAVENOUS THERAPY	25, 836	0	0.0000		0	
	OXYGEN (INHALATION) THERAPY	36, 469	0	0.0000		0	
	PHYSI CAL THERAPY	327, 959	0	0.0000		0	44.00
	OCCUPATI ONAL THERAPY	347, 252	Ü	0.0000		0	45. 00
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	212, 915	0	0.0000		0	46. 00 47. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0. 0000 0. 0000		0	47.00
	DRUGS CHARGED TO PATIENTS	185, 505	0	0.0000		0	49.00
	DENTAL CARE - TITLE XIX ONLY	105, 505	0	0.0000		0	50.00
	SUPPORT SURFACES	20, 365	n	0.0000		0	51.00
	OTHER ANCILLARY SERVICE COST CENTERS	0	Ö	0.0000		0	
	Total (Sum of Lines 40 - 52)	1, 193, 102	0		386, 440	-	100. 00

	Financial Systems ARBOR GL ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315036	In Lie Period: From 01/01/2023 To 12/31/2023		
		Title XVIII	Skilled Nursing Facility	5/13/2024 9: 2 PPS	<u>3 am</u>
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
00	Inpatient days including private room days			39, 990	1.
00	Private room days			686	2.
00	Inpatient days including private room days applicable to the	3		3, 328	
00	Medically necessary private room days applicable to the Progr	am		0	4.
00	Total general inpatient routine service cost			11, 600, 485	5.
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			00 050 000	
0	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5	divided by line ()		20, 952, 032 0. 553669	
10	Enter private room charges from your records	divided by Title 6)		387, 590	
0	Average private room per diem charge (Private room charges li	ne 8 divided by private	room days line	565. 00	1
.0	2)	ne o di vided by private	Toolii days, Title	303.00	1
00					10
00	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	d by	523. 21	11
	semi-private room days)		•		
00	Average per diem private room charge differential (Line 9 min			41. 79	
00	Average per diem private room cost differential (Line 7 times			23. 14	
00	Private room cost differential adjustment (Line 2 times line	,		15, 874	
00	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Line 5	minus line 14)	11, 584, 611	15
00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		289. 69	16
00	Program routine service cost (Line 3 times line 16)	,		964, 088	17
00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18
00	Total program general inpatient routine service cost (Line 1			964, 088	
00	Capital related cost allocated to inpatient routine service of line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	1, 509, 789	20
00	Per diem capital related costs (Line 20 divided by line 1)			37. 75	21
00	Program capital related cost (Line 3 times line 21)			125, 632	
00	Inpatient routine service cost (Line 19 minus line 22)			838, 456	
00	Aggregate charges to beneficiaries for excess costs (From pr	ovi der records)		0	24
00	Total program routine service costs for comparison to the cos	t limitation (Line 23 mi	nus line 24)	838, 456	
00	Enter the per diem limitation (1)				26
00	Inpatient routine service cost limitation (Line 3 times the p				27
00	Reimbursable inpatient routine service costs (Line 22 plus t		line 27)		28
	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be u				I

		1.00	
<u>-</u>	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	39, 990	1.00
2.00	Program inpatient days (see instructions)	3, 328	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. 083221	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	ARBOR GLEN		In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	P TITLE XVIII		From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/13/2024 9:23 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			_	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSI	MENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	_IVILIN I		2, 335, 792	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		2, 333, 772	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	ymerresy		2, 335, 792	3. 00
4. 00	Primary payor amounts			0	4. 00
5. 00	Coinsurance			445, 600	
6. 00	Allowable bad debts (From your records)			77, 192	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		66, 819	
8.00	Adjusted reimbursable bad debts. (See instructions)			50, 175	
9. 00	Recovery of bad debts - for statistical records only			0	
10.00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			1, 940, 367	11. 00
12. 00	Interim payments (See instructions)			1, 895, 744	
13. 00	Tentati ve adjustment			0	13. 00
14. 00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 004	14. 75
14. 99	Sequestration amount (see instructions)			37, 804	14. 99
15.00	Balance due provider/program (see Instructions)			5, 815	15. 00
16.00	Protested amounts (Nonallowable 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	Ancillary services Part B			0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			8, 207	
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			8, 207	
20. 00	Medicare Part B ancillary charges (See instructions)			8, 446	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			8, 207	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			8, 207	
26. 00	Interim payments (See instructions)			4, 966	
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			164	
29. 00	Balance due provider/program (see instructions)	a with CMC Dub 15 2	coction 11E 2	3, 077	29. 00 30. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	with CMS Pub. 15-2,	Section 115. 2	0	30.00

