

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 LAKEVIEW

Provider CCN: 315110

Period: 5/28/2025 6:38 pm
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 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 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> 0 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.	Date:	Time:
Contractor use only:	4. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received:	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 LAKEVIEW, 315110 {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	1	2	ELECTRONIC SIGNATURE STATEMENT	
				Y	
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	(Dated when report is electronically signed.)				4

PART III - SETTLEMENT SUMMARY

	Cost Center Description	Title V	Title XVIII			
			Part A	Part B	Title XIX	
1.00	SKILLED NURSING FACILITY	1.00	0	-268,873	3,017	0 1.00
2.00	NURSING FACILITY		0			0 2.00
3.00	ICF/IID					0 3.00
4.00	SNF - BASED HHA I		0	0	0	4.00
5.00	SNF - BASED RHC I		0		0	5.00
6.00	SNF - BASED FQHC I		0		0	6.00
7.00	SNF - BASED CMHC I		0		0	7.00
100.00	TOTAL		0	-268,873	3,017	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 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 LAKEVIEW

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MCRIF32
2540-10
Version: 11.1.179.1SKILLED 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:	130 TERHUNE DRIVE	P.O. Box:					1.00
2.00	City:	WAYNE	State:	NJ	ZIP Code:	07470		2.00
3.00	County:	PASSAIC	CBSA Code:	35614	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)		
					V	XVIII	XIX
4.00	SNF	COMPLETE CARE AT LAKEVIEW	315110	09/23/1969	N	P	N
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)		4 - Proprietary, Corporation				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	301,592	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	301,592	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
		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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2540-10SKILLED 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	
41.00	List malpractice premiums and paid losses:			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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2540-10
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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	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) If no, 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
		Part A	Part B	
		Description	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	04/04/2025	Y	04/04/2025	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.	KYLE	DRAYTON	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	KYLE.DRAYTON@HCRNJ.NET		21.00

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COMPLEX STATISTICAL DATA

Worksheet S-3

Part I
PPS

	Component	Number of Beds	Inpatient Days/Visits						Discharges					
			Bed Days Available	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	120	43,920	0	2,993	23,538	1,002	27,533	0	85	156	45	286	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			0	0	0	0	0						4.00
5.00	Other Long Term Care	0	0			0	0	0			0	0	0	5.00
6.00	SNF-Based CMHC													6.00
7.00	HOSPICE	0	0	0	0	0	0	0	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	120	43,920	0	2,993	23,538	1,002	27,533	0	85	156	45	286	8.00
	Average Length of Stay						Admissions				Full Time Equivalent			
	Component	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	35.21	150.88	96.27	0	93	121	67	281	98.80	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										0.00	0.00	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	0.00	0.00	0.00	0.00	0	0	0	0	0	0.00	0.00	7.00	
8.00	Total (Sum of lines 1-7)	0.00	35.21	150.88	96.27	0	93	121	67	281	98.80	0.00	8.00	

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2540-10

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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)	7,108,817	0	7,108,817	206,326.00	34.45	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)	7,108,817	0	7,108,817	206,326.00	34.45	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	7,108,817	0	7,108,817	206,326.00	34.45	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	1,194,869	0	1,194,869	19,399.00	61.59	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)	1,059,947	0	1,059,947			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)	1,059,947	0	1,059,947			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	586,263	0	586,263	13,654.00	42.94	2.00
3.00	Plant Operation, Maintenance & Repairs	243,529	0	243,529	6,897.00	35.31	3.00
4.00	Laundry & Linen Service	37,769	0	37,769	2,135.00	17.69	4.00
5.00	Housekeeping	334,124	0	334,124	18,221.00	18.34	5.00
6.00	Dietary	480,622	0	480,622	22,545.00	21.32	6.00
7.00	Nursing Administration	429,232	0	429,232	9,309.00	46.11	7.00
8.00	Central Services and Supply	43,194	0	43,194	1,948.00	22.17	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	88,142	0	88,142	3,702.00	23.81	10.00
11.00	Social Service	107,246	0	107,246	3,194.00	33.58	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	157,407	0	157,407	7,257.00	21.69	13.00
14.00	Total (sum lines 1 thru 13)	2,507,528	0	2,507,528	88,862.00	28.22	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	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	118,818	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	419	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	279,013	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	548,465	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	113,232	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)	1,059,947	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 LAKEVIEW

