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).

OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE	Provider CCN: 315132	Worksheet S Parts L. II & III
COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY		Date/Time Prepared
		5/10/2024 11:47 am

				/ 202		
PART I - COST I	REPORT STATUS					
Provi der	1. [ X ] Electronically prepared cost rep	port	Date: 5/10/2024	Time: 11:47 am		
use only	2. [ ] Manually prepared cost report					
	3. [ 0 ] If this is an amended report ent	er the number of times the provider	resubmitted this cos	t report		
	3.01 [ ] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.				
Contractor	4. [ 1 ] Cost Report Status	6. Contractor No.	<u> </u>			
use only	(1) As Submitted	7.[ N ] First Cost Report for this Provider CCN				
	(2) Settled without audit	8.[ N ] Last Cost Report for this P	rovider CCN			
	(3) Settled with audit	9. NPR Date:				
	(4) Reopened	10.[ 0 ]If line 4, column 1 is "4":	Enter number of time	s reopened		
	(5) Amended	11. Contractor Vendor Code				
	5. Date Received:	12.[ F ] Medicare Utilization. Enter for no utilization.	 "F" for full, "L" fo	r low, or "N"		

## 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 OR PROCURED 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 CARE ONE AT THE HIGHLANDS (315132) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1		2	SI GNATURE STATEMENT	
1	Dav	rid Baruch	l t	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	Davi d Baruch			2
3	Signatory Title	AUTHORIZED SIGNOR			3
4	Date	(Dated when report is electronica			4

			Title XVIII			
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-85, 076	-36	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	-85, 076	-36	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 and review the information collection is estimated 202 hours per response, including the time to review instructions, search existing 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 the 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.

Health Financial Systems CARE ONE AT THE HIGHLANDS In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315132 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:47 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 1350 INMAN AVENUE PO Box: 1.00 2.00 City: EDISON State: NJ Zi p Code: 08820 2.00 3.00 County: MI DDLESEX CBSA Code: 35154 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT THE 315132 04/21/2000 N Р Ν 4.00 HI GHLANDS 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 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) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 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 Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 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. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 482 232 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 482, 232 23.00 23.00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) 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 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 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 Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 61, 936 0 0

Heal th	Financial Systems	CARE ONE AT THE HI	GHLANDS	In Lie	u of Form CMS-2	2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315132	Peri od:	Worksheet S-2	
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023		
					5/10/2024 11:	47 am_
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative a	nd General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting	schedule listing cost	centers and		
	amounts.		-			
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and address	of the home	HB0206	44. 00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of the	home office on the	lines	
	bel ow.	_				
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contrac	ctor's Number: 1200	1	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00
47.00	City: FORT LEE	State: NJ	Zi p Coo	de: 0702	4	47. 00

Health Financial Systems CARE ONE AT THE HIGHLANDS In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315132 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:47 am Date 1. 00 2.00 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 Facilites Provider Organization and Operation 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 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary Is the provider involved in business transactions, including management 3.00 Υ 3.00 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/N Type Date 1.00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public Α Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. Ν 11.00 Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 03/19/2024 Υ 13.00 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.) 14.00 Was the cost report prepared using the PS&R Ν Ν 14 00 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 If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 15.00 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. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Health Financial Systems	CARE ONE AT THE	HI GHLANDS		In Lie	u of Form CMS	-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY	Y HEALTH CARE	Provi der		Peri od:	Worksheet S-	2
COMPLEX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023 To 12/31/2023	Date/Time Pr	epared:
					5/10/2024 11	
		1.	00	2.	00	
Cost Report Preparer Contact Information						
19.00 Enter the first name, last name and the title/		ARLES		REED		19. 00
held by the cost report preparer in columns 1,	2, and 3,					
respecti vel y.						
20.00 Enter the employer/company name of the cost re	eport EX	ECUCARE ASSO	CI ATES			20. 00
preparer.						
21.00 Enter the telephone number and email address o		09) 738-3200		CRWASSC@NETSCAF	PE. NET	21.00
report preparer in columns 1 and 2, respective	el y.					

Health Financial Systems CARE ONE AT THE SKILLED NURSING FACILITY HEALTH CARE CARE ONE AT THE HIGHLANDS Provi der No.: 315132

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2023	Date/Time Prepared:   5/10/2024 11:47 am
		Part B			07 107 202 1 111 17 4
		Date			
		4. 00			
	PS&R Data				
13. 00	Was the cost report prepared using the PS&R	03/19/2024			13. 00
	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.)				
14. 00	Was the cost report prepared using the PS&R				14.00
00	for total and the provider's records for				65
	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				
45.00	4.				45.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that				15. 00
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16.00	If line 13 or 14 is "Y", then were				16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
47.00	information? If yes, see instructions.				17.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?				17. 00
	Describe the other adjustments:				
18. 00	Was the cost report prepared only using the				18.00
	provider's records? If "Y" see Instructions.				
			3.00		
10 00	Cost Report Preparer Contact Information Enter the first name, last name and the title	/poci ti op	VI CE-PRESI DENT		19.00
19.00	held by the cost report preparer in columns 1		VICE-PRESIDENT		19.00
	respectively.	, 2, and 5,			
20.00	Enter the employer/company name of the cost r	report			20. 00
	preparer.	•			
21. 00					21. 00
	report preparer in columns 1 and 2, respective	∕el y.	l		

In Lieu of Form CMS-2540-10 CARE ONE AT THE HIGHLANDS

Health Financial Systems CARE ONE AT THE SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315132 COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 47 am

					5/10/2024 11: 4	17 am
			I npa	atient Days/Vis	si ts	
Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care 6.00 SNF-Based CMHC	122 0 0	44, 530 0 0	0	8, 924	0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7.00 HOSPICE 8.00 Total (Sum of lines 1-7)	122	44, 530	0	8, 924	0 15, 443	7. 00 8. 00
or or protein (odin or remove 1 1)	Inpatient D		3	Di scharges	10/110	0.00
	0.1			T		
Component	0ther 6.00	Total 7. 00	Title V 8.00	7itle XVIII 9.00	Title XIX 10.00	
1.00 SKILLED NURSING FACILITY 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care 6.00 SNF-Based CMHC	13, 175 0 0 0		0	327		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 HOSPI CE	0	0	0	0	0	7. 00
8.00 Total (Sum of lines 1-7)	13, 175			327		8. 00
	Di sch	arges	Aver	age Length of	Stay	
Component	Other	Total	Title V	Title XVIII	Title XIX	
1.00 SKILLED NURSING FACILITY	11.00	12. 00 845	13.00	14. 00 27. 29	15. 00 188. 33	1. 00
2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY COST 5.00 Other Long Term Care 6.00 SNF-Based CMHC	0 0	0			0. 00 0. 00	2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 HOSPICE	0	0	0.00			7. 00
8.00 Total (Sum of lines 1-7)	436 Average Length		0.00 Admis		188. 33	8. 00
	of Stay		Adilii 3	31 0113		
Component	Total	Title V	Title XVIII	Title XIX	Other	
1.00 SKILLED NURSING FACILITY	16. 00	17. 00 0	18.00	19.00	20. 00	1. 00
2.00 NURSING FACILITY	0. 00			0	1	2. 00
3. 00   ICF/IID	0. 00			0	o o	3. 00
4.00 HOME HEALTH AGENCY COST						4. 00
5.00 Other Long Term Care 6.00 SNF-Based CMHC	0. 00				0	5. 00 6. 00
7. 00 HOSPI CE	0. 00	0	0	0	0	7. 00
8.00 Total (Sum of lines 1-7)	44. 43	0	000	34	451	8. 00
	Admissions	Full Time	Equi val ent			
Component	Total	Employees on	Nonpai d			
	21.00	Payrol I	Workers			
1.00   SKILLED NURSING FACILITY	21.00	22. 00 131. 44	23.00			1. 00
2.00 NURSING FACILITY	0					2. 00
3.00   ICF/IID	0					3. 00
4.00 HOME HEALTH AGENCY COST		0.00				4. 00 5. 00
5.00 Other Long Term Care 6.00 SNF-Based CMHC	0	0. 00 0. 00				5. 00 6. 00
7. 00 HOSPI CE	0					7. 00
8.00 Total (Sum of lines 1-7)	845	131. 44	0.00			8. 00

				Т	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6		Salary in col.	col . 4)	
				<u> </u>	3	ĺ	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	8, 945, 645	0	8, 945, 645	i i	l e	1. 00
2.00	Physician salaries-Part A	0	0	0	0.00		2. 00
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	8, 945, 645	0	8, 945, 645	i i		6. 00
7.00	Other Long Term Care	0	0	0	0.00		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		8. 00
9.00	CMHC	0	0	0	0.00		9. 00
10. 00	HOSPI CE	0	0	0	0.00		
11. 00	Other excluded areas	0	0	0	0.00		11. 00
12. 00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12. 00
40.00	through 11)	0 045 445		0 045 445			40.00
13. 00	Total Adjusted Salaries (line 6 minus line	8, 945, 645	0	8, 945, 645	273, 390. 00	32. 72	13. 00
	07 OTHER WAGES & RELATED COSTS						
14. 00		393, 862		393, 862	7, 162. 00	54. 99	14. 00
15. 00	Contract Labor: Physician services-Part A	393, 002	0	393, 002	7, 162.00	l	15. 00
16. 00	Home office salaries & wage related costs	0	0		0.00		16. 00
10.00	WAGE-RELATED COSTS	0			0.00	0.00	10.00
17. 00	Wage-related costs core (See Part IV)	1, 866, 622	0	1, 866, 622			17. 00
18. 00	Wage-related costs other (See Part IV)	1,000,022	0	1,000,022			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20. 00	Physician Part A - WRC	0	0				20.00
21. 00	Physician Part B - WRC						21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 866, 622	١	1, 866, 622			22. 00
22. 30	instructions)	., 555, 622		., 555, 522			55

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: | | Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315132

						5/10/2024 11:	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	(	) C	0.00	0.00	1. 00
2.00	Administrative & General	773, 490	(	773, 490	17, 050. 00	45. 37	2. 00
3.00	Plant Operation, Maintenance & Repairs	151, 822	(	151, 822	6, 165. 00	24. 63	3. 00
4.00	Laundry & Linen Service	92, 594	(	92, 594	5, 277. 00	17. 55	4. 00
5.00	Housekeepi ng	277, 287	(	277, 287	14, 080. 00	19. 69	5. 00
6.00	Di etary	598, 812	(	598, 812	26, 802. 00	22. 34	6. 00
7.00	Nursing Administration	879, 646	(	879, 646	21, 567. 00	40. 79	7. 00
8.00	Central Services and Supply	9, 881		9, 881	428.00	23. 09	8. 00
9.00	Pharmacy	0	C	) c	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	3, 575	C	3, 575	129. 00	27. 71	10.00
11. 00	Soci al Servi ce	178, 204	C	178, 204	4, 991. 00	35. 71	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	238, 414	(	238, 414	11, 368. 00	20. 97	13.00
14.00	Total (sum lines 1 thru 13)	3, 203, 725	c	3, 203, 725	107, 857. 00	29. 70	14.00

From 01/01/2023 Part	orksheet S-3 art IV ate/Time Prepared:

	To 12/31/20	23   Date/Time Pre   5/10/2024 11:4	pared: 47 am
		Amount	17 GIII
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	34, 465	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	Pri or Year Pensi on Servi ce 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	Heal th Insurance (Purchased or Self Funded)	884, 865	8. 00
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 627	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	
14. 00		0	14.00
	Workers' Compensation Insurance	170, 311	
16. 00	Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	663, 987	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00		0	19. 00
	State or Federal Unemployment Taxes	111, 367	20.00
	OTHER		
21. 00	Executive Deferred Compensation	0	21. 00
		0	22. 00
	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of Lines 1 - 23)	1, 866, 622	24. 00
	· · · · · · · · · · · · · · · · · · ·	Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25. 00
			-

				To	12/31/2023		
	Occupational Catagory	Amount	- Fri nac	Adiusted	Paid Hours	5/10/2024 11:	4/ am
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col.		Average Hourly Wage (col. 3 ÷	
		Reported	Benefits		Salary in col.	col. 3 ÷	
				1 + COL. 2)	3 ai ai y 111 coi .	COI. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	Direct Salaries			0.00		3. 55	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	926, 379	201, 801	1, 128, 180	19, 415. 00	58. 11	1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 622, 695	353, 486	1, 976, 181	39, 584. 00	49. 92	2.00
3.00	Certified Nursing Assistant/Nursing	1, 783, 898	388, 602	2, 172, 500	76, 649. 00	28. 34	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	4, 332, 972	943, 889	5, 276, 861	135, 648. 00	38. 90	4. 00
5.00	Physical Therapists	574, 426	125, 132	699, 558	·		5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00	0. 00	6.00
7.00	Physi cal Therapy Ai des	0	0	0	0.00		7. 00
8.00	Occupational Therapists	603, 094	131, 377	734, 471	13, 299. 00	55. 23	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		
11. 00	Speech Therapists	123, 945	27, 000	150, 945	2, 595. 00	58. 17	11.00
12.00	Respi ratory Therapi sts	25	5	30	1. 00	30. 00	
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	90, 493		90, 493			
	Licensed Practical Nurses (LPNs)	211, 649		211, 649	·		
16. 00	Certified Nursing Assistant/Nursing	86, 157		86, 157	2, 393. 00	36. 00	16. 00
47.00	Assi stants/Ai des				7 054 00	== 0=	47.00
17. 00	Total Nursing (sum of lines 14 through 16)	388, 299		388, 299	7, 054. 00		
18. 00	Physical Therapists	0		0	0.00		
19. 00	Physical Therapy Assistants	0		0	0.00		
20. 00	Physical Therapy Aides	0		0	0.00		
21. 00	Occupational Therapists	0		0	0.00		
22. 00	Occupational Therapy Assistants	0		0	0.00		
23. 00	Occupational Therapy Aides	0		0	0.00		
	Speech Therapists	400		400			
25. 00	Respiratory Therapists	5, 163		5, 163			
26. 00	Other Medical Staff	0		0	0. 00	0.00	26. 00

