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).

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

FORM APPROVED

OMB NO. 0938-0463

Expires: 12/31/2021

Provider CCN: 315482 Period: From 01/01/2023 Parts I, II & III

12/31/2023 Date/Time Prepared:

				5/10/	/2024 II: 42 am	
PART I - COST I	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/10/2024	Time: 11:42 an	
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	er the number	of times the provider	resubmitted this cost	t report	
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or	leave blank for no.			
Contractor	4. [1]Cost Report Status	6. Contractor	No.			
use only		7.[N] First Cost Report for this Provider CCN				
	(2) Settled without audit	8.[N] Last Cost Report for this Provider CCN				
	(3) Settled with audit	9. NPR Date:	·			
	(4) Reopened (5) Amended	10.[0]If Ii	ne 4, column 1 is "4":	Enter number of times	s reopened	
		11.Contracto	Vendor Code	4	·	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	 r "F" for full, "L" fo	r low, or "N"	
		for	no utilization.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT MOORESTOWN (315482) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	David Baruch			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Davi d Baruch			2
3	Signatory Title	AUTHORIZED SIGNOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-31, 646	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-31, 646	0	0	100.00
Tho ob	reverse amounts represent "due to" or "due from" the applicable	program for th	o alamant of the	no obovo compl	ov indicated	

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

Health Financial Systems CARE ONE AT MOORESTOWN In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315482 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:42 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 895 WESTFIELD AVENUE PO Box: 1.00 2.00 City: MOORESTOWN State: NJ Zi p Code: 08057 2.00 3.00 County: BURLINGTON CBSA Code: 15804 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT MOORESTOWN 315482 09/11/2003 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 d 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 38.00 Υ 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 44 932

Heal th	Financial Systems	CARE ONE AT MOOR	ESTOWN	In Lie	u of Form CMS-2	2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315482	Peri od:	Worksheet S-2	
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023		
					5/10/2024 11:	42 am_
	Y/N					
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative an	nd General cost	N	42.00
	center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listing cost	centers and		
	amounts.					
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and address	of the home	HB0206	44. 00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of the	home office on the	lines	
	bel ow.					
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contrac	ctor's Number: 1200)1	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00
47.00	City: FORT LEE	State: NJ	Zi p Cod	le: 0702	24	47. 00

Health Financial Systems CARE ONE AT MOORESTOWN In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315482 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:42 am Date 1. 00 2.00 General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public Α Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. 11.00 Ν Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 03/19/2024 Υ 13.00 only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R Ν Ν 14 00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Health Financial Systems CARE ONE AT				MOORESTOWN			In Lieu of Form CMS-2540-10		
	D NURSING FACILITY AND SKILLED NURSING FACILITY	HEALTH CARE		Provi der	No.: 315482		eriod: com 01/01/2023	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					To		Date/Time Pre	pared:
						L		5/10/2024 11:	42 am
				1.	00		2. (00	
	Cost Report Preparer Contact Information								
19.00	Enter the first name, last name and the title/p	position (CHARL	_ES		F	REED		19. 00
	held by the cost report preparer in columns 1,	2, and 3,							
	respecti vel y.								
20.00	Enter the employer/company name of the cost rep	port	EXECL	JCARE ASSO	CI ATES				20. 00
	preparer.								
21.00	Enter the telephone number and email address of		(609)	738-3200		(CRWASSC@NETSCAP	PE. NET	21. 00
	report preparer in columns 1 and 2, respectivel	ly.							

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

CARE ONE AT MOORESTOWN
In Lieu of Form CMS-2540-10
From 01/01/2023
From 01/

COMPLE	EX REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023		
		Part B			07 107 202 1 11: 12	Giii
		Date				
		4.00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	03/19/2024			1	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					1	14. 00
	for total and the provider's records for					
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
45.00	4.					15 00
15.00	If line 13 or 14 is "Y", were adjustments				1	15. 00
	made to PS&R data for additional claims that					
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y", see Instructions.					
16 00	If line 13 or 14 is "Y", then were				1	16. 00
10.00	adjustments made to PS&R data for				'	10.00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17 00	If line 13 or 14 is "Y", then were				1	17. 00
17.00	adjustments made to PS&R data for Other?				'	17.00
	Describe the other adjustments:					
18. 00					1	18. 00
	provider's records? If "Y" see Instructions.					
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title		VI CE-PRESI DENT		1	19. 00
	held by the cost report preparer in columns 1	, 2, and 3,				
	respecti vel y.					
20. 00	Enter the employer/company name of the cost r	eport			2	20. 00
	preparer.	6.11				
21. 00	Enter the telephone number and email address				2	21. 00
	report preparer in columns 1 and 2, respective	el y.			1	

Health Financial Systems CARE ONE AT MINISTREE OF SKILLED NURSING FACILITY HEALTH CARE In Lieu of Form CMS-2540-10 CARE ONE AT MOORESTOWN

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time | Prepared: | Provi der No.: 315482 COMPLEX STATISTICAL DATA

				To	12/31/2023	Date/Time Prep 5/10/2024 11:4	
			· ·	I npa	atient Days/Vis		2 (111
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Ti tle XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	65	23, 725	0	12, 993	0	1. 00
2.00	NURSING FACILITY	0	0			0	2. 00
3.00	I CF/II D	0	0			0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	54	19, 710	0	0	0	4. 00 5. 00
6. 00	SNF-Based CMHC	34	17, 710				6. 00
7. 00	HOSPI CE	o	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	119	43, 435	0	12, 993	0	8. 00
		Inpatient D	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	5, 777	18, 770		439	0	1. 00
2.00	NURSING FACILITY	0	0			0	2. 00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0			0	3. 00 4. 00
5. 00	Other Long Term Care	15, 263	15, 263				5. 00
6. 00	SNF-Based CMHC	10, 200	10, 200				6. 00
7.00	HOSPI CE	o	0	О	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	21, 040	34, 033		439	0	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	344	783		29. 60	0.00	1.00
2. 00 3. 00	NURSING FACILITY	0	0			0. 00 0. 00	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	1	0			0.00	4. 00
5. 00	Other Long Term Care	20	20				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)	364 Average Length	803		29.60	0.00	8. 00
		of Stay		Admi s	SLOUS		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16. 00	17. 00	18. 00	19. 00	20. 00	
1. 00	SKILLED NURSING FACILITY	23. 97	0		0	297	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3. 00 4. 00	HOME HEALTH AGENCY COST	0. 00			U	0	3. 00 4. 00
5. 00	Other Long Term Care	763. 15				17	5. 00
6.00	SNF-Based CMHC						6. 00
7. 00	HOSPI CE	0. 00	0	-	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	42. 38 Admi ssi ons	Full Time	Faui val ent	0	314	8. 00
	Component	Total	Employees on	Nonpai d Workers			
		21.00	Payrol I 22. 00	23. 00			
1. 00	SKILLED NURSING FACILITY	782	101. 54				1. 00
2.00	NURSING FACILITY	O	0.00	0. 00		j	2.00
3. 00	ICF/IID	0	0.00				3. 00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	17	22. 69 0. 00				5. 00 6. 00
7. 00	HOSPI CE	o	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	799	124. 23				8. 00
		,		. '		'	

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT MOORESTOWN

			_	T	0 12/31/2023	Date/Time Prep 5/10/2024 11:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
1 00	SALARI ES	0 504 351	1 0	0 504 251	250 202 00	22.22	1 00
1.00	Total salaries (See Instructions)	8, 584, 351	0	8, 584, 351	258, 392. 00		1.00
2.00	Physician salaries-Part A	0	0	0	0.00		2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	0 504 351	0	0 504 351	0.00		
6.00	Revised wages (line 1 minus line 5)	8, 584, 351	1 220 ((0	8, 584, 351	i i		6. 00
7.00	Other Long Term Care	0	1, 329, 669	1, 329, 669	i i		7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00		
10.00	HOSPI CE	0	0	0	0.00		
11.00	Other excluded areas	0	1 220 ((0	1 220 ((0	0.00		11.00
12. 00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	1, 329, 669	1, 329, 669	47, 197. 00	28. 17	12. 00
13. 00	Total Adjusted Salaries (line 6 minus line	8, 584, 351	-1, 329, 669	7, 254, 682	211, 195. 00	34. 35	13. 00
	12)		.,	,, == ,, ===			
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	16, 695	0	16, 695	256.00	65. 21	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	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	Wage-related costs core (See Part IV)	2, 081, 755	0	2, 081, 755			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	322, 452	0	322, 452			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22. 00	Total Adjusted Wage Related cost (see	1, 759, 303	0	1, 759, 303			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT MOORESTOWN

Provider No.: 315482 | Period: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared:

				T	o 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.		
				<u> </u>	3		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	738, 939	0	738, 939	15, 387. 00	48. 02	2. 00
3.00	Plant Operation, Maintenance & Repairs	137, 412	0	137, 412	4, 891. 00	28. 09	3. 00
4.00	Laundry & Linen Service	72, 495	0	72, 495	4, 308. 00	16. 83	4. 00
5.00	Housekeepi ng	278, 471	0	278, 471	13, 498. 00	20. 63	5. 00
6.00	Di etary	648, 519	0	648, 519	29, 275. 00	22. 15	6. 00
7.00	Nursing Administration	666, 212	0	666, 212	13, 814. 00	48. 23	7. 00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	63, 058	0	63, 058	2, 040. 00	30. 91	10.00
11. 00	Soci al Servi ce	128, 204	0	128, 204	3, 892. 00	32. 94	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	137, 872	0	137, 872	6, 746. 00	20. 44	13. 00
14.00	Total (sum lines 1 thru 13)	2, 871, 182	0	2, 871, 182	93, 851. 00	30. 59	14. 00

Health Financial Systems	CARE ONE AT MOORESTOWN	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315482	Peri od: From 01/01/2023	Worksheet S-3 Part IV
		To 12/31/2023	Date/Time Prepared:

	To 12/31/2023	Date/Time Prep 5/10/2024 11:4	
		Amount Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS	1.00	
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	44, 218	1.00
2. 00	Tax Shel tered Annui ty (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	0	4. 00
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	Ö	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	998, 346	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)	1, 909	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	304, 547	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	616, 086	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	114, 149	20. 00
	OTHER		
	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	2, 500	
24. 00	Total Wage Related cost (Sum of lines 1 - 23)	2, 081, 755	24. 00
		Amount	
		Reported	
		1. 00	
25 02	Part B - Other than Core Related Cost		25.00
25.00	OTHER WAGE RELATED COST	0	25. 00

