

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

WEST CALDWELL CARE CENTER

Provider CCN: 315247

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/27/2025 10:47 am

MCRIF32

Version: 11.1.179.1



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

Worksheet S
Parts I, II & III

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date:	Time:
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report.		
	3.01. ☐ No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only:	4. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Contractor No.: _____	
	5. Date Received: _____	7. ☐ First Cost Report for this Provider CCN	
		8. ☐ 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. ☐ 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 WEST CALDWELL CARE CENTER, 315247 {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 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			2
3	Signatory Title			3
4	Signature Date			4

PART III - SETTLEMENT SUMMARY

		Title XVIII				
		Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
1.00	SKILLED NURSING FACILITY	0	88,899	0	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	88,899	0	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.

WEST CALDWELL CARE CENTER	Period: From: 01/01/2024 To: 12/31/2024	Run Date Time: 5/27/2025 10:47 am MCRIF32 Version: 11.1.179.1	
Provider CCN: 315247			

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:	106 FAIRFIELD AVENUE	P.O. Box:						1.00		
2.00	City:	WEST CALDWELL	State:	NJ	ZIP Code:	07006			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	WEST CALDWELL CARE CENTER	315247	07/09/1987	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)	6 - Proprietary, Other			LLC			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							598,075	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							598,075	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)							Y	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

WEST CALDWELL CARE CENTER

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SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX IDENTIFICATION DATAWorksheet 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)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)	Y	C				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N	N				6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N					7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N					8.00
			Y/N				
			1.00				
Bad Debts							
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.		Y				9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		N				10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		N				11.00
Bed Complement							
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		N				12.00
		Description	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	05/22/2025	Y	05/22/2025		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N			14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N			15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N			16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N		N			17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N			18.00
		1.00	2.00	3.00			
Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATHLEEN	MESKER	PREPARER			19.00
20.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES					20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	KATHLEEN.MESKER@HCRNJ.NET				21.00

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

Worksheet S-3
Part I
PPS

				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	180	65,880	0	4,582	40,369	10,449	55,400	0	118	173	184	475	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)	180	65,880	0	4,582	40,369	10,449	55,400	0	118	173	184	475	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	38.83	233.35	116.63	0	165	140	180	485	114.30	0.00		1.00
2.00	NURSING FACILITY	0.00		0.00	0.00	0		0	0	0	0.00	0.00		2.00
3.00	ICF/IID			0.00	0.00			0	0	0	0.00	0.00		3.00
4.00	HOME HEALTH AGENCY COST													4.00
5.00	Other Long Term Care				0.00				0	0	0.00	0.00		5.00
6.00	SNF-Based CMHC										0.00	0.00		6.00
7.00	HOSPICE	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	38.83	233.35	116.63	0	165	140	180	485	114.30	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)	7,783,698	0	7,783,698	238,304.00	32.66	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)	7,783,698	0	7,783,698	238,304.00	32.66	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST						8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPICE	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)	7,783,698	0	7,783,698	238,304.00	32.66	13.00
OTHER WAGES & RELATED COSTS							
14.00	Contract Labor: Patient Related & Mgmt	2,376,621	0	2,376,621	62,517.00	38.02	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)	1,394,159	0	1,394,159			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)	1,394,159	0	1,394,159			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	575,403	0	575,403	13,926.00	41.32	2.00
3.00	Plant Operation, Maintenance & Repairs	118,346	0	118,346	4,360.00	27.14	3.00
4.00	Laundry & Linen Service	101,469	0	101,469	4,907.00	20.68	4.00
5.00	Housekeeping	466,690	0	466,690	21,657.00	21.55	5.00
6.00	Dietary	689,333	0	689,333	31,140.00	22.14	6.00
7.00	Nursing Administration	511,496	0	511,496	10,182.00	50.24	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	26,704	0	26,704	910.00	29.35	10.00
11.00	Social Service	150,903	0	150,903	3,492.00	43.21	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	237,885	0	237,885	11,011.00	21.60	13.00
14.00	Total (sum lines 1 thru 13)	2,878,229	0	2,878,229	101,585.00	28.33	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		1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		3.00
4.00	Prior Year Pension Service Cost		4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		6.00
7.00	Employee Managed Care Program Administration Fees		7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	249,049	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	3,231	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,795	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	335,075	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	584,495	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	220,514	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)	1,394,159	24.00
			Amount Reported
			1.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

