

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).

FORM APPROVED
OMB NO. 0938-0463
EXPIRES: 12/31/2021

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/27/2025 8:08 pm

MCRIF32

Version: 11.1.179.1



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

Worksheet S
Parts I, II & III

PART I - COST REPORT STATUS

Provider use only:	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date:	Time:
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report.		
	3.01. <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only:	4. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No.: _____	
		7. <input type="checkbox"/> First Cost Report for this Provider CCN	
		8. <input type="checkbox"/> Last Cost Report for this Provider CCN	
		9. NPR Date: _____	
		10. If line 4, column 1 is "4": Enter number of times reopened _____ 0	
		11. Contractor Vendor Code: 4	
		12. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 COMPLETE CARE AT PLAINFIELD, 315101 {Provider Name(s) and CCN(s)} for the cost reporting period beginning 01/01/2024 and ending 12/31/2024 and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.


	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	<i>Shalom Stein</i>	Y	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	SHALOM STEIN		2
3	Signatory Title	CEO		3
4	Signature Date	(Dated when report is electronically signed.)		4

PART III - SETTLEMENT SUMMARY

		Title XVIII			
		Title V	Part A	Part B	Title XIX
		1.00	2.00	3.00	4.00
1.00	SKILLED NURSING FACILITY	0	81,624	0	0
2.00	NURSING FACILITY	0			0
3.00	ICF/IID				0
4.00	SNF - BASED HHA I	0	0	0	4.00
5.00	SNF - BASED RHC I	0		0	5.00
6.00	SNF - BASED FQHC I	0		0	6.00
7.00	SNF - BASED CMHC I	0		0	7.00
100.00	TOTAL	0	81,624	0	0

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 this information collection is estimated 202 hours per response, including the time to review instructions, search existing data 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 this 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.

COMPLETE CARE AT PLAINFIELD		Period:	Run Date Time:	5/27/2025 8:08 pm	
Provider CCN: 315101		From: 01/01/2024	MCRIF32	2540-10	
		To: 12/31/2024	Version:	11.1.179.1	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I
PPS

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:												
1.00	Street:	1340 PARK AVENUE	P.O. Box:						1.00			
2.00	City:	PLAINFIELD	State:	NJ	ZIP Code:	07060			2.00			
3.00	County:	UNION	CBSA Code:	35084	Urban / Rural:	U			3.00			
3.01	CBSA on/after October 1 of the Cost Reporting Period (if applicable)								3.01			
SNF and SNF-Based Component Identification:												
Component		Component Name		Provider CCN	Date Certified	Payment System (P, O, or N)						
		1.00		2.00	3.00	4.00	5.00	6.00				
4.00	SNF	COMPLETE CARE AT PLAINFIELD		315101	01/01/1973	N	P	N	4.00			
5.00	Nursing Facility								5.00			
6.00	ICF/IID								6.00			
7.00	SNF-Based HHA								7.00			
8.00	SNF-Based RHC								8.00			
9.00	SNF-Based FQHC								9.00			
10.00	SNF-Based CMHC								10.00			
11.00	SNF-Based OLTC								11.00			
12.00	SNF-Based HOSPICE								12.00			
13.00	SNF-Based CORF								13.00			
				From:		To:						
				1.00		2.00						
14.00	Cost Reporting Period (mm/dd/yyyy)			01/01/2024		12/31/2024		14.00				
15.00	Type of Control (See Instructions)			2 - Voluntary Nonprofit, Other				15.00				
								Y/N				
								1.00				
Type of Freestanding Skilled Nursing Facility												
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?								N	16.00		
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?								N	17.00		
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.								Y	18.00		
Miscellaneous Cost Reporting Information												
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.								N	19.00		
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.								N	19.01		
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.												
20.00	Straight Line								192,704	20.00		
21.00	Declining Balance								0	21.00		
22.00	Sum of the Year's Digits								0	22.00		
23.00	Sum of line 20 through 22								192,704	23.00		
24.00	If depreciation is funded, enter the balance as of the end of the period.								0	24.00		
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)								N	25.00		
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)								N	26.00		
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)								N	27.00		
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)								N	28.00		
						Part A	Part B	Other				
						1.00	2.00	3.00				
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.												
29.00	Skilled Nursing Facility								N	N		29.00
30.00	Nursing Facility										N	30.00
31.00	ICF/IID											31.00
32.00	SNF-Based HHA								N	N		32.00
33.00	SNF-Based RHC											33.00
34.00	SNF-Based FQHC											34.00
35.00	SNF-Based CMHC									N		35.00
36.00	SNF-Based OLTC											36.00
								Y/N				
								1.00	2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)								Y			37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)								N			38.00


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SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I
PPS

		Y/N		
		1.00	2.00	
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.			39.00
		Premiums	Paid Losses	Self Insurance
		1.00	2.00	3.00
41.00	List malpractice premiums and paid losses:	0	0	41.00
			Y/N	
			1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.		N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?		N	43.00
			Provider CCN	
			1.00	
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.			44.00
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.				
45.00	Name:	Contractor Name:	Contractor Number:	45.00
46.00	Street:	P.O. Box:		46.00
47.00	City:	State:	ZIP Code:	47.00

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SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