		5 12/31/2023	Date/lime Pre 5/10/2024 11:	
	,	Group	Days	
1.00		1. 00 RUX	2. 00	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
7. 00 8. 00		RMX 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 14. 00		RVC RVB		13. 00 14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00 20. 00		RMC RMB		19. 00 20. 00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24. 00		ES3		24. 00
25. 00 26. 00		ES2 ES1		25. 00 26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30.00		HD1		30.00
31. 00 32. 00		HC2 HC1		31. 00 32. 00
33. 00		HB2		33. 00
34. 00		HB1		34.00
35. 00		LE2		35. 00
36.00		LE1		36.00
37. 00 38. 00		LD2 LD1		37. 00 38. 00
39. 00		LC2		39.00
40. 00		LC1		40.00
41. 00		LB2		41. 00
42.00		LB1		42.00
43. 00 44. 00		CE2 CE1		43. 00 44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48.00		CC1		48. 00
49. 00 50. 00		CB2 CB1		49. 00 50. 00
51. 00		CA2		51.00
52. 00		CA1		52. 00
53. 00		SE3		53.00
54.00		SE2		54.00
55. 00 56. 00		SE1 SSC		55. 00 56. 00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		I B2		59. 00
60.00		I B1		60.00
61. 00 62. 00		I A2 I A1		61. 00 62. 00
63. 00		BB2		63. 00
64. 00		BB1		64. 00
65. 00		BA2		65.00
66.00		BA1		66.00
67. 00 68. 00		PE2 PE1		67. 00 68. 00
69. 00		PD2		69.00
70. 00		PD1		70.00
71. 00		PC2		71. 00
72. 00		PC1		72.00
73. 00 74. 00		PB2 PB1		73. 00 74. 00
74. 00   75. 00		PA2		75. 00
· 1		12		,

Health Financial Systems	CARE ONE AT THE HI	GHLANDS		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315132	Peri od:	Worksheet S-	7
				From 01/01/2023 To 12/31/2023	Date/Time Pr	enared·
				10 12/31/2023	5/10/2024 11	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL			_	_		100. 00
			Expenses	Percentage	Y/N	
			1.00	2.00	3. 00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101. 00 Staffing						101. 00 102. 00
102.00 Recruitment 103.00 Retention of employees						102.00
104.00 Training						103.00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne 1 column 3)					106. 00
133. 30 13ta. Sim revenue (normaneet a 2, ruit 1, 11	,		ı	ı I		1.00.00

Heal th	Financial Systems	CARE ONE AT THE	HI GHLANDS		In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet A  Date/Time Pre 5/10/2024 11:	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	47 (3111)
	I	1.00	2.00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS    OO100   CAP REL COSTS - BLDGS & FIXTURES		2 020 (75	2 020 47		2 020 775	1 00
1. 00 2. 00	00200 CAP REL COSTS - BEDGS & FIXTURES		2, 030, 675 300, 306			2, 030, 675 300, 306	1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 948, 708			1, 948, 708	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	773, 490	2, 710, 593			3, 484, 083	1
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	151, 822	549, 764			701, 586	
6.00	00600 LAUNDRY & LINEN SERVICE	92, 594	80, 390			172, 984	1
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	277, 287 598, 812	56, 089 346, 538			333, 376 945, 350	
9. 00	00900 NURSING ADMINISTRATION	879, 646	141, 974			1, 021, 620	1
10. 00	01000 CENTRAL SERVICES & SUPPLY	9, 881	285, 219			295, 050	
11. 00	01100 PHARMACY	0	80, 042			80, 042	1
12.00	01200 MEDICAL RECORDS & LIBRARY	3, 575	0	3, 57		3, 575	
13. 00 14. 00	O1300   SOCIAL SERVICE   O1400   NURSING AND ALLIED HEALTH EDUCATION	178, 204	0	178, 20	0 0	178, 204	13. 00 14. 00
	01500 ACTI VI TES	238, 414	3, 214	1	-	241, 628	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	4, 332, 997	466, 173	1		4, 799, 170	1
31. 00	03100   NURSING FACILITY   03200   CF/IID	0	0	1	0	0	
32. 00 33. 00	03300 OTHER LONG TERM CARE	0	0	1	0 0	0	32. 00 33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	<u> </u>	<u> </u>	00.00
40.00	04000 RADI OLOGY	0	36, 409			36, 409	
41. 00	04100 LABORATORY	0	70, 807			70, 807	
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	261, 180 0	1	0 0	261, 180 0	1
44. 00	04400 PHYSI CAL THERAPY	681, 884	17, 287	1	-	699, 171	
45.00	04500 OCCUPATI ONAL THERAPY	603, 094	0	603, 09	4 0	603, 094	45. 00
46. 00	04600 SPEECH PATHOLOGY	123, 945	400	124, 34		124, 345	
47.00	04700  ELECTROCARDI OLOGY   04800  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0 50	0 50	
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	636, 606	636, 60		636, 606	1
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	)	0 0	0	1
51. 00	05100 SUPPORT SURFACES	0	0		0 0	0	
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52.00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST   05202 MEDICAL SERVICES	0	0		0 0	0	52. 01 52. 02
02. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u> </u>		02.02
60.00	06000 CLI NI C	0	0	)	0 0	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	0 00
	06200   FQHC   06300   DI ALYSI S		0			0	62.00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	/	0	0	03.00
70.00		0	0		0 0	0	70.00
	07100 AMBULANCE	0	111, 886	1		111, 886	
73.00	O7300   CMHC   O7400   OTHER REI MBURSEMENT	0	0	1	0 0	0	
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1	0	0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80. 00
81. 00	08100 I NTEREST EXPENSE		0		0 0	0	
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	
83. 00 84. 00	08300   HOSPI CE   08400   OTHER SPECI AL PURPOSE COST I	0	0		0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0		0 0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	8, 945, 645	10, 134, 260	19, 079, 90	5 0	19, 079, 905	1
	NONREI MBURSABLE COST CENTERS						
90.00		0	4, 214			4, 214	1
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		2, 264 0	1	0 0	2, 264 0	1
	09300 NONPAID WORKERS		0		o o	0	1
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	94. 00
	09500 OTHER NONREIMBURSABLE COST	0	0	10 22	0	0	
100.00	TOTAL	8, 945, 645	10, 140, 738	19, 086, 38	3 0	19, 086, 383	1100.00

CARE ONE AT THE HIGHLANDS In Lieu of Form CMS-2540-10

Heal th FinancialSystemsCARE ONERECLASSIFICATIONAND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315132 