Provider CCN: 315110

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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)	764,609	114,005	878,614	13,782.00	63.75	1.00
2.00	Licensed Practical Nurses (LPNs)	2,282,869	340,383	2,623,252	47,495.00	55.23	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,553,811	231,678	1,785,489	56,187.00	31.78	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4,601,289	686,066	5,287,355	117,464.00	45.01	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)	8,464		8,464	167.00	50.68	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	206,674		206,674	6,218.00	33.24	16.00
17.00	Total Nursing (sum of lines 14 through 16)	215,138		215,138	6,385.00	33.69	17.00
18.00	Physical Therapists	300,563		300,563	3,833.00	78.41	18.00
19.00	Physical Therapy Assistants	165,640		165,640	2,112.00	78.43	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	177,021		177,021	2,402.00	73.70	21.00
22.00	Occupational Therapy Assistants	235,901		235,901	3,201.00	73.70	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	100,606		100,606	1,467.00	68.58	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

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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

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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
		1.00	2.00
			Y/N
			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

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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			2,792,455	2,792,455	0	2,792,455	979,788	3,772,243
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT			0	0	0	0	0	0
3.00	00300	EMPLOYEE BENEFITS	0	1,084,818	1,084,818	0	1,084,818	0	1,084,818	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	586,263	2,113,581	2,699,844	0	2,699,844	-596,658	2,103,186	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	243,529	377,232	620,761	0	620,761	0	620,761	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	37,769	151,232	189,001	0	189,001	0	189,001	6.00
7.00	00700	HOUSEKEEPING	334,124	35,349	369,473	0	369,473	0	369,473	7.00
8.00	00800	DIETARY	480,622	399,732	880,354	0	880,354	0	880,354	8.00
9.00	00900	NURSING ADMINISTRATION	429,232	0	429,232	0	429,232	0	429,232	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	43,194	0	43,194	0	43,194	0	43,194	10.00
11.00	01100	PHARMACY	0	0	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	88,142	0	88,142	0	88,142	0	88,142	12.00
13.00	01300	SOCIAL SERVICE	107,246	0	107,246	0	107,246	0	107,246	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	14.00
15.00	01500	PATIENT ACTIVITIES	157,407	45,888	203,295	0	203,295	0	203,295	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	SKILLED NURSING FACILITY	4,601,289	816,283	5,417,572	0	5,417,572	0	5,417,572	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	11,742	11,742	0	11,742	0	11,742	40.00
41.00	04100	LABORATORY	0	33,678	33,678	0	33,678	0	33,678	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	1,026,712	1,026,712	0	1,026,712	0	1,026,712	43.00
44.00	04400	PHYSICAL THERAPY	0	440,374	440,374	0	440,374	0	440,374	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	402,453	402,453	0	402,453	0	402,453	45.00
46.00	04600	SPEECH PATHOLOGY	0	136,904	136,904	0	136,904	0	136,904	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	355,590	355,590	0	355,590	0	355,590	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS										
60.00	06000	CLINIC	0	0	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	61.00
62.00	06200	FQHC								62.00
OTHER REIMBURSABLE COST CENTERS										
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	19,610	19,610	0	19,610	0	19,610	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	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	0	0	0	0	0	81.00
82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	0	0	82.00
83.00	08300	HOSPICE	0	0	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	7,108,817	10,243,633	17,352,450	0	17,352,450	383,130	17,735,580	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	7,108,817	10,243,633	17,352,450	0	17,352,450	383,130	17,735,580	100.00

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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.