Worksheet S-2
Part II
PPS

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)							
Completed by All Skilled Nursing Facilities							
Provider Organization and Operation							
		Y/N	Date				
		1.00	2.00				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)	Y	C				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N				6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N					7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N					8.00
			Y/N				
			1.00				
Bad Debts							
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y				9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N				10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N				11.00
Bed Complement							
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N				12.00
		Description	Part A	Part B			
			Y/N	Date	Y/N	Date	
		0	1.00	2.00	3.00	4.00	
PS&R Data							
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4.(see Instructions.)	Y	03/20/2025	Y	03/20/2025		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N			14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N			15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N			16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N			17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N			18.00
		1.00	2.00	3.00			
Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATHLEEN	MESKER	PREPARER			19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES					20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	KATHLEEN.MESKER@HCRNJ.NET				21.00

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SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX STATISTICAL DATA

Worksheet S-3
Part I
PPS

	Component	Number of Beds	Bed Days Available	Inpatient Days/Visits					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	11.00	12.00	
1.00	SKILLED NURSING FACILITY	106	38,796	0	1,079	28,987	3,691	33,757	0	27	106	98	231	1.00
2.00	NURSING FACILITY	0	0	0		0	0	0	0		0	0	0	2.00
3.00	ICF/IID	0	0			0	0	0			0	0	0	3.00
4.00	HOME HEALTH AGENCY COST													4.00
5.00	Other Long Term Care	0	0				0	0				0	0	5.00
6.00	SNF-Based CMHC													6.00
7.00	HOSPICE													7.00
8.00	Total (Sum of lines 1-7)	106	38,796	0	1,079	28,987	3,691	33,757	0	27	106	98	231	8.00
	Component	Average Length of Stay				Admissions					Full Time Equivalent			
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers		
		13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00		
1.00	SKILLED NURSING FACILITY	0.00	39.96	273.46	146.13	0	39	93	96	228	82.80	0.00		1.00
2.00	NURSING FACILITY	0.00		0.00	0.00	0		0	0	0	0.00	0.00		2.00
3.00	ICF/IID			0.00	0.00			0	0	0	0.00	0.00		3.00
4.00	HOME HEALTH AGENCY COST													4.00
5.00	Other Long Term Care				0.00				0	0	0.00	0.00		5.00
6.00	SNF-Based CMHC										0.00	0.00		6.00
7.00	HOSPICE													7.00
8.00	Total (Sum of lines 1-7)	0.00	39.96	273.46	146.13	0	39	93	96	228	82.80	0.00		8.00

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SNF WAGE INDEX INFORMATION

Worksheet S-3

Part II

PPS

PART II - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
SALARIES							
1.00	Total salaries (See Instructions)	5,364,666	0	5,364,666	172,968.00	31.02	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	5,364,666	0	5,364,666	172,968.00	31.02	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST						8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPICE						10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	5,364,666	0	5,364,666	172,968.00	31.02	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	480,105	0	480,105	11,474.00	41.84	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs core (See Part IV)	958,991	0	958,991			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	958,991	0	958,991			22.00

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SNF WAGE INDEX INFORMATION

Worksheet S-3

Part III

PPS

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	375,569	0	375,569	10,307.00	36.44	2.00
3.00	Plant Operation, Maintenance & Repairs	114,378	0	114,378	6,055.00	18.89	3.00
4.00	Laundry & Linen Service	24,160	0	24,160	1,327.00	18.21	4.00
5.00	Housekeeping	334,223	0	334,223	15,143.00	22.07	5.00
6.00	Dietary	605,853	0	605,853	27,054.00	22.39	6.00
7.00	Nursing Administration	325,617	0	325,617	5,935.00	54.86	7.00
8.00	Central Services and Supply	25,810	0	25,810	1,205.00	21.42	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	7,531	0	7,531	482.00	15.62	10.00
11.00	Social Service	98,387	0	98,387	1,872.00	52.56	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	135,852	0	135,852	6,335.00	21.44	13.00
14.00	Total (sum lines 1 thru 13)	2,047,380	0	2,047,380	75,715.00	27.04	14.00

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SNF WAGE RELATED COSTS

Worksheet S-3
Part IV
PPS

PART IV - WAGE RELATED COSTS			
			Amount Reported
			1.00
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	10,394	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	164,773	8.00
9.00	Prescription Drug Plan	247	9.00
10.00	Dental, Hearing and Vision Plan	812	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,779	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	218,188	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	408,572	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	154,226	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	958,991	24.00
			Amount Reported
			1.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

COMPLETE CARE AT PLAINFIELD		Period:	Run Date Time:	5/27/2025 8:08 pm
Provider CCN: 315101		From: 01/01/2024	MCRIF32	2540-10
		To: 12/31/2024	Version:	11.1.179.1