WEST CALDWELL CARE CENTER

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Period:

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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)	1,478,368	264,795	1,743,163	27,722.00	62.88	1.00
2.00	Licensed Practical Nurses (LPNs)	1,471,491	263,563	1,735,054	32,590.00	53.24	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,955,610	350,275	2,305,885	76,408.00	30.18	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4,905,469	878,633	5,784,102	136,720.00	42.31	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)	305,927		305,927	6,716.00	45.55	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,397,050		1,397,050	45,646.00	30.61	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1,702,977		1,702,977	52,362.00	32.52	17.00
18.00	Physical Therapists	293,846		293,846	4,690.00	62.65	18.00
19.00	Physical Therapy Assistants	18,922		18,922	362.00	52.27	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	174,354		174,354	2,090.00	83.42	21.00
22.00	Occupational Therapy Assistants	133,495		133,495	1,920.00	69.53	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	53,027		53,027	1,092.00	48.56	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

WEST CALDWELL CARE CENTER

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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		2,841,909	2,841,909	0	2,841,909	241,440	3,083,349	1.00
3.00	00300	EMPLOYEE BENEFITS	0	1,433,576	1,433,576	0	1,433,576	0	1,433,576	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	575,403	2,983,699	3,559,102	0	3,559,102	-272,875	3,286,227	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	118,346	536,204	654,550	0	654,550	0	654,550	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	101,469	12,739	114,208	0	114,208	0	114,208	6.00
7.00	00700	HOUSEKEEPING	466,690	53,877	520,567	0	520,567	0	520,567	7.00
8.00	00800	DIETARY	689,333	709,226	1,398,559	0	1,398,559	0	1,398,559	8.00
9.00	00900	NURSING ADMINISTRATION	511,496	0	511,496	0	511,496	0	511,496	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	10.00
12.00	01200	MEDICAL RECORDS & LIBRARY	26,704	0	26,704	0	26,704	0	26,704	12.00
13.00	01300	SOCIAL SERVICE	150,903	0	150,903	0	150,903	0	150,903	13.00
15.00	01500	PATIENT ACTIVITIES	237,885	8,083	245,968	0	245,968	0	245,968	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	SKILLED NURSING FACILITY	4,905,469	2,067,192	6,972,661	0	6,972,661	0	6,972,661	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	6,921	6,921	0	6,921	0	6,921	40.00
41.00	04100	LABORATORY	0	11,762	11,762	0	11,762	0	11,762	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	5,275	5,275	0	5,275	0	5,275	43.00
44.00	04400	PHYSICAL THERAPY	0	324,802	324,802	0	324,802	0	324,802	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	269,138	269,138	0	269,138	0	269,138	45.00
46.00	04600	SPEECH PATHOLOGY	0	79,700	79,700	0	79,700	0	79,700	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	248,478	248,478	0	248,478	0	248,478	49.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	07100	AMBULANCE	0	22,741	22,741	0	22,741	0	22,741	71.00
73.00	07300	CMHC	0	0	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS										
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	0	0	80.00
81.00	08100	INTEREST EXPENSE		0	0	0	0	0	0	81.00
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)	7,783,698	11,615,322	19,399,020	0	19,399,020	-31,435	19,367,585	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	48	48	0	48	0	48	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
95.00	09500	DIALYSIS	0	0	0	0	0	0	0	95.00
100.00		TOTAL	7,783,698	11,615,370	19,399,068	0	19,399,068	-31,435	19,367,633	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	0	0	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	81,656	0	81,656	0	81,656	0	3.00
4.00	Building Improvements	0	0	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	0	0	5.00
6.00	Movable Equipment	0	255,063	0	255,063	0	255,063	0	6.00
7.00	Subtotal (sum of lines 1-6)	0	336,719	0	336,719	0	336,719	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	0	336,719	0	336,719	0	336,719	0	9.00

