This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0463

Expires: 12/31/2021

			Exp11 03. 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315092	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:36 am

24 II: 36 am				
me: 11:36 am				
eport				
7.[N] First Cost Report for this Provider CCN				
eopened				
ow, 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 HOLMDEL (315092) 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	-98, 464	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-98, 464	0	0	100.00
Tho ob	and amounts represent "due to" or "due from" the applicable	program for th	a alamant of t	ha abaya campl	ov indicated	

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 HOLMDEL In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315092 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:36 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 188 HIGHWAY 34 PO Box: 1.00 2.00 City: HOLMDEL State: NJ Zi p Code: 07733 2.00 3.00 County: MONMOUTH 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 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT HOLMDEL 315092 01/01/1968 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 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) 12/31/2023 01/01/2023 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? 17.00 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 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. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 308, 806 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 308, 806 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 N 26,00 (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 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 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 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 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 malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 38.00 Υ 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 65, 958 41 00

Heal th	Financial Systems	CARE ONE AT HOL	MDEL	In Lie	u of Form CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31509		Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2023		
				To 12/31/2023		
					5/10/2024 11:	36 am
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative	and General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting	schedule listing cos	t centers and		
	amounts.		G			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Ch	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	s 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 Contra	actor's Number: 1200)1	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:	I			46.00
	City: FORT LEE	State: NJ	Zi p Co	ode: 0702	24	47. 00
	J · ·	12.2.2.	Z. P = 0			

Heal th	Financial Systems	CARE ONE AT HOL	MDEL		In Lie	eu of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
					Y/N	5/10/2024 11: Date	30 alli
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	1, "Y" fo	r Yes or "N" 1	1.00 for No. For all	2.00 the date	
1. 00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date 3, "V" for voluntary or "I" for involuntary.			N	2.00	0.00	2.00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider on I, or members of the	es, drug its e board	Y			3.00
				Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports		5			0.00	
4. 00	Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" t te copy or enter da	for te	Y	A		4. 00
5.00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2:	Is the	provider the	N	N	6. 00
7. 00 8. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri	ng the cost reportin		for Nursing	N N		7. 00 8. 00
	School and/or Allied Health Program? (Y/N) s	ee Thstructions.				Y/N 1.00	
9. 00 10. 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				t reporting	Y N	9. 00
11. 00	If line 9 is "Y", are patient deductibles an Bed Complement	d/or coi nsurance wai	ved? If "	Y", see instr	uctions.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting peri	od? If "Y			N	12. 00
		Description	n	Y/N	rt A Date	Part B Y/N	
	PS&R Data	0		1. 00	2. 00	3. 00	
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			Y	03/19/2024	Y	13.00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N		N	14.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			N		N	17. 00
	Describe the other adjustments:						

Heal th	Financial Systems	CARE ONE AT	HOL	MDEL			In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILIT X REIMBURSEMENT QUESTIONNAIRE	Y HEALTH CARE		Provi der	No.: 315092		eriod: fom 01/01/2023 o 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/10/2024 11:	pared:
				1.	00		2. (00	-
	Cost Report Preparer Contact Information								
19. 00	Enter the first name, last name and the title, held by the cost report preparer in columns 1, respectively.		CHARL	ES		F	REED		19. 00
20. 00	Enter the employer/company name of the cost repreparer.	eport [EXECL	JCARE ASSO	CLATES				20. 00
21. 00	Enter the telephone number and email address or report preparer in columns 1 and 2, respective		(609)	738-3200		C	CRWASSC@NETSCAP	PE. NET	21. 00

Health Financial Systems CARE ONE AT HOLMDEL In Lieu of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

CARE ONE AT HOLMDEL
In Lieu of Form CMS-2540-10
Provider No.: 315092
From 01/01/2023
Part II

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023		
		Part B Date 4.00			67.107.202.1.11100	<u> </u>
	PS&R Data					
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/19/2024				13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		VI CE-PRESI DENT			19. 00
20. 00	Enter the employer/company name of the cost r preparer.	report				20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21. 00

In Lieu of Form CMS-2540-10 CARE ONE AT HOLMDEL Provi der No.: 315092

 Heal th Financial
 Systems
 CARE ONE AT

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

						5/10/2024 11:	
				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	130	47, 450		13, 780	8, 197	1.00
2. 00 3. 00	NURSING FACILITY	0	0	0		0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		0	0	0	0	4. 00
5. 00	Other Long Term Care	0	0		Š		5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	130 Inpatient D	47, 450	0	13, 780 Di scharges	8, 197	8. 00
		Impatrent	, ay3, vi 3i t3		Di Schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CIVILLED MUDCING FACILLEY	6.00	7. 00	8.00	9. 00	10.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	10, 608	32, 585 0	0	408	38 0	1. 00 2. 00
3. 00	I CF/IID	0	0	0		0	3. 00
4. 00	HOME HEALTH AGENCY COST	0	0			_	4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	10, 608	32, 585	0	408	0 38	7. 00 8. 00
0.00	Trotal (Sall St Tries 17)	Di sch		Aver	age Length of		0.00
	C	0+1	T-+-1	T: +1 - 1/	T: +1 - \/\/ 1.1	T: +1 - VIV	
	Component	0ther 11.00	Total 12. 00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
1. 00	SKILLED NURSING FACILITY	293	739			215. 71	1. 00
2.00	NURSING FACILITY	0	0	0.00		0. 00	2. 00
3. 00	ICF/IID	0	0			0. 00	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care		0				4. 00 5. 00
6. 00	SNF-Based CMHC		U				6. 00
7. 00	HOSPI CE	0	0	0.00	0. 00	0. 00	7. 00
8. 00	Total (Sum of lines 1-7)	293	739			215. 71	8. 00
		Average Length of Stay		Admi s	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	T	16.00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	44. 09	0			284	1.00
2. 00 3. 00	NURSING FACILITY	0. 00 0. 00	0		0	0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			Ö	o l	4. 00
5.00	Other Long Term Care	0.00				0	5. 00
6. 00	SNF-Based CMHC		_	_	_	_	6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0. 00 44. 09	0	0 448	0 16	0 284	7. 00 8. 00
0.00	Total (Sull of Tries 17)	Admi ssi ons	Full Time		10	204	0.00
	Component	Total	Employees on	Nonnai d			
	Component	Total	Employees on Payroll	Nonpai d Workers			
		21. 00	22. 00	23. 00			
1.00	SKILLED NURSING FACILITY	748	111. 42				1.00
2.00	NURSING FACILITY	0	0.00				2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST		0. 00 0. 00				3. 00 4. 00
5. 00	Other Long Term Care	0	0.00				5. 00
6.00	SNF-Based CMHC		0. 00				6. 00
7. 00	HOSPI CE	0	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	748	111. 42	0.00			8. 00

				T	12/31/2023	Date/Time Prep 5/10/2024 11:3	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		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 II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	7, 798, 704	0	7, 798, 704	231, 749. 00	33. 65	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	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	7, 798, 704	0	7, 798, 704	231, 749. 00	33. 65	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00		9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	7, 798, 704	0	7, 798, 704	231, 749. 00	33. 65	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	264, 459	0	264, 459	·		
	Contract Labor: Physician services-Part A	0	0	0	0. 00		
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 251, 178	0	1, 251, 178			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20. 00		0	0	0			20.00
21. 00		0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 251, 178	0	1, 251, 178			22. 00
	instructions)		l				

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT HOLMDEL

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315092

				1	0 12/31/2023	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.		
				,	3		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	643, 875	0	643, 875	15, 166. 00	42. 46	2. 00
3.00	Plant Operation, Maintenance & Repairs	124, 751	0	124, 751	3, 999. 00	31. 20	3. 00
4.00	Laundry & Li nen Servi ce	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	234, 730	0	234, 730	11, 589. 00	20. 25	5. 00
6.00	Di etary	592, 637	0	592, 637	24, 343. 00	24. 35	6. 00
7.00	Nursing Administration	826, 304	0	826, 304	18, 517. 00	44. 62	7. 00
8.00	Central Services and Supply	37, 773	0	37, 773	2, 182. 00	17. 31	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	40, 635	0	40, 635	1, 246. 00	32. 61	10. 00
11. 00	Soci al Servi ce	84, 038	0	84, 038	1, 915. 00	43. 88	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	196, 266	0	196, 266	9, 380. 00	20. 92	13. 00
14.00	Total (sum lines 1 thru 13)	2, 781, 009	0	2, 781, 009	88, 337. 00	31. 48	14. 00

Health Financial Systems	CARE ONE AT HOLMDEL	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315092	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 5/10/2024 11:	pared:
			Amount	

	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		İ
	RETI REMENT COST		İ
1.00	401K Employer Contributions	40, 651	1.00
2.00	Tax Shel tered 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	l ő	7. 00
7.00	HEALTH AND INSURANCE COST		7.00
8.00	Heal th Insurance (Purchased or Self Funded)	478, 819	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, 737	
12. 00		1, 737	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14. 00		0	14.00
	Workers' Compensation Insurance	76, 723	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	70, 723	16. 00
16.00	Non cumulative portion)	0	10.00
	TAXES		
17 00	FICA-Employers Portion Only	560, 163	17 00
	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19.00
	State or Federal Unemployment Taxes	93, 085	
20.00	OTHER	73,003	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22.00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 - 23)	1, 251, 178	
24.00	Total wage kerated cost (suil of fines 1 - 23)	1, 251, 176 Amount	24.00
		Reported	
		1. 00	
	Part B - Other than Core Related Cost	1.00	
25 00	OTHER WAGE RELATED COST	0	25. 00
20.00	19ee	1	0.00

				Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:	oared: 36 am
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	30 a
		Reported		Salaries (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				<u> </u>	3	,	
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	595, 027	101, 729				1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 403, 669	239, 978				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 637, 527	279, 960	1, 917, 487	65, 828. 00	29. 13	3.00
4 00	Assi stants/Ai des	0 (0(000	.047	4 057 000	440 040 00	20.00	4 00
4.00	Total Nursing (sum of lines 1 through 3)	3, 636, 223	621, 667		i i		4.00
5.00	Physical Therapists	555, 102	94, 903	650, 005	i i		5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
7.00	Physical Therapy Aides	0	0	0	0.00	1	7. 00
8.00	Occupational Therapists	608, 648	104, 057				8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00		10.00
11.00	Speech Therapists	105, 477	18, 033	123, 510			
12.00	Respiratory Therapists	0	0	0	0.00		12.00
13. 00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
14.00	Nursing Occupations	45 (00		45 (00	507.00	00.04	14. 00
14. 00	Registered Nurses (RNs)	45, 609		45, 609			14.00
15. 00	Li censed Practical Nurses (LPNs)	124, 272		124, 272	i i		16. 00
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	61, 510		61, 510	1, 025. 00	60. 01	16.00
17. 00	Total Nursing (sum of lines 14 through 16)	231, 391		231, 391	3, 211. 00	72.06	17. 00
18. 00	Physical Therapists	201, 071		201,071	0.00		18. 00
19. 00	Physical Therapy Assistants			1 0	0.00		19. 00
20. 00	Physical Therapy Aides			1 0	0.00		20.00
21. 00	Occupational Therapists	0		0	0.00		21. 00
22. 00	Occupational Therapy Assistants	0		0	0.00		22. 00
23. 00	Occupational Therapy Aides			١	0.00		23. 00
24. 00	Speech Therapists	4, 400		4, 400			
25. 00	Respiratory Therapists	28, 668		28, 668			25. 00
26. 00	Other Medical Staff	0		0	0.00		
	1	١			3.00	, 3, 66	

