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

FORM APPROVED

OMB NO. 0938-0463

Expires: 12/31/2021

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

Provider CCN: 315479
From 01/01/2023
To 12/31/2023
Parts I, II & III
Date/Time Prepared:
5/10/2024 11: 39 am

			07 107	2021 11.07 am
PART I - COST I	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost rep	oort	Date: 5/10/2024	Time: 11:39 an
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report ent	er the number of times the provide	r resubmitted this cos	t report
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.		
Contractor	4. [1] Cost Report Status	6. Contractor No.		
use only	(1) As Submitted	7.[N] First Cost Report for this	Provider CCN	
	(2) Settled without audit	8. [N] Last Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:		
	(4) Reopened	10.[0]If line 4, column 1 is "4"	Enter number of times	s reopened
	(5) Amended	11.Contractor Vendor Code	4	·
	5. Date Received:	12.[F] Medicare Utilization. Ente	er "F" for full, "L" fo	r low, or "N"
		for no utilization.		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 LIVINGSTON (315479) 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	IGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		ELECTRONI C	
		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	-138, 678	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	-138, 678	0	0	100.00
The ob	to a manufic manufacent "due to" on "due from" the applicable	nroarom for th		as shows somel	i ndi oo+od	

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 LIVINGSTON In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315479 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:39 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 68 PASSAIC AVENUE PO Box: 1.00 2.00 City: LIVINGSTON State: NJ Zi p Code: 07039 2.00 3.00 County: ESSEX CBSA Code: 35084 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 LIVINGSTON 315479 10/15/2002 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 561, 744 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 23 00 561, 744 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) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 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 Υ 38, 00 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: 41 00 64.759

Heal th Financ	ial Systems	CARE ONE AT LIVI	NGSTON	In Li€	In Lieu of Form CMS-25		
SKILLED NURSI	NG FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 31547		Worksheet S-2		
COMPLEX INDEN	NTIFICATION DATA			From 01/01/2023			
				To 12/31/2023			
					5/10/2024 11:	39 am	
					Y/N		
					1.00		
42.00 Are mal	Ipractice premiums and paid loss	es reported in other than	the Administrative	and General cost	N	42.00	
center	? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing cos	st centers and			
amounts	S.		_				
43.00 Are the	ere any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?		Υ	43.00	
44.00 If line	e 43 is yes, enter the home offi	ce chain number and enter	the name and address	ss of the home	HB0206	44. 00	
offi ce	on lines 45, 46 and 47.						
	1. 00	2.00		3. 00			
If this	s facility is part of a chain or	ganization, enter the nam	e and address of the	e home office on the	e lines		
bel ow.	,						
45. 00 Name:	5.00 Name: HEALTHBRIDGE Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 12001					45. 00	
46.00 Street:						46. 00	
47.00 City:	FORT LEE	State: NJ	Zi p (Code: 070	24	47. 00	

Health Financial Systems CARE ONE AT LIVINGSTON In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315479 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:39 am Date 1. 00 2.00 General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public Α Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. 11.00 Ν Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 03/19/2024 Υ 13.00 only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R Ν Ν 14 00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Heal th	Financial Systems CARE ONE	E AT I	LI VI NGSTON	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH	CARE	Provi der No.: 315479	Peri od: From 01/01/2023	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					pared: 39 am
		L]
			1. 00	2. (00	
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position	(CHARLES	REED		19. 00
	held by the cost report preparer in columns 1, 2, and 3	3,				
	respecti vel y.					
20.00	Enter the employer/company name of the cost report		EXECUCARE ASSOCIATES			20. 00
	preparer.					
21.00	Enter the telephone number and email address of the cos	st	(609) 738-3200	CRWASSC@NETSCAF	PE. NET	21. 00
	report preparer in columns 1 and 2, respectively.					

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

CARE ONE AT LIVINGSTON
Provider No.: 315479
Period: Worksheet S-2
From 01/01/2023
From 01/0

PS&R Data PS&R Data PS&R Data	13. 00
PS&R Data	
PS&R Data	
10 00 W the cost assert assert with DC0D 00/10/2004	
13.00 Was the cost report prepared using the PS&R 03/19/2024 1	14.00
only? If either col. 1 or 3 is "Y", enter	14.00
the paid through date of the PS&R used to	14.00
prepare this cost report in cols. 2 and	14 00
4. (see Instructions.)	14 00
	14.00
for total and the provider's records for	
allocation? If either col. 1 or 3 is "Y"	
enter the paid through date of the PS&R used	
to prepare this cost report in columns 2 and	
45.00	15 00
	15. 00
made to PS&R data for additional claims that have been billed but are not included on the	
PS&R used to file this cost report? If "Y",	
see Instructions.	
	16. 00
adjustments made to PS&R data for	10.00
corrections of other PS&R Report	
information? If yes, see instructions.	
	17. 00
adjustments made to PS&R data for Other?	
Describe the other adjustments:	
18.00 Was the cost report prepared only using the	18. 00
provider's records? If "Y" see Instructions.	
3.00	
Cost Report Preparer Contact Information	
	19. 00
held by the cost report preparer in columns 1, 2, and 3, respectively.	
	20. 00
preparer.	10.00
	21. 00
report preparer in columns 1 and 2, respectively.	. 1. 00

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

 Heal th Financial
 Systems
 CARE ONE AT I

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

Provi der No.: 315479

						5/10/2024 11:3	
				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	120	43, 800		4, 093	10, 911	1.00
2. 00 3. 00	NURSING FACILITY	0	0			0	2. 00 3. 00
4.00	HOME HEALTH AGENCY COST		0	0	0	ol ol	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)	120	43, 800	0	0 4, 093	0 10, 911	7. 00 8. 00
0.00	Total (Sail of Titles 1 7)	Inpatient D		J	Di scharges	10, 711	0.00
				- 1	- 1.11 \0.011		
	Component	0ther 6.00	Total 7. 00	Title V 8.00	Title XVIII 9.00	Title XIX 10.00	
1.00	SKILLED NURSING FACILITY	8, 917	23, 921	0.00	173	67	1. 00
2.00	NURSING FACILITY	0	0	0		0	2. 00
3.00	I CF/IID	0	0			0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0				4. 00 5. 00
6.00	SNF-Based CMHC		O				6. 00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	8, 917 Di scha	23, 921	0	age Length of	67 S+ov	8. 00
		DI SCII	ai ges	Avei	age Length of	Stay	
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1.00	SKILLED NURSING FACILITY	11.00	12. 00 613	13.00	14. 00 23. 66	15. 00 162. 85	1. 00
2.00	NURSING FACILITY	0	0		23.00	0.00	2. 00
3.00	ICF/IID	0	0			0.00	3.00
4.00	HOME HEALTH AGENCY COST		0				4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC		0				5. 00 6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8.00	Total (Sum of lines 1-7)	373	613			162. 85	8. 00
		Average Length of Stay		Admi s	SLOUS		
	Component	Total	Title V	Title XVIII	Title XIX	0ther	
1.00	CVILLED MUDCING FACILLEY	16. 00	17. 00	18.00	19. 00	20.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	39. 02 0. 00	0		20 0	389 0	1. 00 2. 00
3.00	ICF/IID	0.00	O		0	o o	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0. 00				0	5. 00 6. 00
7. 00	HOSPI CE	0.00	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	39. 02	0	190	20	389	8. 00
		Admissions	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
			Payrol I	Workers			
1.00	SKILLED NURSING FACILITY	21.00	22. 00 106. 33	23.00			1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	0	0.00	0.00			3.00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	0. 00 0. 00				5. 00 6. 00
7. 00	HOSPI CE	o	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	599	106. 33	0.00			8. 00

Provi der No.: 315479

				Ť	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
		Amount	Reclass. of	Adjusted	Paid Hours	Average Hourly	
		Reported	Salaries from			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)	6, 834, 717	0	6, 834, 717			1. 00
2.00	Physician salaries-Part A	0	0	0	0.00		2. 00
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5. 00	Sum of lines 2 through 4	0	0	0	0.00		5. 00
6.00	Revised wages (line 1 minus line 5)	6, 834, 717	0	6, 834, 717			
7. 00	Other Long Term Care	0	0	0	0.00		7. 00
8. 00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00		
10. 00	HOSPI CE	0	0	0	0.00		
11. 00	Other excluded areas	0	0	0	0.00		
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	6, 834, 717	0	6, 834, 717	221, 160. 00	30. 90	13.00
	12)						
	OTHER WAGES & RELATED COSTS						4.00
14.00	Contract Labor: Patient Related & Mgmt	13, 614		13, 614			
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		
16. 00	Home office salaries & wage related costs	0	0		0.00	0.00	16. 00
47.00	WAGE-RELATED COSTS	4 040 000		4 040 000			47.00
17. 00	,	1, 019, 032	0	1, 019, 032			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	,	0	0	0			19. 00
	Physician Part A - WRC	0	0	0			20.00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	, , , , , , , , , , , , , , , , , , , ,	1, 019, 032	0	1, 019, 032			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT LIVINGSTON

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315479

				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	1 ± col. 2)	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	565, 728	0	565, 728	12, 985. 00	43. 57	2. 00
3.00	Plant Operation, Maintenance & Repairs	56, 866	0	56, 866	3, 055. 00	18. 61	3. 00
4.00	Laundry & Linen Service	5, 145	0	5, 145	281.00	18. 31	4. 00
5.00	Housekeepi ng	334, 625	0	334, 625	17, 549. 00	19. 07	5. 00
6.00	Di etary	510, 222	0	510, 222	21, 613. 00	23. 61	6. 00
7.00	Nursing Administration	571, 900	0	571, 900	11, 859. 00	48. 22	7. 00
8.00	Central Services and Supply	42, 328	0	42, 328	1, 985. 00	21. 32	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10. 00
11. 00	Soci al Servi ce	113, 818	0	113, 818	3, 141. 00	36. 24	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	199, 985	0	199, 985	8, 017. 00	24. 95	13. 00
14.00	Total (sum lines 1 thru 13)	2, 400, 617	0	2, 400, 617	80, 485. 00	29. 83	14.00

Health Financial Systems	CARE ONE AT LIVINGSTON	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315479	Peri od: Worksheet S-3

