

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

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 3/3/2025 12:54 pm

MCRIF32

Version: 10.23.179.0



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 INGLEMOOR CARE CENTER, 315322 {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>Steve Izza</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	STEVE IZZO		2
3	Signatory Title	ADMINISTRATOR		3
4	Signature Date	(Dated when report is electronically signed.)		4

PART III - SETTLEMENT SUMMARY

			Title XVIII			
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
1.00	SKILLED NURSING FACILITY	0	8,297	1,608	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	8,297	1,608	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.

INGLEMOOR CARE CENTER	Period:	Run Date Time:	3/3/2025 12:54 pm
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	To: 12/31/2024	Version:	10.23.179.0



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:	311 SOUTH LIVINGSTON AVENUE	P.O. Box:						1.00		
2.00	City:	LIVINGSTON	State:	NJ	ZIP Code:	07039			2.00		
3.00	County:	ESSEX	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	INGLEMOOR CARE CENTER	315322	01/01/1996	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)	5 - Proprietary, Partnership						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.							N	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							231,208	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							231,208	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	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)		N				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	02/21/2025	Y	02/21/2025	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.	CHRIS	GUILBAULT	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	CHRIS.GUILBAULT@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

				Inpatient Days/Visits					Discharges					
	Component	Number of Beds	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	138	50,508	0	7,903	9,676	18,393	35,972	0	314	12	217	543	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	0	0	0	0	0	0	0	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	138	50,508	0	7,903	9,676	18,393	35,972	0	314	12	217	543	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	25.17	806.33	66.25	0	365	3	158	526	117.90	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													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	25.17	806.33	66.25	0	365	3	158	526	117.90	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)	8,018,816	0	8,018,816	245,870.00	32.61	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)	8,018,816	0	8,018,816	245,870.00	32.61	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						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)	8,018,816	0	8,018,816	245,870.00	32.61	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	1,692,130	0	1,692,130	33,237.00	50.91	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)	1,791,658	0	1,791,658			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)	1,791,658	0	1,791,658			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	887,520	0	887,520	16,288.00	54.49	2.00
3.00	Plant Operation, Maintenance & Repairs	155,748	0	155,748	4,160.00	37.44	3.00
4.00	Laundry & Linen Service	93,633	0	93,633	4,116.00	22.75	4.00
5.00	Housekeeping	333,023	0	333,023	19,004.00	17.52	5.00
6.00	Dietary	658,021	0	658,021	31,573.00	20.84	6.00
7.00	Nursing Administration	781,824	0	781,824	14,099.00	55.45	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	164,179	0	164,179	4,363.00	37.63	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	197,044	0	197,044	10,502.00	18.76	13.00
14.00	Total (sum lines 1 thru 13)	3,270,992	0	3,270,992	104,105.00	31.42	14.00

INGLEMOOR CARE CENTER

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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	42,175	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)	843,099	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	19,174	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,072	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	190,744	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	587,107	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	100,287	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)	1,791,658	24.00

	Amount Reported	
	1.00	

Part B - Other than Core Related Cost

25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00
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INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:
From: 01/01/2024
To: 12/31/2024Run Date Time: 3/3/2025 12:54 pm
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Version: 10.23.179.0

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)	989,370	221,057	1,210,427	21,422.00	56.50	1.00
2.00	Licensed Practical Nurses (LPNs)	1,360,588	303,999	1,664,587	33,945.00	49.04	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,636,138	365,566	2,001,704	72,027.00	27.79	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3,986,096	890,622	4,876,718	127,394.00	38.28	4.00
5.00	Physical Therapists	275,161	61,480	336,641	3,068.00	109.73	5.00
6.00	Physical Therapy Assistants	120,128	26,840	146,968	3,167.00	46.41	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	198,836	44,426	243,262	3,967.00	61.32	8.00
9.00	Occupational Therapy Assistants	125,903	28,131	154,034	3,628.00	42.46	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	31,777	7,100	38,877	541.00	71.86	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)	886,760		886,760	14,843.00	59.74	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	805,370		805,370	18,394.00	43.78	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,692,130		1,692,130	33,237.00	50.91	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	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

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

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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

INGLEMOOR CARE CENTER		Period:	Run Date Time:	3/3/2025 12:54 pm
Provider CCN: 315322		From: 01/01/2024	MCRIF32	2540-10
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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