COSI CONTROL DESCRIPTION					10   12/31/2023   Date/IIME Pro   5/10/2024 11	
Expenses (FF   FO All location		Cost Center Description	Adjustments to	Net Expenses	37 107 2024 11	. 47 diii
		oost content beschiperen				
SIND BALL SUBJECT COST CENTERS						
			WK3t A-0)			
CREMIN SERVICE COST CENTERS   1.00   0.000   0.020			6.00			
1.00   001000 CAP REL COSTS - BLDCS & FIXTURES   -2,586   2,028,689   1,000   30,000   30,000   3,000		CENEDAL SEDVICE COST CENTEDS	0.00	7.00		
2.00   00200   CAP REL COSTS - MOVABLE EQUIPMENT   0   300, 306   2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00		2.504	2 020 000		1 00
3.00   0.0300   EMPLOYEE BENEFITS			,			•
4. 00   00-400   AMJ IN STRATIVE & GENERAL   -1,099,887   2,391,196   4.00   6. 00   00-600   DANT OPERATION, MAINT & REPAIRS   0.00   172,984   6.00   7. 00   00700   DANT OPERATION, MAINT & REPAIRS   0.00   172,984   6.00   9. 00   00-600   DANT OPERATION, MAINT & REPAIRS   0.00   172,984   6.00   9. 00   00-600   DANT OPERATION, MAINT & REPAIRS   0.00   172,984   6.00   9. 00   00-600   DANT OPERATION, MAINT & REPAIRS   0.00   0.00   9. 00   00-600   DANT OPERATION, MAINT & REPAIRS   0.00   0.00   9. 00   00-600   DANT OPERATION, MAINT & REPAIRS   0.00   0.00   11. 00   01-600   CENTRAL SERVICE   0.00   0.00   0.00   13. 00   01-600   DANTAGE   DANTAGE   0.00   0.00   0.00   13. 00   01-600   DANTAGE   0.00   0.00   0.00   14. 00   01-600   DANTAGE   0.00   0.00   0.00   15. 00   01-600   DANTAGE   0.00   0.00   0.00   16. 00   01-600   DANTAGE   0.00   0.00   0.00   17. 00   01-600   DANTAGE   0.00   0.00   0.00   18. 00   01-600			1			•
5.00		1 1	_			•
6.00   00000   LAUNDRY & LINEN SERVICE   0   172, 984   7.00   00000   MUSSKEPIN B   0   945, 350   8.00   9.00   90000   MUSSKEPIN B   0   945, 350   9.00   90000   MUSSKEPIN B   0   945, 350   9.00   90000   MUSSKEPIN B   0   945, 350   9.00   90000   910000   MUSSKEPIN B   0   945, 350   9.00   90000   9100000   9100000   9100000   9100000   9100000   9100000   9100000   9100000   91000000   91000000   910000000   9100000000   910000000000			-1, 092, 887		·	
1,00	5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	701, 586		5. 00
9.00   00000   DIETARY	6.00	00600 LAUNDRY & LINEN SERVICE	0	172, 984		6. 00
9.00 00000 NURSING ADMINISTRATION	7.00	00700 HOUSEKEEPI NG	0	333, 376		7. 00
10.00   01000   CENTRAL SERVICES & SUPPLY   0   295,050   11.00   1100	8.00	00800 DI ETARY	0	945, 350		8. 00
10.00   101000   CENTRAL SERVICES & SUPPLY   0   295, 050   11.00	9. 00	00900 NURSI NG ADMI NI STRATI ON	-3, 197	1, 018, 423		9.00
11.00   01100   PHARMACY	10.00	01000 CENTRAL SERVICES & SUPPLY				10.00
12. 00   01200   MEDICAL RECORDS & LIBRARY   0   3,575   12. 00   130. 00			-6 403		i e	•
13. 00   01300   SOLIAL SERVICE   0   178. 204   114. 00   140. 00   140. 00   140. 00   140. 00   150.		1	0, 100		l e e e e e e e e e e e e e e e e e e e	
14. 00   01-400   NURSING AND ALLIED HEALTH EDUCATION   0   241,028   15,00			0			•
15. 00   01500   ACTIVITES		1	_			•
INPATIENT ROUTINE SERVICE COST CENTERS   30. 00   30. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   32. 00   32. 00   32. 00   32. 00   32. 00   32. 00   33. 0			1		l .	•
30.00	15.00		1 0	241,020		15.00
31.00	20.00		FO 444	4 740 704		20.00
32.00   03200   CIFF LID NS TERR CARE		1 1				•
33.00		1 1			•	•
ANCILLARY SERVICE COST CENTERS   40, 00   40, 00   41, 00   04100   ADDORPORADIOLOGY   0   0   36, 409   41, 00   04100   LABORATORY   0   70, 807   41, 00   42, 00   420, 00   420, 00   420, 00   420, 00   420, 00   420, 00   420, 00   430, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   440, 00   914, 00   142, 435   46, 00   450, 00   550, 00			1		l .	
40. 00   04000   04000   04010   LOGY	33. 00		0	0		33. 00
41.00   04100   LABORATORY   0   70,807   41.00   42.00   04200   OXYGEN (INPALATION) THERAPY   0   0   0   43.00   04300   OXYGEN (INPALATION) THERAPY   0   0   0   44.00   04400   PHYSI CAL THERAPY   0   603,094   45.00   45.00   04500   OCCUPATI ONAL THERAPY   0   603,094   45.00   46.00   04600   SPEECH PATHOLOGY   0   124,345   46.00   47.00   04700   ELECTROCARDIOLOGY   0   124,345   46.00   48.00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   50   48.00   49.00   04900   BRUGS CHARGED TO PATIENTS   0   50   48.00   49.00   04900   DRUGS CHARGED TO PATIENTS   -50,929   585,677   49.00   50.00   05000   DENDAR CHARGED TO PATIENTS   0   0   50   51.00   05100   SDEOON SUPPORT SURFACES   0   0   51.00   52.00   05200   COMPLEX MEDI CAL EQUI PMENT   0   0   52.00   52.01   05201   OTHER AND LLARY SERVICES COST   0   0   0   52.01   05201   OTHER AND LLARY SERVICES COST   0   0   0   52.00   OTHER MEDI CAL SERVICES   0   0   0   52.00   OTHER MEDI CAL SERVICES   0   0   0   52.00   OTHER MEDI CAL SERVICE COST   0   0   0   52.00   OTHER MEDI CAL SERVICE COST   0   0   0   61.00   06400   CHORC   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   60.00   06400   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   60.00   06400   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   60.00   06500   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   CHARLES   60.00   06500   CHARLES   C		ANCILLARY SERVICE COST CENTERS				
42.00   04200   INTRAVENOUS THERAPY   -20,894   240,286   42,000   043,000   044,000   04400   PHYSI CAL THERAPY   0   0,000   0,000   043,000   046,000   044,000   04400   PHYSI CAL THERAPY   0   0,000   0,000   045,000   046,000   044,000   04400   04400   PHYSI CAL THERAPY   0   0,000   0,000   0,000   047,000   044,000   04400   04400   PEPCH PATHOLOGY   0   0   124,345   0   047,000   047	40.00	04000 RADI OLOGY	0	36, 409		40. 00
43. 00 443.00 443.00 440.00 450.00 460.00 46	41.00	04100 LABORATORY	0	70, 807		41.00
43. 00 443.00 443.00 443.00 445.00 4	42.00	04200 I NTRAVENOUS THERAPY	-20, 894	240, 286		42. 00
44. 00 44.00   04400   PHYSICAL THERAPY   0   699,171   45. 00 45. 00   04500   OCUPATIONAL THERAPY   0   0603,094   45. 00 46. 00   04600   SPECH PATHOLOGY   0   124,345   46. 00 47. 00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   47. 00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   50   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   -50,929   585,677   49. 00 51. 00   05000   DENTAL CARE - THITLE XIX ONLY   0   0   50. 00 51. 00   05000   DENTAL CARE - THITLE XIX ONLY   0   0   55. 00 52. 00   05000   DENTAL CARE - THORAGES   0   0   0   55. 00 52. 00   05000   DENTAL CARE - THORAGES   0   0   0   55. 00 52. 00   0500   05000   DENTAL CARE - THORAGES   0   0   0   0   52. 00   05000   DENTAL CARE - THORAGES   0   0   0   0   52. 00   05000   DENTAL CARE - THORAGES   0   0   0   0   52. 00   05000   DENTAL CARE - THORAGES   0   0   0   0   52. 00   05000   DENTAL CARE - THORAGES   0   0   0   0   52. 00   05000   05000   05000   0500   0						
45. 00  46. 00 04500   DECCUPATI ONAL THERAPY			0	699 171		
46. 00 440.0   04600   SPEECH PATHOLOGY   0   124, 345   46. 00 47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   50   0   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   50   0   48. 00   04800   DRIVAT CARE - TITLE XIX ONLY   0   0   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   52. 00   05000   COMPLEX MEDI CAL EQUI PMENT   0   0   0   52. 00   05000   COMPLEX MEDI CAL EQUI PMENT   0   0   0   52. 01   05200   OMPLEX MEDI CAL EQUI PMENT   0   0   0   52. 02   05200   COMPLEX MEDI CAL EQUI PMENT   0   0   0   52. 02   05202   MEDI CAL SERVI CES COST   0   0   0   52. 02   05202   MEDI CAL SERVI CES COST   0   0   0   52. 02   00000   CLI NI C   0   0   0   61. 00   06000   CLI NI C   0   0   0   62. 00   06000   CLI NI C   0   0   0   63. 00   06300   DIALYSIS   0   0   0   64. 00   06300   DIALYSIS   0   0   0   65. 00   06300   DIALYSIS   0   0   0   67. 00   07000   HOME HEALTH AGENCY COST   0   0   0   67. 00   07000   HOME HEALTH AGENCY COST   0   0   0   67. 00   07000   MALPRACTI CE PREMI UMS & PAID LOSSES   0   0   0   68. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   0   0   0   68. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   0   0   0   68. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   0   0   0   68. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   0   0   0   68. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   0   0   0   68. 00   08000   UTIL IZATION REVIEW - SNF   0   0   0   68. 00   08000   UTIL IZATION REVIEW - SNF   0   0   0   68. 00   08000   UTIL IZATION REVIEW - SNF   0   0   0   68. 00   08000   UTIL IZATION REVIEW - SNF   0   0   0   69. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   69. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   69. 00   09000   09000   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   09000   69. 00   09000			0			•
47. 00   04700   ELECTROCARDIOLOGY   47. 00   48. 00   48. 00   49. 00   49. 00   49. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   04. 00   05			0		·	•
48. 00   04800   MEDI CAL. SUPPLIES CHARGED TO PATI ENTS   50   50   48. 00   04900   DRUTSC CHARGED TO PATI ENTS   -50, 929   585, 677   49. 00   50. 00   50000   DRUTAL CARE - TITLE XIX ONLY   0   0   0   50. 00   50.		1 1				
49.00   04900   DRUGS CHARGED TO PATIENTS						
50. 00   05000   DENTAL CARE - TITLE XI ONLY   0   0   0   0   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0			F0 020		· ·	•
51.00			1			•
52.00   05200   COMPLEX MEDI CAL EQUI PMENT   0   0   0   52.01			1		i e	•
52. 01   05201   OTHER ANCILLARY SERVICES COST   0   0   0   0   52. 02			_			
52.02			_			
OUTPATI ENT SERVICE COST CENTERS   OUTPATI ENT SE		1 1	1	l e	i e	•
60. 00   06000   CLINIC   0   0   0   0   0   61. 00   62. 00   62. 00   62. 00   62. 00   62. 00   62. 00   63	52. 02		0	0		52. 02
61. 00						
62. 00   06200   FOHC   06300   DI ALYSIS   0 0 0   0   0   0   0   0   0   0					l .	•
63.00     06300   DI ALYSI S	61. 00		0	0		61. 00
OTHER REIMBURSABLE COST CENTERS   O	62. 00	06200 FQHC				62. 00
70. 00	63.00	06300 DI ALYSI S	0	0		63. 00
71. 00						
73. 00 74. 00 74. 00 74. 00 75. 00 76. 00 77. 00 80. 00 81. 00 80. 00 81. 00 81. 00 81. 00 81. 00 82. 00 82. 00 83. 00 84. 00 84. 00 84. 01 84. 01 85. 00 86. 00 87. 00 87. 00 88. 00 89	70.00	07000 HOME HEALTH AGENCY COST	0	0		70. 00
74. 00	71. 00	07100 AMBULANCE	0	111, 886		71. 00
SPECIAL PURPOSE COST CENTERS   80.00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   0   0   0   0   81.00   81.00   81.00   81.00   81.00   82.00   82.00   82.00   82.00   82.00   82.00   83.00	73.00	07300 CMHC	0	0		73. 00
SPECIAL PURPOSE COST CENTERS   80.00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   0   0   0   0   81.00   81.00   81.00   81.00   81.00   82.00   82.00   82.00   82.00   82.00   82.00   83.00	74.00	07400 OTHER REIMBURSEMENT	0	0		74. 00
80. 00   08000   MALPRACTI CE PREMI UMS & PAI D LOSSES   0 0 0 0   81. 00   82. 00   08200   UTI LI ZATI ON REVI EW - SNF   0 0 0 0   82. 00   83. 00   08300   HOSPI CE   0 0 0   0   83. 00   84. 00   08400   OTHER SPECI AL PURPOSE COST I   0 0 0   0   84. 01   08401   OTHER SPECI AL PURPOSE COST I I   0 0 0   0   0   0   84. 01   89. 00   SUBTOTALS (sum of lines 1-84)   -1, 227, 340   17, 852, 565   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   09900   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   4, 214   90. 00   91. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0 0   09300   NONPAI D WORKERS   0 0   09300   NONPAI D WORKERS   0 0   09400   PAT I ENTS LAUNDRY   0 0 0 95. 00   09500   OTHER NONREI MBURSABLE COST   0 0   95. 00   09500   OTHER NONREI MBURSABLE COST   0 0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0 0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0 0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   0   0   0   0   0   0						
81. 00   08100   INTEREST EXPENSE   0   0   0   0   82. 00   83. 00   08300   HOSPI CE   0   0   0   0   84. 00   08400   OTHER SPECIAL PURPOSE COST I   0   0   0   0   0   84. 00   08400   OTHER SPECIAL PURPOSE COST I   0   0   0   0   0   0   0   0   0	80 00		0	0		80.00
82. 00   08200   UTI LI ZATI ON REVI EW - SNF   0   0   0   83. 00   83. 00   08300   HOSPI CE   0   0   0   0   0   84. 00   08400   OTHER SPECI AL PURPOSE COST I   0   0   0   0   0   0   0   0   0			0	l o		•
83. 00   08300   HOSPI CE   0 0 0   0   84. 00   84. 00   84. 00   84. 01   08401   OTHER SPECIAL PURPOSE COST I I   0 0   0   0   84. 01   89. 00     SUBTOTALS (sum of lines 1-84)   -1, 227, 340   17, 852, 565   89. 00     NONREI MBURSABLE COST CENTERS   90. 00   90900   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   91. 00   9100   BARBER AND BEAUTY SHOP   0   2, 264   91. 00   92. 00   92. 00   94. 00   9300   NONPAI D WORKERS   0   0   0   93. 00   9300   NONPAI D WORKERS   0   0   0   93. 00   94. 00   94. 01   95. 00   95. 00   07500   OTHER NONREI MBURSABLE COST   0   0   95. 00   07500   OTHER NONREI MBURSABLE COST   0   0   95. 00   07500   OTHER NONREI MBURSABLE COST   0   0   95. 00   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   07500   0   0   0   0   0   0   0   0   0			0	0		
84. 00						
84. 01 89. 00    SUBTOTALS (sum of lines 1-84)   -1, 227, 340   17, 852, 565   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   09100   BARBER AND BEAUTY SHOP   0   2, 264   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   09300   NONPAI D WORKERS   0   094. 00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   0   0   0   0						
89. 00   SUBTOTALS (sum of lines 1-84)   -1,227,340   17,852,565   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   4,214   91. 00   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   93. 00   09300   NONPAI D WORKERS   0   0   0   93. 00   94. 00   94. 00   94. 00   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   95. 00   0   0   0   0   0   0   0   0   0		1		0		
NONREI MBURSABLE COST CENTERS   90.00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   4,214   90.00   91.00   91.00   91.00   92.00   92.00   92.00   92.00   92.00   92.00   92.00   92.00   92.00   92.00   93.00   93.00   93.00   93.00   93.00   93.00   93.00   94.00   94.00   94.00   94.00   95.00   071ER NONREI MBURSABLE COST   0   0   95.00   95		1 1	1 227 242	17 050 575		
90. 00   9000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   4, 214   90. 00   91. 00   9100   BARBER AND BEAUTY SHOP   0   2, 264   91. 00   92. 00   92200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   93. 00   9300   NONPAI D WORKERS   0   0   93. 00   94. 00   94. 00   PATI ENTS LAUNDRY   0   0   95. 00   95. 00   07HER NONREI MBURSABLE COST   0   0   95. 00   95. 00   95. 00   07HER NONREI MBURSABLE COST   0   0   0   95. 00   95. 00   07HER NONREI MBURSABLE COST   0   0   0   0   0   0   0   0   0	89.00		-1, 227, 340	17,852,565	<u> </u>	J 89.00
91. 00   09100   BARBER AND BEAUTY SHOP   0   2, 264   91. 00   92. 00   93. 00   93. 00   93. 00   94. 00   94. 00   95. 00   09500   0THER NONREI MBURSABLE COST   0   0   0   95. 00   0   0   0   0   0   0   0   0   0	00.05		-			
92. 00   92.00   94.00   95.00			0			•
93. 00   09300   NONPAI D WORKERS   0 0 0   93. 00   94. 00   95. 00   09500   OTHER NONREI MBURSABLE COST   0 0   95. 00   09500   09			0			
94. 00   09400   PATI ENTS LAUNDRY   0   0   0   95. 00   95. 00   074ER   NONREI   MBURSABLE   COST   0   0   0   0   0   0   0   0   0			0	1		
95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   95. 00			0	0		
			0	0	)	
100. 00   TOTAL   -1, 227, 340   17, 859, 043   100. 00			0	0	)	
	100.00	O   TOTAL	-1, 227, 340	17, 859, 043		100. 00

Health Financial Systems	CARE ONE AT THE HIG	SHLANDS		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Increases  Cost Center Line # Salary					
	Cost Center		Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
(1) A - RECLASS MED SUPP CHARGED						
1.00	MEDICAL SUPPLIES CHAPATIENTS	ARGED TO	48. 0	0 0	50	1. 00
TOTALS						
100. 00	Total Reclassificati	ons (Sum		0	50	100. 00
	of columns 4 and 5 r	must				
	equal sum of columns	s 8 and				
	9)					ı

A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 Transfer to Worksheet A, col. 5, line as appropriate.

Health Financial Systems	CARE ONE AT THE HI	GHLANDS		In Lie	eu of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023		nared:
				10 12/31/2023	5/10/2024 11:	47 am
	Decreases					
	Cost Center	-	Li ne #	Sal ary	Non Salary	
	6. 00		7.00	8. 00	9. 00	
(1) A - RECLASS MED SUPP CHARGED						
1. 00	CENTRAL SERVICES &	SUPPLY	10. (	00	50	1.00
TOTALS						
100. 00				0	50	100. 00

<sup>(1)</sup> A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. (2) Transfer to Worksheet A, col. 5, line as appropriate.