		То	12/31/2023	Date/Time Pre 5/10/2024 11:	
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS		'		
	Part A - Core List				
	RETI REMENT COST]
1.00	401K Employer Contributions			32, 369	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost			0	3.00
4.00	Prior Year Pension Service Cost			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6. 00
7. 00	Employee Managed Care Program Administration Fees			0	7. 00
,, 00	HEALTH AND INSURANCE COST				7.00
8.00	Heal th Insurance (Purchased or Self Funded)			311, 073	8.00
9. 00	Prescription Drug Plan			011,070	1
10.00	Dental, Hearing and Vision Plan			0	
11. 00	Life Insurance (If employee is owner or beneficiary)			1, 487	
	Accident Insurance (If employee is owner or beneficiary)			1, 407	1
13. 00	Disability Insurance (If employee is owner or beneficiary)			0	1
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	
15. 00	Workers' Compensation Insurance			121, 780	
16. 00	Retirement Health Care Cost (Only current year, not the extraord	dinary accrual required by	, EACD 104	121, 760	
16.00	Non cumulative portion)	urnary accrual required by	FASB 100.	U	16.00
	TAXES				
17 00	FICA-Employers Portion Only			478, 348	17 00
	Medicare Taxes - Employers Portion Only			•	1
19. 00	Unemployment Insurance			0	
				ū	
20.00	State or Federal Unemployment Taxes OTHER			73, 975	20.00
21 00				0	21 00
	Executive Deferred Compensation			0	
	Day Care Cost and Allowances			0	
	Tuition Reimbursement			0	
24. 00	Total Wage Related cost (Sum of lines 1 - 23)			1, 019, 032	24. 00
				Amount	
				Reported	
	Don't D. Others these Comp Deleted Cont			1. 00	
25 00	Part B - Other than Core Related Cost			0	25 00
25.00	OTHER WAGE RELATED COST			Ü	25. 00

					rom 01/01/2023		
				T	o 12/31/2023		
	Occupational Catagory	Amount	Frings	Adj usted	Paid Hours	5/10/2024 11: 3	39 am
	Occupational Category	Reported	Fringe Benefits	Salaries (col.		Average Hourly Wage (col. 3 ÷	
		Reported	bellet i tS		Salary in col.	col. 4)	
				1 + COI. 2)	Sarary III COL.	COI. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	3.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	427, 158	72, 133	499, 291	9, 327. 00	53. 53	1. 00
2. 00	Licensed Practical Nurses (LPNs)	1, 194, 202	201, 660		·		2. 00
3. 00	Certified Nursing Assistant/Nursing	1, 709, 001	288, 592		·		3. 00
	Assi stants/Ai des	.,,		.,,			
4.00	Total Nursing (sum of lines 1 through 3)	3, 330, 361	562, 385	3, 892, 746	116, 734. 00	33. 35	4.00
5.00	Physical Therapists	397, 184	67, 071	464, 255	10, 494. 00	44. 24	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	404, 538	68, 313	472, 851	9, 569. 00	49. 41	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	189, 821	32, 054	221, 875	3, 878. 00	57. 21	11.00
12.00	Respi ratory Therapi sts	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0		0	0.00		14.00
15. 00	Licensed Practical Nurses (LPNs)	0		0	0.00		15.00
16. 00	Certified Nursing Assistant/Nursing	1, 795		1, 795	36.00	49. 86	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	1, 795		1, 795			17. 00
18. 00	Physi cal Therapi sts	0		0	0.00		18. 00
19. 00	Physical Therapy Assistants	0		0	0.00		19. 00
20. 00	Physical Therapy Aides	0		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	0		0	0.00		23. 00
24. 00	Speech Therapists	0		0	0.00		24.00
25. 00	Respiratory Therapists	11, 819		11, 819			25. 00
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

Т	From 01/01/2023 Fo 12/31/2023	5/10/2024 11:	pared: 39 am

	10 12/31/202	5/10/2024 11:3	
	Group	Days	
	 1. 00	2. 00	
1.00	RUX		1. 00
2.00	RUL		2. 00
3.00	RVX		3. 00
4. 00 5. 00	RVL RHX		4.00
6. 00	RHL		5. 00 6. 00
7. 00	RMX		7. 00
8. 00	RML		8. 00
9. 00	RLX		9. 00
10. 00	RUC		10.00
11. 00	RUB		11.00
12. 00	RUA		12.00
13. 00	RVC		13.00
14. 00	RVB		14.00
15. 00	RVA		15. 00
16. 00	RHC		16.00
17. 00	RHB		17. 00
18. 00 19. 00	RHA RMC		18. 00 19. 00
20. 00	RMB		20. 00
21. 00	RMA		21. 00
22. 00	RLB		22. 00
23. 00	RLA		23. 00
24. 00	ES3		24.00
25. 00	ES2		25. 00
26. 00	ES1		26. 00
27. 00	HE2		27. 00
28. 00	HE1		28. 00
29. 00	HD2		29. 00
30.00	HD1		30.00
31. 00 32. 00	HC2 HC1		31. 00 32. 00
33. 00	HB2		33. 00
34. 00	HB1		34. 00
35. 00	LE2		35. 00
36. 00	LE1		36.00
37. 00	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 43. 00	LB1 CE2		42. 00 43. 00
44. 00	CE1		44. 00
45. 00	CD2		45. 00
46. 00	CD1		46.00
47. 00	CC2		47.00
48. 00	CC1		48.00
49. 00	CB2		49. 00
50. 00	CB1		50.00
51. 00	CA2		51.00
52. 00 53. 00	CA1 SE3		52. 00 53. 00
54. 00	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	I B2		59.00
60. 00	I B1		60.00
61. 00	I A2		61. 00
62. 00	I A1		62.00
63. 00	BB2		63.00
64. 00 65. 00	BB1 BA2		64. 00 65. 00
66. 00	BA1		66. 00
67. 00	PE2		67. 00
68. 00	PE1		68. 00
69. 00	PD2		69. 00
70. 00	PD1		70.00
71. 00	PC2		71. 00
72. 00	PC1		72. 00
73. 00	PB2		73.00
74. 00	PB1		74.00
75. 00	PA2		75. 00

Health Financial Systems	CARE ONE AT LIVIN	GSTON		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315479	Peri od:	Worksheet S-7	7
				From 01/01/2023 To 12/31/2023		
				Croun	5/10/2024 11:	39 am
				Group 1.00	Days 2.00	_
76. 00				PA1	2.00	76, 00
99.00				AAA		99.00
100. 00 TOTAL				7001		100.00
			Expenses	Percentage	Y/N	
			1.00	2. 00	3. 00	
A notice published in the Federal Register Vol payments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" for with direct patient care and related expenses (See instructions)	ted this increase to column 1 the amoun each category to to 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 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line	e 1, column 3)					101. 00 102. 00 103. 00 104. 00 105. 00 106. 00

Heal th	Financial Systems	CARE ONE AT LI	VINGSTON		In Lie	u of Form CMS-	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·
					10 12/31/2023	5/10/2024 11:	
	Cost Center Description	Sal ari es	Other	Total (col. '	Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col . 4)	
		1.00	2. 00	3.00	A-6) 4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		2, 165, 192	2, 165, 19	2 0	2, 165, 192	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		161, 246		·	152, 565	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 154, 152			1, 154, 152	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	565, 728	2, 457, 803			3, 023, 531	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	56, 866	560, 247			617, 113	5.00
6.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	5, 145	56, 148	1		61, 293	6. 00 7. 00
7. 00 8. 00	00800 DI ETARY	334, 625 510, 222	36, 148 302, 645			370, 773 812, 867	ı
9. 00	00900 NURSING ADMINISTRATION	571, 900	130, 641			702, 541	ı
10. 00	01000 CENTRAL SERVI CES & SUPPLY	42, 328	162, 431			203, 264	ı
11. 00	01100 PHARMACY	12, 323	49, 883			49, 883	
	01200 MEDI CAL RECORDS & LI BRARY	0	0)	o o	0	12.00
13.00	01300 SOCIAL SERVICE	113, 818	0	113, 81	8 0	113, 818	ı
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14. 00
15.00	01500 ACTI VI TES	199, 985	17, 276	217, 26	1 0	217, 261	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	3, 330, 361	72, 993	3, 403, 35		3, 403, 354	1
31. 00	03100 NURSING FACILITY	0	0)	0	0	31.00
	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0		0 0	0	32. 00 33. 00
33.00	ANCI LLARY SERVICE COST CENTERS	l o		1	0	0	33.00
40. 00	04000 RADI OLOGY	0	31, 886	31, 88	6 0	31, 886	40.00
41. 00	04100 LABORATORY	o o	36, 049			36, 049	1
42. 00	04200 I NTRAVENOUS THERAPY	o	197, 077			197, 077	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	1
44.00	04400 PHYSI CAL THERAPY	509, 380	15, 921	525, 30	1 0	525, 301	44. 00
45.00	04500 OCCUPATIONAL THERAPY	404, 538	0	404, 53	8 0	404, 538	45. 00
46.00	04600 SPEECH PATHOLOGY	189, 821	0	189, 82	1 0	189, 821	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 1, 495	1, 495	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	363, 737	363, 73	7 0	363, 737	1
50. 00 51. 00	O5000 DENTAL CARE - TITLE XIX ONLY O5100 SUPPORT SURFACES	0	0		0 8, 681	0 8, 681	
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0,001	0,001	52.00
52. 00	05201 OTHER ANCILLARY SERVICES COST	0	0		0	0	52. 00
	05202 MEDI CAL SERVI CES	o	0		o o	0	ı
	OUTPATIENT SERVICE COST CENTERS			•	<u>'</u>		ĺ
60.00	06000 CLI NI C	0	0)	0 0	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	
	06200 FQHC						62.00
63.00	O6300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	0)	0 0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0)	0	0	70.00
	07100 AMBULANCE	o o	78, 488	78, 48	8 0	78. 488	71.00
73. 00	07300 CMHC	0	0		0	0	1
74.00	07400 OTHER REIMBURSEMENT	0	0		0 0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	1 1		0)	0	0	
81. 00	1 1		0)	0	0	
82.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0		0	0	
83. 00 84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0		0	0	ı
89. 00	SUBTOTALS (sum of lines 1-84)	6, 834, 717	8, 049, 963	14, 884, 68	o o	14, 884, 680	
	NONREI MBURSABLE COST CENTERS	27 22 .7	27 0 117 100		-1	, ,	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	4, 764	4, 76	4 0	4, 764	90. 00
91. 00	1 1	0	317	1			91. 00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	1	0		92.00
	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0		0 0	0	
	09500 OTHER NONREIMBURSABLE COST		0			0	
100.00		6, 834, 717	8, 055, 044	14, 889, 76	1 0		
. 55. 50		5,00 , 111	5, 555, 544	11, 307, 70	-1	. 1, 557, 751	1.00.00

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

 Heal th Financial
 Systems
 CARE ONE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der No.: 315479

				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:39 am
	Cost Center Description	Adjustments to	Net Expenses		57 107 2024 11. 39 alli
	·		For Allocation		
		Wkst A-8)	(col. 5 +- col. 6)		
		6.00	7.00	-	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-14, 221		1	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	C		1	2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	-986, 527	1, 154, 152 2, 037, 004	•	3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	- 760, 527	1	1	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE		1	•	6. 00
7.00	00700 HOUSEKEEPI NG	C	370, 773	1	7. 00
8.00	00800 DI ETARY	C		1	8. 00
9.00	00900 NURSING ADMINISTRATION	-1, 783	1	1	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	2 000	203, 264	1	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	-3, 990	45, 893	1	11. 00
13. 00	01300 SOCI AL SERVI CE		1	1	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	1)	14. 00
15. 00	01500 ACTI VI TES	c	217, 261		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	-18, 838		1	30. 00 31. 00
32. 00	03200 CF/IID			l .	32.00
33. 00	03300 OTHER LONG TERM CARE		1	1	33. 00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	C			40. 00
41. 00	04100 LABORATORY	0 45 7(4	,	•	41.00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY	-15, 766	1	1	42. 00 43. 00
44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY		525, 301	1	44.00
45. 00	04500 OCCUPATI ONAL THERAPY		404, 538	1	45. 00
46.00	04600 SPEECH PATHOLOGY	C	189, 821	•	46. 00
47. 00	04700 ELECTROCARDI OLOGY	C		1	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	000000	.,	1	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	-29, 099	334, 638	1	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES			1	51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	C	1	1	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C			52. 01
52. 02	05202 MEDI CAL SERVI CES	C	0		52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC		0		60.00
61. 00	06100 RURAL HEALTH CLINIC		 	1	61. 00
62. 00	06200 FQHC				62. 00
63. 00	06300 DI ALYSI S	C	0)	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS			ı	70.00
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	C		1	70.00
	07300 CMHC			1	73.00
	07400 OTHER REIMBURSEMENT	C		•	74. 00
	SPECIAL PURPOSE COST CENTERS				
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	C	-		80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF	C	0		81.00
82.00	08300 HOSPI CE		0		82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I		o o		84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	C	0		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 070, 224	13, 814, 456)	89. 00
00.00	NONREI MBURSABLE COST CENTERS	_	4 7/4		00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		4, 764 317	1	90.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0	1	92.00
93. 00	09300 NONPAI D WORKERS		o o		93. 00
	09400 PATIENTS LAUNDRY	C	0		94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	1 070 00	0		95.00
100.00	D TOTAL	-1, 070, 224	13, 819, 537	T	100.00