				Τ̈́	0 12/31/2023	Date/Time Prep 5/10/2024 11:	pared: 42 am
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	12 (3
		Reported		Salaries (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				,	3	,	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	961, 979	244, 899		·		1. 00
2.00	Licensed Practical Nurses (LPNs)	748, 279	190, 496				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 082, 222	275, 511	1, 357, 733	44, 786. 00	30. 32	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	2, 792, 480	710, 906				4. 00
5.00	Physical Therapists	628, 588	160, 025	788, 613	·		5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		6. 00
7.00	Physical Therapy Aides	0	0	0	0.00		7. 00
8.00	Occupational Therapists	636, 275	161, 982	798, 257	·		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00		10.00
11.00	Speech Therapists	255, 089	64, 940	· ·			11.00
12.00	Respiratory Therapists	0	0	0	0.00		12.00
13. 00	Other Medical Staff	0	0	0	0.00	0.00	13. 00
	Contract Labor Nursing Occupations						
14. 00	Registered Nurses (RNs)	O		0	0.00	0.00	14. 00
15. 00	Licensed Practical Nurses (LPNs)	941		941	14.00		
16. 00	Certified Nursing Assistant/Nursing	771		741	0.00		16. 00
10.00	Assi stants/Ai des				0.00	0.00	10.00
17. 00	Total Nursing (sum of lines 14 through 16)	941		941	14.00	67. 21	17. 00
18.00	Physical Therapists	0		0	0.00	0.00	18. 00
19.00	Physical Therapy Assistants	О		0	0.00	0.00	19. 00
20.00	Physical Therapy Aides	О		0	0.00	0.00	20. 00
21.00	Occupational Therapists	O		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	0		0	0.00	0.00	23. 00
24.00	Speech Therapists	10, 895		10, 895	145.00	75. 14	24. 00
25.00	Respi ratory Therapi sts	4, 859		4, 859	97.00	50.09	25. 00
26.00	Other Medical Staff	o		0	0.00	0.00	26. 00

1.00		'	0 12/31/2023	Date/lime Pre 5/10/2024 11:	
1,00				Days	
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Both					
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			PC2		
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74. 00 PB1 74. 00	74.00		PB1		74. 00
75. 00 PA2 75. 00	75. 00		PA2		75. 00

Health Financial Systems	CARE ONE AT MOORE	ESTOWN		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315482	Peri od:	Worksheet S-	7
				From 01/01/2023 To 12/31/2023	Date/Time Pr	enared:
				10 12/31/2023	5/10/2024 11	
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL			1			100. 00
			Expenses	Percentage	Y/N	
			1.00	2. 00	3. 00	
A notice published in the Federal Register Vo payments beginning 10/01/2003. Congress exper expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" for with direct patient care and related expenses (See instructions)	cted this increase to n column 1 the amour r each category to or yes or "N" for no	to be used nt of the total SNF o if the s	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related Iter in Part I, Esociated	
101. 00 Staffing						101.00
102.00 Recruitment						102. 00 103. 00
103.00 Retention of employees 104.00 Training						103.00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne 1 column 3)					106. 00
100. 00 10 tal Sill revenue (Worksheet 0-2, Fart 1, 11	ne i, cordilli 3)		I	į į		1100.00

Health Financial Systems	CARE ONE AT MO	ORESTOWN		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE C)F EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre	nared:
			'	0 12/31/2023	5/10/2024 11:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons	Trial Balance	
				I ncrease/Decre		
				ase (Fr Wkst	col . 4)	
	1.00	2. 00	3.00	A-6) 4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00 O0100 CAP REL COSTS - BLDGS & FLXTURES		1, 967, 590	1, 967, 590	0	1, 967, 590	1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT		7, 451			7, 451	2. 00
3.00 00300 EMPLOYEE BENEFITS	0	2, 185, 393			2, 185, 393	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	738, 939	2, 063, 630			2, 802, 569	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	137, 412	478, 107	615, 519	0	615, 519	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	72, 495	58, 414	130, 909	0	130, 909	6. 00
7. 00 00700 HOUSEKEEPI NG	278, 471	47, 698	326, 169	0	326, 169	7. 00
8. 00 00800 DI ETARY	648, 519	333, 543			982, 062	8. 00
9.00 O0900 NURSING ADMINISTRATION	666, 212	149, 103			815, 315	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	142, 603				10. 00
11. 00 01100 PHARMACY	0	11, 819			11, 819	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	63, 058	0	63, 058		63, 058	12.00
13. 00 01300 SOCIAL SERVICE	128, 204	0	128, 204	0	128, 204	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	127 072	12 (42	150 515	0	150 515	14.00
15. 00 01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	137, 872	12, 643	150, 515	U U	150, 515	15. 00
30. 00 03000 SKILLED NURSING FACILITY	4, 122, 149	63, 024	4, 185, 173	-1, 329, 669	2, 855, 504	30. 00
31. 00 03100 NURSING FACILITY	0	00, 021	1, 100, 170	0	2,000,001	31. 00
32. 00 03200 CF/IID	o	0	o o	0	Ö	32. 00
33.00 03300 OTHER LONG TERM CARE	o	0	o	1, 329, 669	1, 329, 669	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	57, 539	57, 539	0	57, 539	40. 00
41. 00 04100 LABORATORY	0	104, 654		0	104, 654	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0	99, 517	99, 517	0	99, 517	42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	(00 (5)	21 024	721 502	0	721 502	43.00
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 OCCUPATI ONAL THERAPY	699, 656	31, 936		0	731, 592	44. 00 45. 00
46. 00 04600 SPEECH PATHOLOGY	636, 275 255, 089	10, 895	636, 275 265, 984		636, 275 265, 984	46. 00
47. 00 04700 ELECTROCARDI OLOGY	255, 089	10, 673	203, 704	0	203, 784	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		136		48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	ő	507, 164	507, 164		507, 164	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	o	0	0	0	0	50. 00
51. 00 05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
52.00 05200 COMPLEX MEDICAL EQUIPMENT	O	0	0	0	0	52.00
52.01 05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02 05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLINIC	0	0	0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	O O	Ü)	0	0	61.00
62. 00 06200 FQHC		0		0		62.00
63. 00 06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	l U	0	ıl O	U U	0	63. 00
70. 00 07000 HOME HEALTH AGENCY COST	O	0		0	0	70. 00
71. 00 07100 AMBULANCE	0	34, 441	34, 441	0	34, 441	
73. 00 07300 CMHC	o	0 1, 111	0 .,	o	0 .,	73. 00
74. 00 07400 OTHER REIMBURSEMENT	o	0	0	0		74. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	0	0	0	80. 00
81.00 08100 INTEREST EXPENSE		0	0	0	0	81. 00
82.00 08200 UTILIZATION REVIEW - SNF	0	0	0	0	0	82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01 08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	8, 584, 351	8, 367, 164	16, 951, 515	0	16, 951, 515	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		7, 206	7, 206		7, 206	90. 00
91.00 09100 BARBER AND BEAUTY SHOP		17, 200 17, 340			17, 340	90.00
92. 00 09200 PHYSI CLANS PRI VATE OFFICES		.,, 540 0	17,340	n	0	92. 00
93. 00 09300 NONPAI D WORKERS	ol	0	ol o	l	0	93. 00
94. 00 09400 PATIENTS LAUNDRY	0	0	0	o	0	94. 00
95.00 09500 OTHER NONREIMBURSABLE COST	0	0	0	o	0	95. 00
100. 00 TOTAL	8, 584, 351	8, 391, 710	16, 976, 061	o	16, 976, 061	100. 00

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

 Heal th Financial
 Systems
 CARE ONE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315482 | Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To 12/31/2023 Date/Time Pre 5/10/2024 11:	
	Cost Center Description	Adjustments to	Net Expenses	5/10/2024 11.	42 4111
	·		For Allocation		
		Wkst A-8)	(col. 5 +- col. 6)		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-1, 278, 505			1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	7, 451	•	2.00
3.00	00300 EMPLOYEE BENEFITS	(25.224	2, 185, 393	•	3.00
4. 00 5. 00	OO4OO ADMINISTRATIVE & GENERAL OO5OO PLANT OPERATION, MAINT. & REPAIRS	-635, 334		l .	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE			•	6.00
7. 00	00700 HOUSEKEEPING	0	326, 169		7. 00
8.00	00800 DI ETARY	0	982, 062		8. 00
9.00	00900 NURSING ADMINISTRATION	-1, 984			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0.45	142, 467	•	10.00
11. 00 12. 00	O1100 PHARMACY O1200 MEDICAL RECORDS & LIBRARY	-945 0		•	11. 00 12. 00
	01300 SOCIAL SERVICE			•	13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0		•	14. 00
15. 00	01500 ACTI VI TES	0	150, 515		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	10.700	0.040.705		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	-12, 709 0		1	30. 00 31. 00
32.00	03200 CF/IID			l .	32.00
	03300 OTHER LONG TERM CARE				33.00
	ANCILLARY SERVICE COST CENTERS		, , , , ,		
40.00	04000 RADI OLOGY	0		1	40. 00
41. 00	04100 LABORATORY	7 0/1	,		41.00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY	-7, 961		•	42. 00 43. 00
44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY		731, 592	l .	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		636, 275	•	45. 00
46.00	04600 SPEECH PATHOLOGY	0	265, 984	•	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	l .	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	136		48. 00
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	-40, 573	466, 591 0		49. 00 50. 00
	05100 SUPPORT SURFACES			l .	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0		l .	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0		52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0		•	61.00
62.00	06200 FQHC				62. 00
63. 00	06300 DI ALYSI S	0	0		63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		70.00
				l .	71.00
	07300 CMHC	0		•	73. 00
74.00	07400 OTHER REIMBURSEMENT	0	0		74. 00
	SPECIAL PURPOSE COST CENTERS	_	1		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	_	l .	80.00
	O8100 INTEREST EXPENSE O8200 UTI LI ZATI ON REVIEW - SNF	0	0	l control of the cont	81. 00 82. 00
83. 00	08300 HOSPI CE		Ö		83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0		84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 978, 011	14, 973, 504		89. 00
90. 00	NONREI MBURSABLE COST CENTERS O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		7, 206		90.00
	09100 BARBER AND BEAUTY SHOP		17, 340	•	91.00
	09200 PHYSICIANS PRIVATE OFFICES		0	l .	92.00
	09300 NONPALD WORKERS	0	0		93. 00
	09400 PATIENTS LAUNDRY	0	0		94. 00
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST TOTAL	-1, 978, 011	0 14, 998, 050		95. 00 100. 00
100.00	INTE	1,770,011	17, 770, 000	T	1.00.00