WEST CALDWELL CARE CENTER

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ADJUSTMENTS TO EXPENSES

Worksheet A-8

PPS

	Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line No.
		1.00	2.00	3.00	4.00
1.00	Investment income on restricted funds (chapter 2)	B	-4,286	CAP REL COSTS - BLDGS & FIXTURES	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		5.00
6.00	Television and radio service (chapter 21)		0		6.00
7.00	Parking lot (chapter 21)		0		7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0		8.00
9.00	Home office cost (chapter 21)		0		9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	245,726		12.00
13.00	Laundry and linen service		0		13.00
14.00	Revenue - Employee meals		0		14.00
15.00	Cost of meals - Guests		0		15.00
16.00	Sale of medical supplies to other than patients		0		16.00
17.00	Sale of drugs to other than patients		0		17.00
18.00	Sale of medical records and abstracts	B	-55	ADMINISTRATIVE & GENERAL	4.00
19.00	Vending machines		0		19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		21.00
22.00	Utilization review--physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	82.00
23.00	Depreciation--buildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00
24.00	Depreciation--movable equipment		0	*** Cost Center Deleted ***	2.00
25.00			0		25.00
25.01	OTHER INCOME - MISC	B	-870	ADMINISTRATIVE & GENERAL	4.00
25.02	MARKETING	A	-14,557	ADMINISTRATIVE & GENERAL	4.00
25.03	BAD DEBT	A	-257,376	ADMINISTRATIVE & GENERAL	4.00
25.04	RESIDENT MISSING ITEMS	A	-17	ADMINISTRATIVE & GENERAL	4.00
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-31,435		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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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND
HOME OFFICE COSTSWorksheet A-8-1
Parts I & II
PPS**PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:**

	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	RENT	0	2,247,463	-2,247,463	1.00
2.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	DEPRECIATION	549,154	0	549,154	2.00
3.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	INTEREST	2,353,701	0	2,353,701	3.00
4.00	1.00	CAP REL COSTS - BLDGS & FIXTURES	MANAGEMENT FEE	553,802	963,468	-409,666	4.00
5.00	0.00			0	0	0	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.			3,456,657	3,210,931	245,726	10.00

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	B	PC HMH PROPCO HOLDINGS 2 LLC	100.00	PC HMH PROPCO HOLDINGS 2 LLC	100.00	REALTY	1.00
2.00	B	PEACE CARE CAPITAL	100.00	COMPLETE CARE MANAGEMENT	100.00	MANAGEMENT	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	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		0	1.00	3.00	3A	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES	3,083,349	3,083,349							1.00
3.00	EMPLOYEE BENEFITS	1,433,576	0	1,433,576						3.00
4.00	ADMINISTRATIVE & GENERAL	3,286,227	801,980	105,976	4,194,183	4,194,183				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	654,550	336,076	21,797	1,012,423	279,850	1,292,273			5.00
6.00	LAUNDRY & LINEN SERVICE	114,208	178,403	18,688	311,299	86,048	118,515	515,862		6.00
7.00	HOUSEKEEPING	520,567	78,094	85,954	684,615	189,239	51,878	0	925,732	7.00
8.00	DIETARY	1,398,559	516,769	126,959	2,042,287	564,521	343,293	0	283,272	8.00
9.00	NURSING ADMINISTRATION	511,496	33,725	94,206	639,427	176,748	22,404	0	18,487	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	26,704	13,552	4,918	45,174	12,487	9,003	0	7,429	12.00
13.00	SOCIAL SERVICE	150,903	9,406	27,793	188,102	51,994	6,248	0	5,156	13.00
15.00	PATIENT ACTIVITIES	245,968	288,985	43,813	578,766	159,980	191,975	0	158,410	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	6,972,661	623,885	903,472	8,500,018	2,349,540	414,452	515,862	341,988	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	6,921	0	0	6,921	1,913	0	0	0	40.00
41.00	LABORATORY	11,762	0	0	11,762	3,251	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	5,275	0	0	5,275	1,458	0	0	0	43.00
44.00	PHYSICAL THERAPY	324,802	83,168	0	407,970	112,769	55,249	0	45,590	44.00
45.00	OCCUPATIONAL THERAPY	269,138	60,210	0	329,348	91,037	39,998	0	33,005	45.00
46.00	SPEECH PATHOLOGY	79,700	10,396	0	90,096	24,904	6,906	0	5,699	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,193	0	18,193	5,029	12,086	0	9,973	48.00
49.00	DRUGS CHARGED TO PATIENTS	248,478	0	0	248,478	68,683	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	22,741	0	0	22,741	6,286	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)	19,367,585	3,052,842	1,433,576	19,337,078	4,185,737	1,272,007	515,862	909,009	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	48	30,507	0	30,555	8,446	20,266	0	16,723	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
95.00	DIALYSIS	0	0	0	0	0	0	0	0	95.00
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	19,367,633	3,083,349	1,433,576	19,367,633	4,194,183	1,292,273	515,862	925,732	100.00