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RECONCILIATION OF CAPITAL COSTS CENTERS

Worksheet A-7

PPS

		Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		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	92,551	118,399	0	118,399	0	210,950	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	0	0	5.00
6.00	Movable Equipment	7,975	55,048	0	55,048	0	63,023	0	6.00
7.00	Subtotal (sum of lines 1-6)	100,526	173,447	0	173,447	0	273,973	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	100,526	173,447	0	173,447	0	273,973	0	9.00

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ADJUSTMENTS TO EXPENSES

Worksheet A-8

PPS

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Description (1)	(2) Basis For Adjustment	Amount	Cost Center	Line No.
			1.00	2.00	3.00
1.00	Investment income on restricted funds (chapter 2)	B	-9,428	CAP REL COSTS - BLDGS & FIXTURES	1.00 1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00 3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		0.00 4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 5.00
6.00	Television and radio service (chapter 21)		0		0.00 6.00
7.00	Parking lot (chapter 21)		0		0.00 7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0		8.00
9.00	Home office cost (chapter 21)		0		0.00 9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00 11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	649,006		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Revenue - Employee meals		0		0.00 14.00
15.00	Cost of meals - Guests		0		0.00 15.00
16.00	Sale of medical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts		0		0.00 18.00
19.00	Vending machines		0		0.00 19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	82.00 22.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00 23.00
24.00	Depreciation--movable equipment		0	CAP REL COSTS - MOVABLE EQUIPMENT	2.00 24.00
25.00	OTHER REVENUE - DONATIONS/CHARITY	B	-765	ADMINISTRATIVE & GENERAL	4.00 25.00
25.01	RESIDENT MISSING ITEMS	A	-257	ADMINISTRATIVE & GENERAL	4.00 25.01
25.02	FINES & PENALTIES	A	-3,000	ADMINISTRATIVE & GENERAL	4.00 25.02
25.03	DONATIONS/CHARITY	A	-765	ADMINISTRATIVE & GENERAL	4.00 25.03
25.04	MARKETING	A	-9,222	ADMINISTRATIVE & GENERAL	4.00 25.04
25.05	BAD DEBT	A	-242,439	ADMINISTRATIVE & GENERAL	4.00 25.05
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		383,130		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.

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HOME OFFICE COSTS

Worksheet 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	2,339,197	-2,339,197	1.00
2.00	1.00 CAP REL COSTS - BLDGS & FIXTURES	DEPRECIATION	284,950	0	284,950	2.00
3.00	1.00 CAP REL COSTS - BLDGS & FIXTURES	INTEREST	2,827,806	0	2,827,806	3.00
4.00	1.00 CAP REL COSTS - BLDGS & FIXTURES	FINANCING	215,657	0	215,657	4.00
5.00	4.00 ADMINISTRATIVE & GENERAL	MANAGEMENT	373,661	713,871	-340,210	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.			3,702,074	3,053,068	649,006

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 PEACE CAPITAL LLC	100.00	COMPLETE CARE MANAGEMENT	100.00	MANAGEMENT COMPANY	1.00
2.00	B LAKEVIEW HOLDCO LLC	100.00	LAKEVIEW PC PROPCO LLC	100.00	REALTY	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:

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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	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	3,772,243	3,772,243							1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT	0		0						2.00
3.00	EMPLOYEE BENEFITS	1,084,818	52,876	0	1,137,694					3.00
4.00	ADMINISTRATIVE & GENERAL	2,103,186	245,553	0	93,826	2,442,565	2,442,565			4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	620,761	75,425	0	38,974	735,160	117,418	852,578		5.00
6.00	LAUNDRY & LINEN SERVICE	189,001	66,518	0	6,045	261,564	41,776	16,688	320,028	6.00
7.00	HOUSEKEEPING	369,473	65,278	0	53,473	488,224	77,978	16,377	0	7.00
8.00	DIETARY	880,354	357,957	0	76,919	1,315,230	210,066	89,803	0	8.00
9.00	NURSING ADMINISTRATION	429,232	38,558	0	68,694	536,484	85,686	9,673	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	43,194	0	0	6,913	50,107	8,003	0	0	10.00
11.00	PHARMACY	0	0	0	0	0	0	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	88,142	0	0	14,106	102,248	16,331	0	0	12.00
13.00	SOCIAL SERVICE	107,246	0	0	17,164	124,410	19,871	0	0	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	PATIENT ACTIVITIES	203,295	0	0	25,191	228,486	36,493	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	5,417,572	2,505,920	0	736,389	8,659,881	1,383,136	628,678	320,028	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	11,742	0	0	0	11,742	1,875	0	0	40.00
41.00	LABORATORY	33,678	0	0	0	33,678	5,379	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	1,026,712	0	0	0	1,026,712	163,984	0	0	43.00
44.00	PHYSICAL THERAPY	440,374	246,229	0	0	686,603	109,663	61,773	0	44.00
45.00	OCCUPATIONAL THERAPY	402,453	85,571	0	0	488,024	77,946	21,468	0	45.00
46.00	SPEECH PATHOLOGY	136,904	21,647	0	0	158,551	25,323	5,431	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	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	355,590	0	0	0	355,590	56,794	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	19,610	0	0	0	19,610	3,132	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
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	17,735,580	3,761,532	0	1,137,694	17,724,869	2,440,854	849,891	320,028	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	10,711	0	0	10,711	1,711	2,687	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

