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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315488	To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:40 am

			3/10	7 2024 II. 40 alli
PART I - COST I	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost rep	oort	Date: 5/10/2024	Time: 11:40 am
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report ent	er the number of times the provide	er resubmitted this cos	st report
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor No.	<u></u>	
use only	(1) As Submitted	7.[N] First Cost Report for this	s Provider CCN	
	(2) Settled without audit	8. [N] Last Cost Report for this	Provider CCN	
	(2) Settled without audit (3) Settled with audit	9. NPR Date:		
	(4) Reopened	10.[0]If line 4, column 1 is "4"	 ': Enter number of time	es reopened
	(5) Amended	11. Contractor Vendor Code	4	'
	5. Date Received:	12.[F] Medicare Utilization. Ent for no utilization.	er "F" for full, "L" fo	or low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT MADISON AVENUE (315488) 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 FINANCIAL OFFICER OR ADMINISTRATOR 1		CHECKBOX	ELECTRONI C	
			2	SI GNATURE STATEMENT	
1	Dav	rid Baruch	Y	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	AUTHORI ZED SI GNOR			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	-37, 493	181	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	-37, 493	181	0	100.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete and review the information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems CARE ONE AT MADISON AVENUE In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315488 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:40 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 151 MADISON AVENUE 1.00 PO Box: 1.00 2.00 City: MORRISTOWN State: NJ Zi p Code: 07960 2.00 3.00 County: MORRIS 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 XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT MADISON 315488 01/04/2005 N Р Ν 4.00 AVENUE 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 | SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 1 061 251 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 1, 061, 251 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 75 319 0 0

Heal th	Financial Systems	CARE ONE AT MADISO	N AVENUE	In Lie	u of Form CMS-2	2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31548		Worksheet S-2	
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023		
					5/10/2024 11:	40 am
					Y/N	
					1. 00	
42.00	Are malpractice 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 box	x, and submit supporting s	schedule listing cos	t centers and		
	amounts.					
43.00	Are there any home office costs as def	ned in CMS Pub. 15-1, Cha	apter 10?		Υ	43. 00
43.00 Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10? 44.00 If line 43 is yes, enter the home office chain number and enter the name and address of the home HB0206						44. 00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3. 00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of the	home office on the	lines	
	bel ow.					
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contr	actor's Number: 1200	1	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00
47.00	City: FORT LEE	State: NJ	Zi p Ci	ode: 0702	4	47. 00

Health Financial Systems CARE ONE AT MADI	ISON AVENUE		In lie	eu of Form CMS	5-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		No.: 315488	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S- Part II	-2 repared:
			Y/N	Date	1. 40 aiii
General Instruction: For all column 1 responses enter in column responses the format will be (mm/dd/yyyy) Completed by All Skilled Nurshing Facilities	umn 1, "Y" fo	or Yes or "N"	1.00 for No. For all	the date	
Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the I reporting period? If column 1 is "Y", enter the date of the (instructions)	beginning of change in col	umn 2. (see	N		1.00
		1.00	2. 00	V/I 3. 00	
2.00 Has the provider terminated participation in the Medicare Procolumn 1 is yes, enter in column 2 the date of termination at 3, "V" for voluntary or "I" for involuntary.		N			2. 00
3.00 Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home officer medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug r or its the board	Y			3.00
		Y/N 1.00	Type 2. 00	Date 3.00	
Financial Data and Reports 4.00 Column 1: Were the financial statements prepared by a Certifi Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "(Compiled, or "R" for Reviewed. Submit complete copy or enter available in column 3. (see instructions) If no, see instructions	C" for date	Y	A A	3. 00	4. 00
5.00 Are the cost report total expenses and total revenues different those on the filed financial statements? If column 1 is "Y", reconciliation.	ent from	N			5. 00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities 6.00 Column 1: Were costs claimed for Nursing School? (Y/N) Column	n 2. Io tho	nnavi dan +ba	N	N N	/ 00
 6.00 Column 1: Were costs claimed for Nursing School? (Y/N) Column legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instance 8.00 Were approvals and/or renewals obtained during the cost report 	tructions.		N N	IN IN	7. 00 8. 00
School and/or Allied Health Program? (Y/N) see instructions.				Y/N	
				1. 00	
9.00 Is the provider seeking reimbursement for bad debts? (Y/N) so 10.00 If line 9 is "Y", did the provider's bad debt collection poliperiod? If "Y", submit copy.			st reporting	Y N	9. 00
11.00 If line 9 is "Y", are patient deductibles and/or coinsurance Bed Complement	waived? If "	Y", see insti	ructions.	N	11. 00
12.00 Have total beds available changed from prior cost reporting	period? If "Y			N	12. 00
Descri p	ti on	Y/N	art A Date	Part B Y/N	
PS&R Data		1.00	2. 00	3. 00	
13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		Y	03/20/2024	Y	13. 00
14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		N		N	14. 00
15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		N		N	15. 00
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		N		N	16. 00
17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		N		N	17. 00
18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions.		N		N	18. 00

Health Financial Systems	CARE ONE AT MA	DI SON AVENUE		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACIL	TY HEALTH CARE	Provi de		Peri od:	Worksheet S-2	2
COMPLEX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	narod:
				10 12/31/2023	5/10/2024 11:	40 am
		-	1.00	2.	00	
Cost Report Preparer Contact Information						
19.00 Enter the first name, last name and the titl		CHARLES		REED		19. 00
held by the cost report preparer in columns	1, 2, and 3,					
respecti vel y.						ll
20.00 Enter the employer/company name of the cost	report	EXECUCARE ASS	SOCI ATES			20.00
preparer.						
21.00 Enter the telephone number and email address		(609) 738-3200)	CRWASSC@NETSCAI	PE. NET	21. 00
report preparer in columns 1 and 2, respecti	vel y.					

Health Financial Systems CARE ONE AT MAI SKILLED NURSING FACILITY HEALTH CARE CARE ONE AT MADISON AVENUE

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315488 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:40 am
		Part B			9, 19, 2921 111 10 4
		Date			
		4. 00			
	PS&R Data				
13. 00	Was the cost report prepared using the PS&R	03/20/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14. 00
00	for total and the provider's records for				65
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
45.00	4.				45.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that				15. 00
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16.00	If line 13 or 14 is "Y", then were				16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
47.00	information? If yes, see instructions.				47.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?				17. 00
	Describe the other adjustments:				
18. 00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3.00		
10.00	Cost Report Preparer Contact Information Enter the first name, last name and the title	/noci ti on	VI CE-PRESI DENT		19.00
19.00	held by the cost report preparer in columns 1		VICE-PRESIDENT		19.00
	respectively.	, 2, and 5,			
20.00	Enter the employer/company name of the cost r	eport			20. 00
	preparer.	-			
21. 00					21. 00
	report preparer in columns 1 and 2, respective	vel y.	l		

Health Financial Systems CARE ONE AT MAI SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2540-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | | Prepared: | To | 12/31/2023 | Date/Time Prepared: | Prep

				To	12/31/2023	Date/Time Prep 5/10/2024 11:4	
				I npa	atient Days/Vis		
	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	178	64, 970	0	7, 085	18, 543	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	I CF/IID HOME HEALTH AGENCY COST	0	0	0	0	0	3. 00
4. 00 5. 00	Other Long Term Care		0	U	U	U	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)	178	64, 970	0	7, 085	18, 543	8. 00
		Inpatient Da	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	·	6.00	7. 00	8. 00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	11, 446	37, 074	0	227	63	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		U				6. 00
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	11, 446	37, 074	0	227	63	8. 00
		Di scha	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	324	614		31. 21	294. 33	1.00
2. 00 3. 00	NURSING FACILITY	0	0	0.00		0. 00 0. 00	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		U			0.00	4. 00
5. 00	Other Long Term Care	o	0				5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	0	0. 00	0. 00		7. 00
8. 00	Total (Sum of lines 1-7)	324	614		31. 21	294. 33	8. 00
		Average Length of Stay		Admi s	SLONS		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	60. 38	0	274	34	305	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0.00			U	U	3. 00 4. 00
5. 00	Other Long Term Care	0. 00				o	5. 00
6.00	SNF-Based CMHC						6. 00
7. 00	HOSPI CE	0.00	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	60.38 Admissions	Full Time	274 Equi val ent	34	305	8. 00
	Component	Total	Employees on Payroll	Nonpai d Workers			
		21.00	22. 00	23. 00			
1.00	SKILLED NURSING FACILITY	613	137. 50	0. 00			1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	0	0.00				3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	o	0. 00 0. 00				4. 00 5. 00
6. 00	SNF-Based CMHC		0.00				6. 00
7. 00	HOSPI CE	0	0.00				7. 00
8.00	Total (Sum of lines 1-7)	613	137. 50			j	8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION

				Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:4	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6		Salary in col.		
				Í	3	, i	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	9, 271, 906	0	9, 271, 906	· ·		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	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)	9, 271, 906	0	9, 271, 906	285, 990. 00	32. 42	6. 00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	9, 271, 906	0	9, 271, 906	285, 990. 00	32. 42	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	44, 255	0	44, 255			
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15.00
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00		1, 618, 369	0	1, 618, 369			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18.00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20.00	Physician Part A - WRC	0	0	0			20.00
21. 00		0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 618, 369	0	1, 618, 369			22. 00
	instructions)						

9.00

10.00

11.00

12.00

13.00

Pharmacy

Social Service

Other General Service

14.00 Total (sum lines 1 thru 13)

Medical Records & Medical Records Library

Nursing and Allied Health Ed. Act.

0.00

18.72

41.85

19. 36

26. 24 14. 00

9.00

10.00

11.00

12.00

13.00

0.00

1, 963. 00

2, 225. 00

8, 353.00

98, 664. 00

0

36, 747

93, 114

161, 718

2, 588, 526

Worksheet S-3 Part III Date/Time Prepared: SNF WAGE INDEX INFORMATION Provi der No.: 315488 Peri od: From 01/01/2023 To 12/31/2023 5/10/2024 11:40 am Average Hourly Amount Reclass. of Adj usted Paid Hours Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0.00 1.00 2.00 Administrative & General 508, 819 0 508, 819 12, 779. 00 39.82 2.00 3.00 Plant Operation, Maintenance & Repairs 115, 120 0 115, 120 3, 663. 00 31.43 3.00 4.00 Laundry & Linen Service 38, 766 38, 766 2, 342.00 16.55 4.00 5.00 Housekeepi ng 408, 474 0 408, 474 24, 463. 00 16. 70 5.00 0 603, 257 26, 805. 00 Di etary 603, 257 22.51 6.00 6.00 Nursing Administration 591, 105 591, 105 14, 269. 00 41.43 7.00 7.00 8.00 Central Services and Supply 31, 406 0 31, 406 1, 802. 00 17.43 8.00

36, 747

93, 114

161, 718

2, 588, 526

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0

Health Financial Systems	CARE ONE AT MADISON AVENUE	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315488	Period: Worksheet S-3 From 01/01/2023 Part IV
		To 12/31/2023 Date/Time Prepared:

		To 12/31/202	3 Date/Time Pre 5/10/2024 11:	
			Amount	
			Reported	
			1.00	
	PART IV - WAGE RELATED COSTS		·	
	Part A - Core List			1
	RETI REMENT COST			1
1.00	401K Employer Contributions		50, 373	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3. 00
4.00	Pri or Year Pensi on Servi ce Cost		0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		•	1
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST		•	1
8.00	Health Insurance (Purchased or Self Funded)		669, 836	8.00
9.00	Prescription Drug Plan		0	1
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00			1, 864	11. 00
12.00			0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14. 00
15.00	Workers' Compensation Insurance		122, 509	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required by FASB 106.	0	1
	Non cumulative portion)			
	TAXES		•	1
17.00	FICA-Employers Portion Only		679, 529	17. 00
18.00	Medicare Taxes - Employers Portion Only		0	18. 00
19.00			0	19. 00
20.00	State or Federal Unemployment Taxes		94, 258	20.00
	OTHER		<u> </u>	1
21.00	Executive Deferred Compensation		0	21. 00
	Day Care Cost and Allowances		0	22. 00
	Tuition Reimbursement		0	
	Total Wage Related cost (Sum of lines 1 - 23)		1, 618, 369	24. 00
	,		Amount	
			Reported	
			1. 00	
	Part B - Other than Core Related Cost			
	OTHER WAGE RELATED COST		0	25. 00

Provi der No.: 315488

Peri od: From 01/01/2023 To 12/31/2023

Worksheet S-3
3 Part V
3 Date/Time Prepared:
5/10/2024 11: 40 am
Average Hourly
Wage (col. 3 ÷ Occupational Category Pai d Hours Amount Fri nge Adj usted

		Reported	Benefits	Salaries (col.		Wage (col. 3 ÷	
				1 + col. 2)	Salary in col.	col . 4)	
					3		
	To a contract of the contract	1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	617, 645	110, 094		i i		1. 00
2.00	Licensed Practical Nurses (LPNs)	2, 642, 496	471, 020				2. 00
3.00	Certified Nursing Assistant/Nursing	2, 214, 667	394, 760	2, 609, 427	87, 461. 00	29. 84	3. 00
	Assi stants/Ai des	5 474 000	075 074	, ,=, ,,,	4/0.0/0.00		
4.00	Total Nursing (sum of lines 1 through 3)	5, 474, 808	975, 874				4. 00
5. 00	Physical Therapists	498, 270	88, 816	587, 086			
6. 00	Physical Therapy Assistants	0	0	0	0.00		
7.00	Physical Therapy Aides	0	0	0	0.00		
8.00	Occupational Therapists	465, 199	82, 921	548, 120	i i		
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00		
11. 00	Speech Therapists	132, 747	23, 662	156, 409			
12.00	Respi ratory Therapi sts	0	0	0	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)	2, 467		2, 467	27. 00	91. 37	14.00
15. 00	Licensed Practical Nurses (LPNs)	8, 415		8, 415	114.00	73. 82	15. 00
16. 00	Certified Nursing Assistant/Nursing	1, 350		1, 350	27. 00	50.00	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	12, 232		12, 232	168. 00	72. 81	17. 00
18. 00	Physical Therapists	0		0	0.00	0.00	18.00
19. 00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21. 00	Occupational Therapists	0		0	0.00	0.00	21.00
22. 00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23. 00	Occupational Therapy Aides	O		0	0.00	0.00	23. 00
24.00	Speech Therapists	4, 750		4, 750	63.00	75. 40	24. 00
25.00	Respi ratory Therapi sts	27, 273		27, 273	545.00	50. 04	25. 00
26.00	Other Medical Staff	0		0			26. 00
	•					. '	

Peri od: Worksheet S-7
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/10/2024 11:40 am

		0 12/31/2023	5/10/2024 11:	
		Group	Days	
		1. 00	2. 00	
1.00		RUX		1. 00
2.00		RUL		2. 00
3.00		RVX		3. 00
4.00		RVL		4. 00
5.00		RHX		5. 00
6.00		RHL		6. 00
7.00		RMX		7. 00
8.00		RML		8. 00
9.00		RLX		9.00
10. 00 11. 00		RUC RUB		10. 00 11. 00
12. 00		RUA		12. 00
13. 00		RVC		13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18.00		RHA		18. 00
19.00		RMC		19. 00
20.00		RMB		20. 00
21.00		RMA		21.00
22. 00		RLB		22. 00
23.00		RLA		23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00 31. 00		HD1 HC2		30. 00 31. 00
32.00		HC1		32.00
33. 00		HB2		33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00		LD2		37. 00
38. 00		LD1		38. 00
39.00		LC2		39. 00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00		CE2		43.00
44.00		CE1		44.00
45. 00		CD2		45.00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00 51. 00		CB1 CA2		50. 00 51. 00
51.00		CA2 CA1		51.00
53. 00		SE3		53. 00
54. 00		SE2		54. 00
55. 00		SE1		55. 00
56.00		SSC		56.00
57.00		SSB		57. 00
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		BB1		64.00
65. 00		BA2		65.00
66. 00 67. 00		BA1 PE2		66. 00 67. 00
67. 00 68. 00		PE1		67. 00 68. 00
69.00		PD2		69.00
70. 00		PD2 PD1		70. 00
71.00		PC2		71. 00
72.00		PC1		71.00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00		PA2		75. 00

Health Financial Systems	CARE ONE AT MADISON	N AVENUE		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315488	Peri od:	Worksheet S-	7
				From 01/01/2023 To 12/31/2023	Date/Time Pr 5/10/2024 11	
				Group	Days	10 4
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101. 00 Staffing						101. 00
102.00 Recrui tment						102.00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104.00
105.00 OTHER (SPECIFY)	1					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, I	ine i, column 3)		I	l l		106. 00

Heal th	Financial Systems	CARE ONE AT MADI	SON AVENUE		In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	F EXPENSES	Provi der		Peri od: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cati	5/10/2024 11: Reclassi fi ed	40 am
	oost conto. Boson per on		0 (1.10)	+ col . 2)	ons	Trial Balance	
					I ncrease/Decre	(col. 3 +-	
					ase (Fr Wkst A-6)	col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS	1	0.400.400	0 400 40		0. 400. 400	1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		2, 492, 138 533, 171			2, 492, 138 532, 768	1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 652, 700			1, 652, 700	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	508, 819	2, 027, 368			2, 536, 187	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	115, 120	667, 865			782, 985	5. 00 6. 00
6. 00 7. 00	O0600 LAUNDRY & LINEN SERVICE O0700 HOUSEKEEPING	38, 766 408, 474	76, 487 52, 232			115, 253 460, 706	ł
8. 00	00800 DI ETARY	603, 257	383, 957			987, 214	ł
9. 00	00900 NURSING ADMINISTRATION	591, 105	130, 686			721, 791	1
10.00	01000 CENTRAL SERVICES & SUPPLY	31, 406	147, 439			178, 845	
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	36, 747	29, 438 0	29, 43 36, 74		29, 438 36, 747	
13. 00	01300 SOCI AL SERVI CE	93, 114	0	93, 11		93, 114	ı
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14. 00
15. 00	01500 ACTI VI TES	161, 718	14, 843	176, 56	0	176, 561	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	5, 474, 808	145, 744	5, 620, 55	2 0	5, 620, 552	30.00
31. 00	03100 NURSING FACILITY	0	143, 744	3, 020, 33	0 0	0, 020, 332	31.00
	03200 CF/IID	0	0		0 0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	25, 879	25, 87	9 0	25, 879	40. 00
41. 00	04100 LABORATORY		81, 727			81, 727	1
42.00	04200 I NTRAVENOUS THERAPY	O	183, 690			183, 690	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	610, 626 465, 199	26, 831	637, 45 465, 19		637, 457 465, 199	1
	04500 SPEECH PATHOLOGY	132, 747	4, 750			137, 497	ł
47. 00	04700 ELECTROCARDI OLOGY	0	0	,	0 0	0	ı
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	442, 897	442, 89	0	442, 897 0	1
51. 00	05100 SUPPORT SURFACES		0		0 403	403	ł
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0 0	0	
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0		0	0	
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 0	0	52. 02
60. 00	06000 CLINIC	0	0	1	0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	ı
	06200 FQHC						62.00
63.00	06300 DIALYSIS OTHER REIMBURSABLE COST CENTERS	0	0	1	0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	44, 610	44, 61	0 0	44, 610	71. 00
73. 00	07300 CMHC	0	0		0	0	
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0 0	0	74. 00
80. 00			0		0 0	0	80. 00
81. 00	08100 I NTEREST EXPENSE		0		0 0	0	
82.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0		0	0	
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I		0		0 0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	l o	0		0 0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	9, 271, 906	9, 164, 452	18, 436, 35	8 0	18, 436, 358	89. 00
00 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		4 470	4 47		4 470	00 00
90. 00 91. 00			6, 478 3, 459			6, 478 3, 459	90. 00 91. 00
	09200 PHYSI CI ANS PRI VATE OFFI CES		0		0 0	0, 107	1
	09300 NONPAI D WORKERS	0	0		0	0	
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0		0	0	
100.00		9, 271, 906	9, 174, 389	18, 446, 29	5 0	_	
	1	, ., ., .,	, ., -3,		,	.,	

 Heal th Financial
 Systems
 CARE ONE A

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315488 | Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:40 am
	Cost Center Description	Adjustments to	Net Expenses		571072024 11.40 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 & FLXTURES	-4, 997	2, 487, 141	•	1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	532, 768 1, 652, 700	•	2.00
4. 00	00400 ADMINISTRATIVE & GENERAL	490, 698		•	4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	782, 985		5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	115, 253		6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	-13	460, 706 987, 201	•	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	-2, 815		•	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	178, 845	•	10. 00
11. 00	01100 PHARMACY	-2, 355		•	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	36, 747	•	12.00
13. 00 14. 00	O1300 SOCIAL SERVICE O1400 NURSING AND ALLIED HEALTH EDUCATION	0	93, 114 0	•	13. 00 14. 00
15. 00	01500 ACTIVITES	0			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	-41, 283		•	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0		31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		0	l .	33. 00
	ANCILLARY SERVICE COST CENTERS	_			
40.00	04000 RADI OLOGY	0	,		40. 00
41. 00	04100 LABORATORY	0	81, 727	•	41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	-14, 695	168, 995 0		42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		637, 457	•	44. 00
45.00	04500 OCCUPATIONAL THERAPY	0	465, 199	•	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	137, 497		46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS	-35, 431	407, 466		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	l .	50.00
51. 00	05100 SUPPORT SURFACES	0	403	•	51. 00
52.00	O5200 COMPLEX MEDICAL EQUIPMENT	0	0	•	52.00
52. 01 52. 02	05201 OTHER ANCI LLARY SERVI CES COST 05202 MEDI CAL SERVI CES	0	0		52. 01 52. 02
02. 02	OUTPATIENT SERVICE COST CENTERS				02. 02
60.00	06000 CLI NI C	0	1		60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0		63. 00
	OTHER REIMBURSABLE COST CENTERS	-			
70.00	07000 HOME HEALTH AGENCY COST	0	0		70.00
	07100 AMBULANCE	0		•	71.00
	O7300 CMHC O7400 OTHER REI MBURSEMENT				73. 00 74. 00
	SPECIAL PURPOSE COST CENTERS	_			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80.00
81.00	08100 I NTEREST EXPENSE	0	0		81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0		82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	o o		84.00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	389, 109	18, 825, 467		89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	6, 478		90. 00
91.00	09100 BARBER AND BEAUTY SHOP		3, 459	•	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	l .	92. 00
93.00	09300 NONPAI D WORKERS	0	0		93.00
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0		94. 00 95. 00
100.00	1	389, 109	18, 835, 404		100.00
	•	•		•	1