WEST CALDWELL CARE CENTER

Provider CCN: 315247

Period:
From: 01/01/2024
To: 12/31/2024Run Date Time: 5/27/2025 10:47 am
MCRIF32
Version: 11.1.179.1

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Stepdown Adjustments	
		8.00	9.00	10.00	12.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	3,233,373								8.00
9.00	NURSING ADMINISTRATION	0	857,066							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0						10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	74,093					12.00
13.00	SOCIAL SERVICE	0	0	0	0	251,500				13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	1,089,131			15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	3,233,373	857,066	0	74,093	251,500	1,089,131	17,627,023	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	8,834	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	15,013	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	6,733	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	621,578	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	493,388	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	127,605	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	45,281	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	317,161	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	0	0	29,027	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)	3,233,373	857,066	0	74,093	251,500	1,089,131	19,291,643	0	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	75,990	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
95.00	DIALYSIS	0	0	0	0	0	0	0	0	95.00
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	3,233,373	857,066	0	74,093	251,500	1,089,131	19,367,633	0	100.00

WEST CALDWELL CARE CENTER		Period:	Run Date Time:	5/27/2025 10:47 am
Provider CCN: 315247		From: 01/01/2024	MCRIF32	2540-10
		To: 12/31/2024	Version:	11.1.179.1



COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	EMPLOYEE BENEFITS		3.00
4.00	ADMINISTRATIVE & GENERAL		4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	LAUNDRY & LINEN SERVICE		6.00
7.00	HOUSEKEEPING		7.00
8.00	DIETARY		8.00
9.00	NURSING ADMINISTRATION		9.00
10.00	CENTRAL SERVICES & SUPPLY		10.00
12.00	MEDICAL RECORDS & LIBRARY		12.00
13.00	SOCIAL SERVICE		13.00
15.00	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	SKILLED NURSING FACILITY	17,627,023	30.00
31.00	NURSING FACILITY	0	31.00
32.00	ICF/IID	0	32.00
33.00	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	RADIOLOGY	8,834	40.00
41.00	LABORATORY	15,013	41.00
42.00	INTRAVENOUS THERAPY	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	6,733	43.00
44.00	PHYSICAL THERAPY	621,578	44.00
45.00	OCCUPATIONAL THERAPY	493,388	45.00
46.00	SPEECH PATHOLOGY	127,605	46.00
47.00	ELECTROCARDIOLOGY	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,281	48.00
49.00	DRUGS CHARGED TO PATIENTS	317,161	49.00
51.00	SUPPORT SURFACES	0	51.00
OTHER REIMBURSABLE COST CENTERS			
71.00	AMBULANCE	29,027	71.00
73.00	CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	INTEREST EXPENSE		81.00
82.00	UTILIZATION REVIEW - SNF		82.00
83.00	HOSPICE	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	19,291,643	89.00
NONREIMBURSABLE COST CENTERS			
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	BARBER AND BEAUTY SHOP	75,990	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	NONPAID WORKERS	0	93.00
94.00	PATIENTS LAUNDRY	0	94.00
95.00	DIALYSIS	0	95.00
98.00	Cross Foot Adjustments	0	98.00
99.00	Negative Cost Centers	0	99.00
100.00	TOTAL	19,367,633	100.00