Health Financial Systems	CARE ONE AT MOORESTOWN		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS			Peri od: From 01/01/2023	Worksheet A-6	
			To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 42 am
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2. 00	3.00	4. 00	5. 00	
(1) A - RECLASS MED SUPP CHARGED					
1.00	MEDICAL SUPPLIES CHARGED 1 PATIENTS	0 48.	00 0	136	1. 00
(1) E - RECLASS ALF RNS	I ATTENTS				
2. 00	OTHER LONG TERM CARE	33.	00 89, 895	0	2. 00
3. 00	OTHER LONG TERM CARE	33.	00 403, 937	0	3. 00
4. 00	OTHER LONG TERM CARE	33.	00 835, 837	0	4. 00
TOTALS					
100.00	Total Reclassifications (S	Sum	1, 329, 669	136	100. 00
	of columns 4 and 5 must				
	equal sum of columns 8 and 9)	1			

⁽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 MOORES	STOWN		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der 1		Peri od:	Worksheet A-6	
				rom 01/01/2023		
			1	o 12/31/2023	Date/Time Pre	pared:
					5/10/2024 11:	42 am_
			Decreases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - RECLASS MED SUPP CHARGED						
1.00	CENTRAL SERVICES & S	SUPPLY	10.00	0	136	1. 00
(1) E - RECLASS ALF RNS						
2. 00	SKILLED NURSING FACI	LITY	30.00	89, 895	0	2. 00
3. 00	SKILLED NURSING FACI	LITY	30.00	403, 937	0	3. 00
4. 00	SKILLED NURSING FACI	LITY	30.00	835, 837	0	4. 00
TOTALS						
100. 00				1, 329, 669	136	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT MOORESTOWN

				Т	o 12/31/2023	Date/Time Prep 5/10/2024 11:4	pared: 42 am
			·	Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5		T _	т _	_	
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	0	0	0	0	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	0	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	I	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5		T			
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	Subtotal (sum of lines 1-6)	0	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	0	0				9. 00

Provi der No.: 315482 Peri od: Worksheet A-8 Period: | WOFKSHeet A-o | From 01/01/2023 | Date/Time Prepared: | 5/10/2024 | 11:42 am

				10 12/31/2023	5/10/2024 11:	
				Expense Classification on		
				To/From Which the Amount is		
					,	
	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	-1, 403	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		C	ol .	0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		C		0.00	3. 00
4.00	Rental of provider space by suppliers		C)	0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		C)	0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		C		0.00	6. 00
7.00	Parking Lot (chapter 21)		C		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	C)		8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		C		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	10.00
11.00	Nonallowable costs related to certain		C)	0.00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-1, 519, 302	!		12.00
	related organizations (chapter 10)					
13.00	Laundry and linen service	В	C	LAUNDRY & LINEN SERVICE	6. 00	13. 00
14.00	Revenue - Employee meals	В	C	DI ETARY	8. 00	14.00
15.00	Cost of meals - Guests	В	C	DI ETARY	8. 00	15. 00
16.00	Sale of medical supplies to other than		C)	0.00	16. 00
	patients					
17.00	Sale of drugs to other than patients		C		0.00	17. 00
18.00	Sale of medical records and abstracts		C		0.00	18. 00
19.00	Vendi ng machi nes		C)	0.00	19. 00
20.00	Income from imposition of interest, finance		C		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		C		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		C	UTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		C	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24. 00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE	2.00	24. 00
25 00	DESLIDENT DEDLACEMENT LITEMS		/-	EQUI PMENT	4 00	25. 00
25. 00	RESIDENT REPLACEMENT ITEMS REFERAL FEES	A		ADMINISTRATIVE & GENERAL	4.00	
25. 01		A A		ADMINISTRATIVE & GENERAL	4. 00 4. 00	
25. 02 25. 03	MARKETING EXPENSE MARKETING CORP EXPENSE	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4.00	
	MARKETING - MEALS	A		ADMINISTRATIVE & GENERAL		25. 03
25. 04	SHOWS & CONFERENCES	A		ADMINISTRATIVE & GENERAL		25. 04
25. 05	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	•
25. 00	BAD DEBT EXPENSE - MEDICARE	A		ADMINISTRATIVE & GENERAL	4.00	•
25. 07	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	•
25. 06	RESIDENT PERSONAL ITEMS	В		ADMINISTRATIVE & GENERAL	4.00	
25. 10	MAINTENANCE FEE INCOME	В		CAP REL COSTS - BLDGS &	1.00	
25. 10	INMINITURE I LE LINCOINE	ט	-54, 390	FIXTURES	1.00	20.10
25. 11	OTHER REVENUE	В	-20 956	ADMINISTRATIVE & GENERAL	4.00	25. 11
	OTHER INCOME	В		ADMINISTRATIVE & GENERAL		25. 11
	Total (sum of lines 1 through 99) (Transfer		-1, 978, 011	II		100.00
	to Worksheet A, col. 6, line 100)		.,			
				 Control of the control of the control	· ·	-

⁽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 MOORESTOWN

Health Financial Systems CARE ONE AT MOSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315482 OFFICE COSTS

OFFICE COSTS				Ť	o 12/31/2023 Date/Time Pre	
·		Li ne No.	Cost (Center	Expense Items	
		1.00		00	3. 00	
PART I. COSTS I CLAIMED HOME OF	NCURRED AND ADJUSTMENTS REQUIFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS OR	
1.00			CAP REL COSTS FLXTURES	- BLDGS &	RENT - RELATED PARTY	1.00
2. 00		1	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	2.00
3.00		9. 00	NURSING ADMINI	STRATI ON	PHARMACY CONSULTANT	3.00
4. 00			CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPENSE	4.00
5. 00		11. 00	PHARMACY		DRUGS-NON-PRESCRI PTI ON, NON-LEGEND	5. 00
6. 00			PHARMACY		PHARMACY SUPPLIES	6.00
7. 00			INTRAVENOUS TH		IV EXPENSE	7. 00
8.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	8.00
9. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	9. 00
9. 01		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE	9. 01
9. 02		0.00			ſ^	9. 02
9. 03		0.00				9. 03
9. 04		0.00				9. 04
	lines 1-9). Transfer column					10.00
6, line 100 to	Worksheet A-8, column 3, line					
,		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 I CLAIMED HOME OF	NCURRED AND ADJUSTMENTS REQUIFICE COSTS:	RED AS A RESULT		NS WITH RELATE	D ORGANIZATIONS OR	
1.00		490, 084	1, 712, 796	-1, 222, 712		1.00
2.00		621, 689	866, 816	-245, 127	'	2. 00
3.00		22, 820	24, 804		ŀ	3. 00
4.00		31, 067	31, 067	1)	4. 00
5. 00		10, 263	11, 155	1		5. 00
6. 00 7. 00		611	664			6. 00 7. 00
8.00		91, 556 18, 698	99, 517 20, 324	1		8.00
9. 00		134, 666	146, 376	1		9.00
9. 01		313, 227	340, 464	1		9. 01
9. 02		0	0	, c		9. 02
9. 03		0	0	C		9. 03
9. 04		0	0	(c	0	9. 04
	lines 1-9). Transfer column Worksheet A-8, column 3, line	1, 734, 681	3, 253, 983	-1, 519, 302	2	10.00
12.						
*		•				

OFFICE COSTS

Provider No.: 315482

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

12/31/2023

5/10/2024 11:42 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	CARE ONE	100.00	1.00
2.00	Α	CARE ONE	100.00	2.00
3.00	Α	CARE ONE	100.00	3.00
4.00	Α	CARE ONE	100.00	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 rel ated organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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. 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	•	895 WESTFIELD AVE RE	100.00	REALTY COMPANY	1.00
2.00		HEALTHBRIDGE MANAGEMENT	100.00	HOME OFFICE	2.00
3. 00		PARTNERS PHARMACY	64. 87	PHARMACY	3. 00
4.00		TOTAL CARE LLC	100.00	WOUND CARE	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
s	peci 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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					To	12/31/2023	Date/Time Prep 5/10/2024 11:4	
				CAPI TAL REL	ATED COSTS		37 107 2024 11.	42 dili
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		Sect Control Boost (pt. on	for Cost	FIXTURES	EQUI PMENT	BENEFI TS	ouz tota.	
			Allocation (from Wkst A					
			col . 7)					
	GENER	AL SERVICE COST CENTERS	0	1.00	2. 00	3. 00	3A	
1.00		CAP REL COSTS - BLDGS & FIXTURES	689, 085	689, 085				1. 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT	7, 451	0	7, 451	2 105 202		2.00
3. 00 4. 00		EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	2, 185, 393 2, 167, 235	0 51, 229	- 1	2, 185, 393 188, 118	2, 407, 136	3. 00 4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	615, 519	58, 459	632	34, 982	709, 592	5. 00
6. 00 7. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	130, 909 326, 169	28, 148 0		18, 456 70, 893	177, 817 397, 062	6. 00 7. 00
8. 00	1	DI ETARY	982, 062	31, 570	- 1	165, 099	1, 179, 072	8. 00
9.00		NURSING ADMINISTRATION	813, 331	25, 808		169, 604	1, 009, 022	9. 00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	142, 467 10, 874	3, 680 0	40 0	0	146, 187 10, 874	10. 00 11. 00
12. 00		MEDICAL RECORDS & LIBRARY	63, 058	0	Ö	16, 053	79, 111	12. 00
13.00		SOCIAL SERVICE	128, 204	1, 743		32, 638	162, 604	13.00
14. 00 15. 00		NURSING AND ALLIED HEALTH EDUCATION ACTIVITES	150, 515	0	0 0	35, 099	0 185, 614	14. 00 15. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS			-			
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	2, 842, 795	289, 875 0	·	1, 049, 411 0	4, 185, 215 0	30. 00 31. 00
32. 00		ICF/IID	0	0	o O	ő	0	32. 00
33. 00		OTHER LONG TERM CARE	1, 329, 669	163, 047	1, 763	0	1, 494, 479	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	57, 539	0	O	ol	57, 539	40. 00
41.00	04100	LABORATORY	104, 654	1, 566	- 1	ō	106, 237	41. 00
42. 00 43. 00	1	INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	91, 556	0	0	0	91, 556 0	42. 00 43. 00
44. 00		PHYSICAL THERAPY	731, 592	10, 798	- 1	178, 118	920, 625	44. 00
45. 00	1	OCCUPATIONAL THERAPY	636, 275	9, 523		161, 982	807, 883	
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	265, 984	7, 570 0		64, 940 0	338, 576 0	46. 00 47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	136	0	Ö	Ö	136	48. 00
49.00		DRUGS CHARGED TO PATIENTS	466, 591	0	0	o	466, 591	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0	0	ol Ol	0	50. 00 51. 00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	o	0	52. 00
52. 01 52. 02		OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		0	0	52. 01 52. 02
32. 02		TIENT SERVICE COST CENTERS	<u> </u>	0	O ₁		O	32.02
60.00		CLINIC	0	0		0	0	60.00
61. 00 62. 00	06200	RURAL HEALTH CLINIC	0	0	0	0	0	61. 00 62. 00
63. 00		DI ALYSI S	0	0	0	О	0	
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST		0		ol	0	70. 00
71. 00	1	AMBULANCE	34, 441	0	Ö	Ö	34, 441	
73.00	07300		0	0		O	0	73.00
74. 00		OTHER REIMBURSEMENT AL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 82. 00	1	INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00	1	HOSPI CE	0	0	О	О	0	83. 00
84. 00		OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01 89. 00	08401	OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	14, 973, 504	0 683, 016	0 7, 385	0 2, 185, 393	0 14, 967, 369	84. 01 89. 00
		MBURSABLE COST CENTERS		333, 310	7, 303	2, 100, 070		
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	7, 206	0	0	0	7, 206	90.00
91. 00 92. 00	1	BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	17, 340	6, 069 0	66 0	ol Ol	23, 475 0	91. 00 92. 00
93.00	09300	NONPALD WORKERS	0	0	0	O	0	93. 00
94. 00 95. 00	1	PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST	0	0	0	0	0	94. 00 95. 00
98. 00		Cross Foot Adjustments		0	Ö	ő	0	98. 00
99.00		Negative Cost Centers TOTAL	0 14, 998, 050	490 005	0	0 105 202	0 14, 998, 050	99.00
100.00	וי	LIVINE	14, 778, 050	689, 085	7, 451	2, 185, 393	14, 778, 030	100.00