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 3/3/2025 12:54 pm

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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		1,045,598	1,045,598	0	1,045,598	0	1,045,598	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,827,394	1,827,394	0	1,827,394	0	1,827,394	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	887,520	2,540,275	3,427,795	0	3,427,795	-1,210,288	2,217,507	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	155,748	490,720	646,468	0	646,468	0	646,468	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	93,633	8,367	102,000	0	102,000	0	102,000	6.00
7.00	00700	HOUSEKEEPING	333,023	62,217	395,240	0	395,240	0	395,240	7.00
8.00	00800	DIETARY	658,021	482,676	1,140,697	0	1,140,697	-1,239	1,139,458	8.00
9.00	00900	NURSING ADMINISTRATION	781,824	0	781,824	0	781,824	0	781,824	9.00
13.00	01300	SOCIAL SERVICE	164,179	0	164,179	0	164,179	0	164,179	13.00
15.00	01500	PATIENT ACTIVITIES	197,044	33,286	230,330	0	230,330	0	230,330	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	SKILLED NURSING FACILITY	3,986,096	2,166,009	6,152,105	0	6,152,105	0	6,152,105	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	45,360	45,360	0	45,360	0	45,360	40.00
41.00	04100	LABORATORY	0	50,222	50,222	0	50,222	0	50,222	41.00
42.00	04200	INTRAVENOUS THERAPY	0	78,823	78,823	0	78,823	0	78,823	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	17,688	17,688	0	17,688	0	17,688	43.00
44.00	04400	PHYSICAL THERAPY	405,212	114,315	519,527	0	519,527	0	519,527	44.00
45.00	04500	OCCUPATIONAL THERAPY	324,739	0	324,739	0	324,739	0	324,739	45.00
46.00	04600	SPEECH PATHOLOGY	31,777	0	31,777	0	31,777	0	31,777	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	321,635	321,635	0	321,635	0	321,635	49.00
51.00	05100	SUPPORT SURFACES	0	16,875	16,875	0	16,875	0	16,875	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	07100	AMBULANCE	0	1,272	1,272	0	1,272	0	1,272	71.00
SPECIAL PURPOSE COST CENTERS										
83.00	08300	HOSPICE	0	0	0	0	0	0	0	83.00
89.00		SUBTOTALS (sum of lines 1-84)	8,018,816	9,302,732	17,321,548	0	17,321,548	-1,211,527	16,110,021	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	32,892	32,892	0	32,892	0	32,892	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	8,018,816	9,335,624	17,354,440	0	17,354,440	-1,211,527	16,142,913	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.									