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT THE HIGHLANDS In Lieu of Form CMS-2540-10 Provider No.: 315132 | Period: | Worksheet A-7 | From 01/01/2023 | To 12/31/2023 | Date/Time Prens

				Т	o 12/31/2023	Date/Time Prep 5/10/2024 11:4	
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1. 00	Land	324, 450	0	0	0	0	1. 00
2.00	Land Improvements	8, 055	0	0	0	0	2. 00
3.00	Buildings and Fixtures	6, 398, 172	16, 989	0	16, 989	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equi pment	905, 433	0	0	0	0	5. 00
6.00	Movable Equipment	2, 885, 334	50, 597		50, 597		6. 00
7.00	Subtotal (sum of lines 1-6)	10, 521, 444	67, 586	0	67, 586	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9.00	Total (line 7 minus line 8)	10, 521, 444	67, 586	C	67, 586	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	324, 450	0				1. 00
2.00	Land Improvements	8, 055	0				2.00
3.00	Buildings and Fixtures	6, 415, 161	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	905, 433	0				5. 00
6.00	Movable Equipment	2, 935, 931	0				6. 00
7.00	Subtotal (sum of lines 1-6)	10, 589, 030	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	10, 589, 030	0				9. 00

Provi der No.: 315132

Peri od: Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	5/10/2024 11:	pareu: 47 am
				Expense Classification on	Worksheet A	17 (1111
				To/From Which the Amount is		
				TOTT OIL WITTER THE TWINGSTE TS	to be haj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	COST CONTEN	LITIC NO.	
		1.00	2.00	3.00	4. 00	
1.00	Investment income on restricted funds	В		CAP REL COSTS - BLDGS &	1.00	1. 00
1.00	(chapter 2)	, b	-2, 300	FIXTURES	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter	1	0		0.00	2. 00
2.00	8)				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		0		0.00	4. 00
4.00	(chapter 8)		0		0.00	4.00
5. 00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
5.00	(chapter 21)		0		0.00	5.00
6. 00			0		0.00	6. 00
	Television and radio service (chapter 21)	4				7. 00
7.00	Parking lot (chapter 21)	4.0.2	0		0.00	
8.00	Remuneration applicable to provider-based	A-8-2	U	,		8. 00
0.00	physician adjustment				0.00	0.00
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)	4	0	l control of the cont	0.00	10. 00
11. 00	Nonallowable costs related to certain		0	)	0.00	11. 00
40.00	Capital expenditures (chapter 24)					40.00
12. 00	Adjustment resulting from transactions with	A-8-1	-244, 306			12. 00
	related organizations (chapter 10)	4	_			
13. 00	Laundry and linen service		0		0.00	
14. 00	Revenue - Employee meals		0		0.00	
15. 00	Cost of meals - Guests		0		0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17. 00	Sale of drugs to other than patients		0		0.00	
18. 00	Sale of medical records and abstracts		0		0.00	
19. 00	Vending machines		0		0.00	
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
				EQUI PMENT		
25. 00	RESIDENT REPLACEMENT ITEMS	A	-853	ADMINISTRATIVE & GENERAL	4.00	
25. 01	MARKETI NG EXPENSE	A	-12, 581	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	MARKETING CORP EXPENSE	A	-7, 255	ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	MARKETING - MEALS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	SHOWS & CONFERENCES	A		ADMINISTRATIVE & GENERAL	4.00	
25.05	SPONSORSHI PS	A	-3, 500	ADMINISTRATIVE & GENERAL	4.00	25. 05
25.06	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 07	BAD DEBT EXPENSE - MEDICARE	Α		ADMINISTRATIVE & GENERAL	4.00	25. 07
25. 08	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	25. 08
25. 09	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	4.00	
25. 10	OTHER I NCOME	В		ADMINISTRATIVE & GENERAL	4.00	
	Total (sum of lines 1 through 99) (Transfer	1	-1, 227, 340			100. 00
	to Worksheet A, col. 6, line 100)		, 5.0			
(4) 5			0.000 D 1 4 E 4	1 i	•	1

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

Health Financial Systems CARE ONE AT THE HIGHLANDS STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provide

OFFICE COSTS

				Т	To 12/31/2023 Date/Time P 5/10/2024 1	
		Li ne No.	Cost	Center	Expense Items	
		1. 00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS OR	
1.00	CLATIMED HOME OFFICE COSTS.	4 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	1.00
2.00			NURSING ADMINI		PHARMACY CONSULTANT	2.00
3.00		10. 00	CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPENSE	3.00
4. 00		11. 00	PHARMACY		DRUGS-NON-PRESCRI PTI ON, NON-LEGEND	4. 00
5.00		11. 00	PHARMACY		PHARMACY SUPPLIES	5. 00
6.00			INTRAVENOUS TH		IV EXPENSE	6. 00
7. 00		49. 00	DRUGS CHARGED		DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	7. 00
8. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	8. 00
9. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDICAR A	9. 00
9. 01 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	0. 00				9. 01 10. 00
	12.	Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
			5	,		
		4. 00	5. 00	6. 00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00		657, 721				1. 00
2.00		36, 764				2. 00
3.00		82, 650				3. 00
4.00		73, 077	· ·			4. 00
5.00		562				5. 00
6.00		240, 286				6.00
7. 00 8. 00		40, 274 290, 266				7. 00 8. 00
9. 00		290, 266 255, 137				9.00
9. 00		255, 137	277, 323			9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 676, 737	·			10.00

Worksheet A-8-1

OFFICE COSTS

From 01/01/2023 12/31/2023

Parts I-II Date/Time Prepared:

5/10/2024 11:47 am Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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 B 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

1.00	Α	DANI EL STRAUS	41.00	1.00
2.00	A	DANI EL STRAUS	41.00	2.00
3.00	A	DES HOLDING CO. INC.	22. 00	3. 00
4.00	F	PARTNERS PHARMACY SERVICES	0.00	4.00
		LLC		
5. 00			0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0. 00	100.00
speci fy:				

- (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 relative of such person has financial interest in related 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.

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of Ownership	Type of Business	
	4. 00	5. 00	6. 00	1
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(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 B 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

1.00	HEALTHBRIDGE MANAGEMENT LLC	100. 00 MANAGEMENT	1.00
2. 00	TOTALCARE LLC	99.00WOUND CARE	2. 00
3. 00	TOTALCARE LLC	1.00WOUND CARE	3.00
4. 00	PARTNERS PHARMACY LLC	100.00 PHARMACY	4. 00
5. 00		0. 00	5. 00
6.00		0. 00	6. 00
7. 00		0. 00	7. 00
8. 00		0. 00	8. 00
9. 00		0. 00	9. 00
10. 00		0. 00	10.00
100.00 G. Other (financial or non-financial	anci al )	0. 00	100. 00
speci fy:			

- (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 relative of such person has financial interest in related 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.

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/ Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315132

					To	12/31/2023	Date/Time Prep 5/10/2024 11:4	
				CAPI TAL REI	LATED COSTS		37 107 2024 11.	47 diii
				DI DOC A	HOVARIE	FMDI OVEE		
		Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
			Allocation	TTATORES	EQUIT MENT	DENETTIO		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	3. 00	3A	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	3. 00	JA .	
1.00		CAP REL COSTS - BLDGS & FIXTURES	2, 028, 089	2, 028, 089				1. 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT	300, 306		300, 306			2. 00
3.00	1	EMPLOYEE BENEFITS	1, 948, 708	150.000		1, 948, 708	2 742 270	3. 00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	2, 391, 196 701, 586	159, 029 29, 688		168, 496 33, 073	2, 742, 269 768, 743	4. 00 5. 00
6. 00		LAUNDRY & LINEN SERVICE	172, 984	36, 674		20, 171	235, 259	6. 00
7.00		HOUSEKEEPI NG	333, 376	0		60, 404	393, 780	7. 00
8.00	1	DIETARY	945, 350	293, 937		130, 445	1, 413, 256	8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	1, 018, 423 295, 050	27, 942 0		191, 621 2, 152	1, 242, 123 297, 202	9. 00 10. 00
11. 00	1	PHARMACY	73, 639	0		2, 132	73, 639	11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY	3, 575	14, 189	2, 101	779	20, 644	12. 00
13. 00	1	SOCIAL SERVICE	178, 204	17, 464		38, 820	237, 074	13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	0		51 02/	0	14. 00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	241, 628	38, 748	5, 738	51, 936	338, 050	15. 00
30. 00		SKILLED NURSING FACILITY	4, 748, 726	1, 260, 884	186, 704	943, 893	7, 140, 207	30. 00
31.00		NURSING FACILITY	0	0	1	0	0	31. 00
32. 00		ICF/IID	0	0		0	0	32.00
33. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	0	0	0	0	0	33. 00
40. 00		RADI OLOGY	36, 409	10, 915	1, 616	O	48, 940	40. 00
41. 00	1	LABORATORY	70, 807	0		Ö	70, 807	41. 00
42.00	04200	INTRAVENOUS THERAPY	240, 286	10, 915	1, 616	0	252, 817	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	0	١	0	0	43. 00
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	699, 171 603, 094	41, 476 38, 202		148, 541 131, 377	895, 330 778, 330	44. 00 45. 00
46. 00	1	SPEECH PATHOLOGY	124, 345	26, 196		27, 000	181, 420	
47. 00	1	ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	50	10, 915		0	12, 581	48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	585, 677	10, 915		0	598, 208	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
52. 00		COMPLEX MEDICAL EQUIPMENT		0	0	o	0	52. 00
52. 01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02		MEDICAL SERVICES	0	0	0	0	0	52. 02
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	0	0	ol	0	60. 00
61. 00		RURAL HEALTH CLINIC		0	i l	0	0	61. 00
62. 00	06200	l .		_			_	62. 00
63. 00		DI ALYSI S	0	0	0	0	0	63. 00
70.00		REIMBURSABLE COST CENTERS				ما	0	70.00
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0 111, 886	0	I	0	0 111, 886	70. 00 71. 00
73. 00	07300	l .	0	0	1	o	0	73. 00
74.00		OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
		AL PURPOSE COST CENTERS						
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00	1	UTILIZATION REVIEW - SNF						82. 00
83. 00		HOSPI CE	0	0	0	0	0	83. 00
84. 00		OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401	OTHER SPECIAL PURPOSE COST II	17 052 545	0 0 0 0 0 0 0	-	1 040 700	17 052 545	84. 01
89. 00	NONRE	SUBTOTALS (sum of lines 1-84)  IMBURSABLE COST CENTERS	17, 852, 565	2, 028, 089	300, 306	1, 948, 708	17, 852, 565	89. 00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	4, 214	0	0	0	4, 214	90. 00
91. 00		BARBER AND BEAUTY SHOP	2, 264	0	0	0	2, 264	
92.00	1	PHYSICIANS PRIVATE OFFICES	0	0	0	O	0	92.00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY		0	0	0	0	93. 00 94. 00
95.00		OTHER NONREIMBURSABLE COST		0		ol	0	95. 00
98. 00		Cross Foot Adjustments	0	0	0	ō	Ō	98. 00
99. 00		Negative Cost Centers	0	0	0	0	0	99.00
100.00	וי	TOTAL	17, 859, 043	2, 028, 089	300, 306	1, 948, 708	17, 859, 043	100.00

Provi der No.: 315132

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				1	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	47 dili
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
	CENEDAL CEDALCE COCT CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			•			2.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	2, 742, 269					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	139, 455	908, 198				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	42, 677	18, 108	296, 044			6. 00
7.00	00700 HOUSEKEEPI NG	71, 434	0	0	,		7. 00
8.00	00800 DI ETARY	256, 373	145, 133	1	75, 855		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	225, 329	13, 797	] 0	7, 211	0 0	9.00
10. 00 11. 00	01100 PHARMACY	53, 914 13, 359	0	0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	3, 745	7, 006		3, 662	0	12.00
13. 00	01300 SOCIAL SERVICE	43, 007	8, 623	1	4, 507	Ö	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0		0	14.00
15.00	01500 ACTI VI TES	61, 324	19, 132	0	9, 999	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	1, 295, 270	622, 568	1	325, 389	1, 890, 617	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00 33. 00	03200   ICF/IID   03300   OTHER LONG TERM CARE	0	0	0	0	0	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		<u> </u>	U O	0	33.00
40. 00	04000 RADI OLOGY	8, 878	5, 389	0	2, 817	0	40. 00
41. 00	04100 LABORATORY	12, 845	0	1		0	41.00
42.00	04200 I NTRAVENOUS THERAPY	45, 863	5, 389	0	2, 817	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	162, 418	20, 479	1		0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	141, 194	18, 862	1	9, 859	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	32, 911	12, 934 0	1	6, 760	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 282	5, 389	1	2, 817	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	108, 519	5, 389		2, 817	0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	ő	0	0	50.00
51.00	05100 SUPPORT SURFACES	o	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0	0		0	61.00
62. 00	06200 FQHC		O		J		62.00
63. 00	06300 DI ALYSI S	o	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00		0	0	0	0	0	70. 00
	07100 AMBULANCE	20, 297	0	0	0	-	71.00
73.00	07300 CMHC	0	0	0	0	0	
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	0	U	0	74. 00
80. 00							80.00
81. 00	1						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	o	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	2, 741, 094	908, 198	296, 044	465, 214	1, 890, 617	89. 00
90. 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	764			٥	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	411	0	0	0	0	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	411	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS		0	l o	l ől	ő	93. 00
94. 00	09400 PATIENTS LAUNDRY		0	Ō	o	0	94. 00
95. 00	1		0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99.00		0 740 043	000 100	0 000	0	1 000 (17	99.00
100.00	D TOTAL	2, 742, 269	908, 198	296, 044	465, 214	1, 890, 617	1100.00