Health Financial Systems	CARE ONE AT MADISON	N AVENUE		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Pre	
				10 12/31/2023	5/10/2024 11:	40 am
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
(1) C - RECLASS SUPP SURFACES						
1. 00	SUPPORT SURFACES		51. 0	0 0	403	1.00
TOTALS						
100. 00	Total Reclassificat	ions (Sum		0	403	100.00
	of columns 4 and 5 must					
	equal sum of column	s 8 and				
	9)					

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

Health Financial Systems	CARE ONE AT MADISON AVENUE		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:	
	Cost Center	Li ne #	Sal ary	Non Salary	
	6. 00	7. 00	8. 00	9. 00	
(1) C - RECLASS SUPP SURFACES					
1. 00	CAP REL COSTS - MOVABLE	2.0	0 0	403	1. 00
	EQUI PMENT				
TOTALS					
100. 00			0	403	100. 00

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

				Т	o 12/31/2023	Date/Time Prep 5/10/2024 11:4	
	·		·	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	\$					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	14, 131	0	0	0	0	2. 00
3.00	Buildings and Fixtures	18, 413, 696	17, 464	0	17, 464	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equipment	1, 061, 990	52, 847		52, 847	0	5. 00
6.00	Movable Equipment	4, 438, 475	9, 210		9, 210	0	6. 00
7.00	Subtotal (sum of lines 1-6)	23, 928, 292	79, 521	0	79, 521	0	7. 00
8.00	Reconciling Items	0	0	C	0	0	8. 00
9. 00	Total (line 7 minus line 8)	23, 928, 292	79, 521	C	79, 521	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	\$					
1.00	Land	0	0				1. 00
2.00	Land Improvements	14, 131	0				2. 00
3.00	Buildings and Fixtures	18, 431, 160	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	1, 114, 837	0				5. 00
6.00	Movable Equipment	4, 447, 685	0				6. 00
7.00	Subtotal (sum of lines 1-6)	24, 007, 813	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	24, 007, 813	0				9. 00

Provi der No.: 315488

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

				To 12/31/2023	3 Date/lime Pre 5/10/2024 11:	
				Expense Classification on		40 diii
				To/From Which the Amount is		
				TO THOM WITH ON THE THIRD AND THE	to bo hay do tod	
	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		CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7.00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10. 00
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capital expenditures (chapter 24)					
12. 00	Adjustment resulting from transactions with	A-8-1	883, 279			12. 00
	related organizations (chapter 10)					
13. 00	Laundry and linen service	_	0)	0.00	
14. 00	Revenue - Employee meals	В	-13	BDI ETARY	8.00	
15. 00	Cost of meals - Guests		0		0.00	
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients		_			
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18.00	Sale of medical records and abstracts		0		0.00	
19. 00	Vendi ng machi nes		0		1	19. 00
20. 00	Income from imposition of interest, finance		0)	0.00	20. 00
21 00	or penal ty charges (chapter 21)		0		0.00	21 00
21. 00	Interest expense on Medicare overpayments		Ü	7	0.00	21. 00
	and borrowings to repay Medicare					
22. 00	overpayments Utilization reviewphysicians' compensation	1	0	UTILIZATION REVIEW - SNF	82.00	22. 00
22.00	(chapter 21)		U	OTTLIZATION REVIEW - SNF	02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	bepreciationburidings and fixtures		0	FIXTURES	1.00	23.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
24.00	bepreer at ron movabre equipment		O	EQUI PMENT	2.00	24.00
25. 00	RESIDENT REPLACEMENT ITEMS	A	-1 546	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETING EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 01	MARKETI NG CORP EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	MARKETING - MEALS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04		A		ADMINISTRATIVE & GENERAL	4.00	
25. 05	BAD DEBT EXPENSE	Ä		PADMINISTRATIVE & GENERAL		25. 04
25. 06	BAD DEBT EXPENSE - MEDICARE	A		PADMINISTRATIVE & GENERAL	4.00	1
25. 00	BAD DEBT EXPENSE - OTHER	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	25. 07
25. 09	OTHER REVENUE	B		ADMINISTRATIVE & GENERAL	4.00	
25. 10	OTHER INCOME	B B		ADMINISTRATIVE & GENERAL	4.00	
	Total (sum of lines 1 through 99) (Transfer		389, 109		1.00	100.00
100.00	to Worksheet A, col. 6, line 100)		307, 107			. 55. 55
(1) Do	ecription all chapter references in this co	lumn nortain to	CMS Dub 15 1	1 1	1	1

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

CARE ONE AT MADISON AVENUE

Health Financial Systems CARE ONE AT MAD STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315488 OFFICE COSTS

OTTICL	60313			Ť	o 12/31/2023 Date/Time Pi 5/10/2024 1	
		Line No.	Cost (Center	Expense Items	
		1. 00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00	OLIVINES HOME OFFICE GOOTS!	4. 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	1.00
2.00		9. 00	NURSING ADMINI	STRATI ON	PHARMACY CONSULTANT	2.00
3.00		10. 00	CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPENSE	3.00
4.00		11. 00	PHARMACY		DRUGS-NON-PRESCRI PTI ON,	4.00
					NON-LEGEND	
5.00			PHARMACY		PHARMACY SUPPLIES	5. 00
6.00			INTRAVENOUS TH		IV EXPENSE	6. 00
7.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	7. 00
0.00		40.00	DRUGS CHARGED	TO DATI FAITS	DRUGS OTH	8.00
8. 00		49.00	DRUGS CHARGED	IU PATTENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	8.00
9. 00		49 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION. MEDICAR	E 9.00
7. 00		47.00	DINOGS CHANGED	TO TATIENTS	A	7.00
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	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col. 5)		
		4.00	5. 00	6. 00	-	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF				D ODCANI ZATI ONS OD	
	CLAIMED HOME OFFICE COSTS:	KED AS A KESULI	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00	CEATINED HOME OFFICE COSTS.	1, 129, 208	190, 633	938, 575	j	1.00
2.00		32, 371	35, 186			2. 00
3.00		60, 062	60, 062)	3. 00
4.00		26, 211	28, 490	-2, 279	,	4. 00
5.00		872	948	-76		5. 00
6.00		168, 995	183, 690	-14, 695	,	6. 00
7.00		36, 351	39, 512	-3, 161		7. 00
8.00		177, 990	193, 467			8. 00
9.00		193, 125	209, 918			9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column	1, 825, 185	941, 906	883, 279	1	10. 00
	6, line 100 to Worksheet A-8, column 3, line					
	12.			I	I	1

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider No.: 315488

Worksheet A-8-1 From 01/01/2023 Parts I-II Date/Time Prepared:

12/31/2023

5/10/2024 11:40 am Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1.00	Α	DANI EL STRAUS	41.00	1.00
2.00	A	DANI EL STRAUS	41.00	2. 00
3.00	A	DES HOLDING CO. INC.	22. 00	3.00
4.00	F	PARTNERS PHARMACY SERVICES	0.00	4. 00
		LLC		
5. 00			0. 00	5. 00
6. 00			0. 00	6. 00
7. 00			0.00	7. 00
8. 00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0. 00	100. 00
speci fy:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Related Organization(s) and/or Home Office					
	Name	Percentage of	Type of Business			
		Ownershi p	31			
	4. 00	5. 00	6. 00			
DADT II INTERDELATIONOULD TO BELATER ORGANIZ	ATLONICO AND OD 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	99.00	WOUND CARE	2. 00
3.00		TOTALCARE LLC	1.00	WOUND CARE	3. 00
4.00		PARTNERS PHARMACY LLC	100.00	PHARMACY	4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10. 00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	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.: 315488

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPI TAL REI	LATED COSTS		57 107 2024 11.	40 alli
	Cost Contor Dosorintian	Not Eypopsos	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
	Cost Center Description	Net Expenses for Cost	FI XTURES	EQUI PMENT	BENEFI TS	Subtotal	
		Allocation					
		(from Wkst A col. 7)					
		0	1. 00	2. 00	3. 00	3A	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	2, 487, 141	2, 487, 141				1. 00
2.00	00200 CAP REL COSTS - BEDGS & FIXTURES	532, 768	2,407,141	532, 768			2. 00
3.00	00300 EMPLOYEE BENEFITS	1, 652, 700	0		1, 652, 700		3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	3, 026, 885	0	0	90, 696	3, 117, 581	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	782, 985 115, 253	0	0	20, 520 6, 910	803, 505 122, 163	6. 00
7. 00	00700 HOUSEKEEPI NG	460, 706	0	0	72, 810	533, 516	7. 00
8. 00 9. 00	OO800 DI ETARY OO900 NURSI NG ADMI NI STRATI ON	987, 201 718, 976	0	0	107, 529 105, 363	1, 094, 730 824, 339	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	178, 845	0	0	5, 598	184, 443	10. 00
11. 00	01100 PHARMACY	27, 083	0	0	0	27, 083	11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	36, 747 93, 114	0	0	6, 550 16, 597	43, 297 109, 711	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	75, 114	0	0	0, 377	0	14. 00
15. 00	01500 ACTIVITES	176, 561	0	0	28, 826	205, 387	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	5, 579, 269	2, 374, 026	508, 538	975, 875	9, 437, 708	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 1 CF/I I D	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	33. 00
40. 00	04000 RADI OLOGY	25, 879	0		0	25, 879	40. 00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	81, 727 168, 995	0	0	0	81, 727 168, 995	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	100, 995	0	0	0	100, 993	42.00
44. 00	04400 PHYSI CAL THERAPY	637, 457	67, 869		108, 843	828, 707	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	465, 199 137, 497	45, 246 0	1	82, 921 23, 662	603, 058 161, 159	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	137, 497	0	0	23, 662	161, 159	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	407, 466	0	0	0	407, 466 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	403	0	0	0	403	51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01 52. 02	05201 OTHER ANCI LLARY SERVI CES COST 05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 01 52. 02
02.02	OUTPATIENT SERVICE COST CENTERS	9			<u> </u>		02.02
60.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0	0	60.00
61. 00 62. 00	06200 FQHC		U	J J	U	0	61. 00 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	ol	0	70. 00
71. 00	07100 AMBULANCE	44, 610	0		0	44, 610	•
73. 00	07300 CMHC	0	0		0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 NTEREST EXPENSE						81. 00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0	0	0	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	O	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) NONREIMBURSABLE COST CENTERS	18, 825, 467	2, 487, 141	532, 768	1, 652, 700	18, 825, 467	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	6, 478	0	0	0	6, 478	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	3, 459	0	-	0	3, 459	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		0	0	o	0	94. 00
95. 00 98. 00	O9500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	0	0	0	95. 00 98. 00
99.00	Negative Cost Centers		0		0	0	98.00
100.00	1 1 0	18, 835, 404	2, 487, 141	532, 768	1, 652, 700	18, 835, 404	100. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315488