SNF REPORTING OF DIRECT CARE EXPENDITURES

Worksheet S-3
Part V
PPS

	OCCUPATIONAL CATEGORY	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	692,006	123,704	815,710	11,860.00	68.78	1.00
2.00	Licensed Practical Nurses (LPNs)	907,684	162,258	1,069,942	21,562.00	49.62	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,717,596	307,039	2,024,635	63,832.00	31.72	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,317,286	593,001	3,910,287	97,254.00	40.21	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	152,785		152,785	3,457.00	44.20	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	103,602		103,602	3,682.00	28.14	16.00
17.00	Total Nursing (sum of lines 14 through 16)	256,387		256,387	7,139.00	35.91	17.00
18.00	Physical Therapists	65,657		65,657	895.00	73.36	18.00
19.00	Physical Therapy Assistants	33,864		33,864	508.00	66.66	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	26,467		26,467	605.00	43.75	21.00
22.00	Occupational Therapy Assistants	78,524		78,524	1,976.00	39.74	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	19,206		19,206	351.00	54.72	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time:

MCRIF32

Version:

5/27/2025 8:08 pm

2540-10

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Worksheet S-7

PPS

	Group	Days	
	1.00	2.00	
1.00	RUX		1.00
2.00	RUL		2.00
3.00	RVX		3.00
4.00	RVL		4.00
5.00	RHX		5.00
6.00	RHL		6.00
7.00	RMX		7.00
8.00	RML		8.00
9.00	RLX		9.00
10.00	RUC		10.00
11.00	RUB		11.00
12.00	RUA		12.00
13.00	RVC		13.00
14.00	RVB		14.00
15.00	RVA		15.00
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	RLA		23.00
24.00	ES3		24.00
25.00	ES2		25.00
26.00	ES1		26.00
27.00	HE2		27.00
28.00	HE1		28.00
29.00	HD2		29.00
30.00	HD1		30.00
31.00	HC2		31.00
32.00	HC1		32.00
33.00	HB2		33.00
34.00	HB1		34.00
35.00	LE2		35.00
36.00	LE1		36.00
37.00	LD2		37.00
38.00	LD1		38.00
39.00	LC2		39.00
40.00	LC1		40.00
41.00	LB2		41.00
42.00	LB1		42.00
43.00	CE2		43.00
44.00	CE1		44.00
45.00	CD2		45.00
46.00	CD1		46.00
47.00	CC2		47.00
48.00	CC1		48.00
49.00	CB2		49.00
50.00	CB1		50.00
51.00	CA2		51.00
52.00	CA1		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

COMPLETE CARE AT PLAINFIELD	Period:	Run Date Time:	5/27/2025 8:08 pm	
Provider CCN: 315101	From: 01/01/2024	MCRIF32	2540-10	
	To: 12/31/2024	Version:	11.1.179.1	

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Worksheet S-7

PPS

	Group	Days	
	1.00	2.00	
58.00	SSA		58.00
59.00	IB2		59.00
60.00	IB1		60.00
61.00	IA2		61.00
62.00	IA1		62.00
63.00	BB2		63.00
64.00	BB1		64.00
65.00	BA2		65.00
66.00	BA1		66.00
67.00	PE2		67.00
68.00	PE1		68.00
69.00	PD2		69.00
70.00	PD1		70.00
71.00	PC2		71.00
72.00	PC1		72.00
73.00	PB2		73.00
74.00	PB1		74.00
75.00	PA2		75.00
76.00	PA1		76.00
99.00	AAA		99.00
100.00			100.00
	Expenses	Percentage	Y/N
	1.00	2.00	3.00
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)			
101.00	Staffing		101.00
102.00	Recruitment		102.00
103.00	Retention of employees		103.00
104.00	Training		104.00
105.00	OTHER (SPECIFY)		105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)		106.00

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/27/2025 8:08 pm

MCRIF32

Version: 11.1.179.1



RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A

PPS

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		2,289,677	2,289,677	0	2,289,677	116,421	2,406,098	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,000,996	1,000,996	0	1,000,996	0	1,000,996	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	375,569	1,907,954	2,283,523	0	2,283,523	-319,020	1,964,503	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	114,378	462,861	577,239	0	577,239	0	577,239	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	24,160	15,018	39,178	0	39,178	0	39,178	6.00
7.00	00700	HOUSEKEEPING	334,223	39,382	373,605	0	373,605	0	373,605	7.00
8.00	00800	DIETARY	605,853	489,276	1,095,129	0	1,095,129	-60	1,095,069	8.00
9.00	00900	NURSING ADMINISTRATION	325,617	0	325,617	0	325,617	0	325,617	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	25,810	0	25,810	0	25,810	0	25,810	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	7,531	0	7,531	0	7,531	0	7,531	12.00
13.00	01300	SOCIAL SERVICE	98,387	0	98,387	0	98,387	0	98,387	13.00
15.00	01500	PATIENT ACTIVITIES	135,852	22,901	158,753	0	158,753	0	158,753	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	SKILLED NURSING FACILITY	3,317,286	482,014	3,799,300	0	3,799,300	0	3,799,300	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	0	0	31.00
32.00	03200	ICF/IID	0	0	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	04000	RADIOLOGY	0	2,871	2,871	0	2,871	0	2,871	40.00
41.00	04100	LABORATORY	0	5,413	5,413	0	5,413	0	5,413	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	2,231	2,231	0	2,231	0	2,231	43.00
44.00	04400	PHYSICAL THERAPY	0	94,188	94,188	0	94,188	0	94,188	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	104,782	104,782	0	104,782	0	104,782	45.00
46.00	04600	SPEECH PATHOLOGY	0	24,394	24,394	0	24,394	0	24,394	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	108,208	108,208	0	108,208	0	108,208	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	07100	AMBULANCE	0	100	100	0	100	0	100	71.00
73.00	07300	CMHC	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE		0	0	0	0	0	0	81.00
89.00		SUBTOTALS (sum of lines 1-84)	5,364,666	7,052,266	12,416,932	0	12,416,932	-202,659	12,214,273	89.00
NONREIMBURSABLE COST CENTERS										
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	0	0	94.00
100.00		TOTAL	5,364,666	7,052,266	12,416,932	0	12,416,932	-202,659	12,214,273	100.00