Peri od: Worksheet S-7
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/10/2024 11:36 am

	10	12/31/2023	5/10/2024 11:	36 am
		Group	Days	
		1. 00	2. 00	
1.00		RUX		1.00
2. 00 3. 00		RUL RVX		2. 00 3. 00
4.00		RVL		4. 00
5.00		RHX		5. 00
6.00		RHL		6.00
7.00		RMX		7. 00
8.00		RML		8. 00
9.00		RLX		9. 00
10. 00		RUC		10.00
11.00		RUB		11.00
12.00		RUA		12. 00 13. 00
13. 00 14. 00		RVC RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21.00
22. 00		RLB		22. 00
23. 00 24. 00		RLA ES3		23. 00 24. 00
25. 00		ES2		25. 00
26. 00		ES1		26.00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31.00
32.00		HC1		32.00
33. 00 34. 00		HB2		33.00
35. 00		HB1 LE2		34. 00 35. 00
36.00		LE1		36.00
37. 00		LD2		37. 00
38. 00		LD1		38. 00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41.00		LB2		41. 00
42.00		LB1		42.00
43. 00 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		CB2		49. 00
50. 00		CB1		50.00
51.00		CA2		51.00
52. 00 53. 00		CA1 SE3		52. 00 53. 00
53. 00 54. 00		SE3 SE2		54.00
55. 00		SE1		55. 00
56. 00		SSC		56.00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		IB2		59. 00
60.00		I B1		60.00
61.00		I A2		61.00
62. 00 63. 00		I A1 BB2		62. 00 63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66.00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69. 00		PD2		69. 00
70.00		PD1		70.00
71.00		PC2		71.00
72. 00 73. 00		PC1 PB2		72.00
73. 00		PB1		73. 00 74. 00
75. 00		PA2		75. 00
			i	,

Health Financial Systems	CARE ONE AT HOLM	MDEL		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315092	Peri od:	Worksheet S-7	7
				From 01/01/2023 To 12/31/2023	Date/Time Pre 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 N payments beginning 10/01/2003. Congress expexpenses. For lines 101 through 106: Enter i column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" 1 with direct patient care and related expense (See instructions)	ected this increase t n column 1 the amoun or each category to t For yes or "N" for no	o be used t of the otal SNF if the s	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related Iter in Part I, Issociated	
101.00 Staffing						101. 00
102. 00 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)	1					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, I	ine i, column 3)					106. 00

	Financial Systems	CARE ONE AT I	HOLMDEL		In Lie	u of Form CMS-2	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre	pared:
						5/10/2024 11:	36 am
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassified	
				+ col . 2)	ons I ncrease/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col . 4)	
					À-6)	,	
	Joseph Ospidos Coot Ospitspo	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES		2, 633, 263	2, 633, 263		2, 633, 263	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		174, 226			174, 226	2.00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 333, 305			1, 333, 305	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	643, 875	2, 278, 564			2, 922, 439	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	124, 751	570, 534			695, 285	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	216, 857			216, 857	6. 00
7.00	00700 HOUSEKEEPI NG	234, 730	40, 187			274, 917	7. 00
8. 00 9. 00	00800 DI ETARY	592, 637	297, 057			889, 694	
10. 00	O0900 NURSI NG ADMI NI STRATI ON O1000 CENTRAL SERVI CES & SUPPLY	826, 304 37, 773	116, 514 194, 149			942, 818 231, 850	
11. 00	01100 PHARMACY	37,773	24, 809			24, 809	
12. 00	01200 MEDICAL RECORDS & LIBRARY	40, 635	0	40, 635		40, 635	
13.00	01300 SOCIAL SERVICE	84, 038	0	84, 038		84, 038	
14.00		0	0	(0	0	14. 00
15. 00	01500 ACTI VI TES	196, 266	9, 021	205, 287	7 0	205, 287	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 (2(222	207 245	2 042 420		2 042 420	20.00
30.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 636, 223	307, 215	3, 943, 438		3, 943, 438 0	30. 00 31. 00
32. 00	03200 CF/IID		0		-	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0			0	
	ANCILLARY SERVICE COST CENTERS	-1					
40.00	04000 RADI OLOGY	0	39, 572		2 0	39, 572	40. 00
41.00	04100 LABORATORY	0	85, 785			85, 785	
42.00	04200 I NTRAVENOUS THERAPY	0	212, 746	1		212, 746	
43.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	667, 347	17, 000	684, 347	-	0 684, 347	
45. 00	04500 OCCUPATIONAL THERAPY	608, 648	17,000	608, 648		608, 648	
46. 00	04600 SPEECH PATHOLOGY	105, 477	4, 400			109, 877	
47. 00	04700 ELECTROCARDI OLOGY	0	0	(o o	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	(72	72	
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	601, 660	601, 660	0	601, 660	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	
51.00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	0	0	(0	0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST		0			0	
52. 02	05202 MEDI CAL SERVI CES		0		1	_	
	OUTPATIENT SERVICE COST CENTERS	, -,					
60.00	06000 CLI NI C	0	0	(0	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0	(0	0	61.00
	06200 FQHC						62.00
63.00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	U	0) 0	0	63. 00
70 00	07000 HOME HEALTH AGENCY COST		0		0	0	70. 00
	07100 AMBULANCE		59, 824	59, 824	i o		71.00
	07300 CMHC	0	0	(0	0	1
74.00	07400 OTHER REIMBURSEMENT	0	0	(0	0	74. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1		_	
80.00	1		0		0	0	
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF		0	(0	0	
83. 00	08300 HOSPI CE		0			0	1
84. 00	1 1		0		o o	0	1
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	(0	0	1
89. 00		7, 798, 704	9, 216, 688	17, 015, 392	0	17, 015, 392	89. 00
	NONREI MBURSABLE COST CENTERS			T			
90.00		0	7, 247			7, 247	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		5, 530 0	5, 530		5, 530	91. 00 92. 00
	09300 NONPALD WORKERS		0			0	
	09400 PATIENTS LAUNDRY	l ŏl	0		o o	0	
	09500 OTHER NONREIMBURSABLE COST	0	0		o o	0	
100.00	TOTAL	7, 798, 704	9, 229, 465	17, 028, 169	0	17, 028, 169	100. 00

 Heal th Financial
 Systems
 CARE 0

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315092

				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:36 am
	Cost Center Description	Adjustments to	Net Expenses		37 107 2024 11. 30 alli
	p		For Allocation	ו	
		Wkst A-8)	(col. 5 +-		
		4.00	col . 6)	4	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	-1, 871	2, 631, 392		1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	1,071		•	2.00
3.00	00300 EMPLOYEE BENEFITS	0		•	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-741, 509	2, 180, 930		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	695, 285		5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	-1, 460		•	6. 00
7.00	00700 HOUSEKEEPI NG	0	274, 917	•	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	-469 -1, 731			8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	-1, /31		•	10.00
11. 00	01100 PHARMACY	-1, 985		•	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0		•	12. 00
13.00	01300 SOCIAL SERVICE	0	84, 038	3	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		14. 00
15. 00	01500 ACTI VI TES	0	205, 287	7	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	21 107	2 012 241		20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	-31, 197		. 1	30. 00 31. 00
32. 00	03200 CF/11D			1	32.00
33. 00	03300 OTHER LONG TERM CARE	Ö			33.00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	0	39, 572	2	40.00
41. 00	04100 LABORATORY	0	85, 785	•	41.00
42.00	04200 NTRAVENOUS THERAPY	-17, 020		1	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	(04.247	1	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0		•	44. 00 45. 00
46. 00	04500 OCCOPATIONAL THERAPY				46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	1	1	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72	•	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	-48, 133	553, 527	7	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51. 00	05100 SUPPORT SURFACES	0	1		51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	-		52. 00
52. 01 52. 02	05201 OTHER ANCI LLARY SERVI CES COST 05202 MEDI CAL SERVI CES	0	-	1	52. 01 52. 02
32. 02	OUTPATIENT SERVICE COST CENTERS			٧	52.02
60. 00	06000 CLI NI C	0	С		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		61. 00
62. 00	06200 FQHC				62. 00
63. 00	06300 DI ALYSI S	0	0		63. 00
70.00	OTHER REIMBURSABLE COST CENTERS				70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0		•	70.00
	07300 CMHC	0		† 	73.00
	07400 OTHER REIMBURSEMENT	0			74.00
	SPECIAL PURPOSE COST CENTERS			-1	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C		80.00
81. 00	08100 I NTEREST EXPENSE	0	C		81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	0	0		82. 00
83. 00	08300 HOSPI CE	0	0		83. 00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0	1) 	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-845, 375	1	7 7	89. 00
57.00	NONREI MBURSABLE COST CENTERS	1 040, 373	15, 175, 517		37.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	7, 247	7	90.00
	09100 BARBER AND BEAUTY SHOP	0	5, 530	•	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	O	0	92. 00
	09300 NONPALD WORKERS	0	0)	93. 00
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0		ון	94. 00 95. 00
95. 00 100. 00		-845, 375		1	100.00
100.00	1.01/16	1 075,575	10, 102, 774	1	1100.00

Health Financial Systems	CARE ONE AT HOLMDEL		In Lie	u of Form CMS-:	2540-10
RECLASSI FI CATI ONS	Provi de	No.: 315092	Peri od: From 01/01/2023	Worksheet A-6	
			To 12/31/2023	Date/Time Pre 5/10/2024 11:	
		Increases			
	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 CHARGED TO PATIENTS	48. (00	72	1. 00
TOTALS					
100.00	Total Reclassifications (Su	m	0	72	100. 00
	of columns 4 and 5 must equal sum of columns 8 and 9)				

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 HOL	MDEL		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		
	Decreases					
	Cost Cente	r	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. 0	0 0	72	1.00
TOTALS						
100. 00				0	72	100. 00

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
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT HOLMDEL In Lieu of Form CMS-2540-10 Peri od: Worksheet A-7 From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der No.: 315092

				To	12/31/2023	Date/Time Prep 5/10/2024 11:	
	·			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	S					
1.00	Land	300, 000	0	0	0	0	1.00
2.00	Land Improvements	925, 293	43, 349		43, 349	0	2. 00
3.00	Buildings and Fixtures	5, 474, 654	257, 317	0	257, 317	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	542, 592	15, 803		15, 803	0	5. 00
6.00	Movable Equipment	2, 297, 688	49, 207		49, 207	0	6. 00
7.00	Subtotal (sum of lines 1-6)	9, 540, 227	365, 676	0	365, 676	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	9, 540, 227	365, 676	0	365, 676	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	TANALYSIS OF SURVISES IN SARITAL ASSET BALANCE	6.00	7. 00				
4 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						4 00
1.00	Land	300, 000	0				1.00
2.00	Land Improvements	968, 642	0				2. 00
3. 00	Buildings and Fixtures	5, 731, 971	0				3. 00
4.00	Building Improvements	0	0				4. 00
5. 00	Fi xed Equi pment	558, 395	0				5. 00
6. 00	Movable Equipment	2, 346, 895	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	9, 905, 903	0				7. 00
8. 00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	9, 905, 903	0				9. 00