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

5/10/2024 11:40 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, & GENERAL LINEN SERVICE MAINT. & REPAIRS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 3, 117, 581 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 159, 373 962, 878 5.00 00600 LAUNDRY & LINEN SERVICE 146, 394 24.231 6.00 6.00 7.00 00700 HOUSEKEEPI NG 105, 821 C 639, 337 7.00 8.00 00800 DI ETARY 217, 136 0 1, 311, 866 8.00 9.00 00900 NURSING ADMINISTRATION 163, 505 0 9.00 0 01000 CENTRAL SERVICES & SUPPLY 36, 584 0 0 10.00 Λ 10.00 11.00 01100 PHARMACY 5, 372 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 8,588 0 0 0 12.00 o 01300 SOCIAL SERVICE 0 13.00 21, 761 C 0 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 0 14.00 01500 ACTI VI TES 40,738 0 15.00 15.00 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 1, 311, 866 03000 SKILLED NURSING FACILLTY 1, 871, 938 919, 086 146, 394 610, 260 30.00 31.00 03100 NURSING FACILITY C Λ 31.00 32.00 03200 | CF/IID 0 0 0 32.00 C 0 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 5, 133 0 0 0 0 40.00 41.00 04100 LABORATORY 16, 210 0 0 41.00 0 42 00 04200 I NTRAVENOUS THERAPY 33, 520 0 0 42 00 Ω 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 43.00 04400 PHYSI CAL THERAPY 164, 372 26, 275 17, 446 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 119,615 17, 517 0 11, 631 45.00 0 04600 SPEECH PATHOLOGY 46 00 31, 965 0 46 00 0 0 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48.00 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 80,820 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50.00 0 Ω 0 51.00 05100 SUPPORT SURFACES 80 0 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 0 52.00 52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 0 52.01 05202 MEDICAL SERVICES 52.02 0 0 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 61.00 0 0 0 0 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 0 0 0 70.00 71.00 07100 AMBULANCE 8.848 C 0 0 0 71.00 73.00 07300 CMHC 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 C 84.00 08401 OTHER SPECIAL PURPOSE COST II 84.01 84.01 639, 337 89.00 SUBTOTALS (sum of lines 1-84) 3, 115, 610 962, 878 146, 394 1, 311, 866 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 1, 285 90.00 o 09100 BARBER AND BEAUTY SHOP 0 91.00 91.00 686 0 0 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 C 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST 95 00 0 O 0 95 00 Ω 0 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 99.00 0 0 100.00 TOTAL 3, 117, 581 962, 878 146, 394 639, 337 1, 311, 866 100. 00

Provi der No.: 315488

						12/31/2023	5/10/2024 11:	
		Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCIAL SERVICE	
				SUPPLY		LI BRARY		
	CENEDA	AL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00		CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300	EMPLOYEE BENEFITS						3. 00
4.00	00400	ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00		LAUNDRY & LINEN SERVICE						6.00
7. 00 8. 00		HOUSEKEEPI NG DI ETARY						7. 00 8. 00
9. 00		NURSING ADMINISTRATION	987, 844					9.00
10.00		CENTRAL SERVICES & SUPPLY	0	221, 027				10.00
11. 00		PHARMACY	O	0	32, 455			11. 00
12.00		MEDICAL RECORDS & LIBRARY	0	0	0	51, 885		12. 00
13. 00	1 1	SOCIAL SERVICE	0	0	0	0	131, 472	1
14.00	1 1	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	
15. 00		ACTIVITES ENT ROUTINE SERVICE COST CENTERS	j U	U	U U	U	U	15. 00
30. 00		SKILLED NURSING FACILITY	987, 844	221, 027	32, 455	51, 885	131, 472	30.00
31.00	03100	NURSING FACILITY	o	0	1	0	0	31.00
32. 00		ICF/IID	0	0	0	0	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00		LARY SERVICE COST CENTERS		0		٥		1 40 00
40. 00 41. 00		RADI OLOGY LABORATORY		0		0	0	
42. 00	1	INTRAVENOUS THERAPY	l o	0	0	0	0	42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	O	0	0	0	Ö	43. 00
44.00		PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	45. 00
46. 00		SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	1	ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0	0	0	0	48. 00 49. 00
50.00		DENTAL CARE - TITLE XIX ONLY		0	0	0	0	50.00
51. 00		SUPPORT SURFACES	0	0	0	0	0	51. 00
52.00		COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01		OTHER ANCILLARY SERVICES COST	0	0		0	0	52. 01
52. 02		MEDICAL SERVICES FIENT SERVICE COST CENTERS	0	0	0	0	0	52. 02
60. 00		CLINIC	0	0	0	0	0	60.00
61. 00	1 1	RURAL HEALTH CLINIC	0	0	1	Ö	o o	61. 00
62.00	06200	FQHC						62. 00
63. 00		DI ALYSI S	0	0	0	0	0	63. 00
70.00		REI MBURSABLE COST CENTERS		0		O		70.00
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE		0	0	0	0	70. 00 71. 00
73. 00	07300			0	Ö	Ö	Ö	
74. 00	07400	OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
		AL PURPOSE COST CENTERS	1					
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00		HOSPI CE	0	0	0	0	0	
84. 00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	0	Ō	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)	987, 844	221, 027	32, 455	51, 885	131, 472	89. 00
90. 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	0	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP		0		Ö	Ö	
92. 00		PHYSICIANS PRIVATE OFFICES	0	0		0	0	1
93. 00	09300	NONPALD WORKERS	0	0		o	0	1
94.00		PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers		0		n	0	98. 00 99. 00
100.00		TOTAL	987, 844	221, 027		51, 885		
	. '			* 1			- 1	

| 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.: 315488

				-	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			37 107 2024 11.	40 aiii
			SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION			Auj us tillerits		
		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	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00
3. 00 4. 00	00400 ADMINISTRATIVE & GENERAL						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE					•	6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9. 00 10. 00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCI AL SERVI CE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	O1500 ACTIVITES	0	246, 125	5			15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY		246, 125	15, 968, 060	0 (15, 968, 060	30.00
31. 00	03100 NURSING FACILITY				0		31.00
32. 00	03200 CF/IID	0	_		0		32. 00
33.00	03300 OTHER LONG TERM CARE	0	O) (0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	_	1 -		_1		
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0				31, 012	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY		_	97, 93 ⁻ 202, 51!		97, 937 202, 515	
43. 00	04300 OXYGEN (INHALATION) THERAPY		_		0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	o	1, 036, 800	0 0	1, 036, 800	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	751, 82°		751, 821	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	193, 124	4 0	193, 124	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS				0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS			488, 286	6 0	488, 286	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö)	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	O	483	3 0	483	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	_		٥	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	l .	1	0 0	0	52. 01
52. 02	05202 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS			y ·	J 0	0	52. 02
60. 00	06000 CLINIC	0	О		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	O		0 0	0	61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0) (0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0			0 0	0	70. 00
	07100 AMBULANCE			53, 458			71.00
73. 00	07300 CMHC	0	O		0	0	73. 00
74. 00	07400 OTHER REI MBURSEMENT	0	0		0 0	0	74. 00
	SPECIAL PURPOSE COST CENTERS		ı				
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 HOSPI CE	0	o		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	O		0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0			0 0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	246, 125	18, 823, 496	6 0	18, 823, 496	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN			7, 76	3 0	7, 763	90.00
91. 00	09100 BARBER AND BEAUTY SHOP			4, 14!		4, 145	1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	O		0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0		0 0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	94.00
95. 00 98. 00	O9500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments				0	0	95. 00 98. 00
98. 00 99. 00	Negative Cost Centers					0	98.00
100.00			246, 125	18, 835, 40	4 0	18, 835, 404	
		•		•	,		•

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315488

				То	12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS		37 107 2024 11.	40 alli
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		Assigned New	FI XTURES	EQUI PMENT		BENEFITS	
		Capi tal Rel ated Costs					
		0	1. 00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	0	0	3. 00
4. 00 5. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7. 00	00700 HOUSEKEEPING		0	0	0	0	7. 00
8. 00	00800 DI ETARY	0	0	0	0	0	8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	0	0	13. 00 14. 00
15. 00	01500 ACTIVITES		0	0	0	0	15. 00
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	51	<u> </u>		10.00
30.00	03000 SKILLED NURSING FACILITY	0	2, 374, 026	508, 538	2, 882, 564	0	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200 I CF/I I D	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		O	0	O	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	Ö	Ö	Ö	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	O	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	67, 869	14, 538	82, 407	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	45, 246	9, 692	54, 938	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00 48. 00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	47. 00 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	Ö	Ö	Ö	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
(0.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	O	0	0	0	40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		O.	o o	Ŭ	O	62. 00
63.00	06300 DI ALYSI S	O	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS			1			
	07000 HOME HEALTH AGENCY COST	0	0	<u> </u>	0		70. 00
	07100 AMBULANCE	0	0	0	0	0	71. 00
73.00	07300 CMHC 07400 OTHER REI MBURSEMENT		0	0	0	0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	ı o		U ₁	U _I		74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D 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	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01 89. 00	O8401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)		2, 487, 141	0 532, 768	3, 019, 909	0	84. 01 89. 00
07.00	NONREI MBURSABLE COST CENTERS	ı O	۷, ۲۰۰۲, ۱4۱	332, 700	3, 017, 709	0	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	o	O	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	О	o	0	92. 00
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments		O	0	0	0	95. 00 98. 00
99.00	Negative Cost Centers		n	n	0	0	
100.00		o	2, 487, 141	532, 768	3, 019, 909		100. 00
	•						•

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315488

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

5/10/2024 11:40 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 4.00 7.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 0000000000 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 0 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 0 0 0 0 0 0 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 Λ 11.00 01100 PHARMACY 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 01300 SOCIAL SERVICE 13.00 13.00 0 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 C 0 14.00 15.00 01500 ACTI VI TES 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 30.00 n O 0 0 0 0 31.00 03100 NURSING FACILITY 0 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 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 0000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 0 45.00 04600 SPEECH PATHOLOGY 0 46 00 46 00 0 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 Ω 50.00 0 51.00 05100 SUPPORT SURFACES 0 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 52.00 52.00 0 0 52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 52.01 05202 MEDICAL SERVICES 0 52.02 0 0 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 0 61.00 06200 FQHC 62.00 62.00 63.00 06300 DI ALYSI S 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 0 0 0 0 70.00 0 0 71.00 07100 AMBULANCE C 0 0 71.00 73.00 07300 CMHC 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 84.00 0 o 08401 OTHER SPECIAL PURPOSE COST II 0 84.01 84.01 0 89.00 SUBTOTALS (sum of lines 1-84) O 0 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91.00 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 93.00 0 09400 PATIENTS LAUNDRY 0 0 94.00 0 0 94.00 09500 OTHER NONREIMBURSABLE COST 95 00 Ω 0 95 00 0 0 98.00 Cross Foot Adjustments 0 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00 100.00 TOTAL 0 100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315488