Provi der No.: 315482

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

				T	0 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	42 alli
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 407, 136					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	135, 660	845, 252				5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	33, 995 75, 910	41, 064	252, 876	472, 972		6. 00 7. 00
8. 00	00800 DI ETARY	225, 415	46, 056	-	27, 087	1, 477, 630	8. 00
9. 00	00900 NURSING ADMINISTRATION	192, 905	37, 650	1	22, 143	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	27, 948	5, 368	0	3, 157	0	10. 00
11. 00	01100 PHARMACY	2, 079	0	0	0	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	15, 124	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	31, 087	2, 543	0	1, 496	0	13. 00 14. 00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	35, 486	0		0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	33, 400		<u>, </u>	O ₁	0	13.00
30. 00	03000 SKILLED NURSING FACILITY	800, 135	422, 886	139, 467	248, 715	814, 948	30. 00
31.00	03100 NURSING FACILITY	o	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	285, 714	237, 861	113, 409	139, 895	662, 682	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	11 000				0	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	11, 000 20, 310	0 2, 284	-	0 1, 343	0	40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY	17, 504	2, 204		1, 343	0	41.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	17,304	Ö		Ö	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	176, 005	15, 752	0	9, 264	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	154, 451	13, 892	0	8, 170	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	64, 729	11, 043		6, 495	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	26 89, 203	0		0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	07, 203	0		0	0	50.00
51. 00	05100 SUPPORT SURFACES		0	ol ő	0	0	51. 00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	O	O	o	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					0	(0.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		C)	U	U	62.00
63. 00	06300 DI ALYSI S	o	0	o	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0			0	70. 00
71.00	07100 AMBULANCE	6, 584	0	0	0	0	71. 00
	07300 CMHC	0	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	j oj		<u> </u>	U	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2, 401, 270	836, 399	252, 876	467, 765	1, 477, 630	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1, 378	0		n	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	4, 488	8, 853		5, 207	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	O	o	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	О	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98.00	Cross Foot Adjustments	0	0		0	0	98. 00 99. 00
99. 00 100. 00	Negative Cost Centers TOTAL	2, 407, 136	845, 252	252, 876	472, 972		
150.00	1.01112	2, 407, 130	045, 252	202,070	7/2, //2	1, 477, 030	1.00.00

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				'	12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		9. 00	10.00	11.00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00
8. 00 9. 00	00900 NURSI NG ADMI NI STRATI ON	1, 261, 720					8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	1, 201, 720	182, 660				10. 00
11. 00	01100 PHARMACY	0	102, 000	12, 953			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	Ö	12, 700	94, 235		12. 00
13. 00	01300 SOCIAL SERVICE	O	o	Ö	0	197, 730	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	О	0	0	0	14.00
15.00	01500 ACTI VI TES	o	o	0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	695, 868	100, 741	7, 144	51, 973	109, 053	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	565, 852	81, 919	5, 809	42, 262	88, 677	33. 00
40.00	ANCILLARY SERVICE COST CENTERS		ما		ما	0	10.00
40.00	04000 RADI OLOGY	0	0	0	0	- 1	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	U	0	0	0	41. 00 42. 00
42.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		0	0	0	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	Ö	0	Ö	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	o	o	Ö	0	o	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	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		ما		O	0	(0.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		o l	U	U	U	62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u>~</u> _	<u> </u>	<u> </u>		00.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	O	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	73.00
74. 00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00
82.00	08300 HOSPI CE			0	0	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II		0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	1, 261, 720	182, 660	12, 953	94, 235	-	89. 00
07.00	NONREI MBURSABLE COST CENTERS	1,201,720	1027 0001	127 700	7 17 200	1777700	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	o	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98. 00	Cross Foot Adjustments	0	0				98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	1, 261, 720	182, 660	12, 953	94, 235	0 197, 730	99.00
100.00) I TOTAL	1,201,720	102, 000	12, 703	74, 230	177,730	100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315482

					1	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
				OTHER GENERAL			107 107 202 1 111	
		Cost Contar Description	NUDCLNC AND	SERVI CE	Cubtatal	Doot Standown	Total	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
			EDUCATI ON					
			14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES			I			1. 00
2. 00	1	CAP REL COSTS - BEDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00		EMPLOYEE BENEFITS						3. 00
4.00		ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00		HOUSEKEEPING						7.00
8.00		DI ETARY						8. 00
9.00		NURSI NG ADMI NI STRATI ON						9. 00
10. 00 11. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY						10. 00 11. 00
12. 00		MEDICAL RECORDS & LIBRARY						12.00
13.00	1	SOCIAL SERVICE						13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTIVITES ENT ROUTINE SERVICE COST CENTERS	0	221, 100				15. 00
30. 00		SKILLED NURSING FACILITY	T 0	121, 942	7, 698, 087	0	7, 698, 087	30.00
31.00		NURSING FACILITY	0	0			0	31. 00
32. 00	1	I CF/I I D	0	0		0	0	32. 00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	99, 158	3, 817, 717	0	3, 817, 717	33. 00
40. 00		RADI OLOGY	T 0	0	68, 539	0	68, 539	40. 00
41.00	1	LABORATORY	0	0			130, 174	1
42.00	1	I NTRAVENOUS THERAPY	0	0	109, 060	0	109, 060	1
43. 00 44. 00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0	0	1, 121, 646	0	0 1, 121, 646	43. 00 44. 00
45. 00	1	OCCUPATIONAL THERAPY	0	0	984, 396		984, 396	1
46.00	04600	SPEECH PATHOLOGY	0	0	420, 843		420, 843	ı
47. 00	1	ELECTROCARDI OLOGY	0	0	(-	0	
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0			162 555, 794	ł
50.00		DENTAL CARE - TITLE XIX ONLY	0		333, 772		0 0	50.00
51.00		SUPPORT SURFACES	0	0	(0	0	51. 00
52. 00	1	COMPLEX MEDICAL EQUIPMENT	0	0	,	0	0	52.00
52. 01 52. 02	1	OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		_	0	52. 01 52. 02
32. 02		TIENT SERVICE COST CENTERS				,,		32.02
60.00		CLINIC	0				0	•
61. 00		RURAL HEALTH CLINIC	0	0	(0	0	61.00
62. 00 63. 00	06200	DI ALYSI S	0	0		0	0	62. 00 63. 00
00.00		REIMBURSABLE COST CENTERS				,,		00.00
70. 00	1	HOME HEALTH AGENCY COST	0					70. 00
71.00		AMBULANCE	0	0	11,020		11,020	71.00
73. 00 74. 00	07300	OTHER REIMBURSEMENT	0	0			0	ł
		AL PURPOSE COST CENTERS		_				
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00		HOSPICE	0	0	(0	0	•
84. 00		OTHER SPECIAL PURPOSE COST I	0	Ö	d	o o	0	ı
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0	0	(0	0	84. 01
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	0	221, 100	14, 947, 443	8 0	14, 947, 443	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	8, 584	1 0	8, 584	90.00
91. 00	09100	BARBER AND BEAUTY SHOP	0	0	42, 023		42, 023	91.00
92.00		PHYSICIANS PRIVATE OFFICES	0	0	(0	0	92.00
93. 00 94. 00	1	NONPALD WORKERS PATIENTS LAUNDRY					0	93. 00 94. 00
95. 00	1	OTHER NONREIMBURSABLE COST		0			0	1
98. 00		Cross Foot Adjustments	0	0	(0	0	98. 00
99.00		Negative Cost Centers	0	0	14 000 050	0	14 009 050	
100.00	7	TOTAL	1	221, 100	14, 998, 050	0	14, 998, 050	1100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315482