Provi der No.: 315092

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

				10 12/31/2023	5/10/2024 11:	
				Expense Classification or		
				To/From Which the Amount is	to be Adjusted	
	D (4)	(a) D : E		0.10.1	I 12 N	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment	2.00	2.00	4.00	
1. 00	Investment income on restricted funds	1. 00 B	2.00	3. 00 CAP REL COSTS - BLDGS &	4. 00	1. 00
1.00	Investment income on restricted funds (chapter 2)	В	-1,8/1	FIXTURES	1.00	1.00
2. 00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
2.00	(enapter 8)		O		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
	(chapter 8)		_			
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6.00
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10. 00
11. 00	Nonallowable costs related to certain		0)	0.00	11. 00
40.00	Capital expenditures (chapter 24)		004 454			40.00
12. 00	Adjustment resulting from transactions with	A-8-1	-281, 154			12. 00
13. 00	related organizations (chapter 10) Laundry and linen service	В	1 4/0	NI ALINDOV & LINEN CEDVICE	6.00	13. 00
14. 00	Revenue - Employee meals	D	-1, 460	LAUNDRY & LINEN SERVICE	0.00	14. 00
15. 00	Cost of meals - Guests	В	160	DI ETARY	8.00	15. 00
16. 00	Sale of medical supplies to other than		-407	DIETAKI	0.00	16. 00
10.00	patients		0	,	0.00	10.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vending machines		0		0.00	19. 00
20.00	Income from imposition of interest, finance		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)			0.00		
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
24. 00	Dangasi ati an mayahla agui nmant		0	FIXTURES CAP REL COSTS - MOVABLE	2.00	24. 00
24.00	Depreciationmovable equipment		U	EQUI PMENT	2.00	24.00
25. 00	RESIDENT REPLACEMENT ITEMS	А	_6 000	PADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	MARKETI NG EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETI NG CORP EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 03	MARKETING - MEALS	A	· ·	ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	BAD DEBT EXPENSE	A	· ·	ADMINISTRATIVE & GENERAL	4. 00	25. 04
25. 05	BAD DEBT EXPENSE - MEDICARE	A		ADMINISTRATIVE & GENERAL	4. 00	25. 05
25. 06	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	25. 06
25. 07	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	4. 00	25. 07
	OTHER INCOME	В		ADMINISTRATIVE & GENERAL	4.00	25. 08
	Total (sum of lines 1 through 99) (Transfer	1	-845, 375	l .		100. 00
	to Worksheet A, col. 6, line 100)					
(1) De	scription - all chapter references in this co	lumn pertain to	CMS Pub. 15-1	1.		

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

Health Financial Systems CARE ONE AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME CARE ONE AT HOLMDEL

Provi der No.: 315092 OFFICE COSTS

OFFICE	0313			T	To 12/31/2023 Date/Time 5/10/2024	Prepared: 11:36 am
		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 ORGANIZATIONS OR	
1.00		4. 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	1.00
2.00		9. 00	NURSING ADMINI	STRATI ON	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		42. 00	INTRAVENOUS TH	ERAPY	IV EXPENSE	6.00
7. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGENDRUGS OTH	ID 7.00
8. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEN DRUGS MAN	ID 8.00
9. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDIC	ARE 9.00
9. 01		0. 00				9. 01
10.00	TOTALS (sum of lines 1-9). Transfer column					10.00
	6, line 100 to Worksheet A-8, column 3, line					
	12.			1		
		Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col. 5	col . 5)		
		4. 00	5.00	6.00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR				D ORGANIZATIONS OR	
	CLAIMED HOME OFFICE COSTS:					
1.00		670, 390	· ·			1.00
2.00		19, 908				2. 00
3.00		40, 043	· ·	1	1	3.00
4.00		22, 304	· ·			4. 00
5.00		520				5. 00
6. 00 7. 00		195, 726 24, 220				6. 00 7. 00
8. 00		115, 759				8.00
9. 00		413, 548				9.00
9. 00		413, 346	l	1		9. 01
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 502, 418	l ~	1	1	10. 00
	IZ.	I	I	I	I	I

OFFICE COSTS

Parts I-II Date/Time Prepared:

12/31/2023

5/10/2024 11:36 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	A	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	
DADT II INTERDELATIONOULD TO BELATER ORGANIE	ZATLONICO AND COD HOME OFFICE			4

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.

. o. pa	m poode or or ar ini rig i or inbar comorre arraor er er e	*******			
1.00		HEALTHBRIDGE MANAGEMENT LLC	100.00	MANAGEMENT	1.00
2.00		TOTALCARE LLC	99.00	WOUND CARE	2. 00
3.00		TOTALCARE LLC	1.00	WOUND 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)		0.00		100. 00
	specify:				

- (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.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			To	12/31/2023	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/10/2024 11:	36 alli
	l	DI 200 4	1101/151 5	5MB1 01/55		
Cost Center Description	Net Expenses for Cost	BLDGS & FLXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TTATORES	EQ011 WENT	DENETTIS		
	(from Wkst A					
	col . 7)	1.00	2.00	2.00	2.4	
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	3A	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES	2, 631, 392	2, 631, 392				1. 00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	174, 226		174, 226			2. 00
3. 00 00300 EMPLOYEE BENEFITS	1, 333, 305	0 2/0 151	0	1, 333, 305	2 577 002	3.00
4.00 OO400 ADMINISTRATIVE & GENERAL 5.00 OO500 PLANT OPERATION, MAINT. & REPAIRS	2, 180, 930 695, 285	269, 151 48, 252	17, 821 3, 195	110, 080 21, 328	2, 577, 982 768, 060	4. 00 5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	215, 397	48, 252	3, 195	0	266, 844	6. 00
7. 00 00700 HOUSEKEEPI NG	274, 917	48, 252	3, 195	40, 131	366, 495	7. 00
8. 00 00800 DI ETARY	889, 225	228, 523	15, 131	101, 320	1, 234, 199	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY	941, 087 231, 850	50, 954	3, 374	141, 269 6, 458	1, 136, 684 238, 308	9. 00 10. 00
11. 00 01100 PHARMACY	22, 824	o	0	0, 430	22, 824	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	40, 635	O	0	6, 947	47, 582	12. 00
13. 00 01300 SOCI AL SERVI CE	84, 038	24, 126	1, 597	14, 368	124, 129	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITES	205 297	0	0	22 555	229 942	14. 00 15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	205, 287	<u>U</u>	U	33, 555	238, 842	13.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	3, 912, 241	1, 858, 295	123, 037	621, 665	6, 515, 238	30. 00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00 03200 1 CF/I I D	0	0	0	0	0	32.00
33. 00 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	U	U	<u> </u>	0	33. 00
40. 00 04000 RADI OLOGY	39, 572	0	0	0	39, 572	40. 00
41. 00 04100 LABORATORY	85, 785	0	0	0	85, 785	41. 00
42. 00 04200 INTRAVENOUS THERAPY	195, 726	0	0	0	195, 726	42.00
43.00 04300 0XYGEN (I NHALATI ON) THERAPY 44.00 04400 PHYSI CAL THERAPY	0 684, 347	18, 529	1, 227	114, 093	0 818, 196	43. 00 44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	608, 648	18, 529	1, 227	104, 058	732, 462	45. 00
46.00 04600 SPEECH PATHOLOGY	109, 877	18, 529	1, 227	18, 033	147, 666	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49.00 04900 DRUGS CHARGED TO PATIENTS	72 553, 527	0	0	0	72 553, 527	48. 00 49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	o	0	o	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 ANCI LLARY SERVI CES COST 52. 02 05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 01 52. 02
OUTPATIENT SERVICE COST CENTERS	٩	<u> </u>	<u> </u>	<u> </u>		02.02
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 63. 00 06300 DI ALYSI S	0	0	0	0	0	62. 00 63. 00
OTHER REIMBURSABLE COST CENTERS	١	<u> </u>	٥	<u> </u>		03.00
70.00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	59, 824	0	0	0	59, 824	71.00
73. 00 07300 CMHC 74. 00 07400 OTHER REI MBURSEMENT		0	0	0	0	73. 00 74. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		71.00
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 08100 I NTEREST EXPENSE						81.00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF 83. 00 08300 HOSPI CE	0	0	0	0	0	82. 00 83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST I	0	o	0	o	0	84. 00
84. 01 08401 OTHER SPECIAL PURPOSE COST II	O	O	0	0	0	84. 01
89. 00 SUBTOTALS (sum of lines 1-84)	16, 170, 017	2, 631, 392	174, 226	1, 333, 305	16, 170, 017	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	7, 247	ol	O	0	7, 247	90.00
91. 00 09100 BARBER AND BEAUTY SHOP	5, 530	o	0	o	5, 530	91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	O	0	0	0	92.00
93. 00 09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00 09400 PATI ENTS LAUNDRY 95. 00 09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	94. 00 95. 00
98.00 Cross Foot Adjustments		ol	0	ol	0	98.00
99.00 Negative Cost Centers	0	o	Ō	o	0	99. 00
100. 00 TOTAL	16, 182, 794	2, 631, 392	174, 226	1, 333, 305	16, 182, 794	100. 00

Provider No.: 315092

				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	50 aiii
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6.00	7. 00	8. 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 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	2, 577, 982		•			3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	145, 540	913, 600				5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	50, 564	19, 051				6. 00
7.00	00700 HOUSEKEEPI NG	69, 447	19, 051	1	454, 993		7. 00
8.00	00800 DI ETARY	233, 868	90, 225	0	46, 889	1, 605, 181	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	215, 390	20, 118	0	10, 455	0	9.00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	45, 157 4, 325	0	0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	9, 016	0	0	0	0	12.00
13. 00	01300 SOCI AL SERVI CE	23, 521	9, 525	ő	4, 950	Ö	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00	01500 ACTI VI TES	45, 258	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 SKILLED NURSING FACILITY	1, 234, 581	733, 682		381, 293	1, 605, 181	30.00
31.00	03100 NURSING FACILITY 03200 CF/IID		0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		0	0	0	0	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>					00.00
40.00	04000 RADI OLOGY	7, 498	0	0	0	0	40. 00
41. 00	04100 LABORATORY	16, 255	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	37, 088	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	155 040	7 214	0	0 3. 802	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	155, 040 138, 794	7, 316 7, 316		3, 802 3, 802	0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	27, 981	7, 316	1	3, 802	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	1	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	14	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	104, 888	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST		0	0	0	0	52. 00
52. 02	05202 MEDI CAL SERVI CES	o	0	ő	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	_	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200 FOHC 06300 DI ALYSI S		0		0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	l o		<u> </u>	U	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	07100 AMBULANCE	11, 336	0	0	0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						80.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82.00
83. 00	08300 HOSPI CE	o	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	o	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, 575, 561	913, 600	336, 459	454, 993	1, 605, 181	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1, 373			0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	1, 048	0	0	0	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	ő	0	Ö	92.00
93. 00	09300 NONPALD WORKERS	0	0	Ō	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 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00		2, 577, 982	913, 600	336, 459	454, 993		1
. 55. 50	1.0=	2,077,702	, 10, 500	1 333, 137	101, 770	., 000, 101	,