						5/10/2024 11:	40 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
			SUPPLY		LI BRARY		
	CENEDAL CEDIU CE COCT CENTEDO	9. 00	10. 00	11. 00	12. 00	13.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	0					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10. 00
11. 00	1	0	0	0			11. 00
12. 00	1	0	0	0	0	_	12. 00
13.00	1	0	0	0	0	0	
14. 00	1	0	0	0	0	0	
15. 00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	l O	0	U U	0	0	15. 00
30. 00		0	0	O	0	0	30.00
31. 00	1 1	0	0	0	0	1	
32. 00	1 1	o o	0		0		
33. 00	+ I	ő	0		0	l	
	ANCILLARY SERVICE COST CENTERS		-	-1	-		1
40.00		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		0	0	0	0	0	1
45. 00	I I	0	0	0	0	0	
46. 00	1	0	0	0	0	0	1
47. 00	I I	0	0	0	0	0	
48. 00 49. 00	I I		0	0	0	0	1
50.00			0	0	0		
51. 00	1 1		0	0	0	0	
52. 00	1 1		0	0	0	0	
52. 01	05201 OTHER ANCILLARY SERVICES COST	o o	0	0	0	Ö	
52. 02	1 1	o	0	Ö	0	Ō	
	OUTPATIENT SERVICE COST CENTERS	'					1
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	1	0	0	0	0	0	
62. 00	+ +						62. 00
63. 00		0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS	1		1			
70.00	1 1	0	0	0	0	1	1
71. 00 73. 00	+ I	0	0	0	0	0	
74. 00	1 1		0	0	0	0	
74.00	SPECIAL PURPOSE COST CENTERS	1 0		0		0	74.00
80. 00							80.00
81. 00	1 1						81.00
82. 00	1 1						82. 00
83.00	1 1	0	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		0	0	0	0	0	89. 00
	NONREI MBURSABLE COST CENTERS						1
90.00		0	0		0	1	
91.00		0	0	0	0	1	
92.00	1 1	0	0	0	0	0	1
93. 00 94. 00	1	0	0	0	0	0	
94. 00 95. 00		0	0		0		
98. 00	1		0	0	O		98.00
99. 00		0	0	Ö	0	0	
100.00	1 1 0	0	0		0		100.00
				. "			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315488

					To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL				
	Coot Conton Decemintion	NUIDCLNC AND	SERVI CE	Cubtatal	Doot Stop Down	Total	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		EDUCATI ON			/ ray as time. res		
	T	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1	T	1		Γ	1.00
2. 00	00200 CAP REL COSTS - BEDGS & FIXTURES						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPING						7. 00
8. 00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY						10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13.00	01300 SOCI AL SERVI CE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	_				14. 00
15. 00	O1500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0	0)			15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	О	2, 882, 56	4 0	2, 882, 564	30.00
31. 00	03100 NURSING FACILITY	0	o		0 0		31. 00
32.00	03200 CF/ D	0	0	•	0	l	
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0)	0 0	0	33. 00
40. 00	04000 RADI OLOGY	0	О		0 0	0	40. 00
41. 00	04100 LABORATORY	0	o)	0 0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	1	0	0	
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY			82, 40	0 7	0 82, 407	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		Ö	54, 93		1	1
46. 00	04600 SPEECH PATHOLOGY	0	0	1	0 0	0	
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1	0 0	0	
49. 00	04900 DRUGS CHARGED TO PATIENTS			1	0 0		48.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	o	1	o o	0	50.00
51. 00	05100 SUPPORT SURFACES	0	O		0 0	0	51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0		1	0 0	0	
	05202 MEDI CAL SERVI CES			1	0 0		1
	OUTPATIENT SERVICE COST CENTERS			,			
60.00	06000 CLINIC	0		l	0	1	1
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	O	7	0 0	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	o		o	0	1
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	•	0 0	l .	
	07100 AMBULANCE 07300 CMHC			1		ľ	71. 00 73. 00
	07400 OTHER REIMBURSEMENT	0	Ö	•	o o	l	1
	SPECIAL PURPOSE COST CENTERS	ı	1	1		I	
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	0	o		0 0	0	1
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	
84. 01 89. 00	O8401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0		3, 019, 90	0	1	
07.00	NONREI MBURSABLE COST CENTERS			J, 017, 1 0	<u>, </u>	3,017,707	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	•	0 0		1
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS				0 0	0	
94. 00	09400 PATIENTS LAUNDRY				o o	ő	1
95. 00	09500 OTHER NONREI MBURSABLE COST	0	0		0 0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0			0 0	0	
100.00		0		1			
	ı I	,	,		,		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315488

					Τ	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPITAL REI	ATED COSTS			37 107 2024 11.	40 diii
		Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		cost center bescription	FIXTURES	EQUI PMENT	BENEFITS	Reconciliation	& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			1.00	2. 00	SALARI ES) 3. 00	4A	4. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES	36, 280					1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	0	36, 280 0	9, 271, 906			2. 00 3. 00
4. 00		ADMINISTRATIVE & GENERAL	0	0	508, 819		15, 717, 823	4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	0	0	115, 120		803, 505	5.00
6. 00 7. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING		0	38, 766 408, 474		122, 163 533, 516	6. 00 7. 00
8.00	00800	DI ETARY	0	0	603, 257		1, 094, 730	•
9.00	1	NURSING ADMINISTRATION	0	0	591, 105		824, 339	9.00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	0	31, 406		184, 443 27, 083	1
12. 00	01200	MEDICAL RECORDS & LIBRARY	0	0	36, 747	0	43, 297	12. 00
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0	0	93, 114		109, 711 0	13. 00 14. 00
15. 00	1	ACTIVITES	0	0				15. 00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS	1					
30. 00 31. 00	1	SKILLED NURSING FACILITY NURSING FACILITY	34, 630	34, 630 0				30. 00 31. 00
32.00		ICF/IID	0	0				32.00
33. 00	03300	OTHER LONG TERM CARE	0	0			0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	1 0	0) 0	25, 879	40. 00
41.00		LABORATORY	0	0			81, 727	41.00
42.00		INTRAVENOUS THERAPY	0	0	C	1	168, 995	1
43. 00 44. 00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	990	0 990	610, 626	1	0 828, 707	43. 00 44. 00
45.00		OCCUPATIONAL THERAPY	660	660			603, 058	45. 00
46.00	04600	SPEECH PATHOLOGY	0	0	132, 747		161, 159	46. 00
47. 00 48. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	47. 00 48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0		o o	407, 466	49. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	0	0	C	0	0	50. 00
51. 00 52. 00		SUPPORT SURFACES COMPLEX MEDICAL EQUIPMENT	0	0		0	403	51. 00 52. 00
52. 01	05201	OTHER ANCILLARY SERVICES COST	0	0			o o	52. 00
52. 02		MEDICAL SERVICES	0	0	C	0	0	52. 02
60. 00		TIENT SERVICE COST CENTERS CLINIC	1 0	0) 0	0	60. 00
61. 00		RURAL HEALTH CLINIC	0	0			ő	61.00
62.00	06200	l .			_			62.00
63. 00		DI ALYSI S REI MBURSABLE COST CENTERS	0	0) 0	0	63.00
70.00		HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
		AMBULANCE	0	0	(71.00
73. 00 74. 00	07300	OTHER REIMBURSEMENT	0	0			0	1
		AL PURPOSE COST CENTERS				-	_	
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83.00	08300	HOSPI CE	0	0	C	0	0	83. 00
84. 00 84. 01		OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II	0	0		0	0	84. 00 84. 01
89. 00	06401	SUBTOTALS (sum of lines 1-84)	36, 280	36, 280	9, 271, 906	-3, 117, 581	1	89. 00
		MBURSABLE COST CENTERS						
90. 00 91. 00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0				•
92.00		PHYSICIANS PRIVATE OFFICES	0	0			3, 439	92.00
93.00		NONPAID WORKERS	0	0	C	0	0	93. 00
94. 00 95. 00		PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST	0	0		0	0	94. 00 95. 00
98. 00	0 7 3 0 0	Cross Foot Adjustments				_		98.00
99.00		Negative Cost Centers	0 45= -		=- = -			99.00
102.00	ו	Cost to be allocated (per Wkst. B, Part I)	2, 487, 141	532, 768	1, 652, 700	ין	3, 117, 581	102. 00
103.00		Unit cost multiplier (Wkst. B, Part I)	68. 554052	14. 684895	0. 178248	3	0. 198347	
104.00	P	Cost to be allocated (per Wkst. B,					0	104. 00
	I	Part II)	I	I	I	l	I	I

Health Financial Systems	CARE ONE AT MA	DISON AVENUE		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023		pared: 40 am_
	CAPITAL REI	_ATED 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			0.00000		0. 000000	105. 00

Provi der No.: 315488

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11:40 am

						5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION, MAINT. &	(PATIENT DAYS)	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		REPAIRS	(PATTENT DAYS)			(PATIENT DAYS)	
		(SQUARE FEET)				(I / II / EI II / E/II	
		5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	36, 280					4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	30, 200	1				6.00
7. 00	00700 HOUSEKEEPI NG			36, 280			7. 00
8.00	00800 DI ETARY			0	111, 222		8. 00
9.00	00900 NURSING ADMINISTRATION	C	0	0	0	37, 074	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	C	0	0	0	0	10.00
11. 00	01100 PHARMACY	C	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	C	0	0	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	C	0	0	0	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	1	0	0	0	14.00
15. 00	01500 ACTIVITES	C) 0) 0	0	0	15. 00
20 00	O3000 SKILLED NURSING FACILITY	24 420	27.074	24 420	111, 222	27.074	30.00
30. 00 31. 00	03100 NURSING FACILITY	34, 630	37, 074	34, 630	111, 222	37, 074 0	30.00
32. 00	03200 CF/IID				0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		1		0	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS		,	,			00.00
40.00	04000 RADI OLOGY	C	0	0	0	0	40.00
41.00	04100 LABORATORY	C	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	C	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	'l	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	990	-	990	0	0	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	660	B .	660	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	C		0	0	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS				0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS				0	0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY				0	0	50.00
51. 00	05100 SUPPORT SURFACES				0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT			Ö	0	Ō	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C	o	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	C	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	C	1	1		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63. 00	O6300 DI ALYSI S))l O	0	0	63. 00
70 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST			0	0	0	70. 00
	07100 AMBULANCE		1				71.00
	07300 CMHC				0	Ö	73. 00
74. 00	07400 OTHER REIMBURSEMENT				0	Ö	74. 00
	SPECIAL PURPOSE COST CENTERS	'	•		<u>'</u>	<u>'</u>	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF		J]			82.00
83. 00	08300 H0SPI CE	C	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	C		0	0	0	84.00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	24 200	27 074	36, 280	111 222	0	84. 01
69.00	SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	36, 280	37, 074	30, 200	111, 222	37, 074	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN			0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		1			0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES			ا ا	0	Ö	92.00
93. 00	09300 NONPAI D WORKERS) 0) o	Ö	Ö	93. 00
94.00	09400 PATIENTS LAUNDRY		0	0	0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	C) 0	0	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00	71	962, 878	146, 394	639, 337	1, 311, 866	987, 844	102. 00
100 00	Part I)	0/ 540407	0.040407	47 (00000	44 705000	0/ /4540/	102.00
103.00		26. 540187	3. 948697	17. 622299	11. 795023		
104.00	Cost to be allocated (per Wkst. B, Part II)		1	,		1	104. 00
105.00		0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	105 00
100.00		3. 000000	3. 000000	3.000000	3.00000	3.000000	. 55. 55
		•	•	•	'		•