COMPLETE CARE AT PLAINFIELD	Period:	Run Date Time:	5/27/2025 8:08 pm
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RECLASSIFICATIONS

Worksheet A-6

PPS

Increases					Decreases					
	Cost Center	Line #	Salary	Non Salary	Cost Center	Line #	Salary	Non Salary		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
100.00	TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9 (2))		0	0			0	0	100.00	


(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS

Worksheet A-7

PPS

			Acquisitions						
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES									
1.00	Land	0	0	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	0	0	3.00
4.00	Building Improvements	179,644	140,013	0	140,013	0	319,657	0	4.00
5.00	Fixed Equipment	48,421	16,399	0	16,399	0	64,820	0	5.00
6.00	Movable Equipment	0	0	0	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	228,065	156,412	0	156,412	0	384,477	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	228,065	156,412	0	156,412	0	384,477	0	9.00

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ADJUSTMENTS TO EXPENSES

Worksheet A-8

PPS

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line No.
				3.00	4.00
1.00	Investment income on restricted funds (chapter 2)	B	-3,755	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		5.00
6.00	Television and radio service (chapter 21)		0		6.00
7.00	Parking lot (chapter 21)		0		7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0		8.00
9.00	Home office cost (chapter 21)		0		9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-50,385		12.00
13.00	Laundry and linen service		0		13.00
14.00	Revenue - Employee meals		0		14.00
15.00	Cost of meals - Guests	B	-60	DIETARY	8.00
16.00	Sale of medical supplies to other than patients		0		16.00
17.00	Sale of drugs to other than patients		0		17.00
18.00	Sale of medical records and abstracts	B	-30	ADMINISTRATIVE & GENERAL	4.00
19.00	Vending machines		0		19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	82.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00
24.00	Depreciation--movable equipment		0	*** Cost Center Deleted ***	2.00
25.00	RESIDENT MISSING ITEMS	A	-2,892	ADMINISTRATIVE & GENERAL	4.00
25.01	MARKETING	A	-23,749	ADMINISTRATIVE & GENERAL	4.00
25.02	BAD DEBT	A	-121,788	ADMINISTRATIVE & GENERAL	4.00
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-202,659		100.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

COMPLETE CARE AT PLAINFIELD		Period:	Run Date Time:
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND
HOME OFFICE COSTSWorksheet A-8-1
Parts I & II
PPS

PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:							
	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	0	2,164,462	-2,164,462	1.00
2.00	4.00	ADMINISTRATIVE & GENERAL	REALTY A&G	25,505	0	25,505	2.00
3.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	DEPRECIATION	169,771	0	169,771	3.00
4.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	INTEREST	2,114,867	0	2,114,867	4.00
5.00	4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT	332,024	528,090	-196,066	5.00
6.00	0.00			0	0	0	6.00
7.00	0.00			0	0	0	7.00
8.00	0.00			0	0	0	8.00
9.00	0.00			0	0	0	9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 10 to Worksheet A-8, column 3, line 12.			2,642,167	2,692,552	-50,385	10.00

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part II 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	B	PC HMH OPCO HOLDINGS LLC	100.00	PC HMH PROPCO HOLDING LLC	100.00	REALTY	1.00
2.00	B	PEACE CAPITAL LLC	100.00	COMPLETE CARE MANAGEMENT	100.00	MANAGEMENT COMPANY	2.00
3.00			0.00		0.00		3.00
4.00			0.00		0.00		4.00
5.00			0.00		0.00		5.00
6.00			0.00		0.00		6.00
7.00			0.00		0.00		7.00
8.00			0.00		0.00		8.00
9.00			0.00		0.00		9.00
10.00			0.00		0.00		10.00

(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 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.
G. Other (financial or non-financial) specify:

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:

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Version: 11.1.179.1



COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B

Part I

PPS

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		0	1.00	3.00	3A	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	2,406,098	2,406,098							1.00
3.00	EMPLOYEE BENEFITS	1,000,996	0	1,000,996						3.00
4.00	ADMINISTRATIVE & GENERAL	1,964,503	312,803	70,078	2,347,384	2,347,384				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	577,239	170,308	21,342	768,889	182,923	951,812			5.00
6.00	LAUNDRY & LINEN SERVICE	39,178	39,216	4,508	82,902	19,723	19,411	122,036		6.00
7.00	HOUSEKEEPING	373,605	39,309	62,363	475,277	113,071	19,457	0	607,805	7.00
8.00	DIETARY	1,095,069	198,399	113,047	1,406,515	334,617	98,201	0	65,378	8.00
9.00	NURSING ADMINISTRATION	325,617	16,966	60,757	403,340	95,957	8,398	0	5,591	9.00
10.00	CENTRAL SERVICES & SUPPLY	25,810	0	4,816	30,626	7,286	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	7,531	0	1,405	8,936	2,126	0	0	0	12.00
13.00	SOCIAL SERVICE	98,387	16,966	18,358	133,711	31,811	8,398	0	5,591	13.00
15.00	PATIENT ACTIVITIES	158,753	66,936	25,349	251,038	59,723	33,131	0	22,058	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	3,799,300	1,362,835	618,973	5,781,108	1,375,355	674,554	122,036	449,094	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	2,871	0	0	2,871	683	0	0	0	40.00
41.00	LABORATORY	5,413	0	0	5,413	1,288	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	2,231	0	0	2,231	531	0	0	0	43.00
44.00	PHYSICAL THERAPY	94,188	135,356	0	229,544	54,610	66,997	0	44,604	44.00
45.00	OCCUPATIONAL THERAPY	104,782	0	0	104,782	24,928	0	0	0	45.00
46.00	SPEECH PATHOLOGY	24,394	0	0	24,394	5,803	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,567	0	38,567	9,175	19,089	0	12,709	48.00
49.00	DRUGS CHARGED TO PATIENTS	108,208	8,437	0	116,645	27,750	4,176	0	2,780	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	100	0	0	100	24	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
89.00	SUBTOTALS (sum of lines 1-84)	12,214,273	2,406,098	1,000,996	12,214,273	2,347,384	951,812	122,036	607,805	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	12,214,273	2,406,098	1,000,996	12,214,273	2,347,384	951,812	122,036	607,805	100.00

COMPLETE CARE AT PLAINFIELD		Period:	Run Date Time:	5/27/2025 8:08 pm
Provider CCN: 315101		From: 01/01/2024	MCRIF32	2540-10
		To: 12/31/2024	Version:	11.1.179.1



COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Stepdown Adjustments	
		8.00	9.00	10.00	12.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	1,904,711								8.00
9.00	NURSING ADMINISTRATION	0	513,286							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	37,912						10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	11,062					12.00
13.00	SOCIAL SERVICE	0	0	0	0	179,511				13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	365,950			15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	1,904,711	513,286	0	11,062	179,511	365,950	11,376,667	0	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	0	0	3,554	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	6,701	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	2,762	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	395,755	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	129,710	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	30,197	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	79,540	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	37,912	0	0	0	189,263	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	0	0	124	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
89.00	SUBTOTALS (sum of lines 1-84)	1,904,711	513,286	37,912	11,062	179,511	365,950	12,214,273	0	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0			0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	1,904,711	513,286	37,912	11,062	179,511	365,950	12,214,273	0	100.00

COMPLETE CARE AT PLAINFIELD		Period:	Run Date Time:
Provider CCN: 315101		From: 01/01/2024	5/27/2025 8:08 pm
		To: 12/31/2024	MCRIF32 Version: 11.1.179.1



COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	EMPLOYEE BENEFITS		3.00
4.00	ADMINISTRATIVE & GENERAL		4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	LAUNDRY & LINEN SERVICE		6.00
7.00	HOUSEKEEPING		7.00
8.00	DIETARY		8.00
9.00	NURSING ADMINISTRATION		9.00
10.00	CENTRAL SERVICES & SUPPLY		10.00
12.00	MEDICAL RECORDS & LIBRARY		12.00
13.00	SOCIAL SERVICE		13.00
15.00	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	SKILLED NURSING FACILITY	11,376,667	30.00
31.00	NURSING FACILITY	0	31.00
32.00	ICF/IID	0	32.00
33.00	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	RADIOLOGY	3,554	40.00
41.00	LABORATORY	6,701	41.00
42.00	INTRAVENOUS THERAPY	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	2,762	43.00
44.00	PHYSICAL THERAPY	395,755	44.00
45.00	OCCUPATIONAL THERAPY	129,710	45.00
46.00	SPEECH PATHOLOGY	30,197	46.00
47.00	ELECTROCARDIOLOGY	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,540	48.00
49.00	DRUGS CHARGED TO PATIENTS	189,263	49.00
51.00	SUPPORT SURFACES	0	51.00
OTHER REIMBURSABLE COST CENTERS			
71.00	AMBULANCE	124	71.00
73.00	CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	INTEREST EXPENSE		81.00
89.00	SUBTOTALS (sum of lines 1-84)	12,214,273	89.00
NONREIMBURSABLE COST CENTERS			
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	NONPAID WORKERS	0	93.00
94.00	PATIENTS LAUNDRY	0	94.00
98.00	Cross Foot Adjustments	0	98.00
99.00	Negative Cost Centers	0	99.00
100.00	TOTAL	12,214,273	100.00