Health Financial Systems	ARBOR GLEN		In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT T	FITLE V and TITLE XIX ONLY	Provi der No.: 315036	From 01/01/2023	Worksheet E Part II Date/Time Prepared: 5/13/2024 9:23 am
		Title XIX	Skilled Nursing	PPS

		THE XIX	Facility	113	
			Ĺ		
				1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpati ent servi ces			0	
4.00	Inpatient routine services (see instructions)			0	
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			0	
7.00	Differential in charges between semiprivate accommodations and	ess than semiprivate a	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			0	8. 00
9.00	Pri mary payor amounts			0	
10. 00	Total Reasonable Cost (Line 8 minus line 9)			0	10. 00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges				11. 00
12. 00	Outpati ent service charges			0	
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	ess than semiprivate a	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	oayment for services or	n a charge basis	0	17. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20. 00	Cost of covered services (see Instructions)			0	
21. 00	Deducti bl es			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl cost limit	y collected based on co	orrection of	0	27. 00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in p	orogram	0	28. 00
	utilization	·	J I		
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting frif minus, enter amount in parentheses)	om disposition of depre	eciable assets (0	30. 00
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32.00	Interim payments	27 dia 20)		0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overnavments in narenth	1999) (999	0	33. 00
33.00	Instructions)	over payments in parenti	(366	U	33.00
	1		1		1

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:23 am

Title XVIII Skilled Nursing PPS

				Facility		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 879, 728		4, 966	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER	07 /00 /2022	1/ 01/		0	2 01
3. 01	ADJUSTMENTS TO PROVIDER	06/09/2023	16, 016		0	3. 01
3. 02			0		0	3. 02 3. 03
3. 03 3. 04			0		0	3. 03
3. 04			0		0	3. 04
3.03	Provider to Program		U		U	3. 03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ABSOSTMENTS TO TROOK III		Ö		ő	3. 51
3. 52			o		ol	3. 52
3. 53			o		ol	3. 53
3. 54			o		ol	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		16, 016		0	3. 99
	- 3.98)		·			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 895, 744		4, 966	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) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATI VE TO TROVIDER		o		ol ol	5. 02
5. 02			Ö		Ö	5. 02
0.00	Provider to Program		<u> </u>		J	0.00
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		5, 815		3, 077	6. 01
6. 02	PROVI DER TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 901, 559	N	8, 043	7. 00
			Contract	or Name	Contractor Number	
			1. (20	2. 00	
8. 00	Name of Contractor		1.	50	2.00	8. 00
3.00	Treame of contractor		I		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