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	466,928	0	0	0	0	466,928	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	0	0	3.00
4.00	Building Improvements	3,727,147	0	0	0	0	3,727,147	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	0	0	5.00
6.00	Movable Equipment	2,725,824	13,650	0	13,650	0	2,739,474	0	6.00
7.00	Subtotal (sum of lines 1-6)	6,919,899	13,650	0	13,650	0	6,933,549	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	6,919,899	13,650	0	13,650	0	6,933,549	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	4.00	
1.00	Investment income on restricted funds (chapter 2)	B	-860	ADMINISTRATIVE & GENERAL	4.00	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)	B	-9,719	ADMINISTRATIVE & GENERAL	4.00	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	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals	B	-1,239	DIETARY	8.00	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	2.00	24.00
25.00	Other adjustment (specify)		0		0.00	25.00
25.02	MANGEMENT FEES	A	-862,085	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03	CONTRIBUTIONS	A	-8,509	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04	PUBLIC RELATIONS	A	-41,042	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05	BAD DEBTS	A	-82,823	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06	PERSONAL ITEMS	A	-17,675	ADMINISTRATIVE & GENERAL	4.00	25.06
25.07	NJ CBT	A	-187,575	ADMINISTRATIVE & GENERAL	4.00	25.07
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1,211,527			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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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	ADMINISTRA TIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		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	1,045,598	1,045,598							1.00
3.00	EMPLOYEE BENEFITS	1,827,394	0	1,827,394						3.00
4.00	ADMINISTRATIVE & GENERAL	2,217,507	122,988	202,255	2,542,750	2,542,750				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	646,468	31,703	35,493	713,664	133,430	847,094			5.00
6.00	LAUNDRY & LINEN SERVICE	102,000	25,688	21,338	149,026	27,863	24,425	201,314		6.00
7.00	HOUSEKEEPING	395,240	5,171	75,892	476,303	89,052	4,917	0	570,272	7.00
8.00	DIETARY	1,139,458	108,908	149,955	1,398,321	261,437	103,552	0	72,213	8.00
9.00	NURSING ADMINISTRATION	781,824	9,893	178,168	969,885	181,335	9,407	0	6,560	9.00
13.00	SOCIAL SERVICE	164,179	4,019	37,414	205,612	38,442	3,821	0	2,665	13.00
15.00	PATIENT ACTIVITIES	230,330	12,282	44,904	287,516	53,755	11,678	0	8,144	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	6,152,105	688,466	908,386	7,748,957	1,448,779	654,608	201,314	456,502	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	45,360	0	0	45,360	8,481	0	0	0	40.00
41.00	LABORATORY	50,222	0	0	50,222	9,390	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	78,823	0	0	78,823	14,737	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	17,688	0	0	17,688	3,307	0	0	0	43.00
44.00	PHYSICAL THERAPY	519,527	14,783	92,343	626,653	117,162	14,056	0	9,802	44.00
45.00	OCCUPATIONAL THERAPY	324,739	12,254	74,004	410,997	76,842	11,651	0	8,125	45.00
46.00	SPEECH PATHOLOGY	31,777	0	7,242	39,019	7,295	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	321,635	4,384	0	326,019	60,954	4,169	0	2,907	49.00
51.00	SUPPORT SURFACES	16,875	0	0	16,875	3,155	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	1,272	0	0	1,272	238	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS										
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	16,110,021	1,040,539	1,827,394	16,104,962	2,535,654	842,284	201,314	566,918	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	32,892	5,059	0	37,951	7,096	4,810	0	3,354	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	16,142,913	1,045,598	1,827,394	16,142,913	2,542,750	847,094	201,314	570,272	100.00

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 3/3/2025 12:54 pm

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total		
		8.00	9.00	13.00	15.00	16.00	17.00	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	1,835,523								8.00
9.00	NURSING ADMINISTRATION	0	1,167,187							9.00
13.00	SOCIAL SERVICE	0	0	250,540						13.00
15.00	PATIENT ACTIVITIES	0	0	0	361,093					15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	1,835,523	1,167,187	250,540	361,093	14,124,503	0	14,124,503		30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0		31.00
32.00	ICF/IID	0	0	0	0	0	0	0		32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0		33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	53,841	0	53,841		40.00
41.00	LABORATORY	0	0	0	0	59,612	0	59,612		41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	93,560	0	93,560		42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	20,995	0	20,995		43.00
44.00	PHYSICAL THERAPY	0	0	0	0	767,673	0	767,673		44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	507,615	0	507,615		45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	46,314	0	46,314		46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0		47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	394,049	0	394,049		49.00
51.00	SUPPORT SURFACES	0	0	0	0	20,030	0	20,030		51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	1,510	0	1,510		71.00
SPECIAL PURPOSE COST CENTERS										
83.00	HOSPICE	0	0	0	0	0	0	0		83.00
89.00	SUBTOTALS (sum of lines 1-84)	1,835,523	1,167,187	250,540	361,093	16,089,702	0	16,089,702		89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0		90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	53,211	0	53,211		91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0		92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0		93.00
94.00	PATIENTS LAUNDRY	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		99.00
100.00	TOTAL	1,835,523	1,167,187	250,540	361,093	16,142,913	0	16,142,913		100.00

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 3/3/2025 12:54 pm

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	ADMINISTRA TIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		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	122,988	122,988	0	122,988				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	31,703	31,703	0	6,454	38,157			5.00
6.00	LAUNDRY & LINEN SERVICE	0	25,688	25,688	0	1,348	1,100	28,136		6.00
7.00	HOUSEKEEPING	0	5,171	5,171	0	4,307	221	0	9,699	7.00
8.00	DIETARY	0	108,908	108,908	0	12,645	4,664	0	1,228	8.00
9.00	NURSING ADMINISTRATION	0	9,893	9,893	0	8,771	424	0	112	9.00
13.00	SOCIAL SERVICE	0	4,019	4,019	0	1,859	172	0	45	13.00
15.00	PATIENT ACTIVITIES	0	12,282	12,282	0	2,600	526	0	139	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	0	688,466	688,466	0	70,074	29,487	28,136	7,764	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	410	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	454	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	713	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	160	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	14,783	14,783	0	5,667	633	0	167	44.00
45.00	OCCUPATIONAL THERAPY	0	12,254	12,254	0	3,717	525	0	138	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	353	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	4,384	4,384	0	2,948	188	0	49	49.00
51.00	SUPPORT SURFACES	0	0	0	0	153	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	12	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS										
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,040,539	1,040,539	0	122,645	37,940	28,136	9,642	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	5,059	5,059	0	343	217	0	57	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		0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	1,045,598	1,045,598	0	122,988	38,157	28,136	9,699	100.00