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/27/2025 8:08 pm

MCRIF32

Version: 11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		0	1.00	2A	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS	0	0	0	0					3.00
4.00	ADMINISTRATIVE & GENERAL	0	312,803	312,803	0	312,803				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	170,308	170,308	0	24,375	194,683			5.00
6.00	LAUNDRY & LINEN SERVICE	0	39,216	39,216	0	2,628	3,970	45,814		6.00
7.00	HOUSEKEEPING	0	39,309	39,309	0	15,067	3,980	0	58,356	7.00
8.00	DIETARY	0	198,399	198,399	0	44,589	20,086	0	6,277	8.00
9.00	NURSING ADMINISTRATION	0	16,966	16,966	0	12,787	1,718	0	537	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	971	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	283	0	0	0	12.00
13.00	SOCIAL SERVICE	0	16,966	16,966	0	4,239	1,718	0	537	13.00
15.00	PATIENT ACTIVITIES	0	66,936	66,936	0	7,958	6,777	0	2,118	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	0	1,362,835	1,362,835	0	183,276	137,972	45,814	43,118	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	91	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	172	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	71	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	135,356	135,356	0	7,277	13,703	0	4,282	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	3,322	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	773	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,567	38,567	0	1,223	3,905	0	1,220	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	8,437	8,437	0	3,698	854	0	267	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	3	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
89.00	SUBTOTALS (sum of lines 1-84)	0	2,406,098	2,406,098	0	312,803	194,683	45,814	58,356	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments							0	0	98.00
99.00	Negative Cost Centers		0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	2,406,098	2,406,098	0	312,803	194,683	45,814	58,356	100.00

COMPLETE CARE AT PLAINFIELD		Period:	Run Date Time:	5/27/2025 8:08 pm
Provider CCN: 315101		From: 01/01/2024	MCRIF32	2540-10
		To: 12/31/2024	Version:	11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	
		8.00	9.00	10.00	12.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	269,351								8.00
9.00	NURSING ADMINISTRATION	0	32,008							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	971						10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	283					12.00
13.00	SOCIAL SERVICE	0	0	0	0	23,460				13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	83,789			15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	269,351	32,008	0	283	23,460	83,789	2,181,906	0	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	0	0	91	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	172	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	71	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	160,618	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	3,322	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	773	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	44,915	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	971	0	0	0	14,227	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	0	0	3	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
89.00	SUBTOTALS (sum of lines 1-84)	269,351	32,008	971	283	23,460	83,789	2,406,098	0	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0			0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	269,351	32,008	971	283	23,460	83,789	2,406,098	0	100.00

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time:

MCRIF32

Version:

5/27/2025 8:08 pm

2540-10

11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	EMPLOYEE BENEFITS		3.00
4.00	ADMINISTRATIVE & GENERAL		4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	LAUNDRY & LINEN SERVICE		6.00
7.00	HOUSEKEEPING		7.00
8.00	DIETARY		8.00
9.00	NURSING ADMINISTRATION		9.00
10.00	CENTRAL SERVICES & SUPPLY		10.00
12.00	MEDICAL RECORDS & LIBRARY		12.00
13.00	SOCIAL SERVICE		13.00
15.00	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	SKILLED NURSING FACILITY	2,181,906	30.00
31.00	NURSING FACILITY	0	31.00
32.00	ICF/IID	0	32.00
33.00	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	RADIOLOGY	91	40.00
41.00	LABORATORY	172	41.00
42.00	INTRAVENOUS THERAPY	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	71	43.00
44.00	PHYSICAL THERAPY	160,618	44.00
45.00	OCCUPATIONAL THERAPY	3,322	45.00
46.00	SPEECH PATHOLOGY	773	46.00
47.00	ELECTROCARDIOLOGY	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,915	48.00
49.00	DRUGS CHARGED TO PATIENTS	14,227	49.00
51.00	SUPPORT SURFACES	0	51.00
OTHER REIMBURSABLE COST CENTERS			
71.00	AMBULANCE	3	71.00
73.00	CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	INTEREST EXPENSE		81.00
89.00	SUBTOTALS (sum of lines 1-84)	2,406,098	89.00
NONREIMBURSABLE COST CENTERS			
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	NONPAID WORKERS	0	93.00
94.00	PATIENTS LAUNDRY	0	94.00
98.00	Cross Foot Adjustments	0	98.00
99.00	Negative Cost Centers	0	99.00
100.00	TOTAL	2,406,098	100.00

COMPLETE CARE AT PLAINFIELD

Provider CCN: 315101

Period:
From: 01/01/2024
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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT CENSUS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		1.00	3.00	4A	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	25,953								1.00
3.00	EMPLOYEE BENEFITS	0	5,364,666							3.00
4.00	ADMINISTRATIVE & GENERAL	3,374	375,569	-2,347,384	9,866,889					4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	1,837	114,378	0	768,889	20,742				5.00
6.00	LAUNDRY & LINEN SERVICE	423	24,160	0	82,902	423	33,757			6.00
7.00	HOUSEKEEPING	424	334,223	0	475,277	424	0	19,895		7.00
8.00	DIETARY	2,140	605,853	0	1,406,515	2,140	0	2,140	101,271	8.00
9.00	NURSING ADMINISTRATION	183	325,617	0	403,340	183	0	183	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	25,810	0	30,626	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	0	7,531	0	8,936	0	0	0	0	12.00
13.00	SOCIAL SERVICE	183	98,387	0	133,711	183	0	183	0	13.00
15.00	PATIENT ACTIVITIES	722	135,852	0	251,038	722	0	722	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	14,700	3,317,286	0	5,781,108	14,700	33,757	14,700	101,271	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	2,871	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	5,413	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	2,231	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	1,460	0	0	229,544	1,460	0	1,460	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	104,782	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	24,394	0	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	416	0	0	38,567	416	0	416	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	91	0	0	116,645	91	0	91	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	100	0	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
89.00	SUBTOTALS (sum of lines 1-84)	25,953	5,364,666	-2,347,384	9,866,889	20,742	33,757	19,895	101,271	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments									98.00
99.00	Negative Cost Centers									99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,406,098	1,000,996		2,347,384	951,812	122,036	607,805	1,904,711	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	92.709822	0.186591		0.237905	45.888150	3.615132	30.550641	18.808060	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		312,803	194,683	45,814	58,356	269,351	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.031702	9.385932	1.357170	2.933199	2.659705	105.00