Provi der No.: 315132

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: 5/10/2024 | 11: 47 am

						5/10/2024 11:	<u>47 am</u>
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
		1 400 470					1
9.00	00900 NURSI NG ADMI NI STRATI ON	1, 488, 460	0=4.44				9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	351, 116				10.00
11. 00	01100 PHARMACY	0	0	86, 998			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	35, 057		12. 00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	293, 211	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15.00	01500 ACTI VI TES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>.</u>					
30.00	03000 SKILLED NURSING FACILITY	1, 488, 460	351, 116	86, 998	35, 057	293, 211	30. 00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200   CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	o	0	0	33. 00
00.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		,			00.00
40. 00	04000 RADI OLOGY	O	0	0	0	0	40. 00
41. 00	04100 LABORATORY		0		0	0	1
			0	0	0	·	
42. 00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51.00	05100 SUPPORT SURFACES	0	0	o	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	o o	0	o o	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	o o	0	Ö	0	o o	52. 01
52. 02	05202 MEDI CAL SERVI CES		0	l ő	0	0	52. 02
32. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>			0	32.02
40.00	06000 CLINIC	O	0		0	0	40.00
60.00	l l	0	0		_	0	60.00
61.00	06100 RURAL HEALTH CLINIC	U	0	0	0	0	61.00
62. 00	06200 FQHC	_	_	_	_	_	62. 00
63. 00	06300  DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>					1
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE		0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I		0		0	0	84. 00
	l l		0	0	0	-	
84. 01	08401 OTHER SPECIAL PURPOSE COST II	1 400 4(0	054.447	-	05 057	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	1, 488, 460	351, 116	86, 998	35, 057	293, 211	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST	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	1
100.00		1, 488, 460	351, 116	86, 998	35, 057	1	1
. 55. 50	1	., .55, .66	55.,.10	33, 770	22, 307	2,0,211	,

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315132

				1	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			37 107 2024 11.	47 alli
			SERVI CE				
	Cost Center Description	NURSING AND	ACTI VI TES	Subtotal	Post Stepdown	Total	
		ALLIED HEALTH EDUCATION			Adjustments		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	OO300						3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 11. 00	01000   CENTRAL SERVI CES & SUPPLY   01100   PHARMACY						10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13.00	01300 SOCIAL SERVICE						13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTI VI TES	0	428, 505	<u> </u>			15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	1 0	428, 505	14, 253, 442	2 0	14, 253, 442	30.00
31. 00	03100 NURSING FACILITY					1	31. 00
32. 00	03200   CF/IID	0					1
33. 00	03300 OTHER LONG TERM CARE	0	0	) (	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1	1				
40.00	04000 RADI OLOGY 04100 LABORATORY	0					40.00
41. 00 42. 00	04200 I NTRAVENOUS THERAPY	0		1 00,002		83, 652 306, 886	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	Ö		o o	0	1
44. 00	04400 PHYSI CAL THERAPY	0	0	1, 088, 931	0	1, 088, 931	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	948, 245		948, 245	1
46. 00	04600 SPEECH PATHOLOGY	0	0	234, 025	0	234, 025	1
47. 00 48. 00	04700   ELECTROCARDI OLOGY   04800   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	23, 069	0	0 23, 069	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS		0			714, 933	1
	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö		o o	0	1
51.00	05100 SUPPORT SURFACES	0	0	) (	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52. 00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST	0			-		52. 01
52. 02	05202 MEDICAL SERVICES   OUTPATIENT SERVICE COST CENTERS	0	0	η C	)  0		52. 02
60. 00	06000 CLINIC	0	0		0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	) (	0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS  07000 HOME HEALTH AGENCY COST	0	0		0	0	70.00
	07100 AMBULANCE		0	132, 183		132, 183	
	07300 CMHC	0	Ō		0	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	) (	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS	1	ı			l	
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
	08200 UTI LI ZATI ON REVI EW - SNF						82.00
83. 00	08300 HOSPI CE	0	o		0	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	1
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	) (	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	0	428, 505	17, 851, 390	) 0	17, 851, 390	89. 00
90. 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	4, 978	8 0	4, 978	90.00
	09100 BARBER AND BEAUTY SHOP		0	2, 675		2, 675	1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	Ō		0	0	1
	09300 NONPALD WORKERS	0	0	) (	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0		0	0	
95. 00 98. 00	09500 OTHER NONREI MBURSABLE COST	0	0		0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0		) O	0	98.00
100.00		0	428, 505	17, 859, 043	0		1
		•			•		•

Provi der No.: 315132

					12/31/2023	5/10/2024 11:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		Assigned New	FI XTURES	EQUI PMENT		BENEFI TS	
		Capi tal					
		Related Costs	1.00	2.00	2.4	2.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	3. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	0	0	3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	0	159, 029	23, 548	182, 577	0	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	29, 688		34, 084	Ö	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	36, 674		42, 104	Ö	6.00
7. 00	00700 HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	00800 DI ETARY	O	293, 937	43, 524	337, 461	0	8. 00
9.00	00900 NURSING ADMINISTRATION	O	27, 942		32, 079	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	14, 189	2, 101	16, 290	0	12. 00
13.00	01300 SOCI AL SERVI CE	0	17, 464	2, 586	20, 050	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	0	38, 748	5, 738	44, 486	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 SKILLED NURSING FACILITY	0	1, 260, 884	186, 704	1, 447, 588	0	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00	03200   CF/  I D	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	l O	U	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	l ol	10, 915	1, 616	12, 531	0	40.00
41. 00	04100 LABORATORY	0	10, 913	1,010	12, 331	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	10, 915	1, 616	12, 531	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		10, 713	1,010	12, 551	0	43. 00
44. 00	04400 PHYSI CAL THERAPY		41, 476	6, 142	47, 618	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	38, 202		43, 859	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	26, 196		30, 075	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 915	1, 616	12, 531	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	10, 915		12, 531	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63. 00	06300 DI ALYSI S  OTHER REI MBURSABLE COST CENTERS	0	0	0	U	0	63.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
70.00	07100 AMBULANCE	0	0	0	0	0	
73.00	07300 CMHC		0	-	0	0	73.00
74. 00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74.00
7 1. 00	SPECIAL PURPOSE COST CENTERS	9		<u> </u>	<u> </u>		7 1. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00	08100   NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	O	0	0	0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	2, 028, 089	300, 306	2, 328, 395	0	89. 00
	NONREI MBURSABLE COST CENTERS	,					
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	
93. 00	09300 NONPAL D WORKERS	0	0	0	0	0	
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
95.00	09500 OTHER NONREI MBURSABLE COST		0	0	0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		^		0	0	98. 00 99. 00
100.00	1 1 9	0	2, 028, 089	300, 306	2, 328, 395		100.00
130.00	J. 1.011/12	1 9	2, 520, 507	300, 300	2, 320, 373	0	1.00.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315132

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/10/2024 11:47 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 182, 577 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 9, 285 43, 369 5.00 00600 LAUNDRY & LINEN SERVICE 45, 810 2,841 6.00 6.00 865 7.00 00700 HOUSEKEEPI NG 4, 756 C 4, 756 7.00 6, 930 362, 235 8.00 00800 DI ETARY 17,069 0 775 8.00 9.00 00900 NURSING ADMINISTRATION 15,002 0 74 9.00 659 3, 590 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 C 0 Ω 11.00 01100 PHARMACY 889 r 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 249 335 0 37 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 2.863 0 412 46 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 0 14.00 01500 ACTI VI TES 4,083 914 102 0 15.00 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 45, 810 03000 SKILLED NURSING FACILITY 362, 235 30.00 30.00 86, 238 29, 729 3 327 31.00 03100 NURSING FACILITY 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 591 257 0 29 0 40.00 41.00 04100 LABORATORY 855 0 0 41.00 0 42 00 04200 I NTRAVENOUS THERAPY 3 054 257 0 29 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 10,814 978 109 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 9, 401 901 0 101 0 45.00 04600 SPEECH PATHOLOGY 46 00 0 46 00 2, 191 618 69 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 152 257 0 29 48.00 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 7.225 257 0 29 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50 00 50.00 0 C 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 52.00 52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 0 0 52.01 05202 MEDICAL SERVICES 52.02 0 0 0 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 61.00 0 0 61.00 06200 FQHC 62.00 62.00 63.00 06300 DI ALYSI S 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 0 0 0 70.00 71.00 07100 AMBULANCE 1.351 C 0 0 0 71.00 73.00 07300 CMHC 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 84.00 08401 OTHER SPECIAL PURPOSE COST II 84.01 84.01 SUBTOTALS (sum of lines 1-84) 182, 499 89.00 43, 369 45, 810 756 362, 235 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 51 90.00 o 09100 BARBER AND BEAUTY SHOP 27 0 91.00 91.00 0 0 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 C 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 94.00 0 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST 95 00 0 O 0 95 00 0 98.00 Cross Foot Adjustments 0 0 0 98.00 99.00 Negative Cost Centers 99.00 0 0 0 100.00 TOTAL 182, 577 43, 369 45, 810 4, 756 362, 235 100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315132

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/10/2024 11:47 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 47,814 9 00 01000 CENTRAL SERVICES & SUPPLY 3, 590 10.00 10.00 01100 PHARMACY 889 11.00 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 16, 911 12.00 13.00 01300 SOCIAL SERVICE 0 0 23, 371 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 C 0 0 01500 ACTI VI TES 15.00 0 Ω 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 47, 814 3, 590 889 16, 911 23, 371 30.00 03100 NURSING FACILITY 31.00 0 Ω 31.00 32.00 03200 | CF/IID 0 C 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 04000 RADI OLOGY 40.00 0 Ω 0 0 Λ 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000000 0 0 0 0 42.00 0 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 04400 PHYSI CAL THERAPY 0 44.00 0 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY O 50 00 0 05100 SUPPORT SURFACES 0 51.00 0 0 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 52.00 52.00 52.01 0 ol 05201 OTHER ANCILLARY SERVICES COST 0 0 0 52.01 0 05202 MEDICAL SERVICES 0 o 52.02 0 Ω 52.02 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0 0 60.00 60.00 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 o 0 61.00 06200 FOHC 62.00 62.00 63.00 06300 DI ALYSI S 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 C 07100 AMBULANCE 0 71.00 0 C 0 Ω 71.00 73.00 07300 CMHC 0 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 ol 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 H0SPLCE 83.00 0 C 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 C 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 84.01 SUBTOTALS (sum of lines 1-84) 47, 814 16, 911 3, 590 889 23, 371 89.00 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 Ω 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 95.00 C 0 Ω Cross Foot Adjustments 0 98.00 C 0 98 00 99.00 Negative Cost Centers 0 Λ 99.00 16, 911 100.00 47, 814 3,590 889 23, 371 100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315132