Provi der No.: 315092

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/10/2024	11:36 am

					12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINI STRATION	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 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00 6. 00
7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	1, 382, 647					9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	283, 465				10.00
11. 00	01100 PHARMACY	0	0	27, 149			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	56, 598		12.00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	162, 125	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00		0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	1	1, 382, 647	283, 465	27, 149	56, 598		30. 00
31. 00	1	0	0	0	0	0	31. 00
32. 00	1	0	0	0	0	0	32.00
33. 00		0	0	0	O	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	0	0		1 40 00
40. 00 41. 00	1	0	0	0	0	· ·	40. 00 41. 00
41.00	1		0	0	0		41.00
43. 00			0	0	0		43. 00
44. 00	1 1	0	0	0	0	Ö	44. 00
45. 00		0	0	Ö	0	Ö	45. 00
46. 00		o	0	o	0	0	46. 00
47. 00	1	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00		0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	1 1	0	0	0	0	0	51. 00
52.00	1 1	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02		0	0	0	0	0	52. 02
(0.00	OUTPATIENT SERVICE COST CENTERS		٥		0		/ 0 00
60.00	· ·	0	0	0	0	0 1 0	60.00
61. 00 62. 00	· ·	١	U	U	U	U	61. 00 62. 00
63. 00	· ·	0	0	0	0	0	63.00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	٥	0		03.00
70. 00		0	0	0	0	0	70. 00
71. 00	1 1	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						
80.00	1						80. 00
81. 00	i i						81. 00
82. 00		_	_	_	_	_	82. 00
83. 00		0	0	0	0	0	83. 00
84. 00		0	0	0	0	0	84.00
84. 01	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	1 202 (47	202 445	27 140	E / E00	1/2 125	84. 01
89. 00	NONREI MBURSABLE COST CENTERS	1, 382, 647	283, 465	27, 149	56, 598	162, 125	89. 00
90. 00		0	0	0	0	0	90.00
91. 00			0	0	0	l e	91.00
92. 00	1 1	0	0	0	0	ĺ	92. 00
93. 00			o O	Ö	0	Ö	93. 00
94. 00	1 1		Ö	ol	Ō	Ö	94. 00
95. 00	1	0	o	o	0	0	95. 00
98. 00		0	o				98. 00
99. 00	1 1 5	0	0	0	0	0	99. 00
100.0	DTOTAL	1, 382, 647	283, 465	27, 149	56, 598	162, 125	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315092

				Т	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			37 107 2024 11.	30 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	OO3OO EMPLOYEE BENEFITS OO4OO ADMINISTRATIVE & GENERAL						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 NURSING ADMINISTRATION						9. 00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY						10. 00 11. 00
	01200 MEDICAL RECORDS & LIBRARY			•			12.00
13. 00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTI VI TES	0	284, 100				15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		204 100	12 002 510		12 002 510	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0		1		13, 002, 518 0	1
	03200 CF/11D	0					
	03300 OTHER LONG TERM CARE	0		1	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0				47, 070	1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0				102, 040 232, 814	41. 00 42. 00
	04300 OXYGEN (INHALATION) THERAPY	0	0	, - · ·	0	232, 614	1
44. 00	04400 PHYSI CAL THERAPY	0	1	1	o o	984, 354	
45.00	04500 OCCUPATI ONAL THERAPY	0	0	882, 374	0	882, 374	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	186, 765		186, 765	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	_	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		86 658, 415		86 658, 415	1
	05000 DENTAL CARE - TITLE XIX ONLY			030, 413	0	030, 413	1
	05100 SUPPORT SURFACES	0	Ö	d	0	0	1
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	C	0	0	52. 00
	05201 OTHER ANCILLARY SERVICES COST	0		-		0	52. 01
52. 02	05202 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	52. 02
60. 00	06000 CLINIC	0	0		0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	•	l .		Ö	61. 00
62.00	06200 FQHC						62. 00
63.00	06300 DI ALYSI S	0	0	<u> </u>	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST						70.00
	07100 AMBULANCE	0	0	71, 160			70. 00 71. 00
	07300 CMHC	0	Ö		0	0	
	07400 OTHER REIMBURSEMENT	0	0	C	0	0	
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00	08300 H0SPI CE	0	0		0	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	Ö	ď	Ö	Ö	1
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	c	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	284, 100	16, 167, 596	0	16, 167, 596	89. 00
00.00	NONREI MBURSABLE COST CENTERS		Ι ο	0 (20		0.700	00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	8, 620 6, 578		8, 620 6, 578	1
	09200 PHYSICIANS PRIVATE OFFICES			0,570	0	0, 370	1
	09300 NONPAID WORKERS	0	0	l c	o	Ō	1
	09400 PATIENTS LAUNDRY	0	0) c	0	0	
95. 00	09500 OTHER NONREI MBURSABLE COST	0	0	l c	0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers				0	0	98. 00 99. 00
100.00			284, 100	16, 182, 794	0		1
	ı I	'	, ,,,,,,,,		, ,		

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315092

				10	12/31/2023	Date/IIme Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS		7 7 7 7 2 0 2 1 7 1 1 .	00 4111
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE BENEFITS	
		Assigned New Capital	FIXTURES	EQUI PMENT		BENEFI 13	
		Related Costs					
		0	1. 00	2. 00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	0	0		0	2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	0	269, 151	17, 821	286, 972	0	4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	48, 252	3, 195	51, 447	0	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	48, 252	3, 195	51, 447	0	6. 00
7.00	00700 HOUSEKEEPI NG	0	48, 252	3, 195	51, 447	0	7. 00
8.00	00800 DI ETARY	0	228, 523	15, 131	243, 654	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	50, 954	3, 374	54, 328	0	9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0	0	0	0	10. 00 11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		0	0	0	0	12.00
13. 00	01300 SOCIAL SERVICE		24, 126	1, 597	25, 723	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	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	1, 858, 295	123, 037	1, 981, 332	0	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0	0	O O	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
33. 00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	<u> </u>	<u>0</u>		33.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	10 520	1 227	10.754	0	43.00
44. 00 45. 00	04500 OCCUPATI ONAL THERAPY		18, 529 18, 529	1, 227 1, 227	19, 756 19, 756	0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY		18, 529	1, 227	19, 756	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 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	O O	0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 00
52. 02	05202 MEDI CAL SERVI CES	0	o	Ö	Ö	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 63. 00	06200 FQHC 06300 DI ALYSI S	0	0	0		0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	j oj	<u>U</u>	U	<u>U</u>	0	03.00
70. 00		0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	О	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
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	T	T				80.00
81. 00	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 HOSPI CE	0	О	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)	0	2, 631, 392	174, 226	2, 805, 618	0	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	nl	Ω	nl	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	l o	o	o	o	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	o	Ö	o	0	92. 00
93. 00	09300 NONPALD WORKERS	0	О	0	О	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 99. 00	Cross Foot Adjustments Negative Cost Centers			0	0	0	98. 00 99. 00
100.00	1 1 0	0	2, 631, 392	174, 226	2, 805, 618		100.00
. 55. 00	1	٦	_, _0 ., 0 /2	., ., 220	_, 555, 510	Ŭ	,

Provi der No.: 315092

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024

				1	0 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	JO dili
	,	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
		4. 00	5. 00	6. 00	7. 00	8. 00	
4 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	00/ 070					3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	286, 972	(7. (40	,			4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	16, 201 5, 629	67, 648				5. 00 6. 00
7. 00	00700 HOUSEKEEPING	7, 730	1, 411 1, 411	1	60, 588		7.00
8. 00	00800 DI ETARY	26, 033	6, 681	1	6, 244	282, 612	8.00
9. 00	00900 NURSING ADMINISTRATION	23, 976	1, 490	1	1, 392	202, 012	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	5, 027	1, 470		1, 3,2	0	10.00
11. 00	01100 PHARMACY	481	0		0	0	11.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	1, 004	0	0	0	0	12.00
13. 00	01300 SOCIAL SERVICE	2, 618	705	0	659	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15.00	01500 ACTI VI TES	5, 038	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	137, 430	54, 324	58, 487	50, 775	282, 612	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/ D	0	0	1		0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0) 0	0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	025				0	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	835 1, 809	0	1	-	0	40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY	4, 128	0		0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	4, 120	0		0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	17, 258	542		506	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	15, 450	542		506	0	45. 00
46.00	04600 SPEECH PATHOLOGY	3, 115	542	•	506	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	11, 676	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	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	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0) 0	0	0	52. 02
40.00	OUTPATIENT SERVICE COST CENTERS			J 0	O	0	/ 0 00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0		0	60. 00 61. 00
62. 00	06200 FQHC	0	U	,	U	U	62.00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63.00
03.00	OTHER REIMBURSABLE COST CENTERS			,, ,	<u> </u>	U	05.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	1, 262	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						
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 HOSPI CE	0	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	(7.44)	0	(0.500	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	286, 702	67, 648	58, 487	60, 588	282, 612	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	153	0	J 0	٥	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	117	0		0	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	92.00
93. 00	09300 NONPALD WORKERS		0			0	93.00
94. 00	09400 PATIENTS LAUNDRY	o	n	n n	n	0	94.00
95. 00	09500 OTHER NONREI MBURSABLE COST	o	0	ol o	l ől	Ö	95. 00
98. 00	Cross Foot Adjustments		_	0	o	0	98. 00
99. 00	Negative Cost Centers	0	0	0	o	0	99. 00
100.00	TOTAL	286, 972	67, 648	58, 487	60, 588	282, 612	100. 00

Provi der No.: 315092

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/10/2024	11:36 am

				''	J 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
		0.00	SUPPLY	11 00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11.00	12. 00	13. 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						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
9.00	00900 NURSING ADMINISTRATION	81, 186					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	5, 027				10.00
11. 00	01100 PHARMACY	0	0	481			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	1, 004		12. 00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	29, 705	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00	01500 ACTIVITES	0	0	0	0	0	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	01 10/	5, 027	401	1, 004	29, 705	20.00
30. 00 31. 00	03100 NURSING FACILITY	81, 186	5, 027	481 0	1, 004	29, 705	30. 00 31. 00
32. 00	03200 CF/11D		0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	o o	0	0	0	Ö	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	٩	<u> </u>				00.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	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 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		0	0	0	0	52.00
52. 00	05201 OTHER ANCILLARY SERVICES COST		0	0	0	0	52. 00
52. 02	05202 MEDI CAL SERVI CES	o	0	0	0	Ö	52. 02
	OUTPATIENT SERVICE COST CENTERS	-1	-				
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	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
	07300 CMHC 07400 OTHER REI MBURSEMENT	0	0	0	0	0 0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	l d	U	0	U	U	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - 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)	81, 186	5, 027	481	1, 004	29, 705	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	_	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	_	0	_	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00	09300 NONPAL D WORKERS	0	0	0	0	0	93.00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0 0	94. 00 95. 00
95. 00 98. 00	Cross Foot Adjustments		0		0		98.00
99. 00	Negative Cost Centers		0	0	Ω	0	99.00
100.00		81, 186	5, 027	"	1, 004	_	1
	I Total Control of the Control of th	2.7.00	-,,	, , , , , , , , , , , , , , , , , , , ,	., 50 1		