Provi der No.: 315488

CONTROL CONTROL SPRINGE CONTROL CONT					T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
CAPITER TO AVEC CONTINUENCE CONTINUENC		Cost Center Description				SOCIAL SERVICE	NURSI NG AND	10 (3.11)
CASTORIAN CAST				(PATIENT DAYS)		(DATI ENT DAVE)		
CENERAL SERVICE CONT CENTRES 10.00 13.00 13.00 14.00						(PATTENT DAYS)		
SIN INTAL STRAYLET COST CINTURES			(IMITENT BATO)		(I'MITENT BATTS)		•	
0.00 0.00 CAP REL COSTS - BLICS & FIXTURES			10.00	11.00	12.00	13. 00	14. 00	
2.00	4 00			1	1	T T		
0.0000 DEFENDENCE BENEFIT IS 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000								1.00
0.000 0.0000 JAMIN STRATTON ALTHOUGH SERVICE OF THE SERVICE OST CENTERS OD 0.0000 JAMIN STRATTON JAMIN STRATTON OD 0.0000 JAMIN STRATTON JAMIN STRATTON OD 0.0000 JAMIN STRATTON JAMIN STR								2. 00 3. 00
0.0000 DANTO DEPARTION, MAINT & REPAIRS		l e e e e e e e e e e e e e e e e e e e						4.00
0.000 OLANDERY & LINEN SERVICE 0.0000 OLANDERY & SERVICE 0.0000 OLANDERY & SERVICES & SUPPLY 0.0000 OLANDERY & SERVICES & SUPPLY 0.0000 OLANDERY & SUPPLY OLANDERY & OLA		l e e e e e e e e e e e e e e e e e e e						5.00
0.000 0.0000 DETAINY								6. 00
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000000	7.00	00700 HOUSEKEEPI NG						7. 00
10.00 01000 CENTRAL SERVICES & SUPPLY 37,074 12.00 0100 MEDICAL RECORDS & LIBRARY 0 0 37,074 13.00 1300 0300 0501 AL SERVICE 0 0 0 0 0 0 0 0 0	8.00	00800 DI ETARY						8. 00
11.00 01100 PHARMACY 0 37,074 13.00 0300 BUTCAL RECORDS & LI BRARY 0 0 0 0 0 0 0 0 0								9. 00
12 00 10200 MEDICAL RECORDS & LIBRARY 0 0 0 37,074 14.00 0 10400 MURSI MA OAD ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			37, 074	1				10.00
13.00 01300 SOCIAL SERVICE 0 0 0 37,074 15.00			0	37,074	l .			11.00
14. 00 0 0 0 0 0 0 0 0 0								12. 00 13. 00
15.00 0.00		l e e e e e e e e e e e e e e e e e e e				37,074	n	14. 00
INPATI ENT ROUTINE SERVICE COST CENTERS						o		15. 00
31 00 03100 NNRSING FACILITY								
32.00 03200 OFFAT LON STERM CARE	30.00	03000 SKILLED NURSING FACILITY	37, 074	37, 074	37, 074	37, 074	0	30.00
33.00 03300 OTHER LONG TERM CARE		l e e e e e e e e e e e e e e e e e e e	· · · · · · · · · · · · · · · · · · ·	0	C	0	-	31. 00
MACILLARY SERVICE COST CENTERS					1	0		32. 00
40. 00 04000 04000 04000 0 0 0	33. 00		0	0	<u> </u>	0	0	33.00
14. 00 04-100 LABORATORY 0	40.00		1 0	J 0			0	40 00
A2.00 04200 INTRAVENOUS THERAPY								40.00
43.00 04300 OXYCOR (INHALATION) THERAPY 0 0 0 0 0 0 0 0 0		l e e e e e e e e e e e e e e e e e e e			1	_		42.00
44.00 04400 PHYSI CAL THERAPY		l e e e e e e e e e e e e e e e e e e e			i c	Ö		43. 00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 LECTROCADRIOLOGY 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, ,	0		d	0		44. 00
47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	45.00	04500 OCCUPATI ONAL THERAPY	0	0	o c	0	0	45. 00
48. 00 04800 MEDICAL SUPPLIES CHARGE TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46.00	04600 SPEECH PATHOLOGY	0	0	C	0	0	46. 00
49.00 04900 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		l e e e e e e e e e e e e e e e e e e e	0	0	O C	0		47. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0	0	0	0		48. 00
S1-00 OSDOO OSDO		l e	0			0		49.00
52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 0 0 0 0						0	_	50. 00 51. 00
52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 0 0 0 0 0 0						0		52.00
S2-02 05202 MEDICAL SERVICES 0 0 0 0 0 0 0 0 0						0	_	52. 00
OUTPATIENT SERVICE COST CENTERS O			_		Ö	o		52. 02
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0			,	<u>'</u>				
62.00 06200 FOHC 063.00 DIALYSIS 0 0 0 0 0 0 0 0 0	60.00		0)	C	0		60. 00
0 0 0 0 0 0 0 0 0 0			0	0	C	0	0	61. 00
OTHER REIMBURSABLE COST CENTERS		l e e e e e e e e e e e e e e e e e e e						62.00
70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0	63.00) 0	<u> </u>	0	0	63.00
71. 00	70.00			J 0		٥	0	70.00
73.00 07300 CMHC						0		
74.00 07400 OTHER REIMBURSEMENT O O O O O O O O O O O O O O O O O O					Ö	o		73.00
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST COST COST COST COST COST COST COST			0	O	C	0		74. 00
81.00 08100 INTEREST EXPENSE								
82. 00 08200 UTILIZATION REVIEW - SNF 83. 00 08300 HOSPICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								80.00
83.00 08300 HOSPICE 0 0 0 0 0 0 0 0 0 84.00 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								81.00
84. 00						0	_	82.00
84. 01		· ·				0		83. 00 84. 00
89. 00 SUBTOTALS (sum of lines 1-84) 37,074 37,074 37,074 37,074 0			1 0			0		
NONRE MBURSABLE COST CENTERS		l e e e e e e e e e e e e e e e e e e e	37.074	37.074	37.074	37. 074		89.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0			2.,37	, ., .,				1
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 0 0		09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0		90.00
93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 0 0 0			0	0	C	0		
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 0 0			0	0) c	0		92.00
95. 00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 103. 00 Unit cost multiplier (Wkst. B, Part I) 5. 961779 0. 875411 1. 399498 3. 546205 0. 000000 104. 00 Cost to be allocated (per Wkst. B, Part II) 0 0 0 0 0 0 0 0 0			0			0		93.00
98.00 Cross Foot Adjustments 99.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 5.961779 0.875411 1.399498 3.546205 0.000000 11 104.00 Cost to be allocated (per Wkst. B, Part I) 0.875411						0		94. 00 95. 00
99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 5.961779 0.875411 1.399498 3.546205 0.000000 104.00 Cost to be allocated (per Wkst. B, Part II) 0 0 0 0 0 0 0 0 0				1		ا		98.00
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 5.961779 0.875411 1.399498 3.546205 0.000000 104.00 Cost to be allocated (per Wkst. B, Part II) 0 0 0 0 0 0 0 0 0		,						99.00
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Part II) Part I) 0.875411 1.399498 3.546205 0.000000 10 10 10 10 10 10 10 10 10 10 10			221.027	32, 455	51, 885	131, 472	0	102. 00
103.00 Unit cost multiplier (Wkst. B, Part I) 5.961779 0.875411 1.399498 3.546205 0.000000 104.00 Cost to be allocated (per Wkst. B, Part II)	00	,,,]]	, . , 2		
Part II)		Unit cost multiplier (Wkst. B, Part I)	5. 961779	0. 875411	1. 399498	3. 546205		
	104.00		0	0	C	o	0	104. 00
405 001 1011								
105.00	105.00		0.000000	0.000000	0.000000	0. 000000	0. 000000	105. 00
		11)	I .	I	I		<u> </u>	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315488

			Date/lime Prepared: 5/10/2024 11:40 am
		OTHER GENERAL	7, 10, 2021 111 10 4
		SERVI CE	
	Cost Center Description	ACTIVITES (PATIENT DAYS)	
		15. 00	
GEN	NERAL SERVICE COST CENTERS		
1	100 CAP REL COSTS - BLDGS & FIXTURES		1.00
1	200 CAP REL COSTS - MOVABLE EQUIPMENT		2.00
	300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL		3. 00 4. 00
1	500 PLANT OPERATION, MAINT. & REPAIRS		5. 00
1	600 LAUNDRY & LINEN SERVICE		6. 00
4	700 HOUSEKEEPI NG		7. 00
1	BOO DI ETARY		8.00
1	900 NURSING ADMINISTRATION 000 CENTRAL SERVICES & SUPPLY		9. 00 10. 00
1	100 PHARMACY		11. 00
12.00 012	200 MEDICAL RECORDS & LIBRARY		12. 00
	300 SOCIAL SERVICE		13. 00
	400 NURSING AND ALLIED HEALTH EDUCATION	27 074	14. 00
	500 ACTIVITES PATIENT ROUTINE SERVICE COST CENTERS	37, 074	15. 00
	000 SKILLED NURSING FACILITY	37, 074	30.00
31.00 03	100 NURSING FACILITY	0	31. 00
	200 CF/IID	0	32.00
	300 OTHER LONG TERM CARE	0	 33. 00
	CILLARY SERVICE COST CENTERS DOO RADIOLOGY	0	40.00
1	100 LABORATORY		41. 00
1	200 I NTRAVENOUS THERAPY	o o	42. 00
43.00 043	300 OXYGEN (INHALATION) THERAPY	0	43. 00
1	400 PHYSI CAL THERAPY	0	44. 00
1	500 OCCUPATI ONAL THERAPY 600 SPEECH PATHOLOGY	0	45. 00 46. 00
	700 ELECTROCARDI OLOGY		47. 00
4	BOO MEDICAL SUPPLIES CHARGED TO PATIENTS	O	48. 00
49. 00 049	900 DRUGS CHARGED TO PATIENTS	0	49. 00
	DOO DENTAL CARE - TITLE XIX ONLY	0	50.00
1	100 SUPPORT SURFACES	0	51.00
1	200 COMPLEX MEDICAL EQUIPMENT 201 OTHER ANCILLARY SERVICES COST		52. 00 52. 01
1	202 MEDI CAL SERVI CES	o	52. 02
	TPATIENT SERVICE COST CENTERS		
	000 CLINIC	0	60.00
	100 RURAL HEALTH CLINIC 200 FOHC	0	61. 00 62. 00
	300 DI ALYSI S	o	63. 00
	HER REIMBURSABLE COST CENTERS	-	
	DOO HOME HEALTH AGENCY COST	0	70.00
	100 AMBULANCE	0	71.00
73.00 073	400 OTHER REIMBURSEMENT		73. 00 74. 00
	ECIAL PURPOSE COST CENTERS		71.00
80.00	000 MALPRACTICE PREMIUMS & PAID LOSSES		80. 00
	100 INTEREST EXPENSE		81.00
1	200 UTILIZATION REVIEW - SNF 300 HOSPICE		82. 00 83. 00
	400 OTHER SPECIAL PURPOSE COST I		84. 00
	401 OTHER SPECIAL PURPOSE COST II	O	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	37, 074	89. 00
	NREI MBURSABLE COST CENTERS		
	DOO GIFT, FLOWER, COFFEE SHOPS & CANTEEN 100 BARBER AND BEAUTY SHOP	0	90.00
1	200 PHYSICIANS PRIVATE OFFICES		91.00
	300 NONPALD WORKERS		93. 00
94. 00 094	400 PATIENTS LAUNDRY	0	94. 00
	OTHER NONREIMBURSABLE COST	0	95. 00
98. 00	Cross Foot Adjustments		98.00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	246, 125	99. 00 102. 00
102.00	Part I)	240, 120	102.00
103. 00	Unit cost multiplier (Wkst. B, Part I)	6. 638750	103. 00
104. 00	Cost to be allocated (per Wkst. B,	0	104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000000	105 00
105. 00	II)	0.00000	105. 00
Ţ			Į.