COST Center Description					Т	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
Cost Center Description				OTHER GENERAL			07 107 2021 11.	17 (3111
ACLIED HEALTH   EDUCATION   15.00   16.00   17.00   18.00   1.00   16.00   17.00   18.00   1.00   16.00   17.00   18.00   1.00   16.00   17.00   18.00   1.00   16.00   17.00   18.00   1.00   16.00   17.00   18.00   1.			AULDOLAIO AND			D 1 C1 D	<b>.</b>	
EDUCATION		Cost Center Description		ACTIVITES	Subtotal		lotal	
14.00   15.00   16.00   17.00   18.00						Auj us tillerits		
1.00				15. 00	16. 00	17. 00	18. 00	
2.00 00200 CAP REL COSTS - MOVABILE EQUI PMENT 3.00 00300 EMPLOYER EBINEFITS 4.40 00400 ADMINI STRATI VE & GENERAL 5.50 00500 PLANT OPERATION, MAINT. & REPAIRS 5.60 005000 PLANT OPERATION, MAINT. & REPAIRS 5.60 00500 PLANT OPERATION, MAINT. & REP	1 00			1	T			1 00
3.00 00300 [AMPLOYCE BENEFITS 4 0 0 0400 ADMIN ISTRATI VE & GENERAL 5.00 00500 [PLANT OPERATI ON, MAINT. & REPAIRS 5.00 00500 [PLANT OPERATI ON, MAINT. & REPAIRS 5.00 00500 [PLANT OPERATI ON, MAINT. & REPAIRS 5.00 00500 [AUNIDARY & 1.0 NEW PAIR OF THE PAIR O		1 1		-	-			1. 00 2. 00
4.00 00400 JOMIN ISTRATI VE & GENERAL 5.00 00500 PLANT OPERATION, MAIN T. & REPAIRS 6.60 00600 PLANT OPERATION OF THE PAIR O		l l						3. 00
6.00   00600   LAUNDRY & LINEN SERVICE		l l						4. 00
7. 0. 00700 HOUSEKEEPING	5.00							5. 00
8. 00   00800   DITARY   8.   9.   00   00900   NURSI ING ADMINI STRATI ON   9.   0.   10.								6. 00
9. 00 00900 NURSI NG ADM IN STRATI ON 10. 00 1000 CENTRAL SERVI CES & SUPPLY 10. 10. 11. 00 10100 PHARMACY 11. 11. 12. 00 101200 MEDI CAL RECORDS & LI BRARRY 11. 12. 00 101200 MEDI CAL RECORDS & LI BRARRY 11. 13. 00 101300 SOCI AL SERVI CES & SUPPLY 11. 14. 15. 00 101300 SOCI AL SERVI CE & SUPPLY 11. 15. 00 101300 SOCI AL SERVI CE & SUPPLY 11. 15. 00 101300 ACTI NI TES & USAGO SERVI CE COST CENTERS 115. 15. 16. 00 10500 ACTI NI TES & USAGO SERVI CE COST CENTERS 115. 16. 16. 00 10500 ACTI NI TES & USAGO SERVI CE COST CENTERS 115. 16. 16. 16. 16. 16. 16. 16. 16. 16. 16								7. 00
10. 0   01000   CENTRAL SERVICES & SUPPLY   10.   11.   11.   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   12.   00   13.   00   13.   00   13.   00   13.   00   13.   00   13.   00   00   00   00   00   00   00								8.00
11.00   01100   PHARMACY								10.00
12								11. 00
14. 00	12.00							12. 00
15. 00								13. 00
INPATIENT ROUTINE SERVICE COST CENTERS			1	l .				14.00
30. 00 03000   SKILLED NURSING FACILITY	15. 00			49, 585	)			15. 00
31.00   03100   NURSI NG FACILITY   0   0   0   0   0   0   31. 32.00   03200   ICF/I ID   0   0   0   0   0   0   32. 33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   32. 33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   32. 33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   32. 33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   32. 33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   32. 34.00   04000 RADI OLGY   0   0   0   0   13,408   40. 41.00   04100   LABORATORY   0   0   0   0   15,871   0   15,871   42. 42.00   04200   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0	30 00			49 585	2 117 087	7	2 117 087	30.00
32.00   03200   ICF/IID   0   0   0   0   0   0   0   32.1   33.00   03300   OTHER LONG TERM CARE   0   0   0   0   0   0   33.3   40.00   04000   RADI OLOGY   0   0   0   13.408   0   13.408   40.4   41.00   04100   LABORATORY   0   0   0   15,871   0   15,871   42.4   42.00   04200   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   43.4   43.00   04300   0XYGEN (INHALATION) THERAPY   0   0   0   0   0   0   0   0   44.00   04400   PHYSI CAL THERAPY   0   0   0   59,519   0   59,519   44.4   45.00   04500   OCCUPATIONAL THERAPY   0   0   0   54,262   0   54,262   0   54,262   45.46   46.00   04600   SPECH PATHOLOGY   0   0   0   0   0   0   0   0   47.00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   48.00   04800   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0   49.00   04900   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0   51.00   05000   DENTAL CARE = TITLE XIX ONLY   0   0   0   0   0   0   0   0   52.01   05000   COMPLEX MEDI CAL EQUI PMENT   0   0   0   0   0   0   0   0   52.01   05201   OTHER ANGI LLARY SERVI CES COST   0   0   0   0   0   0   0   52.02   05000   COMPLEX MEDI CAL EQUI PMENT   0   0   0   0   0   0   52.05   00   05000   DENTAL RANGI LARY SERVI CES COST   0   0   0   0   0   0   53.00   05000   CURPATI ENT SERVI CE SCOST   0   0   0   0   0   0   54.00   05000   OTHER MICH LLARY SERVI CES COST   0   0   0   0   0   54.00   05000   OTHER ANGI LLARY SERVI CES COST   0   0   0   0   0   54.00   05000   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   55.00   05000   DENTAL HEALTH CLINI C   0   0   0   0   0   57.00   06000   CURPATI ENT SERVI CES COST   0   0   0   0   0   57.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   57.00   07100   MBBULANCE   0   0   0   0   0   0   57.00   07100   MBBULANCE   0   0   0   0   0   0   57.00   07100   MBBULANCE   0   0   0   0   0   0   57.00   07100   MBBULANCE   0   0   0   0   0   0   0   57.00   07100   MBULANCE   0   0   0   0   0   0   0   57.00   07100   07100				1				31.00
ANCILLARY SERVICE COST CENTERS  40. 00 04000 RADI 0LOGY 41. 00 04100 LABORATORY 0 0 0 0 855 0 855 41.  42. 00 04200 I NTRAVENOUS THERAPY 0 0 0 15, 871 0 15, 871 42.  43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 0 0 0 0 59, 519 0 59, 519 44. 40 04400 PHYSI CAL THERAPY 0 0 0 59, 519 0 59, 519 45. 00 04500 0CCUPATI ONAL THERAPY 0 0 0 0 54, 262 0 54, 262 46. 00 04500 SPEECH PATHOLOGY 0 0 0 0 32, 953 0 32, 953 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-					32. 00
40. 00	33.00		0	0	) c	0	0	33. 00
41. 00			_	1				
42. 00   04200   INTRAVENOUS THERAPY   0   0   15,871   0   15,871   42. 43. 00   04300   0XYGEN (I NHALATI1 ON) THERAPY   0   0   0   0   0   0   0   0   43. 44. 40. 00   04400   PHYSI CAL THERAPY   0   0   0   59,519   0   0   0   0   0   0   0   0   0			1	ł .	1			•
43. 00				1	1			•
44. 00		l i			13, 671			43. 00
45. 00				Ö	59, 519	ol ol		1
47. 00       04700       ELECTROCARDI OLOGY       0       0       0       0       0       47. 0         48. 00       04800       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       12, 969       0       12, 969       48. 0         49. 00       04900       DRUGS CHARGED TO PATI ENTS       0       0       20, 042       0       20, 042       49. 0         50. 00       05000       DENTAL CARE - TITLE XIX ONLY       0		1	0	0				ı
48. 00		1 1	0	0	32, 953	0	32, 953	1
49. 00       04900 DRUGS CHARGED TO PATIENTS       0       0       20, 042       0       20, 042       49.0         50. 00       05000 DENTAL CARE - TITLE XIX ONLY       0       0       0       0       0       0       0       0       50.0       50.0       50.0       50.0       50.0       0		1 1	0	_	1	0		47. 00
50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   50. 0   51. 0   05100   SUPPORT SURFACES   0   0   0   0   0   0   51. 0   52. 0   05200   COMPLEX MEDI CAL EQUI PMENT   0   0   0   0   0   0   52. 0   05201   OTHER ANCI LLARY SERVI CES COST   0   0   0   0   0   0   0   52. 0   05202   MEDI CAL SERVI CES   0   0   0   0   0   0   0   0   52. 0   05202   MEDI CAL SERVI CES   0   0   0   0   0   0   0   0   0			0	_				1
51. 00       05100 SUPPORT SURFACES       0       0       0       0       0       0       0       51.00       0					20,042			50.00
52. 00       05200 COMPLEX MEDI CAL EQUI PMENT       0       0       0       0       0       0       52.0         52. 01       05201 OTHER ANCI LLARY SERVI CES COST       0       0       0       0       0       0       0       0       52.0         52. 02       05202 MEDI CAL SERVI CES       0       0       0       0       0       0       0       0       0       0       52.0         60. 00       06000 CLI NI C       0								51.00
52. 02   05202   MEDI CAL SERVI CES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	Ö		ol ol	1	52.00
OUTPATI ENT SERVICE COST CENTERS   O	52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	) c	o	0	52. 01
60. 00   06000   CLINIC   0   0   0   0   0   0   0   0   0	52. 02		0	0	) <u> </u>	0	0	52. 02
61. 00	(0.00						0	/ 0 00
62. 00   06200   FOHC   063. 00   0   0   0   0   0   0   0   0   0				1			0	•
63. 00 06300 DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				,	,	,	0	62. 00
OTHER REI MBURSABLE COST CENTERS         O         <			0	0	) c	o	0	1
71. 00 07100 AMBULANCE 0 0 1, 351 0 1, 351 71.		OTHER REIMBURSABLE COST CENTERS						
			1	1				
73. 00   07300  CMHC   0  0  0  0  73.			9	1 ~			1,001	
74.00 07400 OTHER REIMBURSEMENT 0 0 0 0 74.0			1					•
SPECIAL PURPOSE COST CENTERS	74.00			<u> </u>	ή	)l Ol	0	74.00
	80. 00							80.00
81.00   08100   I NTEREST EXPENSE	81.00	08100 I NTEREST EXPENSE						81. 00
								82. 00
			0	0	) C	0		
			0					84.00
				49 585	2 328 317	7	_	84. 01 89. 00
NONREI MBURSABLE COST CENTERS	07.00			47,303	2,320,317	ı o	2, 320, 317	07.00
	90.00		0	0	51	0	51	90.00
			0	0	27	را		91. 00
			0	0	C	이		92.00
								93.00
							_	
						ol ol	_	1
99.00   Negative Cost Centers   0   0   0   0   99.0		1		O	) c	ol ol		99. 00
100. 00 TOTAL 0 49, 585 2, 328, 395 0 2, 328, 395 100.	100.00	D   TOTAL	0	49, 585	2, 328, 395	5  O	2, 328, 395	100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315132

				Т	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
		CAPITAL REI	ATED COSTS			07 107 202 1 11.	17 Gill
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			` ′	SALARI ES)		, ,	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4A	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	18, 581					1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		18, 581				2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	8, 945, 645		15 11/ 77/	3. 00
4. 00 5. 00	OO4OO   ADMINISTRATIVE & GENERAL   OO5OO   PLANT OPERATION, MAINT. & REPAIRS	1, 457 272	1, 457 272	773, 490 151, 822		15, 116, 774 768, 743	4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	336	336	92, 594		235, 259	6. 00
7.00	00700 HOUSEKEEPI NG	0	0	277, 287	C	393, 780	7. 00
8. 00 9. 00	OO8OO   DI ETARY   OO9OO   NURSI NG   ADMI NI STRATI ON	2, 693 256	2, 693 256	598, 812 879, 646		1, 413, 256 1, 242, 123	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0	9, 881		297, 202	
11. 00	01100 PHARMACY	0	O	0	C	73, 639	
12.00	01200 MEDI CAL RECORDS & LI BRARY	130	130	3, 575	C	20, 644	
13. 00 14. 00	01300   SOCIAL SERVICE   01400   NURSING AND ALLIED HEALTH EDUCATION	160	160	178, 204 0		237, 074	13. 00 14. 00
15. 00	01500 ACTI VI TES	355	355	238, 414	C	1	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14.550			T		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	11, 552 0	11, 552 0	4, 332, 997	C	7, 140, 207	30. 00 31. 00
32. 00	03200   CF/IID	0	o	0	C	1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	C	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	100	100	0	C	48, 940	40. 00
41. 00	04100 LABORATORY	100	0	0	_	1	41. 00
42.00	04200 I NTRAVENOUS THERAPY	100	100	0	C	252, 817	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	(01,004	C	0	43. 00
44. 00 45. 00	04400   PHYSI CAL THERAPY   04500   OCCUPATI ONAL THERAPY	380 350	380 350	681, 884 603, 094		895, 330 778, 330	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	240	240	123, 945		181, 420	
47. 00	04700 ELECTROCARDI OLOGY	0	O	0	C	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	100 100	100 100	0	C	12, 581 598, 208	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	100	0	0		0 390, 200	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0	C	0	51. 00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	C	0	52.00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST   05202 MEDICAL SERVICES	0	0	0		0	52. 01 52. 02
02. 02	OUTPATIENT SERVICE COST CENTERS		٩	3		,	02.02
60.00	06000 CLI NI C	0		0		1	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	C	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0	0	C	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS		ا		Τ		70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	C	0 111, 886	
73.00	07300  CMHC	0	o	0	C	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	C	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 84. 00	08300   HOSPI CE   08400   OTHER SPECI AL PURPOSE COST I	0	0	0		0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	C	o o	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	18, 581	18, 581	8, 945, 645	-2, 742, 269	15, 110, 296	89. 00
90. 00	NONREIMBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	Ι ο	O	0		4, 214	90. 00
	09100 BARBER AND BEAUTY SHOP	0	0	0	C	2, 264	
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	О	0	C	0	92. 00
93.00	09300 NONPAL D WORKERS	0	0	0	C	0	93.00
94. 00 95. 00	09400   PATIENTS LAUNDRY   09500   OTHER NONREI MBURSABLE COST		0	0			94. 00 95. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers	2 020 020	200 201	1 040 700		2.742.242	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2, 028, 089	300, 306	1, 948, 708		2, 742, 269	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	109. 148539	16. 161993	0. 217839		0. 181406	
104.00	Cost to be allocated (per Wkst. B, Part II)			0		182, 577	104. 00
	ligitii)	I	ı l		I	I	I

Health Financial Systems	CARE ONE AT TH	HE HI GHLANDS		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 47 am
	CAPITAL REI	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			SALARI ES)			
	1.00	2.00	3. 00	4A	4.00	
Unit cost multiplier (Wkst. B, Part			0.00000		0. 012078	105. 00

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315132 Period:

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/10/2024 11:47 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, LINEN SERVICE MAINT. & (PATIENT DAYS) (PATIENT DAYS) REPAIRS (SQUARE FEET) 9. 00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 16.852 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 336 37, 542 6.00 7.00 00700 HOUSEKEEPI NG 16, 516 7.00 8.00 00800 DI ETARY 2,693 2,693 112, 626 8.00 00900 NURSING ADMINISTRATION 9 00 256 C 256 37, 542 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 C 0 0 10.00 11.00 01100 PHARMACY 0 C 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 130 130 0 12.00 12.00 0 01300 SOCIAL SERVICE 0 13 00 Ω 13 00 160 160 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C C 0 0 14.00 01500 ACTI VI TES 15.00 355 355 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 11,552 37, 542 11, 552 112, 626 37, 542 30.00 03100 NURSING FACILITY 31.00 31.00 0 32.00 03200 | CF/IID 0 32.00 0 0 0 0 03300 OTHER LONG TERM CARE 33.00 0 Ω O 0 0 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40.00 100 100 0 0 41.00 04100 LABORATORY 0 0 41.00 0 C 0 04200 I NTRAVENOUS THERAPY 42 00 42 00 100 Ω 100 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 44.00 380 380 0 0 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 350 350 0 45.00 04600 SPEECH PATHOLOGY 46.00 240 240 0 46.00 04700 ELECTROCARDI OLOGY 47.00 47.00 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 100 100 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 100 49.00 49.00 100 0 50.00 0 C 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 0 52.01 C 0 52.02 05202 MEDICAL SERVICES O 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 06100 RURAL HEALTH CLINIC 0 C 0 61.00 0 Λ 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 O 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 71.00 0 o 73.00 07300 CMHC C 0 73.00 0 07400 OTHER REIMBURSEMENT 74.00 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 C 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 0 84 01 08401 OTHER SPECIAL PURPOSE COST LL 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 16,852 37, 542 16, 516 112, 626 37, 542 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 0 0 09100 BARBER AND BEAUTY SHOP 0 91 00 0 0 91 00 Ω 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 09300 NONPALD WORKERS 0 0 0 93.00 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 09500 OTHER NONREIMBURSABLE COST 0 0 0 95 00 95.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 908. 198 1, 890, 617 1, 488, 460 102. 00 102.00 296, 044 465, 214 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 53.892594 7.885675 28. 167474 16. 786683 39. 647861 103. 00 104.00 Cost to be allocated (per Wkst. B, 43, 369 45, 810 4, 756 362, 235 47, 814 104. 00 Part II) 1. 273614 105. 00 105 00 Unit cost multiplier (Wkst. B, Part 2 573522 1 220233 0.287963 3 216264 111)