Health Financial Systems	CARE ONE AT LIVIN	NGSTON		In Lie	u 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	Date/Time Pre 5/10/2024 11:	pared: 39 am
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
(1) A - RECLASS MED SUPP						
1.00	MEDICAL SUPPLIES CH PATIENTS	IARGED TO	48. 0	00	1, 495	1. 00
(1) C - RECLASS SUPP SURFACES				<u> </u>		
2.00	SUPPORT SURFACES		51. (0 0	8, 681	2. 00
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	10, 176	100.00
	of columns 4 and 5	must				
	equal sum of column 9)	s 8 and				

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 LIVINGSTON		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi der	Peri od: From 01/01/2023	Worksheet A-6		
			To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 39 am
	Decreases				
	Cost Center	Li ne #	Sal ary	Non Salary	
	6. 00	7. 00	8. 00	9. 00	
(1) A - RECLASS MED SUPP					
1. 00	CENTRAL SERVICES & SUPPLY	10. (00	1, 495	1. 00
(1) C - RECLASS SUPP SURFACES					
2.00	CAP REL COSTS - MOVABLE EQUI PMENT	2. (00 0	8, 681	2. 00
TOTALS					
100. 00			0	10, 176	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 LIVINGSTON In Lieu of Form CMS-2540-10

				To	12/31/2023	Date/Time Prep 5/10/2024 11:3	pared: 39 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2, 184, 059	0	0	0	0	1. 00
2.00	Land Improvements	40, 317	0	0	0	0	2. 00
3.00	Buildings and Fixtures	11, 680, 296	0	0	0	49, 264	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	468, 677	70, 865	0	70, 865		5. 00
6.00	Movable Equipment	3, 370, 207	0	0	0	22, 863	6. 00
7.00	Subtotal (sum of lines 1-6)	17, 743, 556	70, 865	0	70, 865	72, 127	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	17, 743, 556	70, 865	0	70, 865	72, 127	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1. 00	Land	2, 184, 059	0				1. 00
2.00	Land Improvements	40, 317	0				2. 00
3.00	Buildings and Fixtures	11, 631, 032	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	539, 542	0				5. 00
6. 00	Movable Equipment	3, 347, 344	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	17, 742, 294	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	17, 742, 294	0				9. 00

Provi der No.: 315479

From 01/01/2023 | Wul Kalleet A-0 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/202	5/10/2024 11:	
				Expense Classification o		
				To/From Which the Amount is	s to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1.00	2.00	3.00	4.00	
1. 00	Investment income on restricted funds	В	-5, 640	CAP REL COSTS - BLDGS &	1.00	1. 00
2. 00	(chapter 2) Trade, quantity, and time discounts (chapter		0	FI XTURES	0.00	2. 00
2.00	8)		0		0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5. 00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
6. 00	(chapter 21) 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		0.00	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	
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
12. 00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	-19, 155			12. 00
12.00	related organizations (chapter 10)	A-0-1	-17, 100			12.00
13. 00	Laundry and Linen service	В	0	LAUNDRY & LINEN SERVICE	6.00	13. 00
14.00	Revenue - Employee meals		0		0.00	14. 00
15. 00	Cost of meals - Guests	В	0	DI ETARY	8. 00	15. 00
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
17.00	pati ents		0		0.00	17.00
17. 00 18. 00	Sale of drugs to other than patients Sale of medical records and abstracts		0		0.00	•
19. 00	Vending machines		0		0.00	•
20. 00	Income from imposition of interest, finance		0		0.00	•
	or penalty charges (chapter 21)		_			
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
22.00	overpayments		0	UTILLIZATION DEVILEW CNE	02.00	22.00
22. 00	Utilization reviewphysicians' compensation (chapter 21)		U	UTILIZATION REVIEW - SNF	82.00	22. 00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
				FIXTURES		
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
	DEGLESHT DEDLAGENENT LEETS			EQUI PMENT		
25. 00	RESIDENT REPLACEMENT ITEMS	A		ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETING EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	•
25. 02 25. 03	MARKETING CORP EXPENSE MARKETING - MEALS	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4. 00 4. 00	•
	SHOWS & CONFERENCES	A		ADMINISTRATIVE & GENERAL	l e	25. 04
25. 05	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL		25. 05
25. 06	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 07	BAD DEBT EXPENSE - MEDICARE	A		ADMINISTRATIVE & GENERAL	4. 00	1
25. 08	BAD DEBT EXPENSE - OTHER	A		ADMINISTRATIVE & GENERAL	4.00	1
25. 09	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	1
25. 10	MAINTENANCE FEE INCOME	В	-8, 581	CAP REL COSTS - BLDGS &	1.00	25. 10
25. 11	OTHER REVENUE	В	_1 140	FIXTURES ADMINISTRATIVE & GENERAL	4.00	25. 11
	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL		25. 11
	Total (sum of lines 1 through 99) (Transfer		-1, 070, 224	1		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	l.		

⁽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 L
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME In Lieu of Form CMS-2540-10 CARE ONE AT LIVINGSTON

| Period: | Worksheet A-8-1 | From 01/01/2023 | Parts I-II | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315479 OFFICE COSTS

				Т	o 12/31/2023 Date/Time Pre 5/10/2024 11:	
		Li ne No.	Cost	Center	Expense I tems	7 4111
		1.00		00	3.00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
	CLAIMED HOME OFFICE COSTS:					
1.00			ADMI NI STRATI VE		MANAGEMENT FEES	1.00
2.00			NURSING ADMINI		PHARMACY CONSULTANT	2. 00
3.00			CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPENSE	3.00
4.00		11.00	PHARMACY		DRUGS-NON-PRESCRI PTI ON, NON-LEGEND	4. 00
5. 00		11 00	 PHARMACY		PHARMACY SUPPLIES	5. 00
6. 00			INTRAVENOUS TH	EDADV	IV EXPENSE	6.00
7. 00			DRUGS CHARGED		DRUGS-PRESCRIPTION, LEGEND	7.00
7.00		47.00	DROGS CHARGED	10 TATLENTS	DRUGS OTH	7.00
8.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PTI ON, LEGEND	8. 00
					DRUGS MAN	
9.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE	9. 00
					A	
10.00	TOTALS (sum of lines 1-9). Transfer column					10. 00
	6, line 100 to Worksheet A-8, column 3, line					
	12.	Amount	Amount	Adius+mon+s		
		Allowable In	Included in	Adjustments (col. 4 minus		
		Cost	Wkst. A, col.	col. 5)		
		0031	5 5	(01. 3)		
		4. 00	5. 00	6, 00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
	CLAIMED HOME OFFICE COSTS:					
1.00		555, 246				1. 00
2.00		20, 508	· ·			2. 00
3.00		78, 127	· ·	1		3. 00
4.00		45, 220	· ·			4. 00
5.00		673				5. 00
6.00		181, 311				6. 00
7. 00 8. 00		30, 384	1	1		7. 00 8. 00
9. 00		191, 570 112, 684				9.00
10.00	TOTALS (sum of lines 1-9). Transfer column	1, 215, 723	1			10.00
10.00	6, line 100 to Worksheet A-8, column 3, line	1,215,725	1, 234, 070	- 17, 155		10.00
	12.					
	1		1	1	1	

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				
			T-	1			
	Name	Percentage of	Type of Business				
		Ownershi p					
	4. 00	5. 00	6. 00				
DADT II INTERRELATIONSHIP TO BELATER ORGANIZ	ZATLONICO AND COD HOME OFFICE						

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	HEALTHBRIDGE MANAGEMENT LLC	100.00 MANAGEMENT	1.00
2. 00	TOTALCARE LLC	99.00WOUND CARE	2.00
3. 00	TOTALCARE LLC	1. OO 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
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.

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315479

					To	12/31/2023	Date/Time Pre 5/10/2024 11:	
				CAPI TAL REL	ATED COSTS		37 107 2024 11.	37 alli
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		Cost Center Description	for Cost	FI XTURES	EQUI PMENT	BENEFITS	Subtotal	
			Allocation					
			(from Wkst A col. 7)					
			0	1. 00	2. 00	3. 00	3A	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	2, 150, 971	2, 150, 971				1. 00
2. 00	1	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	152, 565	2, 150, 971	152, 565			2.00
3.00	00300	EMPLOYEE BENEFITS	1, 154, 152	0	0	1, 154, 152		3. 00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	2, 037, 004	142, 013 18, 779		95, 532 9, 603	2, 284, 622 646, 827	4. 00 5. 00
6. 00		LAUNDRY & LINEN SERVICE	617, 113 61, 293	23, 197		9, 603 869	87, 004	6.00
7.00	00700	HOUSEKEEPI NG	370, 773	0		56, 507	427, 280	
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON	812, 867 700, 758	185, 921 17, 674		86, 159 96, 574	1, 098, 134 816, 260	8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	203, 264	17, 074	1, 234	7, 148	210, 412	
11.00		PHARMACY	45, 893	0	0	0	45, 893	
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	113, 818	0	0	0 19, 220	0 133, 038	12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	0	Ö	0	0	14. 00
15. 00		ACTIVITES	217, 261	0	0	33, 771	251, 032	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	3, 384, 516	1, 611, 916	114, 330	562, 385	5, 673, 147	30. 00
31. 00	03100	NURSING FACILITY	0	0	0	0	0	31. 00
32.00		ICF/IID	0	0		0	0	32.00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	<u> </u>	0	0	U	0	33. 00
40. 00	04000	RADI OLOGY	31, 886	0		0	31, 886	40. 00
41. 00 42. 00		LABORATORY INTRAVENOUS THERAPY	36, 049 181, 311	0		0	36, 049 181, 311	
43.00		OXYGEN (INHALATION) THERAPY	0	0	0	0	101, 311	42.00
44.00	04400	PHYSI CAL THERAPY	525, 301	18, 364		86, 017	630, 985	
45. 00 46. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	404, 538 189, 821	16, 569 8, 285		68, 313 32, 054	490, 595 230, 748	45. 00 46. 00
47.00		ELECTROCARDI OLOGY	109, 621	0, 200	1	32, 034	230, 746	47.00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 495	0	0	О	1, 495	
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	334, 638	0	0	0	334, 638 0	49. 00 50. 00
51. 00		SUPPORT SURFACES	8, 681	0	0	o	8, 681	
52.00		COMPLEX MEDICAL EQUIPMENT	0	0	· -	0	0	52.00
52. 01 52. 02		OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		0	0	52. 01 52. 02
02. 02		TIENT SERVICE COST CENTERS	9	<u> </u>	,	٥	<u> </u>	02.02
60.00	1	CLINIC	0	0		0	0	
61. 00 62. 00	06200	RURAL HEALTH CLINIC	0	U	U	U	Ü	61. 00 62. 00
63.00	06300	DI ALYSI S	0	0	0	0	0	
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST		0	0	ol	0	70. 00
71. 00		AMBULANCE	78, 488	0	_	o	78, 488	
73. 00	07300	CMHC	0	0		0	0	73. 00
74. 00		OTHER REIMBURSEMENT AL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00		INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0	0	0	0	82. 00 83. 00
84. 00		OTHER SPECIAL PURPOSE COST I	O	0	O	o	0	84. 00
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	13, 814, 456	2, 042, 718	144, 887	1, 154, 152	13, 698, 525	89. 00
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	4, 764	0		0	4, 764	90. 00
91.00		BARBER AND BEAUTY SHOP	317	108, 253	7, 678	0	116, 248	
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94.00	09400	PATIENTS LAUNDRY		0	O	o	0	94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	0	0	0	95. 00 98. 00
99. 00		Negative Cost Centers		0	0	0	0	99.00
100.00)	TOTAL	13, 819, 537	2, 150, 971	152, 565	1, 154, 152	13, 819, 537	100. 00