Health Financial Systems	CARE ONE AT MADISO	N AVENUE	In	Lieu of Form CMS-2540-10
DATIO OF COST TO CHARGES FOR ANCILLAR	V AND OUTDATLENT COST CENTERS	Provider No · 315488	Peri od:	Workshoot C

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/10/2024 11:40 am Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 1.00 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 31, 012 64, 698 0. 479335 40.00 04100 LABORATORY 97, 937 204, 318 0.479336 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 202, 515 459, 225 0.440993 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 036, 800 2, 296, 642 0.451442 44.00 04500 OCCUPATIONAL THERAPY 45.00 751, 821 2, 152, 439 0.349288 45.00 04600 SPEECH PATHOLOGY 46.00 193, 124 610, 614 0. 316278 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 0.440993 49.00 49.00 488, 286 1, 107, 242 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 0 50.00 51.00 05100 SUPPORT SURFACES 483 1, 008 0.479167 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 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

53, 458

2, 855, 436

111, 525

7, 007, 711

0. 479336

71.00

100. 00

71. 00 07100 AMBULANCE

Total

100.00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	
		T: +1 o	V/// / (1)	Ckilled Nussina	5/10/2024 11: PPS	40 am
		litte	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pr	rogram Charges		Program Cost	
			-9 9		g	
	Ratio of Cost	Part A	Part B	Part A (col 1	Part B (col. 1	
	to Charges	l lait A	Tait b	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X 601. 2)	X 661. 6)	
	Col umn 3)					
	1.00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0. 479335	10, 312	(0 4, 943	0	40. 00
41. 00 04100 LABORATORY	0. 479336	34, 699	(0 16, 632	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 440993	55, 291	(0 24, 383	0	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0	(0	0	43. 00
44.00 04400 PHYSI CAL THERAPY	0. 451442	957, 307	(0 432, 169	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 349288	917, 294	(0 320, 400	0	45. 00
46.00 04600 SPEECH PATHOLOGY	0. 316278	293, 751	(92, 907	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0	(0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(0	0	48.00
49.00 O4900 DRUGS CHARGED TO PATIENTS	0. 440993	120, 232		0 53, 021	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00 05100 SUPPORT SURFACES	0. 479167	1, 008		0 483	0	51.00
52.00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000	0		0	0	52.00
52.01 05201 OTHER ANCILLARY SERVICES COST	0. 000000	0	(0	0	52. 01
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0	(0	0	52. 02
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0	(0	0	00.00
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. 479336			0	0	1
100.00 Total (Sum of Lines 40 - 71)		2, 389, 894		944, 938	0	100.00

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

Heal th	Financial Systems	CARE ONE AT MA	DISON AVENUE		In lie	eu of Form CMS-2	2540-10
	TONMENT OF ANCILLARY AND OUTPATIENT COSTS	971112 0112 711 1117	Provi der	No.: 315488	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	Drugs charged to patients - ratio of co			t C, column 3	, line 49)	0. 440993	1.00
2.00 3.00	Program vaccine charges (From your reco			or this amoun	t to Workshoot	661	2. 00 3. 00
3.00	E, Part I, line 18)	AVIII, PPS PIO	viueis, tialisi	er triis alliour	t to worksneet	291	3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
			Allied Health	Nursing &	Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
				Costs - Part		Through (Col.	
				(Col . 2 / Co 1)		3 x Col. 4)	
		1. 00	2.00	3, 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS			0.00	11.00	0.00	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	31, 012	0	0.0000	00 4, 943	0	40. 00
41.00	04100 LABORATORY	97, 937	0	0.0000	00 16, 632	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	202, 515	0	0.0000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.0000		0	
44.00	04400 PHYSI CAL THERAPY	1, 036, 800	0	0.0000			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	751, 821	0	0.0000		l .	45. 00
46. 00	04600 SPEECH PATHOLOGY	193, 124	0	0.0000			46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0.0000		0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000		0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	488, 286	0	0.0000		l	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	100	0	0.0000		0	50. 00 51. 00
51. 00 52. 00	05100 SUPPORT SURFACES	483	0	0. 0000 0. 0000		0	51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST			0.0000		0	
	05202 MEDICAL SERVICES			0.0000		0	
100.00		2, 801, 978			944, 938	_	100.00
100.00	1 1.0.cs. (odili of 111105 10 02)	2,001,770	٥	ı	711,750	1	1.50.00

	Financial Systems CARE ONE AT MADIS ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315488	Peri od: From 01/01/2023	u of Form CMS-2 Worksheet D-1 Parts I-II	
			To 12/31/2023	Date/Time Prep 5/10/2024 11:	
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS				
1. 00	Inpatient days including private room days			37, 074	1.00
2. 00	Private room days			0	2.00
3. 00	Inpatient days including private room days applicable to the F	Program		7, 085	
4. 00	Medically necessary private room days applicable to the Progra	am .		0	4.00
5. 00	Total general inpatient routine service cost			15, 968, 060	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
5.00	General inpatient routine service charges			17, 943, 549	
7.00	General inpatient routine service cost/charge ratio (Line 5 c	iividea by line 6)		0. 889905	
3. 00 9. 00	Enter private room charges from your records Average private room per diem charge (Private room charges lin	oo 9 divided by private	room days line	0 0. 00	8. 00 9. 00
7. 00	2)	ie 8 divided by private	Toolii days, Title	0.00	9.00
10. 00	Enter semi-private room charges from your records			0	10.00
11.00	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	ed by	0.00	11.00
	semi-private room days)				
12.00	Average per diem private room charge differential (Line 9 minu	,			12.00
13.00	Average per diem private room cost differential (Line 7 times			0.00	13. 00 14. 00
14. 00 15. 00	Private room cost differential adjustment (Line 2 times line 1 General inpatient routine service cost net of private room cost		minus line 14)	0 15, 968, 060	
13.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	t differential (Line 5	minus inie 14)	13, 700, 000	13.00
16. 00	Adjusted general inpatient service cost per diem (Line 15 div	vided by line 1)		430. 71	16.00
17. 00	Program routine service cost (Line 3 times line 16)	,		3, 051, 580	17.00
8.00	Medically necessary private room cost applicable to program (0	
9. 00	Total program general inpatient routine service cost (Line 17			3, 051, 580	
20. 00	Capital related cost allocated to inpatient routine service colline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	2, 882, 564	20.00
21. 00	Per diem capital related costs (Line 20 divided by line 1)			77. 75	21.00
22. 00	Program capital related costs (Line 3 times line 21)			550, 859	
23. 00	Inpatient routine service cost (Line 19 minus line 22)			2, 500, 721	
24. 00	Aggregate charges to beneficiaries for excess costs (From pro	ovi der records)		0	24. 0
25. 00	Total program routine service costs for comparison to the cost		nus line 24)	2, 500, 721	25. 0
26. 00	Enter the per diem limitation (1)				26.00
27. 00	Inpatient routine service cost limitation (Line 3 times the pe				27.00
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the	ne lesser of line 25 or	line 27)		28.00
(1) Li	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be us	sed for title V and or t	itle XIX		l
· ·					
				1. 00	
1 00	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		27.074	1
1. 00 2. 00	Total SNF inpatient days Program inpatient days (see instructions)			37, 074 7, 085	
2. 00 3. 00	Total nursing & allied health costs. (see instructions)(Do not	complete for titles V	or XIX)	7,085	3.00
4. 00	Nursing & allied health ratio. (line 2 divided by line 1)	. comprete for titles v	OI AIA)	0. 191104	4.00
5. 00	Program nursing & allied health costs for pass-through. (line	3 times line 4)		0	

	Financial Systems CARE ONE AT MADISO			u of Form CMS-	
OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315488	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre	pare
		T: +I o VI V	Ckilled Nursing	5/10/2024 11:	40 a
		Title XIX	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
0	Inpatient days including private room days			37, 074	1
0	Private room days			0	2
0	Inpatient days including private room days applicable to the Pr			18, 543	3
0	Medically necessary private room days applicable to the Program	1		0	4
0	Total general inpatient routine service cost			15, 968, 060	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				4
0	General inpatient routine service charges			17, 943, 549	
0	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 889905	
0	Enter private room charges from your records			0	
0	Average private room per diem charge (Private room charges line	8 divided by private	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-private room c	harges line 10 divide	d by	0. 00	
00	semi-private room days)	marges iffie to, divide	u by	0.00	1 ''
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 times I			0.00	
00	Private room cost differential adjustment (Line 2 times line 13			0	14
00	General inpatient routine service cost net of private room cost	differential (Line 5	minus line 14)	15, 968, 060	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS				
00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		430. 71	
00	Program routine service cost (Line 3 times line 16)			7, 986, 656	
00	Medically necessary private room cost applicable to program (I			0	1
00	Total program general inpatient routine service cost (Line 17			7, 986, 656	
00	Capital related cost allocated to inpatient routine service cos line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	sts (From Wkst. B, Par	t II column 18,	2, 882, 564	20
00	Per diem capital related costs (Line 20 divided by line 1)			77. 75	21
00	Program capital related cost (Line 3 times line 21)			1, 441, 718	
00	Inpatient routine service cost (Line 19 minus line 22)			6, 544, 938	
00	Aggregate charges to beneficiaries for excess costs (From prov	rider records)		0	
00	Total program routine service costs for comparison to the cost		nus line 24)	6, 544, 938	25
00	Enter the per diem limitation (1)			0.00	26
00	Inpatient routine service cost limitation (Line 3 times the per			0	27
00		elesser of line 25 or	line 27)	7, 986, 656	28
1) !!	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be use	nd for title V and or t	: +1 a VIV		ı

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	37, 074	1.00
2.00	Program inpatient days (see instructions)	18, 543	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. 500162	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	CARE ONE AT MADISON	N AVENUE	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT F	FOR TITLE XVIII	Provi der No.: 315488	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:40 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		1.00	
1.00	Inpatient PPS amount (See Instructions)			5, 446, 645	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)	İ	0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,		5, 446, 645	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			689, 400	5. 00
6.00	Allowable bad debts (From your records)			275, 727	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		146, 577	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			179, 223	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)			4, 936, 468	11. 00
12.00	Interim payments (See instructions)			4, 829, 533	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			45, 699	
14. 75	Sequestration for non-claims based amounts (see instructions)			3, 584	
14. 99	Sequestration amount (see instructions)			95, 145	
15. 00	Balance due provider/program (see Instructions)			-37, 493	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		4 7 00
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			291	18. 00
19.00	Total reasonable costs (Sum of lines 17 and 18)		1	291	
20. 00 21. 00	Medicare Part B ancillary charges (See instructions)			661 291	
21.00	Cost of covered services (Lesser of line 19 or line 20) Primary payor amounts			291	
23. 00	Coinsurance and deductibles		ł	0	
24. 00	Allowable bad debts (From your records)		ł	0	24. 00
24. 00	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 00
24. 01	Adjusted reimbursable bad debts (see instructions)	ctions)		0	24. 01
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			291	
26. 00	Interim payments (See instructions)			104	
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify		0	28. 00	
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			6	28. 99
29. 00	Balance due provider/program (see instructions)			181	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	section 115.2	0	
	1			- 1	