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period:

From: 01/01/2024

To: 12/31/2024

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B

Part I

PPS

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG'S & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	
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	17,735,580	3,772,243	0	1,137,694	17,735,580	2,442,565	852,578	320,028	100.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B

Part I

PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	

GENERAL SERVICE COST CENTERS

1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
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	582,579								7.00
8.00	DIETARY	63,840	1,678,939							8.00
9.00	NURSING ADMINISTRATION	6,877	0	638,720						9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	58,110					10.00
11.00	PHARMACY	0	0	0	0	0				11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	118,579			12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	0	144,281		13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	0	0	0	15.00

INPATIENT ROUTINE SERVICE COST CENTERS

30.00	SKILLED NURSING FACILITY	446,916	1,678,939	638,720	0	0	118,579	144,281	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	0	0	40.00
41.00	LABORATORY	0	0	0	0	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	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	43,914	0	0	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	15,261	0	0	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	3,861	0	0	0	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	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	58,110	0	0	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00

OUTPATIENT SERVICE COST CENTERS

60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00

OTHER REIMBURSABLE COST CENTERS

70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	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
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	580,669	1,678,939	638,720	58,110	0	118,579	144,281	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	1,910	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

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B

Part I

PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
98.00	Cross Foot Adjustments	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	582,579	1,678,939	638,720	58,110	0	118,579	144,281	0	100.00

COMPLETE CARE AT LAKEVIEW

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B

Part I

PPS

	Cost Center Description	PATIENT ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total	
		15.00	16.00	17.00	18.00	

GENERAL SERVICE COST CENTERS

1.00	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
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
11.00	PHARMACY					11.00
12.00	MEDICAL RECORDS & LIBRARY					12.00
13.00	SOCIAL SERVICE					13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION					14.00
15.00	PATIENT ACTIVITIES	264,979				15.00

INPATIENT ROUTINE SERVICE COST CENTERS

30.00	SKILLED NURSING FACILITY	264,979	14,284,137	0	14,284,137	30.00
31.00	NURSING FACILITY	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	33.00

ANCILLARY SERVICE COST CENTERS

40.00	RADIOLOGY	0	13,617	0	13,617	40.00
41.00	LABORATORY	0	39,057	0	39,057	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	1,190,696	0	1,190,696	43.00
44.00	PHYSICAL THERAPY	0	901,953	0	901,953	44.00
45.00	OCCUPATIONAL THERAPY	0	602,699	0	602,699	45.00
46.00	SPEECH PATHOLOGY	0	193,166	0	193,166	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	470,494	0	470,494	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	51.00

OUTPATIENT SERVICE COST CENTERS

60.00	CLINIC	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	FQHC					62.00

OTHER REIMBURSABLE COST CENTERS

70.00	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	AMBULANCE	0	22,742	0	22,742	71.00
73.00	CMHC	0	0	0	0	73.00