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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	NURSING ADMINISTRA TION (DIRECT NURS HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	PATIENT ACTIVITIES (PATIENT DAYS)		
		9.00	10.00	12.00	13.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS - BLDGS & FIXTURES							1.00
3.00	EMPLOYEE BENEFITS							3.00
4.00	ADMINISTRATIVE & GENERAL							4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DIETARY							8.00
9.00	NURSING ADMINISTRATION	104,392						9.00
10.00	CENTRAL SERVICES & SUPPLY	0	108,208					10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	33,757				12.00
13.00	SOCIAL SERVICE	0	0	0	33,757			13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	33,757		15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	SKILLED NURSING FACILITY	104,392	0	33,757	33,757	33,757		30.00
31.00	NURSING FACILITY	0	0	0	0	0		31.00
32.00	ICF/IID	0	0	0	0	0		32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0		33.00
ANCILLARY SERVICE COST CENTERS								
40.00	RADIOLOGY	0	0	0	0	0		40.00
41.00	LABORATORY	0	0	0	0	0		41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0		42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0		43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0		44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0		45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0		46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0		47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	108,208	0	0	0		49.00
51.00	SUPPORT SURFACES	0	0	0	0	0		51.00
OTHER REIMBURSABLE COST CENTERS								
71.00	AMBULANCE	0	0	0	0	0		71.00
73.00	CMHC	0	0	0	0	0		73.00
SPECIAL PURPOSE COST CENTERS								
80.00	MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81.00	INTEREST EXPENSE							81.00
89.00	SUBTOTALS (sum of lines 1-84)	104,392	108,208	33,757	33,757	33,757		89.00
NONREIMBURSABLE COST CENTERS								
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0		90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0		91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0		92.00
93.00	NONPAID WORKERS	0	0	0	0	0		93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0		94.00
98.00	Cross Foot Adjustments							98.00
99.00	Negative Cost Centers							99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	513,286	37,912	11,062	179,511	365,950		102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	4.916909	0.350362	0.327695	5.317742	10.840715		103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	32,008	971	283	23,460	83,789		104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.306614	0.008973	0.008383	0.694967	2.482122		105.00

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Worksheet C

PPS

	Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
40.00	RADIOLOGY	3,554	0	0.000000	40.00
41.00	LABORATORY	6,701	5,413	1.237946	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	OXYGEN (INHALATION) THERAPY	2,762	0	0.000000	43.00
44.00	PHYSICAL THERAPY	395,755	128,041	3.090846	44.00
45.00	OCCUPATIONAL THERAPY	129,710	137,329	0.944520	45.00
46.00	SPEECH PATHOLOGY	30,197	55,742	0.541728	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,540	0	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	189,263	108,208	1.749067	49.00
51.00	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	AMBULANCE	124	0	0.000000	71.00
100.00	Total	837,606	434,733		100.00

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Worksheet D
Part I
PPS

Title XVIII
Skilled Nursing Facility

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST							
			Health Care Program 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	
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	0.000000	0	0	0	0	40.00
41.00	LABORATORY	1.237946	742	0	919	0	41.00
42.00	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	3.090846	34,329	0	106,106	0	44.00
45.00	OCCUPATIONAL THERAPY	0.944520	39,916	0	37,701	0	45.00
46.00	SPEECH PATHOLOGY	0.541728	13,943	0	7,553	0	46.00
47.00	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	1.749067	16,730	0	29,262	0	49.00
51.00	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS							
71.00	AMBULANCE (2)	0.000000		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		105,660	0	181,541	0	100.00

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

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

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Worksheet D


Parts II-III

Title XVIII

Skilled Nursing Facility

PPS

PART II - APPORTIONMENT OF VACCINE COST							
					1.00		
1.00	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)				1.749067		1.00
2.00	Program vaccine charges (From your records, or the PS&R)				0		2.00
3.00	Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)				0		3.00
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH							
	Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	3,554	0	0.000000	0	0	40.00
41.00	LABORATORY	6,701	0	0.000000	919	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	2,762	0	0.000000	0	0	43.00
44.00	PHYSICAL THERAPY	395,755	0	0.000000	106,106	0	44.00
45.00	OCCUPATIONAL THERAPY	129,710	0	0.000000	37,701	0	45.00
46.00	SPEECH PATHOLOGY	30,197	0	0.000000	7,553	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,540	0	0.000000	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	189,263	0	0.000000	29,262	0	49.00
51.00	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00	Total (Sum of lines 40 - 52)	837,482	0		181,541	0	100.00

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COMPUTATION OF INPATIENT ROUTINE COSTS