WEST CALDWELL CARE CENTER

Provider CCN: 315247

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/27/2025 10:47 am

MCRIF32

Version: 11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	Subtotal	EMPLOYEE BENEFITS	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	801,980	801,980	0	801,980				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	336,076	336,076	0	53,511	389,587			5.00
6.00	LAUNDRY & LINEN SERVICE	0	178,403	178,403	0	16,453	35,729	230,585		6.00
7.00	HOUSEKEEPING	0	78,094	78,094	0	36,185	15,640	0	129,919	7.00
8.00	DIETARY	0	516,769	516,769	0	107,943	103,494	0	39,755	8.00
9.00	NURSING ADMINISTRATION	0	33,725	33,725	0	33,796	6,754	0	2,594	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	0	13,552	13,552	0	2,388	2,714	0	1,043	12.00
13.00	SOCIAL SERVICE	0	9,406	9,406	0	9,942	1,884	0	724	13.00
15.00	PATIENT ACTIVITIES	0	288,985	288,985	0	30,590	57,875	0	22,232	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	0	623,885	623,885	0	449,261	124,947	230,585	47,994	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	366	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	622	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	279	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	83,168	83,168	0	21,563	16,656	0	6,398	44.00
45.00	OCCUPATIONAL THERAPY	0	60,210	60,210	0	17,407	12,058	0	4,632	45.00
46.00	SPEECH PATHOLOGY	0	10,396	10,396	0	4,762	2,082	0	800	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,193	18,193	0	962	3,644	0	1,400	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,133	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	1,202	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)	0	3,052,842	3,052,842	0	800,365	383,477	230,585	127,572	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	30,507	30,507	0	1,615	6,110	0	2,347	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
95.00	DIALYSIS	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments							0	0	98.00
99.00	Negative Cost Centers		0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	3,083,349	3,083,349	0	801,980	389,587	230,585	129,919	100.00

WEST CALDWELL CARE CENTER

Provider CCN: 315247

Period:
From: 01/01/2024
To: 12/31/2024Run Date Time: 5/27/2025 10:47 am
MCRIF32
Version: 11.1.179.1

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PATIENT ACTIVITIES	Subtotal	Post Step-Down Adjustments	
		8.00	9.00	10.00	12.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS										
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	767,961								8.00
9.00	NURSING ADMINISTRATION	0	76,869							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0						10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	19,697					12.00
13.00	SOCIAL SERVICE	0	0	0	0	21,956				13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	0	399,682			15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	767,961	76,869	0	19,697	21,956	399,682	2,762,837	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	366	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	622	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	279	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	127,785	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	94,307	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	18,040	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	24,199	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	13,133	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	0	0	0	1,202	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)	767,961	76,869	0	19,697	21,956	399,682	3,042,770	0	89.00
NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	40,579	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	PATIENT'S LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	DIALYSIS	0	0	0	0	0	0	0	0	95.00
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	767,961	76,869	0	19,697	21,956	399,682	3,083,349	0	100.00

WEST CALDWELL CARE CENTER

Provider CCN: 315247

Period:
From: 01/01/2024
To: 12/31/2024Run Date Time: 5/27/2025 10:47 am
MCRIF32
Version: 2540-10
11.1.179.1