SPECIAL PURPOSE COST CENTERS

80.00	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	INTEREST EXPENSE					81.00
82.00	UTILIZATION REVIEW - SNF					82.00
83.00	HOSPICE	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	264,979	17,718,561	0	17,718,561	89.00

NONREIMBURSABLE COST CENTERS

90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	17,019	0	17,019	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	264,979	17,735,580	0	17,735,580	100.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period:

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B

Part II

PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG'S & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	0								1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS	0	52,876	0	52,876	52,876				3.00
4.00	ADMINISTRATIVE & GENERAL	0	245,553	0	245,553	4,361	249,914			4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	75,425	0	75,425	1,811	12,014	89,250		5.00
6.00	LAUNDRY & LINEN SERVICE	0	66,518	0	66,518	281	4,274	1,747	72,820	6.00
7.00	HOUSEKEEPING	0	65,278	0	65,278	2,485	7,979	1,714	0	7.00
8.00	DIETARY	0	357,957	0	357,957	3,575	21,493	9,401	0	8.00
9.00	NURSING ADMINISTRATION	0	38,558	0	38,558	3,193	8,767	1,013	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	321	819	0	0	10.00
11.00	PHARMACY	0	0	0	0	0	0	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	656	1,671	0	0	12.00
13.00	SOCIAL SERVICE	0	0	0	0	798	2,033	0	0	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	PATIENT ACTIVITIES	0	0	0	0	1,171	3,734	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	0	2,505,920	0	2,505,920	34,224	141,517	65,812	72,820	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	192	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	550	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	0	16,779	0	0	43.00
44.00	PHYSICAL THERAPY	0	246,229	0	246,229	0	11,220	6,467	0	44.00
45.00	OCCUPATIONAL THERAPY	0	85,571	0	85,571	0	7,975	2,247	0	45.00
46.00	SPEECH PATHOLOGY	0	21,647	0	21,647	0	2,591	568	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	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	5,811	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	320	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
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	3,761,532	0	3,761,532	52,876	249,739	88,969	72,820	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	10,711	0	10,711	0	175	281	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

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B

Part II

PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG'S & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
98.00	Cross Foot Adjustments	0	1.00	2.00	2A	3.00	4.00	5.00	6.00	
99.00	Negative Cost Centers		0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	3,772,243	0	3,772,243	52,876	249,914	89,250	72,820	100.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B

Part II

PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
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	77,456								7.00
8.00	DIETARY	8,488	400,914							8.00
9.00	NURSING ADMINISTRATION	914	0	52,445						9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	1,140					10.00
11.00	PHARMACY	0	0	0	0	0				11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	2,327			12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	0	2,831		13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	59,420	400,914	52,445	0	0	2,327	2,831	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	0	0	40.00
41.00	LABORATORY	0	0	0	0	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	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	5,838	0	0	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	2,029	0	0	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	513	0	0	0	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	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	1,140	0	0	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	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
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	77,202	400,914	52,445	1,140	0	2,327	2,831	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	254	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

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/28/2025 6:38 pm

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Version: 11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B

Part II

PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
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	77,456	400,914	52,445	1,140	0	2,327	2,831	0	100.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B

Part II

PPS

	Cost Center Description	PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total	
		15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
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
11.00	PHARMACY					11.00
12.00	MEDICAL RECORDS & LIBRARY					12.00
13.00	SOCIAL SERVICE					13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION					14.00
15.00	PATIENT ACTIVITIES	4,905				15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	SKILLED NURSING FACILITY	4,905	3,343,135	0	3,343,135	30.00
31.00	NURSING FACILITY	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	0	192	0	192	40.00
41.00	LABORATORY	0	550	0	550	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	16,779	0	16,779	43.00
44.00	PHYSICAL THERAPY	0	269,754	0	269,754	44.00
45.00	OCCUPATIONAL THERAPY	0	97,822	0	97,822	45.00
46.00	SPEECH PATHOLOGY	0	25,319	0	25,319	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	6,951	0	6,951	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60.00	CLINIC	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00	FQHC					62.00
OTHER REIMBURSABLE COST CENTERS						
70.00	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	AMBULANCE	0	320	0	320	71.00
73.00	CMHC	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS						
80.00	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00	INTEREST EXPENSE					81.00
82.00	UTILIZATION REVIEW - SNF					82.00
83.00	HOSPICE	0	0	0	0	83.00
89.00	Subtotals (sum of lines 1-84)	4,905	3,760,822	0	3,760,822	89.00
NONREIMBURSABLE COST CENTERS						
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	11,421	0	11,421	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	94.00
98.00	Cross Foot Adjustments	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	99.00
100.00	TOTAL	4,905	3,772,243	0	3,772,243	100.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period:

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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	BLDG'S & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (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)		
		1.00	2.00	3.00	4A	4.00	5.00	6.00	7.00		
GENERAL SERVICE COST CENTERS											
1.00	CAP REL COSTS - BLDGS & FIXTURES	33,459								1.00	
2.00	CAP REL COSTS - MOVABLE EQUIPMENT		0							2.00	
3.00	EMPLOYEE BENEFITS	469	0	7,108,817						3.00	
4.00	ADMINISTRATIVE & GENERAL	2,178	0	586,263	-2,442,565	15,293,015				4.00	
5.00	PLANT OPERATION, MAINT. & REPAIRS	669	0	243,529	0	735,160	30,143			5.00	
6.00	LAUNDRY & LINEN SERVICE	590	0	37,769	0	261,564	590	23,223		6.00	
7.00	HOUSEKEEPING	579	0	334,124	0	488,224	579	0	28,974	7.00	
8.00	DIETARY	3,175	0	480,622	0	1,315,230	3,175	0	3,175	8.00	
9.00	NURSING ADMINISTRATION	342	0	429,232	0	536,484	342	0	342	9.00	
10.00	CENTRAL SERVICES & SUPPLY	0	0	43,194	0	50,107	0	0	0	10.00	
11.00	PHARMACY	0	0	0	0	0	0	0	0	11.00	
12.00	MEDICAL RECORDS & LIBRARY	0	0	88,142	0	102,248	0	0	0	12.00	
13.00	SOCIAL SERVICE	0	0	107,246	0	124,410	0	0	0	13.00	
14.00	NURSING AND ALLIED HEALTH EDUCATION		0	0	0	0	0	0	0	14.00	
15.00	PATIENT ACTIVITIES		0	0	157,407	0	228,486	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	SKILLED NURSING FACILITY	22,227	0	4,601,289	0	8,659,881	22,227	23,223	22,227	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	11,742	0	0	0	40.00	
41.00	LABORATORY	0	0	0	0	33,678	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	1,026,712	0	0	0	43.00	
44.00	PHYSICAL THERAPY	2,184	0	0	0	686,603	2,184	0	2,184	44.00	
45.00	OCCUPATIONAL THERAPY	759	0	0	0	488,024	759	0	759	45.00	
46.00	SPEECH PATHOLOGY	192	0	0	0	158,551	192	0	192	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	0	0	48.00	
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	355,590	0	0	0	49.00	
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00	
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00	
OUTPATIENT SERVICE COST CENTERS											
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00	
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00	
62.00	FQHC									62.00	
OTHER REIMBURSABLE COST CENTERS											
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00	
71.00	AMBULANCE	0	0	0	0	19,610	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	
82.00	UTILIZATION REVIEW - SNF									82.00	
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00	
89.00	Subtotals (sum of lines 1-84)	33,364	0	7,108,817	-2,442,565	15,282,304	30,048	23,223	28,879	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	95	0	0	0	10,711	95	0	95	91.00	
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00	