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS		37 107 2024 11.	42 4111
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FI XTURES	EQUI PMENT		BENEFI TS	
		Related 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 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS		0	0	0	0	2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	0	51, 229		51, 783	0	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	o	58, 459		59, 091	0	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	28, 148	304	28, 452	0	6. 00
7.00	00700 HOUSEKEEPI NG	0	0		0	0	7. 00
8.00	00800 DI ETARY	0	31, 570		31, 911	0	8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	25, 808 3, 680		26, 087 3, 720	0	9. 00 10. 00
11. 00	01100 PHARMACY	0	3, 000	0	3, 720	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	o	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	0	1, 743	19	1, 762	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	O1500 ACTIVITES] 0	0	0	0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY		289, 875	3, 134	293, 009	0	30.00
31. 00	03100 NURSING FACILITY	0	207, 073	3, 134	275,007	0	31.00
32. 00	03200 CF/IID	o	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	163, 047	1, 763	164, 810	0	33. 00
	ANCILLARY SERVICE COST CENTERS				_1		
40.00	04000 RADI OLOGY	0	1.5(- 1	1 503	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY		1, 566	17	1, 583	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	10, 798	- 1	10, 915	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	9, 523	103	9, 626	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	7, 570		7, 652	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		0	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES		0	0	Ö	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC		0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0		0	0	61.00
62. 00	06200 FQHC		J	J	Ŭ.	Ŭ	62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	١	0		70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0		0	0	1
	07400 OTHER REIMBURSEMENT		0		0	0	74.00
7 1. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>		<u> </u>	7 1. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	83. 00 84. 00
84. 00	08401 OTHER SPECIAL PURPOSE COST I		0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	o	683, 016		690, 401	0	89. 00
	NONREI MBURSABLE COST CENTERS			,	-, -, -, -,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	6, 069	66	6, 135	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0	0	92. 00 93. 00
93. 00 94. 00	09400 PATI ENTS LAUNDRY		0	0	O O	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST		0		o	0	95. 00
98. 00	Cross Foot Adjustments				o		98. 00
99. 00	Negative Cost Centers		0	0	o	0	
100.00	TOTAL	0	689, 085	7, 451	696, 536	0	100. 00

Provi der No.: 315482

				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	12 (1111
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	51, 783					3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	2, 919	62, 010				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	731	3, 013				6. 00
7.00	00700 HOUSEKEEPI NG	1, 633	0	0	1, 633		7. 00
8.00	00800 DI ETARY	4, 850	3, 379		94	40, 234	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	4, 150	2, 762		76	0	9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	601	394 0		11	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	45 325	0		0	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	669	187	Ö	5	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14. 00
15. 00	01500 ACTI VI TES	763	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 47 007	04.000		050	00.100	
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	17, 207	31, 022		859	22, 190 0	30. 00 31. 00
31.00	03200 CF/IID	0	0	0	0	0	31.00
33. 00	03300 OTHER LONG TERM CARE	6, 147	17, 450	14, 439	483	18, 044	33. 00
	ANCILLARY SERVICE COST CENTERS	2,	,				
40.00	04000 RADI OLOGY	237	0	-	0	0	40. 00
41. 00	04100 LABORATORY	437	168		5	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	377	0	0	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 3, 787	1, 156	0	32	0	43. 00 44. 00
45. 00	04500 OCCUPATIONAL THERAPY	3, 767	1, 130		28	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	1, 393	810	1	22	Ö	46. 00
47.00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	1, 919	0	0	0	0	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		0	0	0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST		0	o o	0	Ö	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	· -	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0		0	0	63.00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		,, ,	J	U	05.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	07100 AMBULANCE	142	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	1
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	0	U	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0 F1 /F/	(1.240	0	1 (15	40.224	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	51, 656	61, 360	32, 196	1, 615	40, 234	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	30	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	97	650	o o	18	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments		0	, 0	0	0	95. 00 98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00		51, 783	62, 010	32, 196	1, 633	_	100. 00
		·		•	·		

Provi der No.: 315482

				''	0 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
			SUPPLY		LI BRARY		
	LOGINGO MAGNICA CONTROL	9. 00	10. 00	11. 00	12. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS					I	1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 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	33, 075					9. 00
10. 00	1	0	4, 726				10. 00
11. 00	1	0	0	45			11. 00
12.00	1	0	0	0	325	0 /00	12.00
13.00	1 1	0	0	0	0	2, 623	13.00
14. 00 15. 00	1 1	0	0	0	0	0	14. 00 15. 00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		U	0	0	15.00
30. 00		18, 242	2, 607	25	179	1, 447	30. 00
31. 00	1	0	0	0	0	0	31. 00
32.00	03200 CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	14, 833	2, 119	20	146	1, 176	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00		0	0	0	0		40. 00
41. 00		0	0	0	0	1	41. 00
42. 00		0	0	0	0	0	42.00
43. 00 44. 00		0	0	0	0	0	43. 00 44. 00
45. 00		0	0	0	0		45. 00
46. 00		0	0	0	0	0	46. 00
47. 00		0	0	0	0	Ö	47. 00
48. 00			0	0	0	o o	48. 00
49. 00		0	0	0	0	Ō	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
52.00	1	0	0	0	0	0	52.00
52. 01	1	0	0	0	0	0	52. 01
52. 02		0	0	0	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS O6000 CLINIC	0	0	0	0	0	60. 00
61. 00	1 1	0	0	0	0	0	61. 00
62. 00	1 1		J	J	0	Ĭ	62.00
63. 00	1	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	70. 00
71. 00		0	0	0	0	0	71. 00
73.00		0	0	0	0	0	73. 00
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00							80. 00
81. 00							81. 00
82. 00							82. 00
83. 00		0	0	0	0	0	83. 00
84.00		0	0	0	0	0	84. 00
84. 01		0	0	0	0	0	84. 01
89. 00		33, 075	4, 726	45	325	2, 623	89. 00
	NONREI MBURSABLE COST CENTERS			_		_	
90.00		0	0	0	0		90.00
91.00		0	0	0	0	0	91.00
92. 00 93. 00	1		O O	0	0		92. 00 93. 00
94. 00	1		0	0	0	0	94.00
95. 00			ol	0	0	Ö	95. 00
98. 00	1	0	o	0			98. 00
99. 00	Negative Cost Centers	0	O	0	0	0	99. 00
100.0	0 TOTAL	33, 075	4, 726	45	325	2, 623	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315482

					7	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				OTHER GENERAL				
		Cost Center Description	NURSI NG AND	SERVI CE ACTI VI TES	Subtotal	Post Step-Down	Total	
		cost center bescription	ALLI ED HEALTH	ACTIVITES	Subtotal	Adjustments	iotai	
			EDUCATION					
	GENER	AL SERVICE COST CENTERS	14.00	15. 00	16. 00	17. 00	18. 00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 4. 00	1	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL						3. 00 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						9. 00
10.00	1	CENTRAL SERVICES & SUPPLY						10. 00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY						11. 00 12. 00
13. 00		SOCIAL SERVICE						13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	0	763				15. 00
30. 00		SKILLED NURSING FACILITY	0	421	404, 965	5 0	404, 965	30. 00
31. 00		NURSING FACILITY	0	0	1	-	0	31. 00
32. 00 33. 00		ICF/IID OTHER LONG TERM CARE	0	0	1	1	240,000	32.00
33.00		LARY SERVICE COST CENTERS		342	240, 009	/ U	240, 009	33. 00
40.00	04000	RADI OLOGY	0		1		237	40. 00
41. 00 42. 00		LABORATORY INTRAVENOUS THERAPY	0	0	2, 193 377		2, 193 377	41. 00 42. 00
42.00		OXYGEN (INHALATION) THERAPY			37.		0	42.00
44.00	04400	PHYSI CAL THERAPY	0	0	15, 890		15, 890	44. 00
45. 00	1	OCCUPATIONAL THERAPY	0	0			13, 996	
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY			9, 87	1	9, 877 0	
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	-	0	1	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0	1, 919	0	1, 919	
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES					0	50. 00 51. 00
52. 00	1	COMPLEX MEDICAL EQUIPMENT	0	0		o	0	52. 00
52. 01		OTHER ANCILLARY SERVICES COST	0	0			0	52. 01
52. 02		MEDICAL SERVICES TIENT SERVICE COST CENTERS	0	0	(<u>) </u>	0	52. 02
60.00	06000	CLI NI C	0	0	(0	60. 00
61.00		RURAL HEALTH CLINIC	0	0	(0	0	61.00
62. 00 63. 00	06200 06300	DI ALYSI S	0	o		o	0	62. 00 63. 00
00.00	OTHER	REIMBURSABLE COST CENTERS				,		00.00
70.00		HOME HEALTH AGENCY COST	0	0	1			70.00
71. 00 73. 00	07100	AMBULANCE CMHC			1 ''-	- "	0	71. 00 73. 00
74. 00	07400	OTHER REIMBURSEMENT	0	0	1		0	
00.00		AL PURPOSE COST CENTERS			1			00.00
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00	08200	UTILIZATION REVIEW - SNF						82. 00
83.00		HOSPI CE	0	0	(0	0	83.00
84. 00 84. 01	1	OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II					0	84. 00 84. 01
89. 00		SUBTOTALS (sum of lines 1-84)	0	763	689, 606	0	689, 606	89. 00
90. 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN		l 0	30		30	90. 00
91.00		BARBER AND BEAUTY SHOP		0	i		6, 900	
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	(o	0	92. 00
93.00		NONPALD WORKERS PATIENTS LAUNDRY	0	0			0	93. 00 94. 00
94. 00 95. 00	1	OTHER NONREIMBURSABLE COST					0	
98. 00		Cross Foot Adjustments	0	0		o o	0	98. 00
99. 00 100. 00		Negative Cost Centers TOTAL	0	763		0 0	0 696, 536	
100.00	1	IOINE	1	1 /03	1 070, 330	رار ا	070, 530	1100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315482