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

Provider No.: 315036 | Period: From 01/01/

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/13/2024 9: 23 am

ш у)					5/13/2024 9: 2	3 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
	sets					-
	RRENT ASSETS sh on hand and in banks	5, 047	0	0	0	1. (
	mporary investments	3,047		0	0	
	tes recei vabl e	Ö	Ö	0	0	
. 00 Ac	counts recei vabl e	1, 996, 608	0	0	0	4. (
	her recei vabl es	10, 823	0	0	0	1
	ss: allowances for uncollectible notes and accounts	-272, 421	0	0	0	6.
1	cei vabl e ventory	31, 274	0	0	0	7. (
4	epai d expenses	31, 2/4		0	0	
	her current assets	559	o	0	Ö	
0. 00 Du	e from other funds	0	0	0	0	10.
	TAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 771, 890	0	0	0	11.
	XED ASSETS		J			1 12 1
	nd nd improvements	79, 858	0	0	_	1
1	ss: Accumulated depreciation	-26, 713	1	0	0	1
	ildings	4, 472, 259		0	0	
	ss Accumulated depreciation	-1, 282, 486	1	0	0	16.
	asehold improvements	298, 226		0	0	1
	ss: Accumulated Amortization	-137, 665		0	0	1
	xed equipment	99, 165		0	0	1
	ss: Accumulated depreciation tomobiles and trucks	-56, 767		0	0	1
4	ss: Accumulated depreciation		Ö	0	0	1
	jor movable equipment	492, 126	o	0	0	
4. 00 Le	ss: Accumulated depreciation	-410, 881	0	0	0	24.
	nor equipment - Depreciable	0	0	0	0	
	nor equi pment nondepreci abl e	0	0	0	0	
1	her fixed assets TAL FIXED ASSETS (Sum of lines 12 - 27)	3, 527, 122	0	0	0 0	1
	HER ASSETS	3, 327, 122	<u> </u>		0	20. (
	vestments	0	0	0	0	29. (
0.00 De	posits on Leases	0	0	0	0	30.0
	e from owners/officers	806, 998	1	0	0	
	her assets	0 000	0	0	0	1
1	TAL OTHER ASSETS (Sum of lines 29 - 32) TAL ASSETS (Sum of lines 11, 28, and 33)	806, 998 6, 106, 010	1	0	0 0	
	abilities and Fund Balances	0, 100, 010				37.
	RRENT LIABILITIES					
	counts payable	1, 775, 591	0	0	0	1
	laries, wages, and fees payable	0	0	0	0	
	yroll taxes payable tes & Loans payable (Short term)	0	0	0	0	1
	ferred income			0	0	
	cel erated payments	Ö		_	_	40.
1. 00 Du	e to other funds	0	0	0	0	41.
	her current liabilities	3, 142, 698		0		1
	TAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4, 918, 289	0	0	0	43.
	NG TERM LIABILITIES rtgage payable	7, 073, 846	O	0	0	44.
	tes payable	7,073,640		0		1
4	secured Loans		Ö	0	0	
1	ans from owners:	0	O	0	0	
8. 00 Ot	her long term liabilities	0	0	0	0	
1	IC DISTRIBUTIONS; R/E EARNINGS	-6, 068, 237	1	0	0	
1	TAL LIABILITIES (Sum of lines 44 - 49	1, 005, 609		0	0 0	
	TAL LIABILITIES (Sum of lines 43 and 50) PITAL ACCOUNTS	5, 923, 898	0	0	0	51.
	neral fund balance	182, 112				52.
1	ecific purpose fund	,	0		•	53.
	nor created - endowment fund balance - restricted			0		54.
1	nor created - endowment fund balance - unrestricted			0		55.
4	verning body created - endowment fund balance			0	_	56.
4	ant fund balance - invested in plant ant fund balance - reserve for plant improvement,				0	
	placement, and expansion					30.
	TAL FUND BALANCES (Sum of lines 52 thru 58)	182, 112	o	0	0	59.
D. 00 TO	TAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	6, 106, 010	1	0	0	
59)					

		1	o 12/31/2023	Date/Time Pre 5/13/2024 9:2	
General	I Fund	Speci al Pu	irpose Fund	Endowment Fund	

						5/13/2024 9: 2	3 am
		Genera	l Fund	Speci al Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		0		(1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		182, 112				2.00
3.00	Total (sum of line 1 and line 2)		182, 112		(ol	3. 00
4.00	Additions (credit adjustments)						4. 00
5. 00	(0. 20. 20. 20. 20. 20. 20. 20. 20. 20. 2	0		l 0		0	5. 00
6.00		0		1		0	l
7. 00		0				0	7. 00
8. 00		0				0	
9. 00		0				0	
	T	U	_	0			9.00
10.00	Total additions (sum of line 5 - 9)				(1	10.00
11. 00	Subtotal (line 3 plus line 10)		182, 112		(P	11. 00
12.00	Deductions (debit adjustments)						12.00
13.00		0		0		0	13. 00
14.00		0		0		0	14.00
15.00		0		0		0	15. 00
16.00		0		l 0		0	16. 00
17.00		0		l o		0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0		(18. 00
19. 00	Fund balance at end of period per balance		182, 112				19. 00
. ,			.02,2			1	
	Isheet (Line 11 - Line 18)						
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
	sheet (Line 11 - line 18)	Endowment Fund 6.00	PI ant	Fund 8.00			
1.00							1. 00
1.00	Fund balances at beginning of period	6.00		8.00			1.00
2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	6.00		8.00			2. 00
2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00		8.00			2. 00 3. 00
2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	6.00		8.00			2. 00 3. 00 4. 00
2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00		8.00			2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9)	6.00		8.00			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00		8.00			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	6.00		8.00			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00