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 | 11/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315092

						0 12/31/2023	Date/lime Pre 5/10/2024 11:	
				OTHER GENERAL				
		Cost Conton Decemintion	NUDCL NC AND	SERVI CE	Cubtatal	Doot Stop Down	Total	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
			EDUCATI ON					
			14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	T					1. 00
2.00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00		EMPLOYEE BENEFITS						3. 00
4.00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS						5.00
6. 00 7. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						6. 00 7. 00
8.00		DI ETARY						8. 00
9.00	1	NURSING ADMINISTRATION						9. 00
10.00		CENTRAL SERVICES & SUPPLY						10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY						11. 00 12. 00
13. 00	1	SOCIAL SERVICE						13. 00
14. 00	01400	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTIVITES	0	5, 038				15. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	0	5, 038	2, 687, 401	0	2, 687, 401	30.00
31. 00		NURSING FACILITY	0	0,030			2,007,401	1
32.00		ICF/IID	0	0		0	0	1
33. 00		OTHER LONG TERM CARE	0	0	C	0	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	0	0	835	0	835	40. 00
41. 00		LABORATORY	0	0			1, 809	
42. 00	1	INTRAVENOUS THERAPY	0	0	4, 128		4, 128	1
43. 00		OXYGEN (INHALATION) THERAPY	0	0	C	_	0	
44. 00	1	PHYSI CAL THERAPY	0	0	38, 062		38, 062	1
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	36, 254 23, 919		36, 254 23, 919	1
47. 00		ELECTROCARDI OLOGY	Ō	Ō	20, 7.7		0	1
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2	0	2	48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0	0	11, 676		11, 676	1
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0) 0		0	0	
52. 00		COMPLEX MEDICAL EQUIPMENT	0	0	Č	o o	0	
52. 01	05201	OTHER ANCILLARY SERVICES COST	0	0	С	0	0	52. 01
52. 02		MEDI CAL SERVI CES	0	0	C	0	0	52. 02
60. 00		TIENT SERVICE COST CENTERS	0	0	C	0	0	60.00
61. 00		RURAL HEALTH CLINIC	0	0			0	61.00
62. 00	06200	FQHC						62. 00
63. 00		DI ALYSI S	0	0	C	0	0	63. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
	1	AMBULANCE	0					71.00
73. 00	07300		0	0			0	
74. 00		OTHER REIMBURSEMENT	0	0	C	0	0	74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81.00
82. 00	08200	UTILIZATION REVIEW - SNF						82. 00
83. 00	1	HOSPI CE	0	0	C	0	0	
84. 00 84. 01		OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II	0	0		0	0	84. 00 84. 01
89. 00	00401	SUBTOTALS (sum of lines 1-84)	0	5, 038	2, 805, 348	0	2, 805, 348	1
		MBURSABLE COST CENTERS		-,				
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			153	1
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0	0	117 		117 0	1
93.00	1	NONPALD WORKERS		0			0	
94.00	09400	PATIENTS LAUNDRY	0	0	C	o	0	94. 00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	C -	0	0	
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers	0	0		0	0	
100.00		TOTAL	0	5, 038	2, 805, 618	3 0	2, 805, 618	
	1		'	,	,	, ,	,	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2023 Date/Time Prepared: 5/10/2024 11:36 am Provi der No.: 315092

					'	0 12/31/2023	5/10/2024 11:	
			CAPITAL REI	LATED COSTS				
		Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		555 55116. 2555. Pt. 5.1	FIXTURES	EQUI PMENT	BENEFITS		& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			1.00	2.00	SALARI ES) 3. 00	4A	4. 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	0.00	171	1. 00	
1.00	1	CAP REL COSTS - BLDGS & FIXTURES	27, 267					1. 00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	0	27, 267 0				2. 00 3. 00
4.00		ADMINISTRATIVE & GENERAL	2, 789				13, 604, 812	4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	500			0	768, 060	5. 00
6.00	1	LAUNDRY & LINEN SERVICE	500			_	266, 844	6.00
7. 00 8. 00	1	HOUSEKEEPI NG DI ETARY	500 2, 368	•			366, 495 1, 234, 199	7. 00 8. 00
9. 00		NURSING ADMINISTRATION	528			Ö	1, 136, 684	9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	0	37, 773	0	238, 308	1
11. 00 12. 00	1	PHARMACY	0	0		0	22, 824	
13. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	250	0 250			47, 582 124, 129	
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	0	l '	0	0	14. 00
15. 00		ACTIVITES	0	0	196, 266	0	238, 842	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	19, 256	19, 256	3, 636, 223	0	6, 515, 238	30.00
31. 00		NURSING FACILITY	0	0		O	0, 010, 200	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	0	0	0	0	39, 572	40. 00
41.00	04100	LABORATORY	0	0	0	0	85, 785	
42. 00	1	I NTRAVENOUS THERAPY	0	0	0	0	195, 726	
43. 00 44. 00	1	OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	192	192	667, 347	0	0 818, 196	43. 00 44. 00
45. 00	1	OCCUPATI ONAL THERAPY	192				732, 462	•
46. 00	1	SPEECH PATHOLOGY	192	•		0	147, 666	
47. 00 48. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 72	47. 00 48. 00
49. 00		DRUGS CHARGED TO PATTENTS					553, 527	49. 00
50. 00		DENTAL CARE - TITLE XIX ONLY	0	Ö	0	0	0	50. 00
51.00	1	SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00 52. 01	1	COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 00 52. 01
52. 01	1	MEDICAL SERVICES		0		0	0	52. 02
		TIENT SERVICE COST CENTERS						
60. 00 61. 00		CLINIC RURAL HEALTH CLINIC	0	0			0 0	60. 00 61. 00
62. 00	06200			0	0	0		62.00
63.00		DI ALYSI S	0	0	0	0	0	63. 00
70.00		REI MBURSABLE COST CENTERS	0	l 0	0	0	0	70.00
70. 00 71. 00	1	HOME HEALTH AGENCY COST AMBULANCE				0	59, 824	70. 00 71. 00
73. 00	07300	СМНС	0	0	0	0	0	
74. 00		OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82.00	1	UTILIZATION REVIEW - SNF						82. 00
83. 00 84. 00	1	HOSPICE OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	83. 00 84. 00
84. 01		OTHER SPECIAL PURPOSE COST II				0	0	84. 00
89. 00		SUBTOTALS (sum of lines 1-84)	27, 267	27, 267	7, 798, 704	-2, 577, 982	13, 592, 035	89. 00
00.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN					7 247	00.00
90. 00 91. 00		BARBER AND BEAUTY SHOP		0		0	7, 247 5, 530	90. 00 91. 00
92. 00	1	PHYSICIANS PRIVATE OFFICES	0	Ö	Ö	0	0	92. 00
93. 00	1	NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00 95. 00	1	PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST	0	0	0	0	0	94. 00 95. 00
98. 00 98. 00	07500	Cross Foot Adjustments		١	١			98.00
99. 00		Negative Cost Centers						99. 00
102.00		Cost to be allocated (per Wkst. B, Part I)	2, 631, 392	174, 226	1, 333, 305		2, 577, 982	102. 00
103.00		Parti) Unit cost multiplier (Wkst. B, Part I)	96. 504639	6. 389628	0. 170965		0. 189490	103. 00
104.00	1	Cost to be allocated (per Wkst. B,			0		286, 972	
	1	Part II)	1	I	I	I	I	I

Health Financial Systems	CARE ONE AT HOLMDEL			In Lieu of Form CMS-2540-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				rom 01/01/2023		
				To 12/31/2023	Date/Time Pre	
				1	5/10/2024 11:	36 am
	CAPITAL RELATED 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	
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 021093	105.00