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II
PPS

	Cost Center Description	Total	
		18.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS - BLDGS & FIXTURES		1.00
3.00	EMPLOYEE BENEFITS		3.00
4.00	ADMINISTRATIVE & GENERAL		4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	LAUNDRY & LINEN SERVICE		6.00
7.00	HOUSEKEEPING		7.00
8.00	DIETARY		8.00
9.00	NURSING ADMINISTRATION		9.00
10.00	CENTRAL SERVICES & SUPPLY		10.00
12.00	MEDICAL RECORDS & LIBRARY		12.00
13.00	SOCIAL SERVICE		13.00
15.00	PATIENT ACTIVITIES		15.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	SKILLED NURSING FACILITY	2,762,837	30.00
31.00	NURSING FACILITY	0	31.00
32.00	ICF/IID	0	32.00
33.00	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS			
40.00	RADIOLOGY	366	40.00
41.00	LABORATORY	622	41.00
42.00	INTRAVENOUS THERAPY	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	279	43.00
44.00	PHYSICAL THERAPY	127,785	44.00
45.00	OCCUPATIONAL THERAPY	94,307	45.00
46.00	SPEECH PATHOLOGY	18,040	46.00
47.00	ELECTROCARDIOLOGY	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,199	48.00
49.00	DRUGS CHARGED TO PATIENTS	13,133	49.00
51.00	SUPPORT SURFACES	0	51.00
OTHER REIMBURSABLE COST CENTERS			
71.00	AMBULANCE	1,202	71.00
73.00	CMHC	0	73.00
SPECIAL PURPOSE COST CENTERS			
80.00	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	INTEREST EXPENSE		81.00
82.00	UTILIZATION REVIEW - SNF		82.00
83.00	HOSPICE	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	3,042,770	89.00
NONREIMBURSABLE COST CENTERS			
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	BARBER AND BEAUTY SHOP	40,579	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	NONPAID WORKERS	0	93.00
94.00	PATIENTS LAUNDRY	0	94.00
95.00	DIALYSIS	0	95.00
98.00	Cross Foot Adjustments	0	98.00
99.00	Negative Cost Centers	0	99.00
100.00	TOTAL	3,083,349	100.00

WEST CALDWELL CARE CENTER

Provider CCN: 315247

Period:

From: 01/01/2024

To: 12/31/2024

Run Date Time: 5/27/2025 10:47 am

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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	49,827								1.00
3.00	EMPLOYEE BENEFITS	0	7,783,698							3.00
4.00	ADMINISTRATIVE & GENERAL	12,960	575,403	-4,194,183	15,173,450					4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	5,431	118,346	0	1,012,423	31,436				5.00
6.00	LAUNDRY & LINEN SERVICE	2,883	101,469	0	311,299	2,883	55,400			6.00
7.00	HOUSEKEEPING	1,262	466,690	0	684,615	1,262	0	27,291		7.00
8.00	DIETARY	8,351	689,333	0	2,042,287	8,351	0	8,351	166,200	8.00
9.00	NURSING ADMINISTRATION	545	511,496	0	639,427	545	0	545	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
12.00	MEDICAL RECORDS & LIBRARY	219	26,704	0	45,174	219	0	219	0	12.00
13.00	SOCIAL SERVICE	152	150,903	0	188,102	152	0	152	0	13.00
15.00	PATIENT ACTIVITIES	4,670	237,885	0	578,766	4,670	0	4,670	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	SKILLED NURSING FACILITY	10,082	4,905,469	0	8,500,018	10,082	55,400	10,082	166,200	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	6,921	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	11,762	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	5,275	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	1,344	0	0	407,970	1,344	0	1,344	0	44.00
45.00	OCCUPATIONAL THERAPY	973	0	0	329,348	973	0	973	0	45.00
46.00	SPEECH PATHOLOGY	168	0	0	90,096	168	0	168	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	294	0	0	18,193	294	0	294	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	248,478	0	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS										
71.00	AMBULANCE	0	0	0	22,741	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)	49,334	7,783,698	-4,194,183	15,142,895	30,943	55,400	26,798	166,200	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	493	0	0	30,555	493	0	493	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
95.00	DIALYSIS	0	0	0	0	0	0	0	0	95.00
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)	3,083,349	1,433,576		4,194,183	1,292,273	515,862	925,732	3,233,373	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	61.881089	0.184177		0.276416	41.108061	9.311588	33.920780	19.454711	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)		0		801,980	389,587	230,585	129,919	767,961	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.052854	12.393021	4.162184	4.760507	4.620704	105.00