INGLEMOOR CARE CENTER

Provider CCN: 315322

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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	Total		
		8.00	9.00	13.00	15.00	16.00	17.00	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	127,445								8.00
9.00	NURSING ADMINISTRATION	0	19,200							9.00
13.00	SOCIAL SERVICE	0	0	6,095						13.00
15.00	PATIENT ACTIVITIES	0	0	0	15,547					15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	127,445	19,200	6,095	15,547	992,214	0	992,214		30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0		31.00
32.00	ICF/IID	0	0	0	0	0	0	0		32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0		33.00
ANCILLARY SERVICE COST CENTERS										
40.00	RADIOLOGY	0	0	0	0	410	0	410		40.00
41.00	LABORATORY	0	0	0	0	454	0	454		41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	713	0	713		42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	160	0	160		43.00
44.00	PHYSICAL THERAPY	0	0	0	0	21,250	0	21,250		44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	16,634	0	16,634		45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	353	0	353		46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0		47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,569	0	7,569		49.00
51.00	SUPPORT SURFACES	0	0	0	0	153	0	153		51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	12	0	12		71.00
SPECIAL PURPOSE COST CENTERS										
83.00	HOSPICE	0	0	0	0	0	0	0		83.00
89.00	SUBTOTALS (sum of lines 1-84)	127,445	19,200	6,095	15,547	1,039,922	0	1,039,922		89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0		90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	5,676	0	5,676		91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0		92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0		93.00
94.00	PATIENTS LAUNDRY	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		99.00
100.00	TOTAL	127,445	19,200	6,095	15,547	1,045,598	0	1,045,598		100.00

INGLEMOOR CARE CENTER

Provider CCN: 315322

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	37,203								1.00
3.00	EMPLOYEE BENEFITS	0	8,018,816							3.00
4.00	ADMINISTRATIVE & GENERAL	4,376	887,520	-2,542,750	13,600,163					4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	1,128	155,748	0	713,664	31,699				5.00
6.00	LAUNDRY & LINEN SERVICE	914	93,633	0	149,026	914	35,972			6.00
7.00	HOUSEKEEPING	184	333,023	0	476,303	184	0	30,601		7.00
8.00	DIETARY	3,875	658,021	0	1,398,321	3,875	0	3,875	107,916	8.00
9.00	NURSING ADMINISTRATION	352	781,824	0	969,885	352	0	352	0	9.00
13.00	SOCIAL SERVICE	143	164,179	0	205,612	143	0	143	0	13.00
15.00	PATIENT ACTIVITIES	437	197,044	0	287,516	437	0	437	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	24,496	3,986,096	0	7,748,957	24,496	35,972	24,496	107,916	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	45,360	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	50,222	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	78,823	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	17,688	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	526	405,212	0	626,653	526	0	526	0	44.00
45.00	OCCUPATIONAL THERAPY	436	324,739	0	410,997	436	0	436	0	45.00
46.00	SPEECH PATHOLOGY	0	31,777	0	39,019	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	156	0	0	326,019	156	0	156	0	49.00
51.00	SUPPORT SURFACES	0	0	0	16,875	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	1,272	0	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS										
83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	37,023	8,018,816	-2,542,750	13,562,212	31,519	35,972	30,421	107,916	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	180	0	0	37,951	180	0	180	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)	1,045,598	1,827,394		2,542,750	847,094	201,314	570,272	1,835,523	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	28.105207	0.227888		0.186965	26.723051	5.596408	18.635731	17.008812	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		122,988	38,157	28,136	9,699	127,445	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.009043	1.203729	0.782164	0.316950	1.180965	105.00