Provi der No.: 315479

				T	0 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J 7 alli
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
	CENEDAL CEDALCE COCT CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVI CE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1					1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			•			2.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	2, 284, 622					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	128, 111	774, 938				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	17, 232	9, 032	113, 268			6. 00
7.00	00700 HOUSEKEEPI NG	84, 628	0	0			7. 00
8. 00	00800 DI ETARY	217, 498	72, 394	1	10,000		8. 00
9.00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	161, 669	6, 882	0	4, 600	0 0	9.00
10. 00 11. 00	01100 PHARMACY	41, 674 9, 090	0	0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	7, 070	0	0	0	0	12.00
13. 00	01300 SOCIAL SERVICE	26, 350	0	ő	o O	Ö	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TES	49, 720	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	1, 123, 633	627, 649		419, 502	1, 436, 412	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0	0	0	0	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		<u> </u>	U	0	33.00
40. 00	04000 RADI OLOGY	6, 315	0	0	0	0	40. 00
41. 00	04100 LABORATORY	7, 140	0	ő	_	Ö	41.00
42. 00	04200 I NTRAVENOUS THERAPY	35, 911	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	124, 974	7, 151		4, 779	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	97, 168	6, 452		4, 312	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	45, 702	3, 226	1	2, 156	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 296	0	0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	66, 279	0	0	0	0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	ő	0	0	50.00
51. 00	05100 SUPPORT SURFACES	1, 719	0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0	0	_	0	61.00
62. 00	06200 FQHC		O		J		62.00
63.00	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00		0	0	0	0	0	70. 00
	07100 AMBULANCE	15, 545	0	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	<u> </u>	0	u	0	0	74. 00
80. 00							80.00
81. 00							81.00
82. 00	08200 UTI LI ZATI ON REVI EW - 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	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	2, 260, 654	732, 786	113, 268	483, 735	1, 436, 412	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	944			0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	23, 024	42, 152	0	28, 173	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	25, 024	42, 132	0	20, 173	0	92.00
93. 00	09300 NONPALD WORKERS		0	l o	Ö	ő	93. 00
94. 00	09400 PATIENTS LAUNDRY		0	Ō	o	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99.00		0	77.4 600	0	0	0	99.00
100.00	D TOTAL	2, 284, 622	774, 938	113, 268	511, 908	1, 436, 412	1100.00

Provi der No.: 315479

				10	12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
		9. 00	SUPPLY 10.00	11.00	LI BRARY 12. 00	13. 00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
1. 00 2. 00 3. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS OO6OO LAUNDRY & LINEN SERVICE						4. 00 5. 00 6. 00
7. 00 8. 00	00700 HOUSEKEEPING 00800 DI ETARY						7. 00 8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	989, 411 0	252, 086				9. 00 10. 00
11. 00 12. 00	O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY	0	0	54, 983 0	0		11. 00 12. 00
13. 00	01300 SOCIAL SERVICE		0	0	0	159, 388	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	0	0	0	0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	989, 411	252, 086	54, 983	0	159, 388	30.00
31. 00	03100 NURSING FACILITY	909, 411	252, 080	0 54, 963	0	139, 300	31.00
32. 00	03200 CF/IID	o	Ö		Ö	ő	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS		_		_		
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0		0	0	40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY		0	0	0	0	41.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	o	0	l o	0	ő	43. 00
44.00	04400 PHYSI CAL THERAPY	o	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 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		0	0	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	o	0	Ö	0	0	50.00
51.00	05100 SUPPORT SURFACES	o	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	52. 02
60. 00	06000 CLINIC	O	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0	O	0	0	70. 00
71.00	07100 AMBULANCE		0	0	0	0	71.00
73. 00	07300 CMHC	o	0	O	0	0	73. 00
74.00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 H0SPI CE	o	0	0	0	0	1
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)	989, 411	252, 086	54, 983	0	159, 388	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	O	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		0	-	0	Ö	
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0	0	0	0	1
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	0	0	0	95. 00 98. 00
98.00	Negative Cost Centers		0	0	Ω	0	1
100.00	1 1 0	989, 411	252, 086	-	0	_	
						•	•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315479

				7	Γο 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			107 107 202 1 111	, <u></u>
		AULDOLAIO AND	SERVI CE		D 1 C1 1	.	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATI ON			Auj ustilierits		
		14. 00	15.00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS		•				2. 00 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 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			•			10.00
11. 00	01100 PHARMACY						11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	l .				14. 00 15. 00
15. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0	300, 752				15.00
30. 00	03000 SKILLED NURSING FACILITY	0	300, 752	11, 150, 231	1 0	11, 150, 231	30.00
31.00	03100 NURSING FACILITY	0	1			0	31.00
32. 00	03200 CF/IID	0	1		-	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	(0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	38, 20	1 0	38, 201	40. 00
41. 00	04100 LABORATORY		ł	43, 189		43, 189	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	Ö	217, 222		217, 222	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	767, 889		767, 889	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	598, 527 281, 832		598, 527 281, 832	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY			201, 032		201, 032	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		Ö	1, 79	٥	1, 791	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	400, 917		400, 917	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	50. 00
51.00	05100 SUPPORT SURFACES	0	0	10, 400	0	10, 400	51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0				0	52. 00 52. 01
52. 02	05202 MEDI CAL SERVI CES		 		1		52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	1	1	0		60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	(0	0	61.00
62. 00 63. 00	06200 FQHC 06300 DI ALYSI S		0		0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS		,		<u> </u>		03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70.00
	07100 AMBULANCE	0	1	71,000		, 1, 000	
73.00		0		(0	0	
74. 00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0) 0	1) 0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			1			80.00
81.00	08100 INTEREST EXPENSE					•	81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	(0	0	83. 00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II		0		0	0 0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)		1	13, 604, 232	2 0	-	89. 00
07.00	NONREI MBURSABLE COST CENTERS		000,702	10/001/201	-1	107 00 17 202	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	5, 708		5, 708	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	209, 597	7 0	209, 597	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	9	0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0		0	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST		n n		o o	0	95.00
98. 00	Cross Foot Adjustments		Ō		o o	0	98. 00
99. 00	Negative Cost Centers	0		(0	0	99. 00
100.00	D TOTAL	0	300, 752	13, 819, 537	/ 0	13, 819, 537	100.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315479

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS		5/10/2024 11.	39 alli
	Cook Control Documents on	D:+1	DI DCC 0	MOVADLE	C	EMPL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal					
		Related Costs	1.00	2.00	2.4	2.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	2A	3. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	0	0	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	142, 013 18, 779	10, 073 1, 332	152, 086 20, 111	0	4. 00 5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	o	23, 197	1, 645	24, 842	0	6. 00
7.00	00700 HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	00800 DI ETARY	0	185, 921	13, 187	199, 108	0	8. 00
9. 00 10. 00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	17, 674	1, 254	18, 928	0	9. 00 10. 00
11. 00	01100 PHARMACY	o	o	O	o	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	o	0	12. 00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	13.00
15. 00	01500 ACTIVITES		0	0	0	0	14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-		-	-1		
30.00	03000 SKILLED NURSING FACILITY	0	1, 611, 916	114, 330	1, 726, 246	0	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	ol	0	33. 00
	ANCILLARY SERVICE COST CENTERS		- 1				
40.00	04000 RADI OLOGY	0	0	0	0	0	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	o	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	18, 364	1, 303	19, 667	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	16, 569	1, 175	17, 744	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	8, 285 0	588 0	8, 873 0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o	o	ő	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	О	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDI CAL EQUI PMENT	0	0	0	0	0	51. 00 52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	o	o	o	ő	0	52. 00
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS		٥		ما		
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		J	S	Ĭ	Ü	62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		ما	0	٥	0	70. 00
70.00	07100 AMBULANCE	0	ol Ol	0	0	0	70.00
73. 00	07300 CMHC	0	0	0	o	0	73. 00
74. 00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 INTEREST 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 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	o	2, 042, 718	144, 887	2, 187, 605	0	
	NONREI MBURSABLE COST CENTERS			-			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	100 252	7 (70	115 021	0	
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	108, 253 0	7, 678 0	115, 931 0	0	
93. 00	09300 NONPAID WORKERS		o	o	ő	0	
94. 00	09400 PATIENTS LAUNDRY	0	0	0	o	0	
95. 00 98. 00	09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	95. 00 98. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		n	0	0	0	1
100.00	1 1 9	0	2, 150, 971	152, 565	2, 303, 536		100.00
		•	•		·		

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315479

				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	39 alli
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
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	152, 086					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	8, 528	28, 639				5.00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	1, 147 5, 634	334	26, 323			6. 00 7. 00
8.00	00800 DI ETARY	14, 479	2, 675	1	5, 634 533	216, 795	8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	10, 762	254		51	210, 773	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	2, 774	0		0	0	10.00
11.00	01100 PHARMACY	605	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	1, 754	0	0	0	0	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	2 210	0	0	0	0	14. 00 15. 00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 310	U	<u> </u>	U	0	15.00
30. 00		74, 800	23, 197	26, 323	4, 616	216, 795	30. 00
31. 00	03100 NURSING FACILITY	0	0	1	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						
40.00	04000 RADI OLOGY	420	0		· ·	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	475 2, 391	0	1	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	2, 391	0		0	0	42.00
44. 00	04400 PHYSI CAL THERAPY	8, 320	264	0	53	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	6, 468	238	•	47	0	45. 00
46.00	04600 SPEECH PATHOLOGY	3, 042	119	0	24	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	20	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	4, 412	0	0	0	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 114	0		0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	o o	ő	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	o	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	0	0	0		0	62.00
63. 00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	<u> </u>	U	ıl O	U	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	1	1, 035	0		1	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	1					
80.00	1						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	1	0	0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	o o	ő	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)	150, 490	27, 081	26, 323	5, 324	216, 795	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	63	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	1, 533	1, 558	0	310	0	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0			0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		0			0	94.00
95. 00	09500 OTHER NONREI MBURSABLE COST		0	ol ő	Ö	0	95. 00
98. 00	Cross Foot Adjustments			0	o	0	98. 00
99. 00		0	0	0	0	0	99. 00
100.00	D TOTAL	152, 086	28, 639	26, 323	5, 634	216, 795	100. 00

