BOARD RESOLUTION

Resolution No. 2022-1497

Let it be resolved that the Atchison County Board of Directors have authorized Julie Martinez (Administrator) to sign declaration statements.

The Administrator would be responsible to review the content of the Documents and ~~his~~ her signature would verify the correctness of the statements.

Such documents would include but not be limited to:

Medicare Cost Report

Medicaid Cost Report

IRS 990 Form

IRS 990T Form

Kansas Not-For-Profit Corporation Report

KDHE Reports

The following signatures represent the Board of Directors approval of this resolution.

Michelle Phillips
Secretary County Clerk

2-15-2022
Date

Eric Noll
Chairman

2-15-2022
Date

DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR
1041502301 ATCHISON SENIOR VILLAGE
FOR THE COST REPORT PERIOD BEGINNING 1/1/2021
AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION, THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE
	Vice-President	

NAME (PRINT OR TYPE)
Chad Burman

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE #
	620-855-4656
	FAX #
P.O. Box 243 Cimarron, KS 67835	620-855-3401

PREPARER'S EMAIL ADDRESS
chad@fmikansas.com

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)