Worksheet D-1


Part I

Title XVIII

Skilled Nursing Facility

PPS

PART I CALCULATION OF INPATIENT ROUTINE COSTS		
		1.00
INPATIENT DAYS		
1.00	Inpatient days including private room days	33,757 1.00
2.00	Private room days	0 2.00
3.00	Inpatient days including private room days applicable to the Program	1,079 3.00
4.00	Medically necessary private room days applicable to the Program	0 4.00
5.00	Total general inpatient routine service cost	11,376,667 5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	10,383,816 6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1.095615 7.00
8.00	Enter private room charges from your records	0 8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00 9.00
10.00	Enter semi-private room charges from your records	0 10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00 11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)	0.00 12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00 13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0 14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	11,376,667 15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	337.02 16.00
17.00	Program routine service cost (Line 3 times line 16)	363,645 17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0 18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	363,645 19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	2,181,906 20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	64.64 21.00
22.00	Program capital related cost (Line 3 times line 21)	69,747 22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	293,898 23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0 24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	293,898 25.00
26.00	Enter the per diem limitation (1)	
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
		1.00
1.00	Total SNF inpatient days	33,757 1.00
2.00	Program inpatient days (see instructions)	1,079 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)	0.031964 4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0 5.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII

Worksheet E

Part I

Title XVIII

Skilled Nursing Facility


PPS

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

		1.00	
1.00	Inpatient PPS amount (See Instructions)	870,288	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	870,288	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	137,496	5.00
6.00	Allowable bad debts (From your records)	128,138	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	57,520	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	83,290	8.00
9.00	Recovery of bad debts - for statistical records only	0	9.00
10.00	Utilization review	0	10.00
11.00	Subtotal (See instructions)	816,082	11.00
12.00	Interim payments (See instructions)	718,136	12.00
13.00	Tentative 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)	1,666	14.75
14.99	Sequestration amount (see instructions)	14,656	14.99
15.00	Balance due provider/program (see Instructions)	81,624	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)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Worksheet E-1

Title XVIII Skilled Nursing Facility PPS

	DESCRIPTION	Inpatient Part A		Part 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		718,136		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		718,136		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE 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 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		81,624		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		799,760		0	7.00
Contractor Name		Contractor Number				
1.00		2.00				
8.00						8.00

(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.

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

Worksheet G

PPS

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	79,479	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,101,284	0	0	0	4.00
5.00	Other receivables	0	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	55,883	0	0	0	8.00
9.00	Other current assets	26,579	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2,263,225	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	319,658	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	64,820	0	0	0	23.00
24.00	Less: Accumulated depreciation	-29,070	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	355,408	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	110,087	0	0	0	31.00
32.00	Other assets	781,761	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	891,848	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	3,510,481	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,286,820	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,091,780	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	291,509	0	0	0	39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	0	0	0	0	41.00
42.00	Other current liabilities	0	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2,670,109	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	5,180,130	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	5,180,130	0	0	0	50.00

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

Worksheet G

PPS

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	7,850,239	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-4,339,758				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-4,339,758	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	3,510,481	0	0	0	60.00

() = contra amount

COMPLETE CARE AT PLAINFIELD

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Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time:

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STATEMENT OF CHANGES IN FUND BALANCES

Worksheet G-1

PPS

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		-2,484,638		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-1,855,124							2.00
3.00	Total (sum of line 1 and line 2)		-4,339,762		0		0		0	3.00
4.00	Additions (credit adjustments)									4.00
5.00	ROUNDING	4		0		0		0		5.00
6.00		0		0		0		0		6.00
7.00		0		0		0		0		7.00
8.00		0		0		0		0		8.00
9.00		0		0		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		4		0		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-4,339,758		0		0		0	11.00
12.00	Deductions (debit adjustments)									12.00
13.00		0		0		0		0		13.00
14.00		0		0		0		0		14.00
15.00		0		0		0		0		15.00
16.00		0		0		0		0		16.00
17.00		0		0		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-4,339,758		0		0		0	19.00

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Part I
PPS

PART I - PATIENT REVENUES					
	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	10,383,816		10,383,816	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	10,383,816		10,383,816	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	434,732	0	434,732	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	10,818,548	0	10,818,548	14.00
PART II - OPERATING EXPENSES					
		1.00	2.00		
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		12,416,932		1.00
2.00	Add (Specify)	0			2.00
3.00		0			3.00
4.00		0			4.00
5.00		0			5.00
6.00		0			6.00
7.00		0			7.00
8.00	Total Additions (Sum of lines 2 - 7)		0		8.00
9.00	Deduct (Specify)	0			9.00
10.00		0			10.00
11.00		0			11.00
12.00		0			12.00
13.00		0			13.00
14.00	Total Deductions (Sum of lines 9 - 13)		0		14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)		12,416,932		15.00

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-3

PPS

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	10,818,548	1.00
2.00	Less: contractual allowances and discounts on patients accounts	301,030	2.00
3.00	Net patient revenues (Line 1 minus line 2)	10,517,518	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	12,416,932	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1,899,414	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	28,230	6.00
7.00	Income from investments	3,755	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 discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	30	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	60	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	NON PATIENT REVENUE	12,215	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	44,290	25.00
26.00	Total (Line 5 plus line 25)	-1,855,124	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-1,855,124	31.00