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

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To: 12/31/2024

Run Date Time: 3/3/2025 12:54 pm

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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	NURSING ADMINISTRA TION (DIRECT NURSING)	SOCIAL SERVICE (PATIENT CENSUS)	PATIENT ACTIVITIES (PATIENT CENSUS)		
		9.00	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	160,631				9.00
13.00	SOCIAL SERVICE	0	35,972			13.00
15.00	PATIENT ACTIVITIES	0	0	35,972		15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	SKILLED NURSING FACILITY	160,631	35,972	35,972		30.00
31.00	NURSING FACILITY	0	0	0		31.00
32.00	ICF/IID	0	0	0		32.00
33.00	OTHER LONG TERM CARE	0	0	0		33.00
ANCILLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	0	0	0		40.00
41.00	LABORATORY	0	0	0		41.00
42.00	INTRAVENOUS THERAPY	0	0	0		42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0		43.00
44.00	PHYSICAL THERAPY	0	0	0		44.00
45.00	OCCUPATIONAL THERAPY	0	0	0		45.00
46.00	SPEECH PATHOLOGY	0	0	0		46.00
47.00	ELECTROCARDIOLOGY	0	0	0		47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0		49.00
51.00	SUPPORT SURFACES	0	0	0		51.00
OTHER REIMBURSABLE COST CENTERS						
71.00	AMBULANCE	0	0	0		71.00
SPECIAL PURPOSE COST CENTERS						
83.00	HOSPICE	0	0	0		83.00
89.00	SUBTOTALS (sum of lines 1-84)	160,631	35,972	35,972		89.00
NONREIMBURSABLE COST CENTERS						
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0		91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0		92.00
93.00	NONPAID WORKERS	0	0	0		93.00
94.00	PATIENT'S LAUNDRY	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)	1,167,187	250,540	361,093		102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	7.266262	6.964862	10.038169		103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	19,200	6,095	15,547		104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.119529	0.169437	0.432197		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	53,841	41,965	1.282998	40.00
41.00	LABORATORY	59,612	46,914	1.270665	41.00
42.00	INTRAVENOUS THERAPY	93,560	9,049	10.339264	42.00
43.00	OXYGEN (INHALATION) THERAPY	20,995	0	0.000000	43.00
44.00	PHYSICAL THERAPY	767,673	879,737	0.872616	44.00
45.00	OCCUPATIONAL THERAPY	507,615	1,028,451	0.493572	45.00
46.00	SPEECH PATHOLOGY	46,314	237,286	0.195182	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,655	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	394,049	406,789	0.968682	49.00
51.00	SUPPORT SURFACES	20,030	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	AMBULANCE	1,510	0	0.000000	71.00
100.00	Total	1,965,199	2,673,846		100.00

INGLEMOOR CARE CENTER		Period:	Run Date Time:	3/3/2025 12:54 pm
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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

			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	1.282998	30,975	0	39,741	0	40.00
41.00	LABORATORY	1.270665	45,781	0	58,172	0	41.00
42.00	INTRAVENOUS THERAPY	10.339264	9,049	0	93,560	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0.872616	475,942	0	415,315	0	44.00
45.00	OCCUPATIONAL THERAPY	0.493572	573,782	0	283,203	0	45.00
46.00	SPEECH PATHOLOGY	0.195182	133,680	0	26,092	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	0.968682	269,426	0	260,988	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)		1,538,635	0	1,177,071	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)	0.968682	1.00
2.00	Program vaccine charges (From your records, or the PS&R)	9,720	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)	9,416	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	53,841	0	0.000000	39,741	0	40.00
41.00	LABORATORY	59,612	0	0.000000	58,172	0	41.00
42.00	INTRAVENOUS THERAPY	93,560	0	0.000000	93,560	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	20,995	0	0.000000	0	0	43.00
44.00	PHYSICAL THERAPY	767,673	0	0.000000	415,315	0	44.00
45.00	OCCUPATIONAL THERAPY	507,615	0	0.000000	283,203	0	45.00
46.00	SPEECH PATHOLOGY	46,314	0	0.000000	26,092	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	394,049	0	0.000000	260,988	0	49.00
51.00	SUPPORT SURFACES	20,030	0	0.000000	0	0	51.00
100.00	Total (Sum of lines 40 - 52)	1,963,689	0		1,177,071	0	100.00