Provi der No.: 315479

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: 39 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	
		ABINITY STICTION	SUPPLY		LI BRARY		
	T	9. 00	10.00	11. 00	12.00	13. 00	
4 00	GENERAL SERVICE COST CENTERS						4 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 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6. 00 7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	29, 995					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	27, 773	2, 774				10. 00
11. 00	01100 PHARMACY	0	2, 7,7	605			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0	0	0		12. 00
13. 00	01300 SOCI AL SERVI CE	o	0	0	0	1, 754	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	ol	0	o	0	0	14. 00
15. 00	01500 ACTIVITES	ol	0	o	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	29, 995	2, 774	605	0	1, 754	30.00
31.00	03100 NURSING FACILITY	O	0	0	0	0	31.00
32.00	03200 CF/IID	O	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
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	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. 01	05201 OTHER ANCIELARY SERVICES COST		0	0	0	0	52. 01
32. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		U U	U	0	32.02
60. 00	06000 CLINIC	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC		0	0	0	Ö	61. 00
62. 00	06200 FQHC		Ŭ	Ĭ	J		62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS	-1	-	-	-		
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0	0	0	0	71. 00
73.00	07300 CMHC	o	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 NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI 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	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	29, 995	2, 774	605	0	1, 754	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS		0	0	0	0	93.00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST		0	0	0	0	94. 00 95. 00
95. 00 98. 00	Cross Foot Adjustments	0	0	0	U	0	95. 00 98. 00
98.00	Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00		29, 995	2, 774	· ·	0		100.00
100.00	1.01112	27,775	۷, ۱۱۹	1 505	O _l	1, 754	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315479

				-	Γο 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			07.107.202.1 1111	, d
		NILIDOL NO. AND	SERVI CE		D 1 C1 D	.	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		EDUCATI ON			Adj d3 tillerits		
		14.00	15. 00	16.00	17.00	18. 00	
	GENERAL SERVICE COST CENTERS		T	_			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES					ı	1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS					ı	2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL					ı	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					1	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE					1	6. 00
7.00	00700 HOUSEKEEPI NG					ı	7. 00
8. 00 9. 00	OO800 DI ETARY OO900 NURSI NG ADMI NI STRATI ON					1	8. 00 9. 00
10. 00	01000 CENTRAL SERVI CES & SUPPLY					1	10.00
11. 00	01100 PHARMACY					ı	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY					1	12. 00
13.00	01300 SOCIAL SERVICE					ı	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	l .			ı	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		3,310	1			13.00
30.00	03000 SKILLED NURSING FACILITY	0	3, 310	2, 110, 41	5 0	2, 110, 415	30. 00
31.00	03100 NURSING FACILITY	0	0		o o	0	31. 00
32.00	03200 CF/ D	0		1	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0) (이	0	33. 00
40. 00	04000 RADI OLOGY	0	0	420	ol lo	420	40.00
41. 00	04100 LABORATORY	0		1		475	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	2, 39 ⁻	1 0	2, 391	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	28, 30		28, 304	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0	24, 49 ³ 12, 058		24, 497 12, 058	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	Ö	12,03		0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	20	o o	20	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	4, 41:		4, 412	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDI CAL EQUI PMENT	0	0	11.		114 0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST	0				0	52. 00
52. 02	05202 MEDI CAL SERVI CES	0		1	o o	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0		1	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	1	0	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0	,	ol ol	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS				51 51		00.00
70. 00	07000 HOME HEALTH AGENCY COST	0			0	0	
	07100 AMBULANCE	0		1, 00.			71.00
73. 00 74. 00	07300 CMHC 07400 OTHER REI MBURSEMENT	0				0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS			1	<u> </u>	0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 INTEREST EXPENSE					i	81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	_	_				82. 00
83.00	08300 HOSPI CE	0	0			0	83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0	0			0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	3, 310	2, 184, 14	1 0		89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	6:		63	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	119, 33:	2 0	119, 332	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0				0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0			0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	0	0			0	95. 00
98. 00	Cross Foot Adjustments	0	0		o o	0	98. 00
99.00	Negative Cost Centers TOTAL	0		2 202 52	0 6 0	2 202 526	99.00
100.00	/ IOTAL	0	3, 310	2, 303, 53	기 이	2, 303, 536	1100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315479

						o 12/31/2023	Date/lime Pre 5/10/2024 11:	
			CAPITAL REI	_ATED COSTS				
		Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	SALARI ES) 3. 00	4A	4.00	
4 00		AL SERVICE COST CENTERS	04.45/		T		T	4 00
1. 00 2. 00	1	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	31, 156	31, 156				1. 00 2. 00
3.00	00300	EMPLOYEE BENEFITS	0	O	6, 834, 717			3. 00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	2, 057 272	2, 057 272	1		11, 534, 915 646, 827	4. 00 5. 00
6.00	1	LAUNDRY & LINEN SERVICE	336	l .			87, 004	1
7. 00		HOUSEKEEPI NG	0	O			427, 280	•
8. 00 9. 00		DI ETARY NURSI NG ADMI NI STRATI ON	2, 693 256	1			1, 098, 134 816, 260	1
10. 00		CENTRAL SERVICES & SUPPLY	0	230	1		210, 412	•
11.00	1	PHARMACY	0	0	C	0	45, 893	1
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0		113, 818	3 0	0 133, 038	12. 00 13. 00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. 00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	0	0	199, 985	5 0	251, 032	15. 00
30. 00		SKILLED NURSING FACILITY	23, 348	23, 348	3, 330, 361	0	5, 673, 147	30. 00
31.00		NURSING FACILITY	0	0	1		0	31.00
32. 00 33. 00			0			0	0	32. 00 33. 00
	ANCI L	LARY SERVICE COST CENTERS	_				-	
40. 00 41. 00		RADI OLOGY LABORATORY	0		1		31, 886 36, 049	1
42. 00		INTRAVENOUS THERAPY	0	Ö	1	0	181, 311	ı
43.00		OXYGEN (INHALATION) THERAPY	0	0	-	0	0	
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	266 240	ŀ			630, 985 490, 595	•
46. 00	04600	SPEECH PATHOLOGY	120	l e	1		230, 748	•
47. 00 48. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0 1, 495	47. 00 48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0			0	334, 638	1
50.00	1	DENTAL CARE - TITLE XIX ONLY	0	O	C	0	0	50. 00
51. 00 52. 00	1	SUPPORT SURFACES COMPLEX MEDICAL EQUIPMENT	0	0		0	8, 681 0	51. 00 52. 00
52. 01	1	OTHER ANCILLARY SERVICES COST	0	Ö	1	Ö	ő	1
52. 02		MEDICAL SERVICES TIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	52. 02
60. 00		CLINIC	0	С	C	0	0	60.00
61.00		RURAL HEALTH CLINIC	0	O	C	0	0	61.00
62. 00 63. 00	06200	DI ALYSI S	0	o	c	0	0	62. 00 63. 00
	OTHER	REIMBURSABLE COST CENTERS						
70. 00 71. 00	1	HOME HEALTH AGENCY COST AMBULANCE	0	0	C	0	0 78, 488	70. 00 71. 00
73. 00	07300		0	Ö	C	0	76, 466	73.00
74. 00		OTHER REIMBURSEMENT	0	C	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 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0) 0	0	82. 00 83. 00
84. 00		OTHER SPECIAL PURPOSE COST I	Ö	Ö	Č	Ö	ő	84. 00
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0	20 500	C 024 717	0	0	84. 01
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	29, 588	29, 588	6, 834, 717	-2, 284, 622	11, 413, 903	89. 00
90. 00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			4, 764	
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	1, 568	1, 568	C	0	116, 248 0	1
93. 00	1	NONPALD WORKERS	0	Ö	C	Ö	ő	1
94.00		PATIENTS LAUNDRY	0	0	C	0	0	94.00
95. 00 98. 00	04200	OTHER NONREIMBURSABLE COST Cross Foot Adjustments				,	0	95. 00 98. 00
99. 00		Negative Cost Centers	0 45					99. 00
102.00)	Cost to be allocated (per Wkst. B, Part I)	2, 150, 971	152, 565	1, 154, 152	2	2, 284, 622	102. 00
103.00	1	Unit cost multiplier (Wkst. B, Part I)	69. 038741	4. 896810	0. 168866		0. 198061	1
104.00)	Cost to be allocated (per Wkst. B, Part II)			C		152, 086	104. 00
	1	i · · ·	1	i	ı	1	ı	1

Health Financial Systems	CARE ONE AT	LIVINGSTON		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				rom 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/10/2024 11:	<u>39 am</u>
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			SALARI ES)			
	1.00	2.00	3. 00	4A	4. 00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 013185	105. 00