WEST CALDWELL CARE CENTER		Period:	Run Date Time:
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COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

	Cost Center Description	NURSING ADMINISTRA TION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT CENSUS)	SOCIAL SERVICE (PATIENT CENSUS)	PATIENT ACTIVITIES (CENSUS)	
		9.00	10.00	12.00	13.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	EMPLOYEE BENEFITS						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	189,081					9.00
10.00	CENTRAL SERVICES & SUPPLY	0	248,478				10.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	55,400			12.00
13.00	SOCIAL SERVICE	0	0	0	55,400		13.00
15.00	PATIENT ACTIVITIES	0	0	0	0	55,400	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	SKILLED NURSING FACILITY	189,081	0	55,400	55,400	55,400	30.00
31.00	NURSING FACILITY	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	RADIOLOGY	0	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	248,478	0	0	0	49.00
51.00	SUPPORT SURFACES	0	0	0	0	0	51.00
OTHER REIMBURSABLE COST CENTERS							
71.00	AMBULANCE	0	0	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	73.00
SPECIAL PURPOSE COST CENTERS							
80.00	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	INTEREST EXPENSE						81.00
82.00	UTILIZATION REVIEW - SNF						82.00
83.00	HOSPICE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	189,081	248,478	55,400	55,400	55,400	89.00
NONREIMBURSABLE COST CENTERS							
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	DIALYSIS	0	0	0	0	0	95.00
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)	857,066	0	74,093	251,500	1,089,131	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	4.532798	0.000000	1.337419	4.539711	19.659404	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	76,869	0	19,697	21,956	399,682	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.406540	0.000000	0.355542	0.396318	7.214477	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	8,834	0	0.000000	40.00
41.00	LABORATORY	15,013	0	0.000000	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	42.00
43.00	OXYGEN (INHALATION) THERAPY	6,733	0	0.000000	43.00
44.00	PHYSICAL THERAPY	621,578	482,281	1.288830	44.00
45.00	OCCUPATIONAL THERAPY	493,388	432,238	1.141473	45.00
46.00	SPEECH PATHOLOGY	127,605	212,311	0.601029	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,281	0	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	317,161	248,478	1.276415	49.00
51.00	SUPPORT SURFACES	0	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
71.00	AMBULANCE	29,027	0	0.000000	71.00
100.00	Total	1,664,620	1,375,308		100.00

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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	0.000000	0	0	0	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	1.288830	199,871	0	257,600	0	44.00
45.00	OCCUPATIONAL THERAPY	1.141473	163,691	0	186,849	0	45.00
46.00	SPEECH PATHOLOGY	0.601029	84,481	0	50,776	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	1.276415	22,603	0	28,851	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)		470,646	0	524,076	0	100.00

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

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

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APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Worksheet D

Parts II-III

Title XVIII

Skilled Nursing Facility

PPS

PART II - APPORTIONMENT OF VACCINE COST

		1.00	
1.00	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	1.276415	1.00
2.00	Program vaccine charges (From your records, or the PS&R)	0	2.00
3.00	Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)	0	3.00

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

	Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	

ANCILLARY SERVICE COST CENTERS

40.00	RADIOLOGY	8,834	0	0.000000	0	0	40.00
41.00	LABORATORY	15,013	0	0.000000	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	6,733	0	0.000000	0	0	43.00
44.00	PHYSICAL THERAPY	621,578	0	0.000000	257,600	0	44.00
45.00	OCCUPATIONAL THERAPY	493,388	0	0.000000	186,849	0	45.00
46.00	SPEECH PATHOLOGY	127,605	0	0.000000	50,776	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,281	0	0.000000	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	317,161	0	0.000000	28,851	0	49.00
51.00	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
100.00	Total (Sum of lines 40 - 52)	1,635,593	0		524,076	0	100.00