Provi der No.: 315092

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11:36 am

0.000 0.000 DETARY 2.30E							5/10/2024 11:	
### SPENIS CRATIFICATIONS CRATIFICATIONS CRATIFICATIONS		Cost Center Description						
			·		(SQUARE FEET)	(MEALS SERVED)	ADMINISTRATION	
CALIFORNIA SERVICE COST CENTERS 1.00				(FAITENT DATS)			(PATIENT DAYS)	
SPURPAL SERVICE COST CENTERS 1.00							(
1.00			5. 00	6. 00	7. 00	8. 00	9. 00	
2.00 00000 CARP REL COSTS - NOVABLE EQUIPMENT 2.00 MANUAL EQUIPMENT 3.00 M	1 00		1		I		ı	1 00
3.00								
4.00 0.000 ADMINISTRATIVE & CENERAL		l						
0.000 0.0000 LANT OPERATI ON, MAINT. & REPAIRS 23.978 5.00 0.0000 CALLANDEY & LINES ESPRICE 5.00 0.32, 585 7.700 7.000								
0.00 0.000 LAIMBRY & LINEN STRVICE			23, 978	3				
8.00 00000 DETARY 2,348 0 2,348 97,755 3,88 9,00 10.00 10.000 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 10.00 10.0000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.0000000000			1	l .				
9.00 0.000 MURSING ADMINISTRATION 528	7.00	00700 HOUSEKEEPI NG	500	0	22, 978			7. 00
10.00 010000 CRITIRAL SERVICES & SURPLY 0	8.00	00800 DI ETARY	2, 368	0	2, 368	97, 755		8. 00
11.00 01100 PIARAMACY 0 0 0 0 0 11.00 12.00 12.00 01200 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 13.00 01300 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 15.00 13.00 01300 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 15.00 13.00 01300 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 0 15.00 13.00 01300 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 0 15.00 13.00 01300 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 0 15.00 01300 01300 SOCI AL SERVI CE 02.00 0 0 0 0 0 0 0 0 0			528	0	528	0	32, 585	
12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 13.00 13.01 01300 COLLA SERVICE COST CENTERS 0 0 0 0 0 0 13.00 13.01 01300 COLLA SERVICE COST CENTERS 0 0 0 0 0 0 0 0 15.00 13			C	0	0	0	-	
13.00 0.1300 SOCIAL SERVICE 250 0 0 0 0 0 0 13.00 15.00 0.1500 AUTHOR SIGN AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0 15.00 0.1500 AUTHOR SIGN AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0		l	C	0	0	0		
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 15.00			250		0	0		
15.00 0.500 ACTIVITES 0.0 0.0 0.0 0.1 15.00		l		1				
IMPATE INT. ROUTH & SERVICE COST CENTERS 19,256 32,585 19,256 97,755 33,586 30,00 31,00 30,00 31,0		l		1	_	0		1
30.00	13.00			,				13.00
31.00	30. 00		19, 256	32, 585	19, 256	97. 755	32, 585	30.00
33.00 03000 OTHER LONG TERM CARE			C	0	0	0		
## AMCILLARY SERVICE COST CENTERS 0	32. 00	03200 CF/IID	C	0	0	0	0	32. 00
0.000 0.00	33.00		C	0	0	0	0	33. 00
1.00 0.0								
42 00 04200 NTRAVENOUS THERAPY 0 0 0 0 0 0 42 00			1	1	· -	_	-	
43.00 04300 NYSER (IMHALATION) THERAPY 0 0 0 0 0 43.00			1	1	· -	0	-	
44.00 04400 PHYSICAL THERAPY			1	1	1	0	-	
45.00 04500 OCLUPATIONAL THERAPY 192 0 192 0 0 45.00			1	Ί	ľ	0	-	
46.00 04600 SPEECH PATHOLOGY 192 0 192 0 0 46.00 0 0 0 0 0 0 0 0 0			1	l control of the cont	•		-	
47.00 04700 ELECTROCARDIOLOGY		l	1	l control of the cont	•	0	-	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 49.00 0490 070 070 080		l	1	1	i e	0		1
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 50.00		l		o	0	0	-	
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51.00	49.00	04900 DRUGS CHARGED TO PATIENTS	C	0	0	0	0	49. 00
52.00	50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0	0	0	0	50.00
52.01			C	0	0	0	0	51.00
Second S			C	0	0	0	-	
OLIPATIENT SERVICE COST CENTERS		l	1	1	"	0		
60.00	52. 02) 0	0	0	0	52.02
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 62.00 62.00 06200 FOHC 0 0 0 0 0 0 0 0 0	60.00						1 0	60 00
Company Comp		l		1				
63.00)				
OTHER REIMBURSABLE COST CENTERS			0	0	0	0	0	
70. 00								
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 0	70.00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70.00
74.00 07400 07HER REIMBURSEMENT 0 0 0 0 0 0 0 0 0			C	0	0	0		
SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTI CE PREMI UNS & PAID LOSSES 81. 00 08100 INTEREST EXPENSE 82. 00 08200 UTILIZATI ON REVIEW - SNF 82. 00 08200 UTILIZATI ON REVIEW - SNF 82. 00 08300 HOSPI CE 0 0 0 0 0 0 0 0 0 83. 00 084. 01 08401 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 0 0 0 084. 01 08401 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	C	0	0	0		
80.00	74. 00			0	0	0	0	74.00
81. 00 82. 00 08200 UTI LI ZATI ON REVIEW - SNF 82. 00 08200 UTI LI ZATI ON REVIEW - SNF 82. 00 08400 OTHER SPECI AL PURPOSE COST 0 0 0 0 0 0 0 0 0	90.00							90 00
82. 00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 0 0 0 0 0		l						
83.00 08300 HOSPICE 0 0 0 0 0 0 83.00 84.01 08401 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.01 08401 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 23,978 32,585 22,978 97,755 32,585 89.00 NONREI MBURSABLE COST CENTERS								
84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 0 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 23,978 32,585 22,978 97,755 32,585 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 91.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 0 0 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 0 0 92.00 93.00 09300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 92.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 0 0 92.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 0 0 95.00 98.00 VORMED STANDARD SHOP SHOP SHOP SHOP SHOP SHOP SHOP SHOP		l	0	0	0	0	0	83.00
84. 01				ol o	ĺ	0	-	84. 00
NONREI MBURSABLE COST CENTERS O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN O O O O O O O O O				0	0	0		84. 01
90. 00			23, 978	32, 585	22, 978	97, 755	32, 585	
91. 00								
92. 00				1				
93. 00		l		0	0	0		1
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 94.00 95.00 98.00 99.00 Cross Foot Adjustments 0 0 0 0 0 0 95.00 98.00 99.00 Negative Cost Centers 0 0 336,459 454,993 1,605,181 1,382,647 102.00 Cost to be allocated (per Wkst. B, Part I) 38.101593 10.325579 19.801245 16.420449 42.432009 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 38.101593 10.32579 19.801245 16.420449 42.432009 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 38.101593 10.32579 19.801245 16.420449 42.432009 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 28.21253 1.794906 2.636783 2.891023 2.491515 105.00						0		
95. 00 09500 0THER NONREIMBURSABLE COST 0 0 0 0 0 95. 00 98. 00 99. 00 0 0 0 98. 00 99. 00 0 0 0 0 98. 00 99. 00 0 0 0 0 0 98. 00 99. 00 0 0 0 0 0 0 0 0 0		l						
98.00 99.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		l					-	1
99.00 Negative Cost Centers				1				98.00
102.00 Cost to be allocated (per Wkst. B, Part I) 38.101593 10.325579 19.801245 16.420449 42.432009 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 2.821253 1.794906 2.636783 2.891023 2.491515 105.00			1					99.00
103.00 Unit cost multiplier (Wkst. B, Part I) 38.101593 10.325579 19.801245 16.420449 42.432009 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 67,648 58,487 60,588 282,612 81,186 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 2.821253 1.794906 2.636783 2.891023 2.491515 105.00			913, 600	336, 459	454, 993	1, 605, 181	1, 382, 647	
104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part 2.821253 1.794906 2.636783 2.891023 2.491515 105.00								
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 2.821253 1.794906 2.636783 2.891023 2.491515 105.00				1	1			
105.00 Unit cost multiplier (Wkst. B, Part 2.821253 1.794906 2.636783 2.891023 2.491515 105.00	104.00		67, 648	58, 487	60, 588	282, 612	81, 186	104. 00
	105.00		2 021252	1 704004	2 / 2/ 702	2 001022	2 401515	105 00
	105.00		2. 821253	1. /94906	2. 636/83	2. 891023	2. 491515	105.00
		1 1117	1	I .	I .	1	I	1

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11:36 am Provi der No.: 315092

					0 12/31/2023	5/10/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY		SOCIAL SERVICE		
		SERVICES & SUPPLY	(PATIENT DAYS)	RECORDS & LI BRARY	(PATIENT DAYS)	ALLIED HEALTH EDUCATION	
		(PATIENT DAYS)		(PATIENT DAYS)	(FAITENT DATS)	(ASSI GNED	
		((TIME)	
		10.00	11. 00	12. 00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS			ı			1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT			•			1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMI NI STRATI VE & 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
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	32, 585	00 505				10.00
11.00	01100 PHARMACY	0	32, 585	1			11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0	32, 585 0			12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	32, 303 0	0	14.00
15. 00	01500 ACTIVITES	0	0	1	0	Ö	15. 00
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS						10.00
30.00	03000 SKILLED NURSING FACILITY	32, 585	32, 585	32, 585	32, 585	0	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	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS			1		_	
40.00	04000 RADI OLOGY	0	0	0	_	0	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	_	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	o o	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	o	0	Ō	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	50.00
51. 00 52. 00	O5100 SUPPORT SURFACES O5200 COMPLEX MEDI CAL EQUI PMENT	0	0	0	0	0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.00
52. 02	05202 MEDI CAL SERVI CES	o o	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS			-			
60.00	06000 CLI NI C	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	0	0	0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS		_	1	0		70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0		0	_		70.00
	07300 CMHC	0	0		0	0	
74. 00	07400 OTHER REIMBURSEMENT	ő	Ö	Ö	0	Ö	74.00
	SPECIAL PURPOSE COST CENTERS						
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 HOSPI CE	0	0	0	0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST 08401 OTHER SPECIAL PURPOSE COST 1	0	0		0	0	84.00
84. 01 89. 00	1	22 505	22 505	22 505	22 505	0	84. 01 89. 00
07.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	32, 585	32, 585	32, 585	32, 585	<u> </u>	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	Ö	_	Ö	91.00
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 NONREI MBURSABLE COST	0	0	9	0	0	95.00
98. 00	Cross Foot Adjustments						98.00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	202 445	27, 149	56, 598	162, 125	_	99. 00 102. 00
102.00	Part I)	283, 465	21, 149	30, 398	102, 125		102.00
103.00	1 1 '	8. 699248	0. 833175	1. 736934	4. 975449	0. 000000	103. 00
104.00	1 1	5, 027	481	1, 004			104.00
	Part II)						
105.00		0. 154273	0. 014761	0. 030812	0. 911616	0. 000000	105. 00
				[I

CARE ONE AT HOLMDEL In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 36 am Provi der No.: 315092

			10 12/31/2023	5/10/2024 11: 36 am
		OTHER GENERAL		
		SERVI CE		
	Cost Center Description	ACTI VI TES		
		(PATIENT DAYS) 15.00		
	GENERAL SERVICE COST CENTERS	15.00	 	
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
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 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE			12. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION			14.00
15. 00	01500 ACTIVITES	32, 585		15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	32, 303		13.00
30. 00	03000 SKILLED NURSING FACILITY	32, 585		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	04000 RADI OLOGY	0		40. 00
41. 00	04100 LABORATORY	0		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00	04400 PHYSI CAL THERAPY	0		44.00
45. 00	04500 OCCUPATIONAL THERAPY	0 0		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0		46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS			49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	05100 SUPPORT SURFACES			51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	O		52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0		52. 01
52.02	05202 MEDI CAL SERVI CES	0		52. 02
	OUTPATIENT SERVICE COST CENTERS	,		
60. 00	06000 CLI NI C	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
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0		70, 00
70.00		0		71. 00
	07300 CMHC			73.00
	07400 OTHER REIMBURSEMENT	o o		74. 00
, ,, ,,	SPECIAL PURPOSE COST CENTERS	<u> </u>		7 90
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		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0		84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	32, 585		89. 00
00.00	NONREI MBURSABLE COST CENTERS			00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0		91. 00 92. 00
93. 00	09300 NONPALD WORKERS	0		93. 00
94. 00	09400 PATIENTS LAUNDRY	0		94.00
95. 00	09500 OTHER NONREIMBURSABLE COST	0		95. 00
98. 00	Cross Foot Adjustments			98. 00
99. 00	Negative Cost Centers			99. 00
102.00		284, 100		102. 00
	Part I)			
103.00		8. 718736		103. 00
104.00	1	5, 038		104. 00
105.00	Part II)	0.454444		405 00
105.00	Unit cost multiplier (Wkst. B, Part	0. 154611		105. 00
		ı l		I

Health Financial Systems	CARE ONE AT HOLMD	DEL	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES	FOR ANCILLARY AND OUTPATIENT COST CENTERS P	Provi der No.: 315092	Peri od:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:36 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 47, 070 98, 930 0. 475791 40.00 04100 LABORATORY 102, 040 214, 463 0.475793 41.00 41.00 232, 814 42.00 04200 I NTRAVENOUS THERAPY 531, 865 0.437731 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 984, 354 2, 616, 724 0.376178 44.00 04500 OCCUPATIONAL THERAPY 45.00 882, 374 2, 933, 930 0.300748 45.00 04600 SPEECH PATHOLOGY 563, 985 0. 331152 46.00 186, 765 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 86 180 0. 477778 48.00 04900 DRUGS CHARGED TO PATIENTS 1, 504, 150 0. 437732 49.00 49.00 658, 415 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 0.000000 0 52.01 05202 MEDICAL SERVICES 0 0.000000 52.02 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 63.00 06300 DI ALYSI S 0.000000 63.00