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COMPUTATION OF INPATIENT ROUTINE COSTS

Worksheet D-1


Part I

PPS

Title XVIII

Skilled Nursing Facility

PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
INPATIENT DAYS				
1.00	Inpatient days including private room days		35,972	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		7,903	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		14,124,503	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		16,628,758	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		0.849402	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)		14,124,503	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		392.65	16.00
17.00	Program routine service cost (Line 3 times line 16)		3,103,113	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)		3,103,113	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)		992,214	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		27.58	21.00
22.00	Program capital related cost (Line 3 times line 21)		217,965	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		2,885,148	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)		2,885,148	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		35,972	1.00
2.00	Program inpatient days (see instructions)		7,903	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)		0.219699	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)	5,756,181	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)	5,756,181	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	618,732	5.00
6.00	Allowable bad debts (From your records)	13,023	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	8,465	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)	5,145,914	11.00
12.00	Interim payments (See instructions)	5,034,699	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)	169	14.75
14.99	Sequestration amount (see instructions)	102,749	14.99
15.00	Balance due provider/program (see Instructions)	8,297	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)	9,416	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	9,416	19.00
20.00	Medicare Part B ancillary charges (See instructions)	9,720	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	9,416	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)	9,416	25.00
26.00	Interim payments (See instructions)	7,620	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)	188	28.99
29.00	Balance due provider/program (see instructions)	1,608	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	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		5,034,699		7,620	1.00
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)		0		0	2.00
						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)		5,034,699		7,620	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		8,297		1,608	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,042,996		9,228	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.

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

From: 01/01/2024

To: 12/31/2024

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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	2,061,297	0	0	0	1.00
2.00	Temporary investments	84,100	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,121,013	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	278,687	0	0	0	8.00
9.00	Other current assets	436,225	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)	3,981,322	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	466,928	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	3,020,072	0	0	0	15.00
16.00	Less Accumulated depreciation	-2,415,443	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	707,075	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	26,550	0	0	0	21.00
22.00	Less: Accumulated depreciation	-26,550	0	0	0	22.00
23.00	Major movable equipment	2,712,924	0	0	0	23.00
24.00	Less: Accumulated depreciation	-3,161,053	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)	1,330,503	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	108,117	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	108,117	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5,419,942	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	609,187	0	0	0	35.00
36.00	Salaries, wages, and fees payable	812,749	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	425,066	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	5,246	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1,852,248	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	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)	0	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)	1,852,248	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,567,694				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)	3,567,694	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	5,419,942	0	0	0	60.00

() = contra amount

INGLEMOOR CARE CENTER

Provider CCN: 315322

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time:

MCRIF32

Version:

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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		3,984,690		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		1,803,006							2.00
3.00	Total (sum of line 1 and line 2)		5,787,696		0		0		0	3.00
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	10.00
11.00	Subtotal (line 3 plus line 10)		5,787,696		0		0		0	11.00
12.00	Deductions (debit adjustments)									12.00
13.00	ROUNDING	2		0		0		0		13.00
14.00	DIVIDENDS	2,220,000		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)		2,220,002		0		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		3,567,694		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	16,628,758		16,628,758	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)	16,628,758		16,628,758	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	2,673,845	0	2,673,845	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	72,341	0	72,341	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	19,374,944	0	19,374,944	14.00
PART II - OPERATING EXPENSES					
		1.00	2.00		
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			17,354,440	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)			17,354,440	15.00

INGLEMOOR CARE CENTER		Period:	Run Date Time:	3/3/2025 12:54 pm
Provider CCN: 315322		From: 01/01/2024	MCRIF32	2540-10
		To: 12/31/2024	Version:	10.23.179.0



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)	19,374,944	1.00
2.00	Less: contractual allowances and discounts on patients accounts	381,837	2.00
3.00	Net patient revenues (Line 1 minus line 2)	18,993,107	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17,354,440	4.00
5.00	Net income from service to patients (Line 3 minus 4)	1,638,667	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	42,299	7.00
8.00	Revenues from communications (Telephone and Internet service)	9,719	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	1,239	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	PRIOR YEAR	10,512	24.00
24.01	NON PATIENT REVENUE	68,998	24.01
24.02	BARBER BEAUTY	31,572	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	164,339	25.00
26.00	Total (Line 5 plus line 25)	1,803,006	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)	1,803,006	31.00