WEST CALDWELL CARE CENTER		Period:	Run Date Time:	5/27/2025 10:47 am	
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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	55,400 1.00
2.00	Private room days	0 2.00
3.00	Inpatient days including private room days applicable to the Program	4,582 3.00
4.00	Medically necessary private room days applicable to the Program	0 4.00
5.00	Total general inpatient routine service cost	17,627,023 5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	18,958,416 6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.929773 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)	17,627,023 15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	318.18 16.00
17.00	Program routine service cost (Line 3 times line 16)	1,457,901 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)	1,457,901 19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	2,762,837 20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	49.87 21.00
22.00	Program capital related cost (Line 3 times line 21)	228,504 22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	1,229,397 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)	1,229,397 25.00
26.00	Enter the per diem limitation (1)	
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
		1.00
1.00	Total SNF inpatient days	55,400 1.00
2.00	Program inpatient days (see instructions)	4,582 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)	0.082708 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)	3,693,149	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)	3,693,149	3.00
4.00	Primary payor amounts	45,240	4.00
5.00	Coinsurance	538,356	5.00
6.00	Allowable bad debts (From your records)	219,510	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	79,825	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	142,682	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)	3,252,235	11.00
12.00	Interim payments (See instructions)	3,098,291	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)	2,854	14.75
14.99	Sequestration amount (see instructions)	62,191	14.99
15.00	Balance due provider/program (see Instructions)	88,899	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY			
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

WEST CALDWELL CARE CENTER	Period:	Run Date Time:	5/27/2025 10:47 am	
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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 mm/dd/yyyy	Amount	Part B mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,088,022		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/17/2024	10,269		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)		10,269		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)		3,098,291		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	PROGRAM TO PROVIDER		88,899		0	6.01
6.02	PROVIDER TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,187,190		0	7.00
Contractor Name		Contractor Number				
1.00		2.00				
8.00						8.00

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

WEST CALDWELL CARE CENTER

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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	160,466	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	3,324,605	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	99,388	0	0	0	8.00
9.00	Other current assets	80,908	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)	3,665,367	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	81,656	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	255,063	0	0	0	23.00
24.00	Less: Accumulated depreciation	-54,818	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)	281,901	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	2,772,813	0	0	0	31.00
32.00	Other assets	18,669	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2,791,482	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	6,738,750	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	3,301,946	0	0	0	35.00
36.00	Salaries, wages, and fees payable	445,341	0	0	0	36.00
37.00	Payroll taxes payable	-830	0	0	0	37.00
38.00	Notes & loans payable (Short term)	3,100,000	0	0	0	38.00
39.00	Deferred income	297,903	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)	7,144,360	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)	7,144,360	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-405,610				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)	-405,610	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	6,738,750	0	0	0	60.00

() = contra amount

WEST CALDWELL CARE CENTER

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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				0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-275,902							2.00
3.00	Total (sum of line 1 and line 2)		-405,609		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)		-405,609		0		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		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)		1		0		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-405,610		0		0		0	19.00

WEST CALDWELL CARE CENTER

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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 1.00	Outpatient 2.00	Total 3.00	
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	18,958,416		18,958,416	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)	18,958,416		18,958,416	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	1,375,309	0	1,375,309	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	20,333,725	0	20,333,725	14.00

PART II - OPERATING EXPENSES

		1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		19,399,068	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)		19,399,068	15.00

WEST CALDWELL CARE CENTER

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-3

PPS

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	20,333,725	1.00
2.00	Less: contractual allowances and discounts on patients accounts	1,084,175	2.00
3.00	Net patient revenues (Line 1 minus line 2)	19,249,550	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	19,399,068	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-149,518	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	2,600	6.00
7.00	Income from investments	4,286	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	55	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	12,870	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	19,811	25.00
26.00	Total (Line 5 plus line 25)	-129,707	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)	-129,707	31.00