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period:
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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	BLDG'S & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (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)	
		1.00	2.00	3.00	4A	4.00	5.00	6.00	7.00	
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)	3,772,243	0	1,137,694		2,442,565	852,578	320,028	582,579	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	112.742252	0.000000	0.160040		0.159718	28.284444	13.780648	20.106958	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			52,876		249,914	89,250	72,820	77,456	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.007438		0.016342	2.960886	3.135684	2.673293	105.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRA TION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	PATIENT ACTIVITIES (PATIENT CENSUS)	
		8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
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	69,669								8.00
9.00	NURSING ADMINISTRATION	0	123,847							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	355,590						10.00
11.00	PHARMACY	0	0	0	0					11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	23,223				12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	23,223			13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0		14.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	0	0	23,223	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	69,669	123,847	0	0	23,223	23,223	0	23,223	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	0	0	40.00
41.00	LABORATORY	0	0	0	0	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	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	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	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	355,590	0	0	0	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS										
60.00	CLINIC		0	0		0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	FQHC									62.00
OTHER REIMBURSABLE COST CENTERS										
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	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
82.00	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	69,669	123,847	355,590	0	23,223	23,223	0	23,223	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

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period:

From: 01/01/2024

To: 12/31/2024

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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRA TION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	PATIENT ACTIVITIES (PATIENT CENSUS)	
		8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
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)	1,678,939	638,720	58,110	0	118,579	144,281	0	264,979	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	24.098796	5.157331	0.163419	0.000000	5.106102	6.212849	0.000000	11.410197	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	400,914	52,445	1,140	0	2,327	2,831	0	4,905	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	5.754554	0.423466	0.003206	0.000000	0.100202	0.121905	0.000000	0.211213	105.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

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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	13,617	0	0.000000	40.00
41.00	LABORATORY	39,057	947	41.242872	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	OXYGEN (INHALATION) THERAPY	1,190,696	0	0.000000	43.00
44.00	PHYSICAL THERAPY	901,953	683,498	1.319613	44.00
45.00	OCCUPATIONAL THERAPY	602,699	627,344	0.960715	45.00
46.00	SPEECH PATHOLOGY	193,166	247,337	0.780983	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	470,494	355,590	1.323136	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
60.00	CLINIC	0	0	0.000000	60.00
61.00	RURAL HEALTH CLINIC				61.00
62.00	FQHC				62.00
71.00	AMBULANCE	22,742	0	0.000000	71.00
100.00	Total	3,434,424	1,914,716		100.00

COMPLETE CARE AT LAKEVIEW

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Worksheet D

Part I

Title XVIII

Skilled Nursing Facility

PPS

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

		Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost	
			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	41.242872	947	0	39,057	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	1.319613	91,656	0	120,950	0	44.00
45.00	OCCUPATIONAL THERAPY	0.960715	106,453	0	102,271	0	45.00
46.00	SPEECH PATHOLOGY	0.780983	78,086	0	60,984	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	1.323136	246,534	0	326,198	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0.000000	0	0	0	0	51.00

OUTPATIENT SERVICE COST CENTERS

60.00	CLINIC	0.000000	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC						61.00
62.00	FQHC						62.00
71.00	AMBULANCE (2)	0.000000		0			71.00
100.00	Total (Sum of lines 40 - 71)		523,676	0	649,460	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.

COMPLETE CARE AT LAKEVIEW

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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)				1.323136	1.00
2.00	Program vaccine charges (From your records, or the PS&R)				6,841	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)				9,052	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	13,617	0	0.000000	0	0	40.00
41.00	LABORATORY	39,057	0	0.000000	39,057	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	1,190,696	0	0.000000	0	0	43.00
44.00	PHYSICAL THERAPY	901,953	0	0.000000	120,950	0	44.00
45.00	OCCUPATIONAL THERAPY	602,699	0	0.000000	102,271	0	45.00
46.00	SPEECH PATHOLOGY	193,166	0	0.000000	60,984	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	470,494	0	0.000000	326,198	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00	Total (Sum of lines 40 - 52)	3,411,682	0		649,460	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	27,533	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	2,993	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	14,284,137	5.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6.00	General inpatient routine service charges	13,518,983	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	1,056598	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)	14,284,137	15.00

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	518.80	16.00
17.00	Program routine service cost (Line 3 times line 16)	1,552,768	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)	1,552,768	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)	3,343,135	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	121.42	21.00
22.00	Program capital related cost (Line 3 times line 21)	363,410	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,189,358	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)	1,189,358	25.00
26.00	Enter the per diem limitation (1)	26.00	
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	27.00	
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)	28.00	