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315132

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/10/2024 11:47 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND ALLI ED HEALTH SERVICES & (PATIENT DAYS) RECORDS & **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (PATIENT DAYS) (PATLENT DAYS) (ASSI GNED TIME) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 37, 542 10.00 11.00 01100 PHARMACY 37, 542 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 37, 542 12.00 01300 SOCIAL SERVICE 37, 542 13 00 0 13 00 C C14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 37, 542 37, 542 37, 542 37, 542 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 0 33 00 33.00 Ω 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 C 0 0 41.00 04100 LABORATORY 0 0 0 0 41.00 000000000000 04200 INTRAVENOUS THERAPY 0 42 00 42 00 Ω 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 0 0 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 49.00 0 0 0 50.00 0 50.00 0 05100 SUPPORT SURFACES 51.00 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 0 0 52.01 52.01 C 0 52.02 05202 MEDICAL SERVICES 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 Λ 0 0 Λ 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 63.00 0 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 71.00 0 o 73.00 07300 CMHC C 0 73.00 0 07400 OTHER REIMBURSEMENT 0 74.00 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 84.00 84 01 08401 OTHER SPECIAL PURPOSE COST II 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 37, 542 37, 542 37, 542 37, 542 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 91 00 0 0 91 00 Ω 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 09300 NONPALD WORKERS 0 0 0 93.00 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 0 95.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 351, 116 86, 998 35, 057 293, 211 0 102, 00 102.00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 9. 352618 2. 317351 0.933807 7.810213 0. 000000 103. 00 104.00 Cost to be allocated (per Wkst. B, 3,590 889 16, 911 23, 371 0 104.00 Part II) 105 00 Unit cost multiplier (Wkst. B, Part 0.095626 0.023680 0.450455 0 622529 0.000000 105.00 111)

In Lieu of Form CMS-2540-10 CARE ONE AT THE HIGHLANDS

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Ti me Prepared: 5/10/2024 11: 47 am Provi der No.: 315132

				5/10/2024 11:47 am
	·	OTHER GENERAL		
		SERVI CE		
	Cost Center Description	ACTI VI TES		
		(PATIENT DAYS)		
		15. 00	<u> </u>	
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3.00
4.00	00400 ADMINISTRATIVE & GENERAL			4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING			6.00
7. 00 8. 00	00800 DI ETARY			7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00	01100 PHARMACY			11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY			12. 00
13. 00	1 1			13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	1	37, 542		15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	37, 542		30.00
31.00	03100 NURSING FACILITY	0		31.00
32.00	03200   CF/IID	0		32.00
33.00	03300 OTHER LONG TERM CARE	0		33.00
	ANCILLARY SERVICE COST CENTERS			
40. 00	1	0		40. 00
41.00		0		41. 00
42.00	1	0		42. 00
43.00		0		43. 00
44. 00	1	0		44. 00
45. 00	1	0		45. 00
46. 00	04600 SPEECH PATHOLOGY	0		46.00
47. 00	1	0		47.00
48. 00	l l	0		48. 00
49. 00		0		49.00
50.00	1	0		50.00
51. 00 52. 00	05100   SUPPORT SURFACES   05200   COMPLEX MEDICAL EQUIPMENT	0		51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST			52. 00
	05202 MEDI CAL SERVI CES	0		52. 02
02.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		32. 32
60.00		0		60.00
61.00	06100 RURAL HEALTH CLINIC	0		61. 00
62.00	06200 FQHC			62.00
63.00	06300 DI ALYSI S	0		63.00
	OTHER REIMBURSABLE COST CENTERS			
70. 00		0		70.00
		0		71. 00
	07300 CMHC	0		73.00
74.00	07400 OTHER REIMBURSEMENT	0		74. 00
00.00	SPECIAL PURPOSE COST CENTERS			20.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE	1		80. 00 81. 00
81.00	08200 UTILIZATION REVIEW - SNF			82. 00
83. 00	08300 HOSPI CE	0		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0		84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	l ol		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	37, 542		89. 00
	NONREI MBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00	09300 NONPALD WORKERS	0		93. 00
94.00	09400 PATIENTS LAUNDRY	0		94.00
95. 00	09500 OTHER NONREI MBURSABLE COST	0		95. 00
98. 00	Cross Foot Adjustments			98. 00
99.00	Negative Cost Centers	400 505		99.00
102.00		428, 505		102. 00
102 0	Part I)	11 414014		102.00
103.00		11. 414016		103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	49, 585		104. 00
105.00		1. 320787		105. 00
	(mat. b, runt			1.55. 66
				•

Health Financial Systems	CARE ONE AT THE HIGHLANDS	In Lieu of Form CMS-2540-10
DATIO OF COST TO CHARGES FOR ANCI	LARY AND OUTDATIENT COST CENTERS   Drovi dor No : 215122	Pariod: Warkshoot C

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:47 am Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 18 col. 2 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 66, 024 91, 023 0. 725355 40.00 04100 LABORATORY 177, 018 0. 472562 41.00 83, 652 41.00 42.00 04200 I NTRAVENOUS THERAPY 306, 886 652, 950 0.469999 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 088, 931 2, 470, 168 0.440833 44.00 04500 OCCUPATIONAL THERAPY 45.00 948, 245 2, 596, 339 0. 365224 45.00 04600 SPEECH PATHOLOGY 826, 587 46.00 234, 025 0.283122 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 23, 069 124 186.040323 48.00 04900 DRUGS CHARGED TO PATIENTS 1, 591, 515 0.449215 49.00 49.00 714, 933 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 0 52.01 05202 MEDICAL SERVICES 52.02 0 0.000000 52.02 OUTPATIENT SERVICE COST CENTERS 0 0. 000000 60.00 06000 CLI NI C 0 60.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62. 00 06200 FQHC 62.00

0.000000

0. 472563 71. 00

279, 715

8, 685, 439

132, 183

3, 597, 948

63.00

100.00

63. 00 06300 DI ALYSI S

100.00

71. 00 07100 AMBULANCE

Total

Health Financial Systems	CARE ONE AT TH	HE HI GHLANDS			u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315132	Peri od: From 01/01/2023 To 12/31/2023	5/10/2024 11:	epared: 47 am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges (Fr. Wkst. C Column 3)			x col. 2)	x col. 3)	
	1.00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST			<u>.</u>		
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	0. 725355	15, 091		0 10, 946	0	40. 00
41. 00   04100   LABORATORY	0. 472562	35, 003		0 16, 541	0	
42. 00   04200   I NTRAVENOUS THERAPY	0. 469999	38, 440		0 18, 067	0	
43. 00   04300   0XYGEN (INHALATION) THERAPY	0. 000000	0		0	0	1
44. 00   04400   PHYSI CAL THERAPY	0. 440833	1, 123, 114		0 495, 106	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 365224	1, 187, 705		0 433, 778	0	
46. 00 04600 SPEECH PATHOLOGY	0. 283122	403, 542		0 114, 252	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0	0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	186. 040323	124		0 23, 069	0	
49.00 04900 DRUGS CHARGED TO PATIENTS	0. 449215	159, 982		0 71, 866	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00   05100   SUPPORT SURFACES	0. 000000	0		0	0	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000	0		0	0	
52. 01 05201 OTHER ANCILLARY SERVICES COST	0. 000000	0		0	0	1
52. 02   05202   MEDI CAL   SERVI CES	0. 000000	0		0 0	0	52. 02
OUTPATIENT SERVICE COST CENTERS						
60. 00   06000   CLI NI C	0. 000000	0		0	0	
61. 00   06100   RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC						62.00
63. 00   06300   DI ALYSI S	0.000000	0		0	0	
71. 00   07100   AMBULANCE (2)	0. 472563	2 0/2 224		1 102 (05	0	
100.00 Total (Sum of lines 40 - 71)		2, 963, 001		0 1, 183, 625	0	100.00

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

CARE ONE AT TH	IF HIGHLANDS		Inlie	u of Form CMS-1	2540-10
OTHE ONE THE			Peri od: From 01/01/2023	Worksheet D Parts II-III Date/Time Pre 5/10/2024 11:	pared:
	Ti tl	e XVIII	Skilled Nursing Facility	PPS	
				1. 00	
rds, or the PS&	kR)		ĺ	0. 449215 688 309	1. 00 2. 00 3. 00
	(From Wkst. B, Part I, Col. 14)	Costs to Tota Costs - Part (Col. 2 / Col 1)	Cost (From Mkst. D Part II I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
1.00	2. 00	3. 00	4. 00	5. 00	
FOR NURSING &	ALLIED HEALIH				1
66, 024 83, 652 306, 886 0 1, 088, 931 948, 245 234, 025 0 23, 069 714, 933 0 0	0 0 0 0 0 0 0 0 0 0	0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000	16, 541 18, 067 100 00 00 495, 106 100 433, 778 114, 252 100 00 00 23, 069 100 00 00 00 00 00 00 00 00 0	0 0 0 0 0 0 0 0 0 0	41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00 51. 00 52. 01 52. 02
	1.00 FOR NURSING & 1,088,931 948,245 234,069 714,933	Titl  Set to charges (From Workshee) ords, or the PS&R)  XVIII, PPS providers, transfer  Total Cost (From Wkst. B, Part I, Col. 14)  1.00 2.00  FOR NURSING & ALLIED HEALTH  66,024 83,652 00 306,886 00 1,088,931 00 1,088,931 00 23,069 714,933 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Provider No.: 315132	Provider No.: 315132	Provider No.: 315132

	Financial Systems	CARE ONE AT THE H			u of Form CMS-2	
COMPUT	ATION OF INPATIENT ROUTINE COSTS		Provi der No.: 315132	Peri od: From 01/01/2023 To 12/31/2023		pared:
			Title XVIII	Skilled Nursing Facility	PPS	
					1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COS	TS			1.00	
	I NPATI ENT DAYS					1
1.00	Inpatient days including private room days				37, 542	1.00
2. 00	Private room days				0	
3. 00	Inpatient days including private room days	• •	9		8, 924	
. 00 5. 00	Medically necessary private room days appli Total general inpatient routine service cos		1		0 14, 253, 442	4. 0 5. 0
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	<u> </u>			14, 200, 442	3.0
. 00	General inpatient routine service charges				19, 236, 625	6.0
. 00	General inpatient routine service cost/char	ge ratio (Line 5 di	vided by line 6)		0. 740953	
. 00	Enter private room charges from your record				0	8.0
. 00	Average private room per diem charge (Priva	te room charges line	e 8 divided by private	room days, line	0.00	9. 0
0. 00						
1. 00	Enter semi-private room charges from your r Average semi-private room per diem charge		charges line 10 divide	d hy	0 0. 00	10. 0 11. 0
1.00	semi -pri vate room days)	(Seiii -pi i vate 100iii c	charges fille 10, divide	d by	0.00	11.0
2. 00	Average per diem private room charge differ	ential (Line 9 minus	s line 11)		0.00	12. 0
3. 00	Average per diem private room cost differen	tial (Line 7 times I	ine 12)		0. 00	13. 0
4. 00	Private room cost differential adjustment (				0	14. 0
5. 00	General inpatient routine service cost net PROGRAM INPATIENT ROUTINE SERVICE COSTS	of private room cost	differential (Line 5	minus line 14)	14, 253, 442	15.0
6. 00	Adjusted general inpatient service cost per	diem (line 15 divi	ded by Line 1)		379. 67	16.0
7. 00	Program routine service cost (Line 3 times	•	ded by Title 1)		3, 388, 175	
8. 00	Medically necessary private room cost appli		ine 4 times line 13)		0	1
9. 00	Total program general inpatient routine ser	•	. ,		3, 388, 175	
0. 00	Capital related cost allocated to inpatient		sts (From Wkst. B, Par	t II column 18,	2, 117, 087	20. 0
1. 00	line 30 for SNF; line 31 for NF, or line 32				56. 39	21.0
2. 00	Per diem capital related costs (Line 20 di Program capital related cost (Line 3 times				56. 39 503. 224	
3. 00	Inpatient routine service cost (Line 19 mi				2, 884, 951	
4. 00	Aggregate charges to beneficiaries for exce	,	vider records)		0	1
5. 00	Total program routine service costs for com	parison to the cost	limitation (Line 23 mi	nus line 24)	2, 884, 951	25. 0
6. 00	Enter the per diem limitation (1)					26. 0
7. 00	Inpatient routine service cost limitation (					27. 0
8. 00	Reimbursable inpatient routine service cost (Transfer to Worksheet E, Part II, line 4)	` '	e resser of line 25 or	iine 2/)		28. 0
1)  :	nes 26 and 27 are not applicable for title A	,	nd for +: +1 o V and or +	:: +1 a VIV		1