71, 160

3, 165, 078

149, 560

8, 613, 787

0. 475796

71.00

100. 00

71. 00 07100 AMBULANCE

Total

100.00

Health Financial Systems	CARE ONE AT				eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	epared: 36 am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th 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	, a. c ,		x col. 2)	x col. 3)	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	FLENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0. 475791	28, 615		0 13, 615		
41. 00 04100 LABORATORY	0. 475793	69, 752	l .	0 33, 188		
42. 00 04200 I NTRAVENOUS THERAPY	0. 437731	50, 296	•	0 22, 016		
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 376178			0 639, 029		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 300748			0 571, 694		
46. 00 04600 SPEECH PATHOLOGY	0. 331152	412, 821		0 136, 706		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 477778			0 86		
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 437732	220, 962		0 96, 722	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	
52. 00 05200 COMPLEX MEDI CAL EQUI PMENT	0.000000			0	0	
52. 01 05201 OTHER ANCILLARY SERVICES COST	0.000000			0 0	0	
52. 02 O5202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0. 000000	0		0 0	0	52.02
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.000000	0			0	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. 475796				0	
100.00 Total (Sum of lines 40 - 71)	0.473790	4, 382, 273		0 1, 513, 056		100.00
(1) For title V and XIX use columns 1, 2, and 4 on	.	4,302,273	I	0 1,313,030	1	1100.00

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

Heal th	Financial Systems	CARE ONE A	F HOLMDEL		In Lie	eu of Form CMS-2	2540-10
	TIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315092	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/10/2024 11:	pared:
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	0. 437732	1.00
2.00	Program vaccine charges (From your reco	rds, or the PS	&R)		,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transfe	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col. 18	(From Wkst. B,	Costs to Tota		Health Costs for Pass	
		18		Costs - Part		Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)	•	3 X COI . 4)	
		1, 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	47, 070	0	0. 00000	00 13, 615	0	40. 00
41.00	04100 LABORATORY	102, 040	0	0.0000			
42.00	04200 I NTRAVENOUS THERAPY	232, 814	0	0. 00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0. 00000		0	
44. 00	04400 PHYSI CAL THERAPY	984, 354	0	0. 00000			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	882, 374	0	0. 00000			45. 00
46. 00	04600 SPEECH PATHOLOGY	186, 765	0	0. 00000		l e	
47. 00	04700 ELECTROCARDI OLOGY	0	0	0. 00000		0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	86	0	0.0000			
49. 00	04900 DRUGS CHARGED TO PATIENTS	658, 415	0	0.0000	•	l e	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.0000		0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0.0000		0	
	O5200 COMPLEX MEDICAL EQUIPMENT O5201 OTHER ANCILLARY SERVICES COST	0	0	0. 00000 0. 00000		0	
52. 01 52. 02			0	0.0000		0	
100.00		3, 093, 918	0	1	1, 513, 056		100.00
100.00	1 10tal (3011 01 111163 40 - 32)	3,073,710	0	П	1, 515, 050	,	1100.00

Heal th	Financial Systems CARE ONE A	T HOLMDEL	In Lie	eu of Form CMS-2	2540-10
COMPUT	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315092	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title XVIII	Skilled Nursing Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
1.00	Inpatient days including private room days			32, 585	1.00
2.00	Private room days			0	2. 00
3.00	Inpatient days including private room days applicable to the			13, 780	
4.00	Medically necessary private room days applicable to the Pro	ogram		0	
5.00	Total general inpatient routine service cost			13, 002, 518	5. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			15 000 070	
6. 00 7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line	E divided by Line 6)		15, 930, 978 0. 816178	
8.00	Enter private room charges from your records	5 divided by Title 0)		0.810178	1
9.00	Average private room per diem charge (Private room charges	line 8 divided by private	room days line	0.00	
7. 00	2)	Title o di vided by private	Toom days, Title	0.00	7.00
10.00				0	10.00
11.00	Average semi-private room per diem charge (Semi-private ro	oom charges line 10, divide	ed by	0.00	11.00
	semi-private room days)				
12.00	Average per diem private room charge differential (Line 9 m			0.00	
13.00	3 1	,		0.00	
14. 00 15. 00			minus line 14)	13, 002, 518	
13.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	III IIus IIIle 14)	13,002,316] 13.00
16. 00		divided by line 1)		399. 03	16. 00
17. 00	Program routine service cost (Line 3 times line 16)			5, 498, 633	
18.00	Medically necessary private room cost applicable to program	n (line 4 times line 13)		0	18. 00
19.00	Total program general inpatient routine service cost (Line	e 17 plus line 18)		5, 498, 633	19. 00
20. 00	Capital related cost allocated to inpatient routine service	e costs (From Wkst. B, Par	t II column 18,	2, 687, 401	20. 00
21. 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1)			82. 47	21. 00
22. 00	Program capital related costs (Line 3 times line 21)	,		1, 136, 437	
23. 00	, , , , , , , , , , , , , , , , , , , ,			4, 362, 196	
24. 00				0	l l
25. 00				4, 362, 196	25. 00
26. 00	Enter the per diem limitation (1)				26.00
	Inpatient routine service cost limitation (Line 3 times the				27. 00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus		line 27)		28. 00
(1) !:	(Transfer to Worksheet E, Part II, line 4) (See instruction nes 26 and 27 are not applicable for title XVIII, but may be		i tlo VIV	I	I
(1) LI	nes zo anu z <i>i</i> are not appricable for title XVIII, but may be	e used for title vand or t	ILIE ALA		
				1.00	
				1. 00	

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	32, 585	1.00
2.00	Program inpatient days (see instructions)	13, 780	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. 422894	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

		Peri od: From 01/01/2023 To 12/31/2023		pared
	Title XIX	Skilled Nursing Facility		
			1. 00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
NPATIENT DAYS				
			32, 585	1.
•			0	
	n			4.
			13, 002, 518	5
			15 030 078	6
1	vided by line 6)			
·	vided by Time 0)			
1 9 9	e 8 divided by private	room days. Line	_	-
2)			1	
Enter semi-private room charges from your records			0	10
	charges line 10, divide	d by	0.00	11
1			1	
	,			
,	,	minus Lino 14)	_	1
	t differential (Line 5	minus iine 14)	13, 002, 518	1 15
	ided by Line 1)		399 03	16
	. dou 23			
	ine 4 times line 13)		0	
Total program general inpatient routine service cost (Line 17	plus line 18)		3, 270, 849	19
		t II column 18,	2, 687, 401	20
Per diem capital related costs (Line 20 divided by line 1)			82. 47	
Program capital related cost (Line 3 times line 21)			676, 007	
1				
33 3		04)	_	1
·	ıımıtatıon (Line 23 mi	nus line 24)		
1	s diam limitation line	24) (1)		
			_	1 -
, , ,	e resser of fille 20 Of	11110 21)	3, 210, 049	20
	PRATIENT DAYS npatient days including private room days Private room days npatient days including private room days applicable to the Prograf npatient days including private room days applicable to the Prograf Medically necessary private room days applicable to the Prograf Total general inpatient routine service cost RIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 di Center private room charges from your records Average private room per diem charge (Private room charges line Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room cost Average per diem private room charge differential (Line 9 minus Average per diem private room cost differential (Line 7 times lo Private room cost differential adjustment (Line 2 times line 13 General inpatient routine service cost net of private room cost ROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divi Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (Lo Total program general inpatient routine service cost Line 17 Capital related cost allocated to inpatient routine service cost Line 30 for SNF; line 31 for NF, or line 32 for LCF/IID) Per diem capital related cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capital related cost (Line 3 times line 22) Aggregate charges to beneficiaries for excess costs (From prov Total program routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From prov Total program routine service cost (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 3 times the per Reimbursable inpatient routine service costs (Line 22 plus the Cost (Transfer to Worksheet E, Part II, Line 4) (See instructions)	PATIENT DAYS npatient days including private room days Private room days npatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost RIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divide 50 cmiter private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room charge differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 modella) ROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Medically necessary private room cost applicable to program (line 4 times line 13) Program capital related costs (Line 3 times line 21) Program capital related costs (Line 3 times line 21) Program capital related costs (Line 3 times line 21) Program capital related costs (Line 3 times line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Fortial program routine service cost (Line 3 times line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Fortial program routine service cost (Line 3 times line 22) Rograpatient routine service cost (Line 3 times the per diem limitation (Line 23 minute the per diem limitation (Line 3 time	npatient days including private room days rivate room days npatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room charges Meneral inpatient routine service cost /charge ratio (Line 5 divided by line 6) Meneral private room charges from your records Merage per diem private room charges from your records Merage per diem private room charge differential (Line 9 minus line 10, divided by semi-private room days) Merage per diem private room cost differential (Line 9 minus line 11) Merage per diem private room cost differential (Line 7 times line 12) Merivate room cost differential adjustment (Line 2 times line 13) Merage per diem private room cost differential (Line 15 divided by line 1) Merage per diem pratient routine service cost net of private room cost differential (Line 5 minus line 14) Merage per diem pratient service cost per diem (Line 15 divided by line 1) Merage per diem capital related cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Merage general inpatient routine service cost (Line 17 plus line 18) Merage general inpatient routine service cost (Line 17 plus line 18) Merage general inpatient routine service cost (Line 19 minus line 21) Merage general inpatient routine service cost (Line 19 minus line 21) Merage general inpatient routine service cost (Line 19 minus line 22) Magregate charges to beneficiaries for excess costs (From provider records) Merage general ma	ART I CALCULATION OF INPATIENT ROUTINE COSTS NPATIENT DAYS npatient days including private room days npatient days including private room days applicable to the Program npatient days including private room days applicable to the Program npatient days including private room days applicable to the Program npatient days including private room days applicable to the Program npatient routine service cost Notal general inpatient routine service cost Notal general inpatient routine service cost (Line 5 divided by line 6) notal general inpatient routine service cost/charge ratio (Line 5 divided by line 6) notal general inpatient routine service cost/charge ratio (Line 5 divided by line 6) notal general inpatient routine service cost (Line 9 minus line 8 divided by private room days, line 2) notare semi-private room charges from your records notare private room days notare semi-private room charges from your records notare semi-private room days notare semi-private room days notare semi-private room charges from your records notare

		1. 00	
<u> </u>	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	32, 585	1.00
2.00	Program inpatient days (see instructions)	8, 197	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. 251557	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	CARE ONE AT HOL	MDEL	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315092		Worksheet E
			From 01/01/2023	i Part I
			To 12/31/2023	Date/Time Prepared:
				5/10/2024 11:36 am
		Title XVIII	Skilled Nursing	PPS
			F	i