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

		1.00	
1.00	Total SNF inpatient days	27,533	1.00
2.00	Program inpatient days (see instructions)	2,993	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)	0.108706	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)	3,409,439	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)	3,409,439	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinurance	479,808	5.00
6.00	Allowable bad debts (From your records)	246,809	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	152,284	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	160,426	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)	3,090,057	11.00
12.00	Interim payments (See instructions)	3,297,128	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)	3,209	14.75
14.99	Sequestration amount (see instructions)	58,593	14.99
15.00	Balance due provider/program (see Instructions)	-268,873	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)	9,052	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	9,052	19.00
20.00	Medicare Part B ancillary charges (See instructions)	6,841	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	6,841	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinurance 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)	6,841	25.00
26.00	Interim payments (See instructions)	3,687	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)	137	28.99
29.00	Balance due provider/program (see instructions)	3,017	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

COMPLETE CARE AT LAKEVIEW

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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	Total interim payments paid to provider	1.00	2.00	3.00	4.00	
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	07/03/2024	54,591		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)		54,591		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)		3,297,128		3,687	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
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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		0		3,017	6.01
6.02	PROVIDER TO PROGRAM		268,873		0	6.02
7.00	Total Medicare program liability (see instructions)		3,028,255		6,704	7.00

Contractor Name

Contractor Number

1.00

2.00

(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	448,969	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	4,908,702	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	-995,501	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	60,472	0	0	0	8.00
9.00	Other current assets	37,964	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)	4,460,606	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	210,950	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	63,023	0	0	0	23.00
24.00	Less: Accumulated depreciation	-23,969	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)	250,004	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	115,929	0	0	0	31.00
32.00	Other assets	70,210	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	186,139	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	4,896,749	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	1,702,574	0	0	0	35.00
36.00	Salaries, wages, and fees payable	1,585,531	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	7,925,488	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)	11,213,593	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	266,153	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	0	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)	266,153	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	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	1.00	2.00	3.00	4.00	
		11,479,746	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-6,582,997				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)	-6,582,997	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	4,896,749	0	0	0	60.00

(-) = contra amount

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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				-419,180		0			0
2.00	Net income (loss) (from Wkst. G-3, line 31)				-2,965,622					2.00
3.00	Total (sum of line 1 and line 2)			-3,384,802		0		0		0
4.00	Additions (credit adjustments)									4.00
5.00			0		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)			0		0		0		0
11.00	Subtotal (line 3 plus line 10)			-3,384,802		0		0		11.00
12.00	Deductions (debit adjustments)									12.00
13.00	ROUNDING		1		0		0		0	13.00
14.00			0		0		0		0	14.00
15.00	OTHER DEDUCTIONS		3,198,194		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)			3,198,195		0		0		0
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)			-6,582,997		0		0		19.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period: 01/01/2024
From: 01/01/2024
To: 12/31/2024Run Date Time: 5/28/2025 6:38 pm
MCRIF32
2540-10
Version: 11.1.179.1

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		1.00	2.00	3.00	
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	13,518,983		13,518,983	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/HID	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)	13,518,983		13,518,983	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,914,716	0	1,914,716	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	ROUTINE CHARGES / BED HOLD	108,933	0	108,933	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	15,542,632		0	15,542,632
14.00					14.00
15.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	15,542,632			
15.00					15.00

PART II - OPERATING EXPENSES

		1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		17,352,450	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)		17,352,450	15.00

COMPLETE CARE AT LAKEVIEW

Provider CCN: 315110

Period: 01/01/2024 From: 01/01/2024 To: 12/31/2024 Run Date Time: 5/28/2025 6:38 pm MCRIF32 Version: 11.1.179.1 2540-10



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)	15,542,632	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,165,997	2.00
3.00	Net patient revenues (Line 1 minus line 2)	14,376,635	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17,352,450	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-2,975,815	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	9,428	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	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	NON PATIENT REVENUE	765	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	10,193	25.00
26.00	Total (Line 5 plus line 25)	-2,965,622	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)	-2,965,622	31.00