					'	0 12/31/2023	Date/lime Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS				
	Cost Ce	nter Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	3. 00	4A	4. 00	
		CE COST CENTERS	10.00		T			
1.00 2.00 3.00	00200 CAP REL 00300 EMPLOYE		42, 694	42, 694 0	8, 584, 351		12 500 014	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00	00500 PLANT 0	TRATIVE & GENERAL PERATION, MAINT. & REPAIRS & LINEN SERVICE FOLING	3, 174 3, 622 1, 744		137, 412 72, 495	0 0	709, 592	4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00	00800 DI ETARY 00900 NURSI NG		1, 956 1, 599 228	1, 956 1, 599	648, 519 666, 212	0 0	1, 179, 072 1, 009, 022 146, 187	8. 00 9. 00
11. 00 12. 00 13. 00	01100 PHARMAC	Y RECORDS & LIBRARY	0 0 108	0 0 108	63, 058	0	10, 874 79, 111 162, 604	1
14. 00 15. 00	01500 ACTI VI T	AND ALLIED HEALTH EDUCATION ES ITINE SERVICE COST CENTERS	0	0			0 185, 614	14. 00 15. 00
30. 00 31. 00	03000 SKI LLED 03100 NURSI NG	NURSING FACILITY FACILITY	17, 960 0	17, 960 0	4, 122, 149 (30. 00 31. 00
32. 00 33. 00		ONG TERM CARE VICE COST CENTERS	10, 102	0 10, 102	(32. 00 33. 00
40. 00 41. 00 42. 00	04000 RADI 0L0 04100 LABORAT 04200 I NTRAVE	ORY	97 0	0 97 0	C	0	57, 539 106, 237 91, 556	41. 00
43. 00 44. 00 45. 00	04400 PHYSI CA 04500 OCCUPAT	I ONAL THERAPY	0 669 590	590	699, 656	0	920, 625 807, 883	
46. 00 47. 00 48. 00		CARDIOLOGY SUPPLIES CHARGED TO PATIENTS	469 0 0	469 0 0			338, 576 0 136	46. 00 47. 00 48. 00
49. 00 50. 00 51. 00	05000 DENTAL 05100 SUPPORT		0 0	0 0	(0 0	466, 591 0 0	49. 00 50. 00 51. 00
52. 00 52. 01 52. 02	05201 OTHER A 05202 MEDI CAL		0 0	0 0	(0	0 0	52. 00 52. 01 52. 02
60. 00 61. 00 62. 00	06000 CLINIC 06100 RURAL H 06200 FQHC	RVICE COST CENTERS EALTH CLINIC	0	0			l	60. 00 61. 00 62. 00
63. 00	06300 DI ALYSI	S SABLE COST CENTERS	0	0	(0	0	
70. 00 71. 00		ALTH AGENCY COST	0	0	(0 34, 441	
73. 00 74. 00	07300 CMHC 07400 OTHER R		0 0	0	C	0	0	73. 00
80. 00 81. 00 82. 00	08000 MALPRAC 08100 I NTERES	TICE PREMIUMS & PAID LOSSES						80. 00 81. 00 82. 00
83. 00 84. 00 84. 01		PECIAL PURPOSE COST I PECIAL PURPOSE COST II	0 0	0 0	(0 0	0 0 0	83. 00 84. 00 84. 01
89. 00 90. 00	NONREI MBURSAE	LS (sum of lines 1-84) BLE COST CENTERS LOWER, COFFEE SHOPS & CANTEEN	42, 318					90.00
91. 00 92. 00 93. 00	09100 BARBER	AND BEAUTY SHOP ANS PRIVATE OFFICES	376			0 0	23, 475	91. 00 92. 00
94. 00 95. 00 98. 00	09400 PATI ENT 09500 OTHER N		0 0	0	(1	0 0	94. 00 95. 00 98. 00
99. 00 102. 00	Negativ Cost to	e Cost Centers be allocated (per Wkst. B,	689, 085	7, 451	2, 185, 393	3	2, 407, 136	99. 00
103. 00 104. 00		st multiplier (Wkst. B, Part I) be allocated (per Wkst. B,)	16. 140090	0. 174521	0. 254579		0. 191180 51, 783	103. 00 104. 00

Health Financial Systems	CARE ONE AT MOORESTOWN			In Lieu of Form CMS-2540-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der	Provi der No.: 315482		Worksheet B-1		
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/10/2024 11:		
	CAPITAL REI	LATED COSTS					
Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
	1.00	2.00	3. 00	4A	4.00		
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000	D	0. 004113	105. 00	

Provi der No.: 315482

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11:42 am

						5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAI NT. & REPAI RS	(PATIENT DAYS)			(PATIENT DAYS)	
		(SQUARE FEET)				(I ATTENT DATS)	
		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	OO300						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	35, 898					5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 744	l .				6.00
7. 00	00700 HOUSEKEEPING	1,711	i .	34, 154			7.00
8.00	00800 DI ETARY	1, 956	ō	1, 956			8.00
9.00	00900 NURSING ADMINISTRATION	1, 599		1, 599		34, 033	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	228	0	228	0	0	10.00
11. 00	01100 PHARMACY	C	0	0	0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	C	1	0	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	108	1	108		0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C		0	0	0	14.00
15. 00	01500 ACTI VI TES	C	0	0	0	0	15. 00
20 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	17.040	10 770	17.040	E4 210	10 770	30.00
30. 00 31. 00	03100 NURSING FACILITY	17, 960	18, 770	17, 960	56, 310	18, 770 0	31.00
32. 00	03200 CF/IID				0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	10, 102	15, 263	10, 102	45, 789		33.00
00.00	ANCI LLARY SERVI CE COST CENTERS	107.02	. 10/200	107.02	107707	10,200	00.00
40.00	04000 RADI OLOGY	C	0	0	0	0	40.00
41.00	04100 LABORATORY	97	0	97	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	C	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	1	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	669	1	669	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	590	ł	590		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	469	l .	469	0	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C	_		0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS				0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY				0	0	50.00
51. 00	05100 SUPPORT SURFACES			i o	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	d	Ö	Ö	0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C	0	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		_		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63. 00	06300 DI ALYSI S) 0	1 0	0	0	63.00
70 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	C		0	0	0	70.00
	07100 AMBULANCE						
	07300 CMHC				0	l ő	73.00
74. 00	07400 OTHER REIMBURSEMENT	l c	o o	Ö	0	l o	74. 00
	SPECIAL PURPOSE COST CENTERS				<u>'</u>	<u>'</u>	ĺ
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE		0	0	0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I		0	9	0	0	84.00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	25 522	24 022	0 770	102.000	0 34, 033	84. 01
09.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	35, 522	34, 033	33, 778	102, 099	34, 033	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	С	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	376	1				91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	ol o	0	0	Ö	92.00
93. 00	09300 NONPAI D WORKERS		o o	Ö	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	The state of the s	845, 252	252, 876	472, 972	1, 477, 630	1, 261, 720	102. 00
102.00	Part I)	22 E4E024	7 420210	12 040217	1/ /70500	27 072420	102 00
103. 00 104. 00		23. 545936 62, 010	l	i			103.00
104.00	Part II)	02,010	32, 190	1, 033	40, 234	33,075	104.00
105.00	1 1	1. 727394	0. 946023	0. 047813	0. 394069	0. 971851	105. 00
22.00	II)				2.37.037		
		•	•	•	*	•	-

Provi der No.: 315482

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11:42 am

					0 12/31/2023	5/10/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY		SOCIAL SERVICE		
		SERVICES & SUPPLY	(PATIENT DAYS)	RECORDS & LI BRARY	(PATIENT DAYS)	ALLI ED HEALTH EDUCATI ON	
		(PATIENT DAYS)		(PATIENT DAYS)	(PATTENT DAYS)	(ASSI GNED	
		(I'MITEMI DATO)		(17117ENT D/110)		TIME)	
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	OO300						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6. 00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPING						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	34, 033					10.00
11. 00	01100 PHARMACY	0	34, 033				11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	34, 033			12. 00
13. 00	01300 SOCIAL SERVICE	0	0	0	34, 033	_	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00	01500 ACTI VI TES	0	0	0	0	0	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	18, 770	10 770	10 770	10 770	0	30.00
30. 00 31. 00	03100 NURSING FACILITY	18,770	18, 770	18, 770	18, 770	0	31.00
32. 00	03200 CF/IID	0	0		0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	15, 263	15, 263	15, 263	15, 263	0	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS	107200	.0, 200	10,200	10/200		00.00
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS	0	0		0	0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES	o o	0	0	Ö	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	Ö	O	Ō	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52.02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0		0	· ·	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63. 00	O6300 DI ALYSI S	0	0	0	0	0	63.00
70 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
	07100 AMBULANCE	0	0		1		
	07300 CMHC	o o	0	0	Ö	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS]
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF		_	_	_	_	82.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0	0			0	84.00
84. 01 89. 00	SUBTOTALS (sum of lines 1-84)	34, 033	34, 033	34, 033	34, 033	0	84. 01 89. 00
07.00	NONREI MBURSABLE COST CENTERS	34, 033	34, 033	1 34, 033	34, 033	<u> </u>	1 07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	O	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	o	Ö	· ·	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	Ō	Ö	o	0	92.00
93.00	09300 NONPALD WORKERS	0	0	0	o	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99.00	Negative Cost Centers	100 /:-	40 6==	0.5=	407 7	_	99. 00
102.00		182, 660	12, 953	94, 235	197, 730	0	102. 00
103.00	Part I) Unit cost multiplier (Wkst. B, Part I)	5. 367144	0. 380601	2. 768930	5. 809949	0. 000000	103 00
103.00		5. 36/144 4, 726	0. 380601 45		5. 809949 2, 623		103.00
104.00	Part II)	4,720	45	323	2, 023		1.54.00
105.00		0. 138865	0. 001322	0. 009550	0. 077072	0. 000000	105.00

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

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.: 315482

				To 12/31/2023 Date/Ti me Pre	
			OTHER GENERAL		
		Cook Cooks December	SERVI CE		
		Cost Center Description	ACTIVITES (PATIENT DAYS)		
			15. 00		
		AL SERVICE COST CENTERS	1		
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT			1.00
3.00	1	EMPLOYEE BENEFITS			3. 00
4.00	00400	ADMINISTRATIVE & GENERAL			4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS			5. 00
6. 00 7. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING			6. 00 7. 00
8.00		DI ETARY			8. 00
9.00	1	NURSING ADMINISTRATION			9. 00
10.00	1	CENTRAL SERVICES & SUPPLY			10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY			11. 00 12. 00
13. 00	1	SOCIAL SERVICE			13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	34, 033		15. 00
30. 00		SKILLED NURSING FACILITY	18, 770		30. 00
31. 00		NURSING FACILITY	0		31. 00
32.00		ICF/IID	0		32. 00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	15, 263		33.00
40. 00		RADI OLOGY	0		40. 00
41. 00	1	LABORATORY	0		41. 00
42. 00	1	INTRAVENOUS THERAPY	0		42.00
43. 00 44. 00	1	OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0		43. 00 44. 00
45. 00	1	OCCUPATI ONAL THERAPY	O		45. 00
46. 00		SPEECH PATHOLOGY	0		46. 00
47. 00 48. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0		47. 00 48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0		49. 00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0		50.00
51.00		SUPPORT SURFACES	0		51.00
52. 00 52. 01	1	COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST	0		52. 00 52. 01
52. 02	1	MEDICAL SERVICES	o		52. 02
		TIENT SERVICE COST CENTERS			
60. 00 61. 00	1	CLINIC RURAL HEALTH CLINIC	0		60.00
62. 00	06200				62. 00
63.00	06300	DI ALYSI S	0		63. 00
70.00		REI MBURSABLE COST CENTERS			70.00
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0		70.00
	07300		O		73. 00
74. 00		OTHER REIMBURSEMENT	0		74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00	1	INTEREST EXPENSE			81. 00
82. 00		UTILIZATION REVIEW - SNF			82. 00
83.00		HOSPI CE	0		83. 00
84. 00 84. 01	1	OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II	0		84. 00 84. 01
89. 00	00401	SUBTOTALS (sum of lines 1-84)	34, 033		89. 00
		MBURSABLE COST CENTERS			
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0		90.00
91.00		PHYSICIANS PRIVATE OFFICES			91.00
93.00	09300	NONPALD WORKERS	0		93. 00
94.00		PATIENTS LAUNDRY	0		94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0		95. 00 98. 00
99. 00		Negative Cost Centers			99. 00
102.00		Cost to be allocated (per Wkst. B,	221, 100		102. 00
102.00		Part I)	6 104424		102 00
103. 00 104. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	6. 496636 763		103. 00 104. 00
		Part II)			
105.00		Unit cost multiplier (Wkst. B, Part	0. 022419		105. 00
	1	11)	ı l		I