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	37, 542	1.00
2.00	Program inpatient days (see instructions)	8, 924	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. 237707	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems CARE ONE AT THE ATTION OF INPATIENT ROUTINE COSTS	Provi der No.: 315132	In Lie Period: From 01/01/2023 To 12/31/2023		pare
		Title XIX	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
00	Inpatient days including private room days			37, 542	] 1
00	Private room days			0	
00	Inpatient days including private room days applicable to the			15, 443	
00	Medically necessary private room days applicable to the Prog	gram		0	
00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			14, 253, 442	5
00	General inpatient routine service charges			19, 236, 625	1 6
00	General inpatient routine service charges  [General inpatient routine service cost/charge ratio] (Line 5)	divided by line 6)		0. 740953	
0	Enter private room charges from your records	ar vided by Time 6)		0.710700	1
0	Average private room per diem charge (Private room charges line 8 divided by private room days, line				9
	2)				
00	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private room	om charges line 10, divide	ed by	0.00	11
	semi-private room days)			'	
00	Average per diem private room charge differential (Line 9 mi			0.00	
00	Average per diem private room cost differential (Line 7 time	,		0.00	
00	Private room cost differential adjustment (Line 2 times line General inpatient routine service cost net of private room of	,	minus Lino 14)	14, 253, 442	
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	III Tius TTTle 14)	14, 233, 442	1 10
00	Adjusted general inpatient service cost per diem (Line 15 c	livided by line 1)		379. 67	16
00	Program routine service cost (Line 3 times line 16)			5, 863, 244	
00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	
00	Total program general inpatient routine service cost (Line	17 plus line 18)		5, 863, 244	19
00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	2, 117, 087	20
00	Per diem capital related costs (Line 20 divided by line 1)			56. 39	
00	Program capital related cost (Line 3 times line 21)			870, 831	
00	Inpatient routine service cost (Line 19 minus line 22)			4, 992, 413	
00	Aggregate charges to beneficiaries for excess costs (From p			0	
00	Total program routine service costs for comparison to the co	ost limitation (Line 23 mi	nus line 24)	4, 992, 413	
00	Enter the per diem limitation (1)	nor diam limitation !!	2() (1)	0.00	
. 00	Inpatient routine service cost limitation (Line 3 times the Reimbursable inpatient routine service costs (Line 22 plus	•	, , ,	0 5, 863, 244	1 -
. 00		THE LESSEL OF TIME 75 OF	TITLE Z/J	J. 803, 244'	ıΖċ

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH Total SNF inpatient days

Program nursing & allied health costs for pass-through. (line 3 times line 4)

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)

1.00

37, 542

15, 443

0. 411353

0

2. 00 3. 00

4.00

1.00

2.00

4.00

5.00

Health Financial Systems	CARE ONE AT THE HI	GHLANDS	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315132	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:47 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		1.00	
1.00	Inpatient PPS amount (See Instructions)			6, 738, 721	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	
3.00	Subtotal (Sum of lines 1 and 2)	3		6, 738, 721	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			936, 800	5. 00
6.00	Allowable bad debts (From your records)			383, 044	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		185, 333	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			248, 979	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)			6, 050, 900	11. 00
12.00	Interim payments (See instructions)			5, 984, 668	12.00
13.00	Tentati ve 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			30, 290	
14. 75	Sequestration for non-claims based amounts (see instructions)				14. 75
14. 99	Sequestration amount (see instructions)			116, 038	
15. 00	Balance due provider/program (see Instructions)			-85, 076	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - I	TILE XVIII ONLY	0	47.00
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			309	
19.00	Total reasonable costs (Sum of lines 17 and 18)			309	
20.00	Medicare Part B ancillary charges (See instructions)			688 309	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			309	
22. 00 23. 00	Primary payor amounts Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 00	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
24. 01	Adjusted reimbursable bad debts (see instructions)	Ctions)		0	24. 01
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			309	
26. 00	Interim payments (See instructions)			339	
27. 00	Tentative adjustment			0	
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	
28. 55	Demonstration payment adjustment amount after sequestration			0	
28. 99	Sequestration amount (see instructions)			6	28. 99
29. 00	Balance due provider/program (see instructions)			-36	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115.2	-30	
55. 50	1	00 . 0.00 2,		٥١	, 50. 00

WOLKSTEE

PROVIDERS FOR SERVICES RENDERED

PROVIDER NO.: 315132 Pet 102:
From 01/01/2023
To 12/31/2023 Date/Til

Title XVIII Skilled Nursing PPS

To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 47 am

PPS

		11 (1	e Aviii	Facility	FFS	
		Inpatien	t Part A		t B	
		·				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		5, 655, 593		339	1. 00
2.00	Interim payments payable on individual bills, either		356, 754		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	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	06/01/2023	27, 679		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0	3. 53 3. 54
3. 54 3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-27, 679			3. 54 3. 99
3. 99	- 3.98)		-21,019		ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 984, 668		339	4. 00
1. 00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		0, 701, 000		007	1. 00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider				_	
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03	Provider to Program		0		0	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		o		0	5. 51
5. 52			Ö		ا	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		Ö		Ö	5. 99
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		0		0	6. 01
6.02	PROVI DER TO PROGRAM		85, 076		36	6. 02
7.00	Total Medicare program liability (see instructions)		5, 899, 592		303	7. 00
			Contract	or Name	Contractor	
			1	00	Number	
8. 00	Name of Contractor		1. !	00	2. 00	8. 00
0.00	INAME OF COULT ACTO		l .		I	0.00

<sup>(1)</sup> 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.

Health Financial Systems CARE ONE AT THE BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column onl y)

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 47 am |

oni y)		_		12/01/2020	5/10/2024 11:	
		General Fund	Specific	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	Assets					
	CURRENT ASSETS	7, 00,	Г .	1		
1.00	Cash on hand and in banks	76, 084	0		0	
2.00	Temporary investments Notes receivable				0	
4. 00	Accounts receivable	2, 309, 949		0	0	
5. 00	Other recei vabl es	0	i c	0	Ö	
6.00	Less: allowances for uncollectible notes and accounts	-565, 929	C	0	0	6.00
	recei vabl e					
7.00	Inventory	0	0	0	0	
8. 00 9. 00	Prepaid expenses	29, 895 267, 146		0	0	
10.00	Other current assets Due from other funds	207, 140	i c	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 117, 145	1	_		
	FIXED ASSETS					
12.00	Land	324, 450	C	0	0	
13.00	Land improvements	8, 055	C	_	0	
14.00	Less: Accumulated depreciation	-789	C	_	0	
15.00	Buildings	6, 415, 161	C	0	0	
16. 00 17. 00	Less Accumulated depreciation Leasehold improvements	-5, 166, 024	i d	0	0	
18. 00	Less: Accumulated Amortization	0		_	0	
19. 00	Fi xed equipment	905, 433	1	_	0	
20.00	Less: Accumulated depreciation	-871, 434	C	0	0	
21. 00	Automobiles and trucks	0	C	0	0	21.00
22. 00	Less: Accumulated depreciation	0	C	0	0	
23. 00	Major movable equipment	2, 935, 931	C	0	0	
24. 00	Less: Accumulated depreciation	-2, 591, 453	C	0	0	
25. 00 26. 00	Minor equipment - Depreciable Minor equipment nondepreciable	0	i d	0	0	
27. 00	Other fixed assets	635, 474		_	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 594, 804	ĺ	_	Ö	
	OTHER ASSETS	,				
29. 00	Investments	0	C	0	0	29. 00
30.00	Deposits on Leases	0	C	0	0	
31.00	Due from owners/officers	0	0	0	0	
32. 00 33. 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 434, 002 1, 434, 002			0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	6, 145, 951		_		
0 00	Liabilities and Fund Balances	0,110,701		1		1 0 00
	CURRENT LI ABI LI TI ES					]
35.00	Accounts payable	1, 202, 647	C		0	
36. 00	Salaries, wages, and fees payable	77, 337	C			
37. 00	Payroll taxes payable (Chart tarm)	-7, 919	0	0	0	
38. 00 39. 00	Notes & Loans payable (Short term) Deferred income			0	0	
40.00	Accel erated payments	0		,		40.00
41. 00	Due to other funds	17, 260	l c	0	0	
42.00	Other current liabilities	1, 554, 183		0		1
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 843, 508	C	0	0	43.00
	LONG TERM LIABILITIES					1
44.00	Mortgage payable	19, 189, 672	C		0	•
45.00	Notes payable		0	0	0	
46. 00 47. 00	Unsecured Loans Loans from owners:				0	
48. 00	Other long term liabilities	-25, 279, 319	1	0	0	
49. 00	OTHER (SPECIFY)	0	ĺ	Ö	Ö	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-6, 089, 647			0	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-3, 246, 139	C	0	0	51.00
	CAPI TAL ACCOUNTS	_				
52. 00	General fund balance	9, 392, 090				52.00
53. 00 54. 00	Specific purpose fund		C			53.00
	Donor greated andowment fund belence meetrict			ı ()		54.00
	Donor created - endowment fund balance - restricted			n		55 00
55. 00	Donor created - endowment fund balance - unrestricted			0		
	· ·			0	0	56.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0	0	56. 00 57. 00
55. 00 56. 00 57. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion			0	0	56. 00 57. 00 58. 00
55. 00 56. 00 57. 00 58. 00 59. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	9, 392, 090	C	0	0	58. 00 59. 00
55. 00 56. 00 57. 00 58. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	9, 392, 090 6, 145, 951	C	00000	0	56. 00 57. 00 58. 00 59. 00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES CARE ONE AT THE HIGHLANDS In Lieu of Form CMS-2540-10

Provi der No.: 315132

					10 12/31/2023	5/10/2024 11:	
		General	Fund	Special P	urpose Fund	Endowment Fund	77 (311)
	,	1.00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		11, 259, 888		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-1, 867, 800				2. 00
3.00	Total (sum of line 1 and line 2)		9, 392, 088		0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00	ROUNDI NG	2			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 5 - 9)		2		0		10. 00
11. 00	Subtotal (line 3 plus line 10)		9, 392, 090		0		11. 00
12.00	Deductions (debit adjustments)						12. 00
13. 00		0			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		9, 392, 090		0		19. 00
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
		Lildowillett Turid	Frant	Tuliu	-		
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)						
							2.00
3.00	Total (sum of line 1 and line 2)	0			0		2. 00 3. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments)	0			0		
	1 ,	0	0		0		3. 00
4.00	Additions (credit adjustments)	o	0		0		3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments)	0	0 0 0		0		3. 00 4. 00 5. 00
4.00 5.00 6.00 7.00 8.00	Additions (credit adjustments)	0	0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
4. 00 5. 00 6. 00 7. 00	Additions (credit adjustments)	0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00
4.00 5.00 6.00 7.00 8.00	Additions (credit adjustments)	0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)		0 0 0 0				3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9)	0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0		3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0		3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)  Total deductions (sum of lines 13 - 17)	0 0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Additions (credit adjustments)  ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)  Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0 0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Additions (credit adjustments) ROUNDING  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)  Total deductions (sum of lines 13 - 17)	0 0	0 0 0 0 0		0		3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

Health Financial Systems	CARE ONE AT THE HIGHLAND	IDS		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSE	S Provi	vider N	No.: 315132	From 01/01/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/10/2024 11:	pared:
Cost Center Description			Inpatient	Outpati ent	Total	
			1. 00	2. 00	3. 00	

STATEN	MENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider		From 01/01/2023 To 12/31/2023		oared: 47 am
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		19, 236, 62	5	19, 236, 625	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)		19, 236, 62	5	19, 236, 625	5.00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		8, 685, 43	9 0	8, 685, 439	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	HOSPI CE			0	0	12.00
13.00	OTHER (SPECIFY)			0	0	13.00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	27, 922, 06	4 0	27, 922, 064	14.00
	Worksheet G-3, Line 1)					
	Cost Center Description					
	DADT III ODEDATING EVENING			1. 00	2. 00	
4 00	PART II - OPERATING EXPENSES				40.007.000	1 00
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				19, 086, 383	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 8. 00	Total Additions (Sum of lines 2 - 7)			0	0	7. 00 8. 00
9. 00	Deduct (Specify)			0	U	9. 00
10.00	Deduct (Specify)			0		10. 00
11. 00						11. 00
12. 00						12.00
13. 00						13. 00
14. 00	Total Deductions (Sum of lines 9 - 13)				0	14. 00
	Total Operating Expenses (Sum of Lines 1 and 8, minus line 14)				19, 086, 383	
13.00	Trotal operating Expenses (Sum of Times I and 0, Illinus Time 14)			1	17,000,303	13.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315132	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	,		27, 922, 064	
2.00	Less: contractual allowances and discounts on patients account	S		11, 321, 264	
3.00	Net patient revenues (Line 1 minus line 2)			16, 600, 800	
4.00	Less: total operating expenses (From Worksheet G-2, Part II, I	ine 15)		19, 086, 383	
5.00	Net income from service to patients (Line 3 minus 4)			-2, 485, 583	5. 00
	Other income:				
6. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			611, 948	
8. 00	Revenues from communications (Telephone and Internet service)			0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
12. 00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other th	nan patients		0	10.00
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	
	Rental of vending machines			0	
22. 00	Rental of skilled nursing space			0	
23.00	Governmental appropriations			0	
24.00	BARBER AND BEAUTY			1, 907	24. 00
24. 01	OTHER REV			3, 086	24. 01
24. 02	OTHER INCOME			842	
24. 50	COVI D-19 PHE Fundi ng			0	
25.00	Total other income (Sum of lines 6 - 24)			617, 783	25. 00
26.00	Total (Line 5 plus line 25)			-1, 867, 800	26. 00
27. 00	Other expenses (specify)			0	
28.00				0	28. 00

28. 00 29. 00

0 30.00 -1, 867, 800 31.00

29.00

30.00 Total other expenses (Sum of lines 27 - 29)
31.00 Net income (or loss) for the period (Line 26 minus line 30)