Provi der No.: 315488

Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:40 am

Title XVIII Skilled Nursing

PPS

		11 (1	e AVIII	Facility	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 616, 401		104	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		233, 214		0	2. 00
3. 00	enter zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02			0		0	3. 02
3. 04			0		0	3. 04
3. 05			0		0	3. 05
3.03	Provider to Program		0		U	3. 00
3.50	ADJUSTMENTS TO PROGRAM	06/09/2023	20, 082		0	3. 50
3. 51	7.65 CO TIME TO TO THOUSE MIN	00, 07, 2020	0		o	3. 51
3. 52			0		0	3. 52
3. 53			0		o	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		-20, 082		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		4, 829, 533		104	4. 00
	TO BE COMPLETED BY CONTRACTOR		l.	<u>I</u>		
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider			1		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		_			6. 00
6. 01	PROGRAM TO PROVIDER		0		181	6. 01
6. 02	PROVI DER TO PROGRAM		37, 493		0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 792, 040 Contract		285 Contractor	7. 00
			1	00	Number	
9 00	Name of Contractor		1.	00	2. 00	8. 00
8.00	Name of Contractor		l		·	ø. U(

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

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

Provi der No.: 315488 | Peri od: From 01/01/2023 To 12/31/2023

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:40 am

General Fund Specific Endowmen	
1.00 2.00 3.0 Assets	00 4.00
CHRENI ASSETS	
1.00 Cash on hand and in banks 55,623 0 2.00 Temporary investments 0	0 0 1
2.00 Temporary i nvestments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 3
4.00 Accounts receivable 1,747,775 0	
5.00 Other receivables 0 0	
6.00 Less: allowances for uncollectible notes and accounts -397,610	ol ol a
recei vabl e	
7.00 Inventory 0 0	0 0 7
8.00 Prepaid expenses 30, 203 0	0 0 8
9.00 Other current assets 8,366,108 0	0 0 9
10. 00 Due from other funds 0 0	0 0 10
11. 00 TOTAL CURRENT ASSETS (Sum of lines 1 - 10) 9, 802, 099 0	0 0 11
FIXED ASSETS	0 0 12
12. 00 Land	0 0 12
14. 00 Less: Accumulated depreciation -4, 842 0	0 0 12
15. 00 Bui I di ngs 18, 431, 160 0	0 0 15
16. 00 Less Accumulated depreciation -11, 799, 003 0	0 0 16
17.00 Leasehold improvements 0 0	0 0 17
18.00 Less: Accumulated Amortization 0 0	0 0 18
19. 00 Fi xed equi pment 1, 114, 837 0	0 0 19
20.00 Less: Accumulated depreciation -786,021 0	0 0 20
21.00 Automobiles and trucks 0 0	0 0 21
22.00 Less: Accumulated depreciation 0 0	0 0 22
23.00 Major movable equipment 4,447,685 0	0 0 23
24. 00 Less: Accumulated depreciation -4,169,667 0	0 0 24
25. 00 Minor equipment - Depreciable 0 0	0 0 25
26. 00 Mi nor equi pment nondepreci abl e 0 0	0 0 26
27. 00 Other fixed assets 954, 634 0 28. 00 TOTAL FLXED ASSETS (Sum of Lines 12 - 27) 8. 202, 914 0	0 0 27
28. 00 TOTAL FIXED ASSETS (Sum of lines 12 - 27) 8, 202, 914 0 OTHER ASSETS	0 28
29. 00 Investments 0 0	0 0 29
30. 00 Deposits on leases 0 0	
31.00 Due from owners/officers 0 0	0 0 31
32.00 Other assets 1,965,895 0	0 0 32
33.00 TOTAL OTHER ASSETS (Sum of lines 29 - 32) 1,965,895 0	0 0 33
34. 00 TOTAL ASSETS (Sum of Lines 11, 28, and 33) 19,970,908 0	0 0 34
Liabilities and Fund Balances	
CURRENT LIABILITIES	
35. 00 Accounts payable 1, 587, 582 0	0 0 35
36.00 Salaries, wages, and fees payable 239, 249 0	0 36
37. 00 Payroll taxes payable 946 0 38. 00 Notes & Loans payable (Short term) 0 0	0 0 37
39. 00 Deferred income 0 0	0 0 39
40. 00 Accel erated payments 0	9 40
41. 00 Due to other funds 17, 806	0 0 41
42.00 Other current liabilities 1,733,054 0	0 0 42
43.00 TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) 3,578,637 0	0 0 43
LONG TERM LIABILITIES	
44.00 Mortgage payable 13,821,752 0	0 0 44
45.00 Notes payable 0 0	0 0 45
46. 00 Unsecured Loans 0 0	0 0 46
47.00 Loans from owners: 0 0	0 0 47
48.00 Other long term liabilities 13,384,946 0	0 0 48
49. 00 OTHER (SPECIFY) 0 0	0 0 49
50.00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 27,206,698 0 51.00 TOTAL LIABILITIES (Sum of lines 43 and 50) 30,785,335 0	0 0 50
51. 00 TOTAL LIABILITIES (Sum of lines 43 and 50) 30, 785, 335 0 CAPITAL ACCOUNTS	0 0 51
52. 00 General fund balance -10, 814, 427	52
53.00 Specific purpose fund 0	53
54.00 Donor created - endowment fund balance - restricted	0 54
55.00 Donor created - endowment fund balance - unrestricted	0 55
56.00 Governing body created - endowment fund balance	0 56
57.00 Plant fund balance - invested in plant	0 57
	0 58
58.00 Plant fund balance - reserve for plant improvement,	" "
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -10,814,427 0	0 0 59
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					То	12/31/2023	Date/Time Prep 5/10/2024 11:4	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1. 00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		-8, 325, 354			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-2, 489, 069					2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments)		-10, 814, 423			0		3. 00 4. 00
5.00	Additions (credit adjustments)	0			0		o	5. 00
6. 00		o			0		Ö	6. 00
7.00		0			0		0	7. 00
8. 00		0			0		0	8. 00
9.00	Total additions (sum of line 5 - 9)	0	0		0	0	0	9. 00 10. 00
10. 00 11. 00	Subtotal (line 3 plus line 10)		-10, 814, 423			0		10.00
12. 00	Deductions (debit adjustments)		-10,014,425			0		12. 00
13. 00	ROUNDI NG	4			0		0	13. 00
14.00		0			0		0	14.00
15.00		0			0		0	15. 00
16. 00 17. 00		0			0		0	16. 00 17. 00
18. 00	Total deductions (sum of lines 13 - 17)		4		U	0	U	18. 00
19. 00	Fund balance at end of period per balance		-10, 814, 427			0		19. 00
	sheet (Line 11 - line 18)			L				
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8.00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)				0			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments)	١			0			3. 00 4. 00
5.00	Additions (credit adjustments)		0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 5 - 9)	0	U		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12.00	Deductions (debit adjustments)							12.00
13. 00	ROUNDI NG		0					13.00
14.00			0					14.00
15. 00 16. 00			0					15. 00 16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 13 - 17)	o	Ĭ		0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (Line 11 - line 18)							

	Financial Systems CARE ONE AT MADIS				eu of Form CMS-	
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315488	Period: From 01/01/2023	Worksheet G-2 Parts I-II	2
				To 12/31/2023	Date/Time Pre	epared:
					5/10/2024 11:	40 am
	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 SKILLED NURSING FACILITY		17 042 5	40	17, 943, 549	1.00
1. 00 2. 00	NURSING FACILITY		17, 943, 5	49	17, 943, 549	1
2. 00 3. 00	ICF/IID			0		•
	OTHER LONG TERM CARE			0		1
4.00			17 042 5	40	_	
5. 00	Total general inpatient care services (Sum of lines 1 - 4) All Other Care Services		17, 943, 5	49	17, 943, 549	5. 00
6. 00	ANCI LLARY SERVI CES		7, 007, 7	11	7, 007, 711	6.00
7. 00	CLINIC		7,007,7		7,007,711	1
8. 00	HOME HEALTH AGENCY COST					
9. 00	AMBULANCE					
10. 00	RURAL HEALTH CLINIC					
10. 00	FQHC					
11. 00	CMHC					
12. 00	HOSPI CE					
13. 00	OTHER (SPECIFY)					
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column	3 to	24, 951, 2	60 0	24, 951, 260	
11.00	Worksheet G-3, Line 1)	0 10	21,701,2		21, 701, 200	11.00
	Cost Center Description		'			
	•			1. 00	2.00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				18, 446, 295	1.00
2.00	Add (Specify)			0		2. 00
3.00				0		3. 00
4.00				0		4. 00
5.00				0		5. 00
6.00				0		6. 00
7.00				0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				0	
9.00	Deduct (Specify)			0		9. 00
10.00				0		10.00
11. 00				0		11. 00
12.00				0		12. 00
13.00				0		13. 00
1/ 00	Total Doductions (Sum of Lines 0 12)			1	1	1 1 1 00

12.00 13. 00 14. 00

0

18, 446, 295 15. 00

14.00 Total Deductions (Sum of lines 9 - 13)

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

	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315488 Period:		Peri od:	u of Form CMS-2 Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			12, 01, 2020	5/10/2024 11:	
				1 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line	14)		1. 00 24, 951, 260	1. 00
2. 00	Less: contractual allowances and discounts on patients accounts			9, 006, 734	
3.00	Net patient revenues (Line 1 minus line 2)			15, 944, 526	
4. 00	Less: total operating expenses (From Worksheet G-2, Part II, Line 15)			18, 446, 295	
5.00	Net income from service to patients (Line 3 minus 4)			-2, 501, 769	
3.00	Other income:			-2, 301, 707	3.00
6. 00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			4. 997	7.00
8. 00	Revenues from communications (Telephone and Internet service)			4, 777	
9. 00	Revenue from television and radio service			0	1
10.00	Purchase di scounts			0	1
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking Lot receipts			0	
13.00	Revenue from laundry and linen service			0	1
14.00	Revenue from meals sold to employees and guests			13	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than patients			0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	BARBER AND BEAUTY			2, 679	24. 00
24. 01	OTHER REV			4, 054	24. 01
24. 02	OTHER INCOME			957	24. 02
24. 50	COVID-19 PHE Funding			0	1 00
25. 00	Total other income (Sum of lines 6 - 24)			12, 700	
26. 00	Total (Line 5 plus line 25)			-2, 489, 069	
27. 00	Other expenses (specify)			0	
28.00				0	28. 00

29.00

0 30.00 -2, 489, 069 31.00

29.00

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