Provi der No.: 315479

DERRETION NAME CAPIENT DAYS CAPIENT D		Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/10/2024 11: NURSI NG	
CATIENT MAYS CONTROL		oost center bescription	OPERATI ON,	LINEN SERVICE	(SQUARE FEET)			
1.00				(PATTENT DAYS)			(PATIENT DAYS)	
DEFURBAL SERVICE COST CHITESS 1.00 0.000 0.				6.00	7 00	8 00	9.00	
2.00 00000 CAR PELLOSTS - MOVABLE EQUI PREVIT 4.00 00000 CANTINISTRATI VE & CENTENT 5.00 00000 CANTINISTRATI VE & CENTENT 6.00 00000 CANTINISTRATI			0.00	0.00	7.00	0.00	7. 00	
3.00 00000 PUPLOYEE BENEFIT S 3.00 0.00		1						1.00
5.00 005000 LAND OPERATION, MAINT. A REPAIRS 28,877 0.00 005000 LANDROW A LINES SERVICE 330 23,921 28,475 7.763 7.77		1						3.00
0.000 0.0000 LAMINDRY AL LINETH SERVICE 3306 23.921 2.693 71.763 7.700 7.700 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000								4. 00
7.00 00700 MUSICKEEPING				1				
0.000 0.0000 DETARY 2, 973								
10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 11.00 12.00 0100 PARMACY 0 0 0 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 12.00 13			1	1				8.00
11.0 0 1100 MARMACY 0 0 0 0 12.00 13.0 0 1300 MARINACY 0 0 0 0 0 12.00 13.0 0 1300 MARINACY 0 0 0 0 0 0 13.0 0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 0 0 0 15.0 1300 MARINACY 0 0 0 0 0 0 0 0 0			256	0	256	0	23, 921	9. 00
12 00 1200 MERICAL RECORDS & LIBRARY 0 0 0 0 0 0 13 00 13 00 13 00 13 00 13 00 13 00 13 00 0 0 0 0 0 0 0 0 0			C	0		0		1
13.00 01300 SOCIAL SERVICE 0 0 0 0 0 0 0 13.00						0		
15.00 01500] ACTIVITIES 0 0 0 0 15.00			C			0		13. 00
IMPATTENT ROUTH RESERVICE OOST CENTERS 23,348 23,921 23,348 71,763 23,921 30,000 3000 (SILLED MURSIN FACILITY 23,348 23,921 23,348 71,763 23,921 30,000 31.00			C	0) c	0		14. 00
30.00	15. 00		C	0) <u> </u>	0	0	15. 00
31.00	30.00		23 348	23 921	23 348	71 763	23 921	30.00
) 20,010	0		1
ANCILLARY SERVICE COST CENTERS		1		1) c	0		32. 00
0.000 04000 RADIOLOGY	33. 00		C	0) <u> </u>	0	0	33. 00
41.00 04100 LABORATORY 0 0 0 0 0 0 42.00	40 00					0	0	40 00
43.00 04300 04300 04300 04500 0 0 0 0 0 0 43.00		1	1	1	1	0		41.00
44.00 04400 PHYSI CAL THERAPY 266 0 266 0 0 44.00		1		-) c	0		42. 00
45.00 04500 04500 04500 04500 04500 04500 0460				1	C	0		
46.00 04600 SPEECH PATHOLOGY 120		1			1			
47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 47.00 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 48.00 49. 00 04900 DRUIGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 52. 00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 0 52. 00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 52. 00 05200 MEDICAL SERVICES COST 0 0 0 0 0 0 52. 00 05200 MEDICAL SERVICES COST 0 0 0 0 0 0 52. 00 05200 MEDICAL SERVICES COST 0 0 0 0 0 0 52. 00 05200 MEDICAL SERVICES COST 0 0 0 0 0 0 61. 00 06000 CLI NIC 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 06100 CLI NIC 0 0 0 0 0 0 0 0 61. 00 07000 CHIC CLI NIC 0 0 0 0 0 0 0 0 61. 00 07000 CHIC CLI NIC 0 0 0 0 0 0 0 0 0 61. 00 07000 CHIC CLI NIC 0 0 0 0 0 0 0 0 0		1	1	l l	1			46.00
49.00 04900 0RUSC CHARCED TO PATIENTS 0 0 0 0 0 0 0 0 0			C	0) c	0	l .	47. 00
50.00 050000 050000 050000 050000 050000 050000 050000 050000 050000 0500000 050000 050000			C	0	0	0		48. 00
51.00			C			0		
52.00 05200 COMPLEX MEDICAL EQUI PMENT 0 0 0 0 0 52.00						0		
S2.02 MEDICAL SERVICE SOT CENTERS			C			0		52. 00
OUTPATIENT SERVICE COST CENTERS 0				1) c	0		52. 01
60.00	52. 02		C) <u> </u>) <u> </u>	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 63.00 63.00 06300 DIALYSIS 0 0 0 0 0 0 0 63.00 OTHER REI MBURSABLE COST CENTERS	60. 00) (0	60.00
63.00				1				61.00
OTHER RELMBURSABLE COST CENTERS O								62. 00
70.00	63. 00		C) <u> </u>) <u> </u>	0	0	63.00
71.00 07100 AMBULANCE 0 0 0 0 0 0 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74	70 00					0	0	70 00
74. 00 074.00 074.00 074.00 074.00 0 0 0 0 0 0 0 0 0				1				
SPECIAL PURPOSE COST CENTERS 80. 00			1	1	1			
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80. 00 81. 00 08100 INTEREST EXPENSE 82. 00 08200 UTILLIZATION REVIEW - SNF 82. 00 08200 UTILLIZATION REVIEW - SNF 82. 00 08400 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 0 084. 00 08400 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 0 084. 00 08400 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 0 084. 00 084. 00 08400 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 0 0 084. 00 0	74. 00		C	0) <u> </u>	0	0	74.00
81.00	80. 00							80.00
83. 00								81.00
84. 00								82. 00
84. 01			C	0		0		
89. 00 SUBTOTALS (sum of lines 1-84) 27,259 23,921 26,923 71,763 23,921 89. 00						0		
90. 00		1	27, 259	23, 921	26, 923	71, 763		89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 1,568 0 1,568 0 0 91. 00 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 0 0 0 95. 00 09500 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0						1		
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 98. 00 99. 00 Cross Foot Adjustments Negative Cost Centers 99. 00 102. 00 Cost to be allocated (per Wkst. B, Part I) 26. 882367 4. 735086 17. 967358 20. 016053 41. 361607 103. 00 104. 00 Cost to be allocated (per Wkst. B, Part II) 26. 882367 4. 735086 17. 967358 20. 016053 41. 361607 103. 00 104. 00 Cost to be allocated (per Wkst. B, Part II) 26. 882367 4. 735086 17. 967358 20. 016053 41. 361607 103. 00 105. 00 Unit cost multiplier (Wkst. B, Part III) 0. 993478 1. 100414 0. 197747 3. 020986 1. 253919 105. 00			1.500	0	1 5/6			1
93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 93. 00 94. 00 94. 00 95. 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 0 99. 00 0 0 0 0 0 0 0 0 0			1,568		1,568	0		
95. 00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 0 95. 00 98. 00 99. 00 0 0 0 0 98. 00 99. 00 0 0 0 0 0 0 0 0 0			C			0		
98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 26.882367 4.735086 17.967358 20.016053 41.361607 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 26.882367 26.323 5.634 216.795 29.995 104.00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 0.993478 1.100414 0.197747 3.020986 1.253919 105.00			C	0) c	0		94. 00
99.00 Negative Cost Centers			C	0	0	0	0	1
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 106.00 Unit cost multiplier (Wkst. B, Part I) 107.00 Unit cost multiplier (Wkst. B, Part I) 108.00 Unit cost multiplier (Wkst. B, Part II) 109.00 Unit cost multiplier (Wkst. B, Part II) 109.00 Unit cost multiplier (Wkst. B, Part II) 109.00 Unit cost multiplier (Wkst. B, Part II) 100.00 Unit cost multiplier (Wkst. B, Part III) 100.00 Unit cost multiplier (Wkst. B, Part IIII) 100.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		1 1						
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			774, 938	113, 268	511, 908	1, 436, 412	989, 411	
104.00 Cost to be allocated (per Wkst. B, Part II) 28,639 26,323 5,634 216,795 29,995 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.993478 1.100414 0.197747 3.020986 1.253919 105.00		Part I)						
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.993478 1.100414 0.197747 3.020986 1.253919 105.00				l l	1			
105.00 Unit cost multiplier (Wkst. B, Part 0.993478 1.100414 0.197747 3.020986 1.253919 105.00	104.00	,,,	28, 639	26, 323	5, 634	216, 795	29, 995	104.00
	105.00	,	0. 993478	1. 100414	0. 197747	3. 020986	1. 253919	105. 00
)		1	1			

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315479

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

5/10/2024 11:39 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND ALLI ED HEALTH SERVICES & (PATIENT DAYS) RECORDS & **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (PATIENT DAYS) (PATLENT DAYS) (ASSI GNED TIME) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 23, 921 10.00 11.00 01100 PHARMACY 23, 921 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 23, 921 12.00 01300 SOCIAL SERVICE 23, 921 13 00 0 13 00 C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 23, 921 23, 921 23, 921 23, 921 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 0 33 00 33.00 Ω 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 C 0 0 41.00 04100 LABORATORY 0 0 0 0 41.00 000000000000 04200 INTRAVENOUS THERAPY 0 42 00 42 00 Ω 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 49.00 0 0 0 50.00 0 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 52.01 C 0 05202 MEDICAL SERVICES 52.02 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 Λ 0 0 Λ 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 63.00 0 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 71.00 0 o 73.00 07300 CMHC C 0 73.00 0 07400 OTHER REIMBURSEMENT 0 74.00 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 84.00 84 01 08401 OTHER SPECIAL PURPOSE COST II 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 23, 921 23, 921 23, 921 23, 921 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 91 00 0 0 91 00 Ω 0 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 09300 NONPALD WORKERS 0 0 0 93.00 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 95.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 252, 086 54, 983 159, 388 0 102, 00 102.00 0 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 10.538272 2. 298524 0.000000 6.663099 0. 000000 103. 00 104.00 Cost to be allocated (per Wkst. B, 2,774 605 1, 754 0 104.00 Part II) 105 00 Unit cost multiplier (Wkst. B, Part 0 115965 0.025292 0.000000 0.073325 0.000000 105.00 111)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS CARE ONE AT LIVINGSTON In Lieu of Form CMS-2540-10

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 39 am Provi der No.: 315479

			10 12/31/2023	5/10/2024 11: 39 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 00800 DI ETARY			7.00
8. 00 9. 00	00900 NURSI NG ADMI NI STRATI ON			8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00	01100 PHARMACY			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY			12. 00
13.00	01300 SOCIAL SERVICE			13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	01500 ACTI VI TES	23, 921		15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	22,024		20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	23, 921		30. 00 31. 00
32. 00	03200 CF/11D	0		32.00
33. 00	03300 OTHER LONG TERM CARE			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 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0		45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	O		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	05100 SUPPORT SURFACES	0		51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0		52. 00
52. 01	05201 OTHER ANCI LLARY SERVICES COST	0		52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	l U		52. 02
60. 00	06000 CLINIC	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	o		61. 00
62.00	06200 FQHC			62. 00
63. 00	06300 DI ALYSI S	0		63. 00
	OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0		70.00
71.00	07100 AMBULANCE 07300 CMHC	0		71.00
	07400 OTHER REIMBURSEMENT	0		74. 00
, ,, ,,	SPECIAL PURPOSE COST CENTERS	5		7 99
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		83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0		84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	23, 921		89.00
07.00	NONREI MBURSABLE COST CENTERS	25, 721		07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91.00	09100 BARBER AND BEAUTY SHOP	O		91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00	09300 NONPALD WORKERS	0		93. 00
94. 00	09400 PATIENTS LAUNDRY	0		94.00
95. 00 98. 00	09500 OTHER NONREI MBURSABLE COST	0		95. 00 98. 00
98.00	Cross Foot Adjustments Negative Cost Centers			99.00
102.00		300, 752		102.00
102.00	Part I)	330, 732		102.00
103.00		12. 572719		103. 00
104.00	71	3, 310		104. 00
405 5	Part II)	0.400070		105
105.00		0. 138372		105. 00
	1)	1		I

Health Financial Systems CARE ONE AT LIVI		NGSTON	In Lie	u of Form CMS-2540-10
RATIO OF COST TO CHARGES	FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der No.: 315479	Peri od:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:39 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 38, 201 79, 715 0. 479220 40.00 04100 LABORATORY 43, 189 90, 123 0.479223 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 217, 222 492, 692 0.440888 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 767, 889 1, 805, 173 0. 425382 44.00 04500 OCCUPATIONAL THERAPY 1, 859, 952 45.00 598, 527 0. 321797 45.00 04600 SPEECH PATHOLOGY 0.383312 46.00 281, 832 735, 255 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 791 3, 738 0.479133 48.00 04900 DRUGS CHARGED TO PATIENTS 0.440887 49.00 49.00 400, 917 909, 342 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 Λ 50.00 51.00 05100 SUPPORT SURFACES 10, 400 21, 703 0.479196 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 0 52.01 05202 MEDICAL SERVICES 0.000000 52.02 0 52.02 OUTPATIENT SERVICE COST CENTERS 0. 000000 60.00 06000 CLI NI C 0 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. 00 07100 AMBULANCE 94, 033 196, 220 0. 479222 71.00