		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)			10, 716, 634	1. 00
2. 00	Nursing and Allied Health Education Activities (pass through payments)			0	2. 00
3. 00	Subtotal (Sum of Lines 1 and 2)			10, 716, 634	3. 00
4. 00	Primary payor amounts			0	4. 00
5.00	Coinsurance			1, 621, 200	5. 00
6.00	Allowable bad debts (From your records)			421, 040	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		176, 697	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)	,		273, 676	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			o	10.00
11. 00	Subtotal (See instructions)			9, 369, 110	11. 00
12.00	Interim payments (See instructions)			9, 204, 485	12.00
13.00	Tentati ve adjustment			o	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			75, 706	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			5, 474	14. 75
14. 99	, ,			181, 909	14. 99
15. 00	Balance due provider/program (see Instructions)			-98, 464	15.00
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (OF COST OR CHARGES - T	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00				0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)	o with CMC Dub 1F 2 -	sootion 11F 2	0	29. 00
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2, S	section 115.2	0	30. 00

From 01/01/2023
To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11: 36 am

Title XVIII Skilled Nursing

PPS

		11 (1	e viiii 3	Facility	FF3	
		Inpatier	it 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		8, 837, 819		0	1. 00
2.00	Interim payments payable on individual bills, either		404, 499		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
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)]
	Program to Provider		1		1	
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	
3. 04			0		0	
3. 05			0		0	
	Provider to Program			l.		
3.50	ADJUSTMENTS TO PROGRAM	06/02/2023	37, 833		0	3. 50
3. 51			0		0	
3. 52			0		0	
3. 53 3. 54			0		0	
3. 54 3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-37, 833			
3. 77	- 3.98)		-37, 633			3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 204, 485		0	4.00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					1
F 00	TO BE COMPLETED BY CONTRACTOR		ı		ı	F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER		0		0	
5.02			0		0	
5. 03	Durani dana da Duranyan		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATIVE TO FROGRAM		0			
5. 52			0		Ö	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) PROGRAM TO PROVIDER		_		0	6. 01
6. 01	PROVIDER TO PROGRAM		98, 464			
7. 00	Total Medicare program liability (see instructions)		9, 106, 021			
	, , (222 2001 0110)			tor Name	Contractor	1.50
					Number	
	To the second se		1.	00	2. 00	
8. 00	Name of Contractor					8.00

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

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

Provi der No.: 315092 | Peri od: | From 01/01/2023 | To 12/31/2023

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 36 am

oni y)					5/10/2024 11:	36 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets					
1. 00	CURRENT ASSETS Cash on hand and in banks	75, 000		0	0	1.00
2. 00	Temporary investments	75,000			0	
3. 00	Notes recei vabl e	0			0	
4.00	Accounts receivable	1, 913, 262	2 (0	0	4.00
5.00	Other receivables	0) (0	0	
6. 00	Less: allowances for uncollectible notes and accounts	-260, 301		0	0	6.00
7. 00	recei vabl e Inventory				0	7. 00
8. 00	Prepai d expenses	26, 608	1		0	
9. 00	Other current assets	4, 546	1	o o	Ö	
10. 00	Due from other funds	0		0	0	10.00
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 759, 115	5 (0	0	11.00
	FI XED ASSETS	T				
12.00	Land	300, 000	1		0	1
13. 00 14. 00	Land improvements	968, 642 -15, 393	1	-	0	
15. 00	Less: Accumulated depreciation Buildings	5, 731, 971		-		
16. 00	Less Accumulated depreciation	-3, 979, 047	1		0	
17. 00	Leasehold improvements	0,777,017		o o	Ö	
18. 00	Less: Accumulated Amortization	0		0	0	18. 00
19. 00	Fi xed equipment	558, 395	1	0	0	
20. 00	Less: Accumulated depreciation	-656, 777		1	0	
21. 00	Automobiles and trucks	59, 967		-	0	
22. 00	Less: Accumulated depreciation	-59, 967		-	0	
23. 00 24. 00	Major movable equipment Less: Accumulated depreciation	2, 286, 928 -1, 833, 381	1	, i	0	
25. 00	Mi nor equi pment - Depreci abl e	-1, 033, 301				
26. 00	Minor equipment nondepreciable			o o	Ö	
27. 00	Other fixed assets	146, 942	2	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	3, 508, 280) (0	0	28.00
	OTHER ASSETS	Т				ļ
29. 00	Investments	0		-	0	•
30. 00 31. 00	Deposits on Leases Due from owners/officers				0	
32. 00	Other assets	5, 811, 100	Ί `	٥	0	
33. 00	TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	5, 811, 100	1	-	Ö	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	11, 078, 495	1	0	0	
	Liabilities and Fund Balances					
	CURRENT LIABILITIES	T				
35. 00	Accounts payable	1, 199, 593	1	-	0	
36. 00 37. 00	Salaries, wages, and fees payable Payroll taxes payable	187, 430 -9, 625	1		0	
38. 00	Notes & Loans payable (Short term)	- 7, 023			0	
39. 00	Deferred income			o o	Ö	
40.00	Accel erated payments	0				40.00
41. 00	Due to other funds	4, 546		0	0	
42. 00	Other current liabilities	951, 233		0		
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 333, 177	<u>'</u>	0	0	43.00
44.00	LONG TERM LIABILITIES	27, 939, 986) (0	0	144 00
44. 00 45. 00	Mortgage payable Notes payable	27, 939, 980			0	1
46. 00	Unsecured Loans				0	
47. 00	Loans from owners:			o o	Ö	
48. 00	Other long term liabilities	-54, 947, 882		0	0	
49. 00	OTHER (SPECIFY)	0) (0	0	49.00
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-27, 007, 896		-	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-24, 674, 719) (0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	35, 753, 214	·I			52.00
53. 00	Specific purpose fund	35, 755, 214	΄			53.00
54. 00	Donor created - endowment fund balance - restricted)	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0	•	55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
E0 00	replacement, and expansion	25 752 214	,		,	50.00
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	35, 753, 214 11, 078, 495	1		0	
55. 50	[59]	11, 070, 470	1] 30.00
	•	'	•	'	•	•

CARE ONE AT HOLMDEL

| Period: | Worksheet G-1 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der No.: 315092

					Т		Date/Time Pro 5/10/2024 11:	pared: 36 am	
		General	l Fund	Speci al	Pu	rpose Fund	Endowment Fund		
									İ
		1.00	2. 00	3. 00		4. 00	5. 00		ĺ
1.00	Fund balances at beginning of period		34, 951, 438			0		1.00	
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		801, 773 35, 753, 211			0		2.00	
4. 00	Additions (credit adjustments)		33, 733, 211			O		4. 00	
5.00	ROUNDI NG	3			0		C		
6.00		0			0		C		
7. 00 8. 00		0			0				
9. 00					0				
10.00	Total additions (sum of line 5 - 9)		3			0		10.00	
11. 00	Subtotal (line 3 plus line 10)		35, 753, 214			0		11. 00	
12.00	Deductions (debit adjustments)						_	12.00	
13. 00 14. 00		0			0				
15. 00					0				
16. 00		O			0		C	1	
17. 00		0	_		0	_	C		
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance		0 35, 753, 214			0		18. 00 19. 00	
19.00	sheet (Line 11 - line 18)		33, 733, 214			Ü		19.00	
		Endowment Fund	PI ant	Fund					
		6.00	7. 00	8. 00					
1. 00	Fund balances at beginning of period	0.00	7.00	8.00	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			3. 00	
4.00	Additions (credit adjustments)		0					4.00	
5. 00 6. 00	ROUNDI NG		0					5. 00 6. 00	
7. 00			0					7. 00	
8.00			0					8. 00	
9.00	T + 1 - 1" + 1 - (0					9.00	
10. 00 11. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0			0			10.00	
12. 00	Deductions (debit adjustments)				U			12.00	
13. 00			0					13. 00	
14. 00			0					14. 00	
15.00			0					15. 00 16. 00	
16. 00 17. 00			0					17. 00	
18. 00	Total deductions (sum of lines 13 - 17)	o	0		0			18. 00	
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0			0			19. 00	

Heal th	Financial Systems CARE ONE AT H	HOLMDEL		In Lie	u of Form CMS-2	2540-10
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II Date/Time Prep 5/10/2024 11:3	oared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	<u> </u>		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		15, 930, 97	8	15, 930, 978	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	I CF/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)		15, 930, 97	8	15, 930, 978	5.00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES	·	8, 613, 78	7 0	8, 613, 787	6.00
7 00	OLI NILO		I		ا م	

7.00

8.00

9. 00

0

0

0

7.00	AMBOLANCE		Ч	U	7.00
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	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to	24, 544, 765	0	24, 544, 765	14. 00
	Worksheet G-3, Line 1)				
	Cost Center Description				
			1. 00	2. 00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			17, 028, 169	1. 00
2.00	Add (Specify)		0		2. 00
3.00			0		3. 00
4.00			0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7.00			0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)			0	8. 00
9. 00	Deduct (Specify)		0		9. 00
10.00			0		10. 00
11. 00			0		11. 00
12. 00			0		12. 00
13. 00			0		13. 00
14. 00	Total Deductions (Sum of lines 9 - 13)			0	14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			17, 028, 169	15. 00

7.00

8.00

9.00

CLINIC

AMBULANCE

HOME HEALTH AGENCY COST

Heal th	Financial Systems CARE ON	E AT HOLMDEL	In Lie	u of Form CMS	2540-10
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315092	Peri od: From 01/01/2023 To 12/31/2023		pared:
				4.00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3,	line 14)		1. 00 24, 544, 765	1.00
2. 00	Less: contractual allowances and discounts on patients a	,		6, 734, 274	1
3. 00	Net patient revenues (Line 1 minus line 2)	17, 810, 491	1		
4. 00					
5.00					4. 00 5. 00
	Other income:				1
6.00	Contributions, donations, bequests, etc				
7.00	Income from investments	1, 871	7. 00		
8.00	Revenues from communications (Telephone and Internet service)				8. 00
9.00	Revenue from television and radio service				9. 00
					10.00
					11. 00
					12. 00
	00 Revenue from Laundry and Linen service				13. 00
14. 00	Revenue from meals sold to employees and guests				14. 00

0 15.00

0 19.00

0 22.00

0 23.00

0 24.50

Ω

0 28.00

0 29.00 30.00

0

801, 773 31. 00

3, 077

4, 263

8, 311

19, 451

801, 773

16.00

17.00

18.00

20.00

21.00

24.00

24. 01

24.02

25.00

26.00

27.00

15.00 Revenue from rental of living quarters

Rental of vending machines

Governmental appropriations

Total (Line 5 plus line 25)

24.00 BARBER AND BEAUTY

OTHER INCOME

COVI D-19 PHE Funding

27.00 Other expenses (specify)

OTHER REV

Rental of skilled nursing space

20.00

21.00

22. 00

23.00

24. 01

24. 02

24. 50

26. 00

28.00

29.00

30.00

16.00 Revenue from sale of medical and surgical supplies to other than patients

Revenue from sale of drugs to other than patients

Revenue from gifts, flower, coffee shops, canteen

18.00 Revenue from sale of medical records and abstracts

19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

Total other income (Sum of lines 6 - 24)

Total other expenses (Sum of lines 27 - 29)

31.00 Net income (or loss) for the period (Line 26 minus line 30)