Health Financial Systems	CARE ONE AT MOORESTOWN	In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES F	OR ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315482 Period:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:42 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 col . 18 3. 00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 68, 539 143, 847 0. 476472 40.00 04100 LABORATORY 130, 174 261, 635 0.497540 41.00 41.00 0. 438356 42.00 04200 I NTRAVENOUS THERAPY 109, 060 248, 793 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 121, 646 2, 640, 601 0. 424769 44.00 04500 OCCUPATIONAL THERAPY 45.00 984, 396 2, 463, 532 0. 399587 45.00 04600 SPEECH PATHOLOGY 1, 247, 778 0. 337274 46.00 420, 843 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 162 339 0.477876 48.00 04900 DRUGS CHARGED TO PATIENTS 0. 438354 49.00 49.00 555, 794 1, 267, 910 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 50.00 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0 0.000000 0 52.01 05202 MEDICAL SERVICES 0 0.000000 52.02 52.02 OUTPATIENT SERVICE COST CENTERS 0 0. 000000 60.00 06000 CLI NI C 0 60.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62. 00 06200 FQHC 62.00 63. 00 06300 DI ALYSI S 0.000000 63.00 71. 00 07100 AMBULANCE 41,025 86, 102 0. 476470 71.00

3, 431, 639

8, 360, 537

100.00

100.00

Total

Health Financial Systems	CARE ONE AT				eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	epared: 42 am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pi	rogram Charge	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col 1	Part B (col. 1	
	to Charges (Fr. Wkst. C			x col. 2)	x col. 3)	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						_
40. 00 04000 RADI OLOGY	0. 476472			0 17, 028		
41. 00 04100 LABORATORY	0. 497540			0 34, 009		
42. 00 04200 I NTRAVENOUS THERAPY	0. 438356			0 11, 789		
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	l e		0 0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 424769			0 718, 770		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 399587	1, 581, 516		0 631, 953		
46. 00 04600 SPEECH PATHOLOGY	0. 337274	782, 955		0 264, 070		
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 477876			0 01 003	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 438354			0 81, 083	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	l .		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	l .		0	0	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT 52. 01 05201 OTHER ANCILLARY SERVICES COST	0. 000000 0. 000000			0 0	0	
52. 01 05201 0THER ANCILLARY SERVICES COST 52. 02 05202 MEDICAL SERVICES	0. 000000			0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000			0 0		32.02
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.000000	0				61.00
62. 00 06200 FQHC						62. 00
63. 00 06300 DI ALYSI S	0. 000000	0		0	0	
71. 00 07100 AMBULANCE (2)	0. 476470			ō	0	
100.00 Total (Sum of lines 40 - 71)	0. 170170	4, 372, 571		0 1, 758, 702		100.00
(1) For title V and XIX use columns 1, 2, and 4 or	. '	., .,	1	., .,	'	1 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	MOORESTOWN		In Lie	eu of Form CMS-2	2540-10
	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315482	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/10/2024 11:	pared:
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	0. 438354	1.00
2.00	Program vaccine charges (From your reco	ords, or the PS	&R)	•	,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,		Nursing &	Cost (From	& Allied	
		· ·	(From Wkst. B,			Heal th Costs	
		18		Costs to Tota Costs - Part		for Pass Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		3 X COI . 4)	
		1, 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	68, 539	0			0	40. 00
41.00	04100 LABORATORY	130, 174	0	0.00000			
42.00	04200 I NTRAVENOUS THERAPY	109, 060	0	0. 00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	ľ	0. 00000		0	
44. 00	04400 PHYSI CAL THERAPY	1, 121, 646		0.00000			44. 00
45. 00	04500 OCCUPATIONAL THERAPY	984, 396		0. 00000			45. 00
46. 00	04600 SPEECH PATHOLOGY	420, 843		0. 00000		l e	
	04700 ELECTROCARDI OLOGY	0	-	0.00000		0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	162		0.00000		0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	555, 794	0	0.00000		l e	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0		0. 00000 0. 00000		0	50. 00 51. 00
	05200 COMPLEX MEDICAL EQUIPMENT			0.00000		0	
52. 00	05201 OTHER ANCILLARY SERVICES COST			0.00000		0	1
52. 01	05201 OTHER ANCITELARY SERVICES COST			0.00000		0	
100.00		3, 390, 614	Ö		1, 758, 702		100.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		١	1	1 .,,	,	, , , , , ,

lealth Financial Systems	CARE ONE	AT MOORESTOWN	In Lie	u of Form CMS-2	2540-1
COMPUTATION OF INPATIENT ROUTINE	COSTS	Provi der No.: 315482	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
PART I CALCULATION OF INPA	TIENT ROUTINE COSTS			1.00	
I NPATI ENT DAYS					
.00 Inpatient days including p	orivate room days			18, 770	
2.00 Private room days				0	2. 0
	orivate room days applicable to			12, 993	3. 0
	te room days applicable to the	Program		0	4.0
7.00 Total general inpatient ro PRIVATE ROOM DIFFERENTIAL				7, 698, 087	5.0
o.00 General inpatient routine				17, 134, 811	6.0
•	service charges service cost/charge ratio (Li	ne 5 divided by Line 6)		0. 449266	7. C
.00 Enter private room charges	· ·			0	8.0
.00 Average private room per o	Average private room per diem charge (Private room charges line 8 divided by private room days, line			0. 00	9. (
1 /	2) 00 Enter semi-private room charges from your records			0	10. (
	per diem charge (Semi-private	e room charges line 10, divide	d by	0. 00	
	room charge differential (Line	9 minus line 11)		0.00	12. (
, , , ,	room cost differential (Line 7	,		0.00	
4.00 Private room cost differer	ntial adjustment (Line 2 times	line 13)		0	14. (
5.00 General inpatient routine PROGRAM INPATIENT ROUTINE	service cost net of private re	oom cost differential (Line 5	minus line 14)	7, 698, 087	15. (
	t service cost per diem (Line	15 divided by line 1)		410. 13	16. (
	ost (Line 3 times line 16)			5, 328, 819	
	te room cost applicable to pro	gram (line 4 times line 13)		0	18. (
9.00 Total program general inpa	atient routine service cost (I	Line 17 plus line 18)		5, 328, 819	19. (
·	cated to inpatient routine serv for NF, or line 32 for ICF/IID	•	t II column 18,	404, 965	20. (
•	costs (Line 20 divided by line	e 1)		21. 58	
9 1	ost (Line 3 times line 21)			280, 389	
, ·	cost (Line 19 minus line 22)			5, 048, 430	
	ficiaries for excess costs (Fi			0	24.
1 . 3	vice costs for comparison to the	ne cost limitation (Line 23 mi	nus line 24)	5, 048, 430	25.
0.00 Enter the per diem limitat	• •	the new diam limitation line	2() (1)		26.
3.00 Reimbursable inpatient rou	cost limitation (Line 3 times utine service costs (Line 22 pl	us the lesser of line 25 or	, , ,		27. 28.
1.		,	i tlo VIV		l
(Transfer to Worksheet E, 1) Lines 26 and 27 are not appli	Part II, line 4) (See instructions for title XVIII, but many	,	itle XIX		
				1. 00	
					_

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	18, 770	1. 00
2.00	Program inpatient days (see instructions)	12, 993	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. 692222	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems CARE ONE AT M	OORESTOWN	In Lie	u of Form CMS-2	2540-10
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315482	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	pared:
		Title XIX	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				İ
1.00	Inpatient days including private room days			18, 770	1.00
2. 00	Private room days			0	2. 00
3.00	Inpatient days including private room days applicable to the			0	3.00
4. 00	Medically necessary private room days applicable to the Prog	yram		0	4. 00
5.00	Total general inpatient routine service cost			7, 698, 087	5. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			17 124 011	/ 00
6. 00 7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5	divided by Line 6)		17, 134, 811 0. 449266	6. 00 7. 00
7. 00 8. 00	Enter private room charges from your records	divided by Title 0)		0. 447200	8.00
9. 00	Average private room per diem charge (Private room charges I	ine 8 divided by private	room days line	0.00	
,, 00	2)	c a. v. aca zy p vate	. com dayo,c	0.00	/. 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 roo	om 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 mi			0.00	
13.00	Average per diem private room cost differential (Line 7 times			0.00	•
14. 00 15. 00	Private room cost differential adjustment (Line 2 times line General inpatient routine service cost net of private room of		minus Lino 14)	0 7, 698, 087	14. 00 15. 00
15.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Eine 5	III IIus TTHE 14)	7, 070, 007	13.00
16. 00	Adjusted general inpatient service cost per diem (Line 15 c	livided by line 1)		410. 13	16. 00
17. 00	Program routine service cost (Line 3 times line 16)	,		0	17. 00
18. 00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18.00
19. 00	Total program general inpatient routine service cost (Line			0	19. 00
20. 00	Capital related cost allocated to inpatient routine service	costs (From Wkst. B, Par	t II column 18,	404, 965	20. 00
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			04 50	
21. 00	Per diem capital related costs (Line 20 divided by line 1)			21. 58	•
22. 00	Program capital related cost (Line 3 times line 21)			0	22. 00 23. 00
23. 00 24. 00	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From p	arovi don roconde)		0	24.00
24. 00 25. 00	Total program routine service costs for comparison to the co		nus line 24)	0	
26. 00	Enter the per diem limitation (1)	St Tim tation (Line 23 IIII	1100 24)	0.00	
27. 00	Inpatient routine service cost limitation (Line 3 times the	per diem limitation line	26) (1)	0.00	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instructions	the lesser of line 25 or		0	
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be	•	itle XIX		'