2, 454, 001

6, 193, 913

100. 00

100.00

Total

Health Financial Systems	CARE ONE AT	LIVINGSTON		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 39 am
		Title	XVIII (1)	Skilled Nursing		
				Facility		
		Heal th Care Pi	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2. 00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	LENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0. 479220		l .	0 2, 176		
41. 00 04100 LABORATORY	0. 479223		l .	0 8, 680		
42. 00 04200 I NTRAVENOUS THERAPY	0. 440888			0 11, 139		
43.00 O4300 OXYGEN (INHALATION) THERAPY	0. 000000	l .		0	0	
44. 00 O4400 PHYSI CAL THERAPY	0. 425382			0 202, 160		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 321797			0 164, 088	•	
46. 00 04600 SPEECH PATHOLOGY	0. 383312			0 69, 983	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 479133			0 1, 791	0	
49. 00 O4900 DRUGS CHARGED TO PATIENTS	0. 440887			0 34, 268	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	0. 479196	21, 703		0 10, 400	0	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000			0	0	
52. 01 05201 OTHER ANCILLARY SERVICES COST	0. 000000			0	0	
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52. 02
OUTPAȚI ENT SERVI CE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62. 00
63. 00 06300 DI ALYSI S	0. 000000			0	0	
71. 00 07100 AMBULANCE (2)	0. 479222	l .		0	0	
100.00 Total (Sum of lines 40 - 71)		1, 318, 813		0 504, 685	0	100. 00

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

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

Heal th	Financial Systems	CARE ONE AT	LI VI NGSTON		In Lie	u of Form CMS-2	2540-10
	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315479	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. 440887	1.00
2.00	Program vaccine charges (From your reco				,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)		1				
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health	Nursing &	Cost (From	& Allied	
		Part I, Col. 18	(From Wkst. B, Part I, Col.	Costs to Tota		Health Costs for Pass	
		10		Costs to Tota		Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)	•	0 X 001. 1)	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
	04000 RADI OLOGY	38, 201	0				
	04100 LABORATORY	43, 189	l e	0. 00000			
	04200 I NTRAVENOUS THERAPY	217, 222	ł	0. 00000			
	04300 OXYGEN (INHALATION) THERAPY	0	ı	0. 00000		0	10.00
	04400 PHYSI CAL THERAPY	767, 889	0	0. 00000		0	44. 00
	04500 OCCUPATI ONAL THERAPY	598, 527	0	0.00000		0	
	04600 SPEECH PATHOLOGY	281, 832	0	0.00000		0	
	04700 ELECTROCARDI OLOGY	0	0	0.00000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	1, 791 400, 917	0	0. 00000 0. 00000		0	48. 00 49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	400, 917	0	0.00000		0	
	05100 SUPPORT SURFACES	10, 400		0.00000		0	
	05200 COMPLEX MEDICAL EQUIPMENT	10, 400		0.00000		0	
	05201 OTHER ANCILLARY SERVICES COST			0.00000		0	
	05201 MEDI CAL SERVI CES		0			0	
100.00		2, 359, 968	·		504, 685	-	100.00
		,		'	, ,	- 1	

	Financial Systems CARE ONE ATION OF INPATIENT ROUTINE COSTS	AT LIVINGSTON Provider No.: 315479	Peri od: From 01/01/2023 To 12/31/2023		pared
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			23, 921	
00	Private room days			0	
00	Inpatient days including private room days applicable t	3		4, 093	
00	Medically necessary private room days applicable to the	Program		0	
00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			11, 150, 231	5
0	General inpatient routine service charges			13, 464, 902	6
0	General inpatient routine service charges (Learning of the control of the contro	ine 5 divided by line 6)		0. 828096	
0	Enter private room charges from your records	c a.v. aca zyc c)		0.020070	1
0	Average private room per diem charge (Private room char	ges line 8 divided by private	room days, line	0.00	
	2)	3 1	3 .		
00	Enter semi-private room charges from your records			0	
00	Average semi-private room per diem charge (Semi-privat	e room charges line 10, divid	ed by	0. 00	11
00	semi-private room days) Average per diem private room charge differential (Line	0 minus lina 11)		0. 00	12
00	Average per diem private room charge differential (Line 7	,		0.00	
00	Private room cost differential adjustment (Line 2 times	•		0.00	
00	General inpatient routine service cost net of private r		minus line 14)	11, 150, 231	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	,	,		
00	Adjusted general inpatient service cost per diem (Line	15 divided by line 1)		466. 13	
00	Program routine service cost (Line 3 times line 16)			1, 907, 870	
00	Medically necessary private room cost applicable to pro	J ,		0	1 .~
00	Total program general inpatient routine service cost (t III 10	1, 907, 870	
00	Capital related cost allocated to inpatient routine ser line 30 for SNF; line 31 for NF, or line 32 for ICF/IID		it ii Column 18,	2, 110, 415	20
00	Per diem capital related costs (Line 20 divided by lin	•		88. 22	21
00	Program capital related cost (Line 3 times line 21)			361, 084	
00	Inpatient routine service cost (Line 19 minus line 22)			1, 546, 786	
00	Aggregate charges to beneficiaries for excess costs (F	rom provider records)		0	
00	Total program routine service costs for comparison to t	he cost limitation (Line 23 m	inus line 24)	1, 546, 786	25
00	Enter the per diem limitation (1)				26
00	Inpatient routine service cost limitation (Line 3 times				27
00	Reimbursable inpatient routine service costs (Line 22 p		line 27)		28
	(Transfer to Worksheet E, Part II, line 4) (See instruc	tions)			

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	23, 921	1.00
2.00	Program inpatient days (see instructions)	4, 093	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. 171105	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems CARE ONE ATION OF INPATIENT ROUTINE COSTS	AT LIVINGSTON Provi der No.: 315			pare
		Title XIX	Skilled Nursing Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days including private room days			23, 921] 1
00	Private room days			0	2
00	Inpatient days including private room days applicable t			10, 911	3
00	Medically necessary private room days applicable to the	Program		0	
00	Total general inpatient routine service cost			11, 150, 231] 5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
0	General inpatient routine service charges			13, 464, 902	
0	General inpatient routine service cost/charge ratio (L	ine 5 divided by line 6)		0. 828096	
0	Enter private room charges from your records			0	
0	Average private room per diem charge (Private room char	ges line 8 divided by priv	ate room days, line	0.00	9
00	2) Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-privat	a room charges line 10 di	vided by	0.00	1 .,
00	semi -private room days)	e room charges rifle ro, di	vided by	0.00	'
00	Average per diem private room charge differential (Line	9 minus line 11)		0.00	12
00	Average per diem private room cost differential (Line 7			0.00	
00	Private room cost differential adjustment (Line 2 times	,		0	
00	General inpatient routine service cost net of private r	oom cost differential (Lin	e 5 minus line 14)	11, 150, 231	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		<u> </u>		ĺ
00	Adjusted general inpatient service cost per diem (Line	15 divided by line 1)		466. 13	16
00	Program routine service cost (Line 3 times line 16)			5, 085, 944	17
00	Medically necessary private room cost applicable to pro		3)	0	
00	Total program general inpatient routine service cost (5, 085, 944	
00	Capital related cost allocated to inpatient routine ser line 30 for SNF; line 31 for NF, or line 32 for ICF/IID		Part II column 18,	2, 110, 415	20
00	Per diem capital related costs (Line 20 divided by lin	e 1)		88. 22	
00	Program capital related cost (Line 3 times line 21)			962, 568	
00	Inpatient routine service cost (Line 19 minus line 22)			4, 123, 376	
00	Aggregate charges to beneficiaries for excess costs (F			0	
00	Total program routine service costs for comparison to t	ne cost limitation (Line 2	3 minus line 24)	4, 123, 376	
00	Enter the per diem limitation (1)	***	: 2/) (1)	0.00	
00	Inpatient routine service cost limitation (Line 3 times	•	, , ,	0	1 -
. 00	Reimbursable inpatient routine service costs (Line 22 p	ius ine lesser of line 25	or line 27)	5, 085, 944	28

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

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

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

1.00

23, 921

10, 911

0. 456126

0

2. 00 3. 00

4.00

MCRI F32 - 10. 17. 178. 0

1.00

2.00

4.00

5.00

Health Financial Systems	CARE ONE AT LIVIN	NGSTON	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FO	OR TITLE XVIII	Provi der No.: 315479	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:39 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			3, 093, 786	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3. 00	Subtotal (Sum of lines 1 and 2)			3, 093, 786	3. 00
4.00	Pri mary payor amounts			0	4. 00
5. 00	Coinsurance			375, 600	5. 00
6.00	Allowable bad debts (From your records)			215, 232	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ıcti ons)		76, 516	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			139, 901	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10. 00	Utilization review			0	10. 00
11. 00	Subtotal (See instructions)			2, 858, 087	11. 00
12. 00	Interim payments (See instructions)			2, 939, 603	12.00
13. 00	Tentati ve adj ustment			0	13. 00
14. 00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			2, 798	14. 75
14. 99				54, 364	14. 99
15. 00	Balance due provider/program (see Instructions)			-138, 678	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 - 1	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ıcti ons)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentati ve adjustment			0	27. 00
28.00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			0	29. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	ce with CMS Pub.15-2, s	section 115.2	0	30.00

From 01/01/2023 Date/Time F

To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 39 am

Title XVIII Skilled Nursing PPS

		11 11	e XVIII S	Killed Nursing	PPS	
		Lonation	t Part A	Facility	t B	
		<u>'</u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I=	1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 663, 822		0	
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		332, 284		0	2. 00
	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					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	
3. 05			0		0	3. 05
	Provi der to Program	0.4.04.40000	F. 500			
3.50	ADJUSTMENTS TO PROGRAM	06/06/2023	56, 503		0	
3. 51 3. 52					0	3. 51 3. 52
3. 52			0		0	3. 52
3. 54			0		0	
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-56, 503		0	3. 99
3. 77	- 3.98)		30, 303		· ·	3. //
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 939, 603		0	4.00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line		, ,			
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5. 01
5. 01	TENTATIVE TO PROVIDER		0		0	5.01
5. 02			0		0	
5.05	Provider to Program		0		0	3.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			Ö		0	
5. 52			Ö		Ō	
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
	the cost report. (1)					
6. 01	PROGRAM TO PROVI DER		0		0	6. 01
6. 02	PROVI DER TO PROGRAM		138, 678		0	
7. 00	Total Medicare program liability (see instructions)		2, 800, 925		0	7. 00
			Contract	tor Name	Contractor Number	
			1.	00	2. 00	
8 00	Name of Contractor		1.	00	2.00	8. 00
	lines 3 5 and 6 where an amount is due provider to progr	am show the a	ı mount and date	on which the	ı orovi der	

⁽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.