Health Financial Systems	ARBOR GLEN				In Lie	u of Form CMS-	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	F	Provi der 1	No.: 315036	From	01/01/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/13/2024 9:2	pared:
				_		T	

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315036	Peri od:	Worksheet G-2	
				From 01/01/2023	Parts I-II	narad.
				To 12/31/2023	Date/Time Pre 5/13/2024 9:2	
	Cost Center Description		Inpati ent	Outpati ent	Total	J dill
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES		1.00	2.00	0.00	
	General Inpatient Routine Care Services					1
1.00	SKILLED NURSING FACILITY		21, 087, 2	76	21, 087, 276	1.00
2.00	NURSING FACILITY		21,007,2	0	21,007,270	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)		21, 087, 2	76	21, 087, 276	5. 00
	All Other Care Services		21,007,2	70	21,007,270	3.00
6.00	ANCI LLARY SERVICES		2, 568, 3	34 0	2, 568, 384	6. 00
7. 00	CLINIC		2, 300, 3	0	2, 300, 304	7.00
8.00	HOME HEALTH AGENCY COST			0	0	8.00
				0	_	
9.00	AMBULANCE			0	0	9.00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FOHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
11. 10	CORF			0	0	11. 10
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	23, 655, 6	60 0	23, 655, 660	14.00
	Worksheet G-3, Line 1)					
	Cost Center Description					
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				13, 562, 466	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	Ü	9. 00
10.00	bedder (Specify)			o o		10. 00
11. 00				0		11.00
12. 00				0		12.00
13.00	Total Dadustians (Cum of Lines 0 12)			U	_	13.00
14.00	Total Deductions (Sum of lines 9 - 13)				0	
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				13, 562, 466	1 15.00

Health Financial Systems	ARBOR GLEN		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSE	S	Provi der No.: 315036	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Prep 5/13/2024 9: 2:	
				1. 00	
1.00 Total patient revenues (From Wkst. G-2, Par	t I, col. 3, line 14	1)		23, 655, 660	1. 00
2.00 Less: contractual allowances and discounts of	n patients accounts			9, 948, 766	2. 00
3.00 Net patient revenues (Line 1 minus line 2)	•			13, 706, 894	3. 00
4 00 Local total apprating expenses (From Workshop	ot C 2 Dort II lir	30 1E)		12 542 444	1 1 00

	10 12/01/2020	5/13/2024 9: 23	
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	23, 655, 660	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	9, 948, 766	2.00
3.00	Net patient revenues (Line 1 minus line 2)	13, 706, 894	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	13, 562, 466	4.00
5.00	Net income from service to patients (Line 3 minus 4)	144, 428	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase di scounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12. 00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	
14. 00	Revenue from meals sold to employees and guests	0	
15. 00	Revenue from rental of living quarters	0	15.00
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17.00
18. 00	Revenue from sale of medical records and abstracts	0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21. 00	Rental of vending machines	0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23. 00	Governmental appropriations	0	23.00
24. 00	MISC INCOME	37, 684	
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)	37, 684	
26. 00	Total (Line 5 plus line 25)	182, 112	
27. 00	Other expenses (specify)	0	27. 00
28. 00		0	28. 00
29. 00		0	29. 00
	Total other expenses (Sum of lines 27 - 29)	0	
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	182, 112	31.00