	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	18, 770	1.00
2.00	Program inpatient days (see instructions)	0	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)	0.000000	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 MOOR	ESTOWN	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FO	OR TITLE XVIII	Provider No.: 315482	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:42 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)			9, 682, 040	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,		9, 682, 040	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			1, 416, 584	5. 00
6.00	Allowable bad debts (From your records)			89, 519	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			58, 187	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)			8, 323, 643	11. 00
12.00	Interim payments (See instructions)			8, 188, 816	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			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 164	14. 75
14. 99	Sequestration amount (see instructions)			165, 309	14. 99
15. 00	Balance due provider/program (see Instructions)			-31, 646	15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)	-+!>		0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02 25. 00	Adjusted reimbursable bad debts (see instructions) Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	24. 02 25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentati ve adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			0	29. 00
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	0	
55. 50	1. States amounts (nonarrowable cost report riting) in accordance	5 til 5.10 l ub. 15 2,		O ₁	55. 66

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11: 42 am PPS Title XVIII

			9 ,	Facility		
		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		8, 100, 147		0	1. 00
2.00	Interim payments payable on individual bills, either		101, 469		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	
3. 04			0		0	
3. 05			0		0	
3.03	Provider to Program					3.03
3.50	ADJUSTMENTS TO PROGRAM	06/01/2023	12, 800		0	3.50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-12, 800		0	3. 99
	- 3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 188, 816		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TERMINE TO THOUSEN		ő		Ö	ı
5. 03			0		0	
	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					6. 00
5. 55	the cost report. (1)					0.00
6. 01	PROGRAM TO PROVIDER		o		0	6. 01
6. 02	PROVI DER TO PROGRAM		31, 646		0	
7.00	Total Medicare program liability (see instructions)		8, 157, 170		0	•
			Contract	tor Name	Contractor	
			1.	00	Number 2.00	
8. 00	Name of Contractor		1.		2.00	8. 00
5. 55	1 1. 11 10.00.		l .		1	1 0.00

^{8.00 |}Name of Contractor | | (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.

ealth Financial Systems CARE ONE AT MOORESTOWN In Lieu of Form CMS-2540-10

Health Financial Systems

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

Provi der No.: 315482 | Peri od: From 01/01/2023 To 12/31/2023

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11: 42 am

ıı y <i>)</i>					5/10/2024 11:	42 8
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					+
	Cash on hand and in banks	390, 952	. 0	0	0	1
1	Temporary investments	0	0	0		
00	Notes recei vabl e	0	0	0	0	
	Accounts receivable	1, 785, 637	0	0	0	
	Other recei vabl es	0	0	0	0	
	Less: allowances for uncollectible notes and accounts	-136, 613	0	0	0) (
	recei vabl e Inventory		0	0	0	, .
- 1	Prepaid expenses	42, 892	_		0	
	Other current assets	219, 756	l .	Ö	0	
- 1	Due from other funds	0	o	0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 302, 624	0	0	0	1
	FIXED ASSETS	_				
	Land	0	0	_		
1	Land improvements	0	1			
	Less: Accumulated depreciation	0	0	_		
	Buildings Less Accumulated depreciation	0	0		0	
	Leasehold improvements	0			0	
	Less: Accumulated Amortization	0		0	0	1 '
	Fi xed equi pment	0	l č	Ö	0	
	Less: Accumulated depreciation	0	Ö	0	0	
1	Automobiles and trucks	0	d c	0	0) 2
00	Less: Accumulated depreciation	0	0	0	0) 2
00	Major movable equipment	0	0	0	0) 2
00	Less: Accumulated depreciation	0	0	0	0	
	Minor equipment - Depreciable	0	0	0	0	
	Mi nor equi pment nondepreci abl e	0	0	0	0	
1	Other fixed assets	0	0			
	TOTAL FIXED ASSETS (Sum of lines 12 - 27)] 0	0	0	0	2
	OTHER ASSETS Investments	1 0	0	0	0	2
	Deposits on Leases	0		_		
- 1	Due from owners/officers	0			l ő	
	Other assets	2, 583	_	_	Ö	
	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	2, 583		0	0) 3
00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	2, 305, 207	0	0	0	3
	Liabilities and Fund Balances					
	CURRENT LI ABI LI TI ES	T	1	1	T	١.
	Accounts payable	1, 280, 577	l .			
	Salaries, wages, and fees payable	151, 195	I			1 .
	Payroll taxes payable Notes & Loans payable (Short term)	-9, 391	0	0	0	
	Deferred income	0			0	
	Accel erated payments	0	Ĭ			4
	Due to other funds	206, 756	0	0	0	
	Other current liabilities	1, 464, 664	1	0		1
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3, 093, 801	l .	0		
	LONG TERM LIABILITIES					
00	Mortgage payable	0	0	0		
	Notes payable	0	0			
	Unsecured Loans	0	0	0	0	
- 1	Loans from owners:	0	0	0	0	
	Other long term liabilities	-24, 818, 263] 0	0	0	
	OTHER (SPECIFY)	24 010 242	0		0	
	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	-24, 818, 263 -21, 724, 462				
H	CAPITAL ACCOUNTS	21, 724, 402				1 '
	General fund balance	24, 029, 669				5
	Specific purpose fund		l o)		5
	Donor created - endowment fund balance - restricted			0		5
	Donor created - endowment fund balance - unrestricted			0		5
1	Governing body created - endowment fund balance			0		5
00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	5
		1	1			
	replacement, and expansion				i e	
. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	24, 029, 669 2, 305, 207	1	0	0	

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

Provi der No.: 315482

					To 12/31/2023	Date/Time Prep 5/10/2024 11:4	
		General Fund		Special F	Purpose Fund	Endowment Fund	+2 alii
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		23, 484, 465		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		545, 204				2.00
3.00	Total (sum of line 1 and line 2)		24, 029, 669		0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 5 - 9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)		24, 029, 669		0		11. 00
12.00	Deductions (debit adjustments)						12.00
13.00		0			0	0	13.00
14. 00		0			0	0	14.00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16.00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		24, 029, 669		0		19. 00
	sheet (Line 11 - line 18)	Endowment Fund	 PI ant	Eund			
		LIIdowillett Turid	Frant	Tuliu	_		
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3.00	Total (sum of line 1 and line 2)	o			0		3.00
4.00	Additions (credit adjustments)						4.00
5.00	, ,		o				5.00
6.00			o				6.00
7.00			o				7.00
8.00			o				8.00
9.00			o				9.00
10.00	Total additions (sum of line 5 - 9)	o			0		10.00
11. 00	Subtotal (line 3 plus line 10)	o			0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00			O				13.00
14.00			O				14.00
15.00			O				15.00
16.00			o				16.00
17. 00		1	o				17.00
18. 00	Total deductions (sum of lines 13 - 17)	0	7		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 MOORE				u of Form CMS-2	
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENS	ES	Provi der		Peri od: From 01/01/2023	Worksheet G-2 Parts I-II	
						Date/Time Pre	pared:
						5/10/2024 11:	
	Cost Center Description			I npati ent	Outpati ent	Total	
				1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY			17, 134, 81	1	17, 134, 811	
2.00	NURSING FACILITY				0	0	2. 00
3.00	ICF/IID				0	0	3. 00
4.00	OTHER LONG TERM CARE				0	0	4. 00
5.00	Total general inpatient care services (Sum	of lines 1 - 4)		17, 134, 81	1	17, 134, 811	5. 00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES			8, 360, 53	0 0	8, 360, 537	6. 00
7.00	CLINIC				0	0	7. 00
8.00	HOME HEALTH AGENCY COST				0	0	8. 00
9.00	AMBULANCE				0	0	9. 00
10.00	RURAL HEALTH CLINIC				0	0	10. 00
10. 10	FQHC				0	0	10. 10
11. 00	CMHC				0	0	11. 00
12. 00	HOSPI CE				0	0	12. 00
13. 00	OTHER (SPECIFY)				0	0	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13)) (Transfer column 3	to	25, 495, 34	8 0	25, 495, 348	14. 00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES						
1.00	Operating Expenses (Per Worksheet A, Col. 3,	, Line 100)			_	16, 976, 061	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
0 00	Total Additions (Sum of Lines 2 7)					Λ .	

8.00 9. 00 10. 00 11. 00

12.00

13. 00 14. 00 0 16, 976, 061 15. 00

8. 00 9. 00 10. 00

11.00 12.00 Total Additions (Sum of lines 2 - 7)

13.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

Deduct (Specify)

		AT MOORESTOWN	_	u of Form CMS-2	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315482	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3			25, 495, 348	
2.00	Less: contractual allowances and discounts on patients	accounts		8, 078, 707	
3.00	Net patient revenues (Line 1 minus line 2)			17, 416, 641	
4.00	Less: total operating expenses (From Worksheet G-2, Par	t II, line 15)		16, 976, 061	
5.00	Net income from service to patients (Line 3 minus 4)			440, 580	5.00
	Other income:				, ,,
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			1, 403	
8.00	Revenues from communications (Telephone and Internet so	ervi ce)		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0 0	1
11.00	Rebates and refunds of expenses			_	
12.00	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to o	ther than patients		0	
	Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts			0	
				0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flower, coffee shops, canteen			0	
	Rental of vending machines			0	
22. 00	Rental of skilled nursing space			0	00
23. 00	Governmental appropriations			0	23.00
24. 00	BARBER AND BEAUTY			22, 425	
24. 01	RESIDENT PERSONAL ITEMS			3, 036	
	MAINT FEE INCOME			54, 390	
	OTHER REV			20, 956	
24. 04	OTHER I NCOME			2, 414	
	COVID-19 PHE Funding			104 (24	
	Total other income (Sum of lines 6 - 24)			104, 624	
26. 00	Total (Line 5 plus line 25)			545, 204	1
27. 00 28. 00	Other expenses (specify)			0	
∠ŏ. UU				0	₁ ∠δ. ∪0

28. 00 29. 00 0 0

0 30.00 545, 204 31. 00

28. 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)