In Lieu of Form CMS-2540-10 CARE ONE AT LIVINGSTON Provi der No.: 315479

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

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 39 am

oni y)		General Fund	Specific E	ndowment Fund	5/10/2024 11: Plant Fund	
			Purpose Fund			
	Assets	1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	541, 656	1	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	1, 890, 675	0	0	0	
5. 00	Other recei vables	1,070,073	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	-618, 207	O	o	0	
	recei vabl e					
7. 00	Inventory	0	0	0	0	
8.00	Prepai d expenses	28, 013	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	8, 902	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	1, 851, 039		0	0	1 .
11.00	FIXED ASSETS	1,031,037	<u> </u>	<u> </u>		1
12. 00	Land	2, 184, 059	0	0	0	12.0
13. 00	Land improvements	40, 317	0	0	0	13.0
14. 00	Less: Accumulated depreciation	-14, 119	0	0	0	14. 0
15. 00	Bui I di ngs	11, 631, 032	0	0	0	
16. 00	Less Accumulated depreciation	-7, 723, 642	0	0	0	
17. 00 18. 00	Leasehold improvements	0	0	O O	0	1
19.00	Less: Accumulated Amortization Fixed equipment	539, 542	1	0	0	
20. 00	Less: Accumulated depreciation	-551, 637	0	0	0	
21. 00	Automobiles and trucks	6, 696	0	0	0	
22. 00	Less: Accumulated depreciation	-6, 696	0	o	0	
23. 00	Major movable equipment	3, 340, 648	0	0	0	23. 0
24. 00	Less: Accumulated depreciation	-2, 979, 162	0	0	0	
25. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	
26. 00	Mi nor equi pment nondepreci abl e	0	0	0	0	1
27. 00	Other fixed assets	131, 485	0	O O	0	1
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	6, 598, 523	l o	<u> </u>	0	28. (
29. 00	Investments	0	0	0	0	29. 0
30. 00	Deposits on Leases	o o	Ö	o	0	
31. 00	Due from owners/officers	0	0	0	0	
32. 00	Other assets	1, 342, 179	0	o	0	32.0
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 342, 179		0	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	9, 791, 741	0	0	0	34.0
	Liabilities and Fund Balances CURRENT LIABILITIES					1
35. 00	Accounts payable	1, 082, 344	0	O	0	35. 0
36. 00	Salaries, wages, and fees payable	239, 497	o	o	0	
37. 00	Payroll taxes payable	32, 718	0	0	0	37.0
38. 00	Notes & Loans payable (Short term)	0	0	0	0	38.0
39. 00	Deferred income	0	0	0	0	
40. 00	Accel erated payments	0		_	_	40.0
41.00	Due to other funds	8, 902		0	0	
42. 00 43. 00	Other current liabilities TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 915, 791 3, 279, 252		0	0	
+3.00	LONG TERM LIABILITIES LONG TERM LIABILITIES	3,214,232	<u> </u>	<u> </u>		43.0
44. 00	Mortgage payable	17, 081, 558	0	0	0	44. 0
45. 00	Notes payable	0	Ö	Ö	0	1
46. 00	Unsecured Loans	0	0	0	0	46. 0
47. 00	Loans from owners:	0	0	0	0	
18. 00	Other long term liabilities	-12, 805, 987	0	0	0	
19. 00	OTHER (SPECIFY)	0	0	0	0	1
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	4, 275, 571	0	0	0	
1. 00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	7, 554, 823	0	0	0	51.
52. 00	General fund balance	2, 236, 918				52. (
53. 00	Specific purpose fund	2,200,7.0	0			53. (
4. 00	Donor created - endowment fund balance - restricted			О		54. (
5.00	Donor created - endowment fund balance - unrestricted			О		55.
6. 00	Governing body created - endowment fund balance			0		56.
7. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. (
	replacement, and expansion			_		
-0.00	TOTAL FUND DALANCES (Sum of Line 50 +box 50)	2 22/ 040	I ^!			
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	2, 236, 918 9, 791, 741		0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES CARE ONE AT LIVINGSTON

Provider No.: 315479 | Period: From 01/01/2023 | Worksheet G-1

Special Purpose Fund Special Purpose Fund Endowment Fund
1.00
1.00
2.00 Net income (loss) (from Wkst. G-3, line 31)
3.00 Total (sum of line 1 and line 2) 2,236,922 0 3.00 4.00 6.00 6.00 0 0 0 0 0 0 0 0 0
4.00
5.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9
7. 00 8. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
8. 00
9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 Subtotal (line 3 plus line 10) 12. 00 Deductions (debit adjustments) 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 17. 00 19. 00 10. 00 10. 00 11. 00 2, 236, 922 0 0 11. 00 12. 00 12. 00 13. 00 0 0 0 14. 00 0 0 0 0 15. 00 0 0 0 0 0 0 0 16. 00 17. 00 18. 00 17. 00 19. 00 19. 00 19. 00 0 11. 00 0 11. 00 0 0 0 0 11. 00 0 0 0 0 15. 00 0 0 0 0 0 0 0 0 16. 00 0 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Total additions (sum of line 5 - 9)
11.00 Subtotal (line 3 plus line 10) 2,236,922 0 11.00 12.00 12.00 13.00 14.00 14.00 15.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 19.00 19.00 10.00 10.00 19.00 19.00 10.00
13.00 ROUNDING
14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance sheet (Line 11 - line 18) Endowment Fund Plant Fund 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) 0 0 14.00 0 0 0 0 15.00 0 0 0 0 0 16.00 0 0 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
15. 00 16. 00 16. 00 0 0 0 0 0 16. 00 17. 00 18. 00 19. 00
16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance 2, 236, 918 0 19.00 19.00
17.00 18.00 Total deductions (sum of lines 13 - 17) 18.00 19.00 Fund balance at end of period per balance 2,236,918 0 19.00
19.00 Fund balance at end of period per balance 2,236,918 0 19.00
Sheet (Line 11 - line 18)
Endowment Fund
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) 0 0 3.00 4.00 5.00 6.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) 0 0 3.00 4.00 5.00 6.00 7.00 0 0 0 0 7.00
2.00
4.00 Additions (credit adjustments) 4.00 5.00 6.00 7.00 0 0 6.00 7.00
5. 00 6. 00 7. 00 5. 00 6. 00 7. 00
6. 00 7. 00 0 6. 00 7. 00
7.00
0.00
9.00
10.00 Total additions (sum of line 5 - 9) 0 10.00
11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 Deductions (debit adjustments) 12.00
13.00 Beddet of a desired adjustments)
14.00
15.00
16.00
17.00 18.00 Total deductions (sum of lines 13 - 17) 0 18.00
19.00 Fund balance at end of period per balance 0 19.00
sheet (Line 11 - line 18)

Haal th	Financial Systems	CARE ONE AT LIVIN	ICSTON		Inlie	eu of Form CMS-2	2540_10	
	IENT OF PATIENT REVENUES AND OPERATING EXPENSE				Peri od: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II	pared:	
	Cost Center Description			Inpati ent	Outpati ent	Total		
	DADT I DATI ENT DEVENUES			1.00	2. 00	3. 00		
	PART I - PATIENT REVENUES							
1 00	General Inpatient Routine Care Services			12 4/4 00	20	12 4/4 002	1 00	
1.00	SKILLED NURSING FACILITY			13, 464, 90)2	13, 464, 902	1.00	
2.00	NURSING FACILITY				0	0	2.00	
3. 00 4. 00	OTHER LONG TERM CARE				0	0	3. 00 4. 00	
		6 l: 1 4)		10 4/4 00	0	0		
5. 00	Total general inpatient care services (Sum of All Other Care Services	r irnes i - 4)		13, 464, 90)2	13, 464, 902	5. 00	
6. 00	ANCI LLARY SERVICES			6, 193, 91	2 0	6, 193, 913	6. 00	
7. 00	CLINIC			0, 193, 91	3	0, 193, 913	7.00	
8. 00	HOME HEALTH AGENCY COST				0	0	8.00	
9.00	AMBULANCE				0	0	9.00	
10.00	RURAL HEALTH CLINIC				0	0	10.00	
10. 00	FOHC				0	0		
	CMHC				0	0	10. 10	
11.00	HOSPI CE				0		11.00	
12.00					0	0	12. 00 13. 00	
13.00	OTHER (SPECIFY)	/T		10 (50 01	0	-		
14. 00	Total Patient Revenues (Sum of lines 5 - 13) Worksheet G-3, Line 1)	(Transfer column 3	το	19, 658, 81	5	19, 658, 815	14. 00	
Cost Center Description								
	Cost Conter Bescription				1. 00	2. 00		
	PART II - OPERATING EXPENSES				11.00			
1.00	Operating Expenses (Per Worksheet A, Col. 3,	Li ne 100)				14, 889, 761	1.00	
2.00	Add (Specify)	ŕ			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	
					1		7.00	

8. 00 9. 00 10. 00

11. 00 12. 00 13. 00 14. 00

0

14, 889, 761 15. 00

8. 00 9. 00

10. 00 11. 00

12.00

Total Additions (Sum of lines 2 - 7) Deduct (Specify)

15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

13.00 14.00 Total Deductions (Sum of lines 9 - 13)

Health Financial Systems CARE ONE AT LIVINGSTON In Lieu of Form CMS-2540-10											
Heal th	u of Form CMS-2540-10										
STATE	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315479	Peri od: From 01/01/2023	Worksheet G-3							
	Date/Time Prepared: 5/10/2024 11:39 am										
				1. 00							
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1			19, 658, 815							
2.00	Less: contractual allowances and discounts on patients accounts			7, 986, 077							
3.00	Net patient revenues (Line 1 minus line 2)			11, 672, 738							
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		14, 889, 761	1						
5.00	Net income from service to patients (Line 3 minus 4)			-3, 217, 023	5. 00						
	Other income:										
6.00	Contributions, donations, bequests, etc			0	6. 00						
7. 00	Income from investments	5, 640	7. 00								
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00								
9.00	Revenue from television and radio service			0	9. 00						
10. 00	Purchase di scounts			0	10.00						
11. 00	Rebates and refunds of expenses			0	11. 00						
12. 00	Parking lot receipts			0	12. 00						
13. 00	Revenue from Laundry and Linen service			0	13. 00						
14. 00	Revenue from meals sold to employees and guests			0	14. 00						
15. 00	Revenue from rental of living quarters			0	15. 00						
	Revenue from sale of medical and surgical supplies to other tha	0	16. 00								
17. 00	Revenue from sale of drugs to other than patients	0	17. 00								
18. 00	Revenue from sale of medical records and abstracts	0	18. 00								
	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00								
20. 00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00								
21. 00	Rental of vending machines	0	21. 00								
22. 00	Rental of skilled nursing space	0	22. 00								
23.00	Governmental appropriations			0	23. 00						
24.00	BARBER & BEAUTY			578							
24. 01	MAINTENANCE FEE INCOME			8, 581	24. 01						
24. 02	OTHER REVENUE			1, 169	24. 02						
24. 03	OTHER INCOME			6, 817	24. 03						
24. 50	COVI D-19 PHE Fundi ng			0	24. 50						
05 00				00 705							

0 | 24. 50 22, 785 | 25. 00 -3, 194, 238 | 26. 00 0 | 27. 00 0 | 28. 00 0 | 29. 00 0 | 30. 00

-3, 194, 238 31. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (Sum of lines 6 - 24)
26.00 Total (Line 5 plus line 25)

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

27. 00 28. 00 29. 00