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

OMB NO. 0938-0463

Expires: 12/31/2021

			EXPIT 65. 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315468	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:43 am

				5/10	1/2024 II:43 alli
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/10/2024	Time: 11:43 an
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent	ter the numbe	r of times the provide	r resubmitted this cos	t report
	3.01 [] No Medicare Utilization. Enter '	'Y" for yes o	r leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[N] Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:	·		
	(4) Reopened	10.[0]If I	ine 4, column 1 is "4"	 : Enter number of time	es reopened
	(5) Amended	11.Contracto	r Vendor Code	4	·
	5. Date Received:	12.[F] Medi	care Utilization. Ente	er "F" for full, "L" fo	or 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 PARSIPPANY (315468) 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			SI GNATURE STATEMENT	
1	Dav	rid Baruch	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Davi d Baruch			2
3	Signatory Title	AUTHORIZED SIGNOR			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	32, 029	119	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	32, 029	119	0	100.00

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

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

Health Financial Systems CARE ONE AT PARSIPPANY In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315468 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:43 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 100 MAZDABROOK PO Box: 1.00 2.00 City: PARSIPPANY - TROY State: NJ Zi p Code: 07054 2.00 3.00 County: MORRIS CBSA Code: 35084 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT PARSIPPANY 315468 08/15/2001 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 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 Υ 38.00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 54 049

Heal th	Financial Systems	CARE ONE AT PARS	In Lie	2540-10		
SKI LLE	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315468 Period:					
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023		
				To 12/31/2023		
					5/10/2024 11:	43 am
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative a	nd General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	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?		Y	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	e lines	
	bel ow.					
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contra	ctor's Number: 1200	01	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46, 00
47.00	City: FORT LEE	State: NJ	Zi p Co	de: 0702	24	47. 00
46. 00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00

Health Financial Systems CARE ONE AT PARSIPPANY In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315468 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:43 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 PA			PARSI PPANY		In Lieu of Form CMS-2540		
	D NURSING FACILITY AND SKILLED NURSING FACILITY	HEALTH CARE	Provi d	er No.: 315468	Peri od: From 01/01/2023	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				To 12/31/2023	Date/Time Pre	pared:
						5/10/2024 11:	43 am
				1.00	2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/p	position	CHARLES		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	EXECUCARE AS	SSOCI ATES			20. 00
	preparer.						
21.00	Enter the telephone number and email address of	f the cost	(609) 738-320	00	CRWASSC@NETSCAF	PE. NET	21. 00
	report preparer in columns 1 and 2, respectivel	۱y.					

 Heal th Financial
 Systems
 CARE ONE AT I

 SKILLED NURSING
 FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 CARE ONE AT PARSIPPANY Provi der No.: 315468

| In Lieu of Form CMS-2540-10 | Period: Worksheet S-2 | From 01/01/2023 Part II | To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 43 am COMPLEX REIMBURSEMENT QUESTIONNAIRE

				5/10/2024 11:	43 am
		Part B			
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	03/19/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14. 00
	for total and the provider's records for				
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and 4.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
13.00	made to PS&R data for additional claims that				15.00
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16.00	If line 13 or 14 is "Y", then were				16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00					17. 00
	adjustments made to PS&R data for Other?				
	Describe the other adjustments:				
18. 00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			2.00		
	Cost Report Preparer Contact Information		3.00		
19. 00	Enter the first name, last name and the title	/noci ti on	VI CE-PRESI DENT		19. 00
19.00	held by the cost report preparer in columns		VI CE-FRESI DENI		19.00
	respectively.	i, 2, and 3,			
20. 00	Enter the employer/company name of the cost i	report			20.00
	preparer.	-1			
21.00	Enter the telephone number and email address	of the cost			21. 00
	report preparer in columns 1 and 2, respective				
	•	-	•	•	

Health Financial Systems CARE ONE AT PARSIPPANY In Lieu of Form CMS-2540-10

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

Provider No.: 315468 | Period: | Worksheet S-3 | From 01/01/2023 | Part I | Date/Time Prepared:

5/10/2024 11:43 am Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 118 43, 070 С 7, 966 12, 760 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 7.00 0 0 8.00 Total (Sum of lines 1-7) 118 43,070 7,966 12, 760 8.00 Inpatient Days/Visits Di scharges Title XIX Title XVIII Component Other Total Title V 6.00 7.00 8.00 9.00 10.00 26, 566 1.00 SKILLED NURSING FACILITY 5, 840 0 275 86 1. 00 0 2.00 NURSING FACILITY 0 C 0 2.00 0 ICE/LID 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 0 4.00 5.00 Other Long Term Care 0 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 7.00 8.00 Total (Sum of lines 1-7) 5,840 26, 566 275 86 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 148. 37 1.00 186 547 28.97 NURSING FACILITY 2.00 0.00 0.00 2.00 0 C 3.00 ICF/IID 0 C 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 7.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 186 547 0.00 28. 97 148.37 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16, 00 17.00 18.00 19.00 20.00 1.00 SKILLED NURSING FACILITY 48. 57 321 50 197 1. 00 NURSING FACILITY 0.00 2.00 2.00 0 0 LCF/LLD 0.00 0 3.00 0 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 0.00 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 00 C 0 7 00 Total (Sum of lines 1-7) 48.57 321 50 197 8.00 8.00 Admi ssi ons Full Time Equivalent Total Component Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 568 0.00 87.72 1.00 0.00 2.00 NURSING FACILITY 0.00 2.00 0 3.00 ICF/IID 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0 0.00 0.00 5.00 6.00 SNF-Based CMHC 0.00 0.00 6.00 7.00 HOSPI CE 0.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 568 87.72 0.00 8.00

2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2 3.00 Physician salaries-Part B 0 0 0 0 0.00 0.00 3 4.00 Home office personnel 0 0 0 0 0.00 0.00 4 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 5	ed:
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	4111
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	
PART II - DIRECT SALARIES SALARIES	
SALARIES 1.00 Total salaries (See Instructions) 5,941,103 0 5,941,103 182,461.00 32.56 1 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 3 4.00 Home office personnel 0 0 0 0.00 0.00 0 0.00 0 <td< td=""><td></td></td<>	
1.00 Total salaries (See Instructions) 5,941,103 0 5,941,103 182,461.00 32.56 1 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2 3.00 Physician salaries-Part B 0 0 0 0 0.00 0.00 3 4.00 Home office personnel 0 0 0 0 0.00 0.00 4 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 5	
2.00 Physician salaries-Part A 0 0 0.00 0.00 2 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 3 4.00 Home office personnel 0 0 0 0 0.00 0 0 5.00 Sum of lines 2 through 4 0 0 0 0 0.00 0 0	
3.00 Physician salaries-Part B 0 0 0 0.00 0.00 3 4.00 Home office personnel 0 0 0 0 0.00 4 5.00 Sum of lines 2 through 4 0 0 0 0 0.00 0 0	. 00
4.00 Home office personnel 0 0 0.00 0.00 4 5.00 Sum of lines 2 through 4 0 0 0 0 0.00 5	. 00
5.00 Sum of lines 2 through 4 0 0 0 0 0.00 5	. 00
	. 00
	. 00
	. 00
	. 00
8.00 HOME HEALTH AGENCY COST 0 0 0.00 0.00 8	. 00
	. 00
10. 00 H0SPI CE 0 0 0 0 0 0. 00 0. 00 10	. 00
	. 00
	. 00
through 11)	
13.00 Total Adjusted Salaries (line 6 minus line 5,941,103 0 5,941,103 182,461.00 32.56 13	. 00
12)	
OTHER WAGES & RELATED COSTS	
	. 00
	. 00
	. 00
WAGE-RELATED COSTS	
	. 00
	. 00
	. 00
	. 00
	. 00
	. 00
instructions)	

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT PARSIPPANY

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315468

				1	0 12/31/2023	5/10/2024 11:4	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	489, 298	0	489, 298	11, 581. 00	42. 25	2.00
3.00	Plant Operation, Maintenance & Repairs	110, 107	0	110, 107	4, 136. 00	26. 62	3.00
4.00	Laundry & Li nen Servi ce	69, 297	0	69, 297	4, 130. 00	16. 78	4.00
5.00	Housekeepi ng	279, 109	0	279, 109	14, 339. 00	19. 47	5.00
6.00	Di etary	407, 720	0	407, 720	18, 860. 00	21. 62	6.00
7.00	Nursing Administration	595, 694	0	595, 694	12, 966. 00	45. 94	7.00
8.00	Central Services and Supply	10, 100	0	10, 100	624.00	16. 19	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	47, 523	0	47, 523	2, 129. 00	22. 32	10.00
11.00	Soci al Servi ce	17, 465	0	17, 465	530.00	32. 95	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	128, 194	0	128, 194	6, 046. 00	21. 20	13.00
14.00	Total (sum lines 1 thru 13)	2, 154, 507	0	2, 154, 507	75, 341. 00	28. 60	14.00

Health Financial Systems	CARE ONE AT PARSIPPANY	In Lieu	of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315468	Period: V From 01/01/2023 F	Worksheet S-3 Part IV
		To 12/31/2023 [Date/Time Prepared:

	To 12/31/2023		
		Amount	45 4111
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS	1.00	
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	27, 855	1. 00
2. 00	Tax Shel tered Annui ty (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	l o	3. 00
4. 00	Prior Year Pension Service Cost	0	4. 00
1.00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1.00
5.00	401K/TSA Plan Administration fees	0	5. 00
6. 00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
7.00	HEALTH AND INSURANCE COST		7.00
8. 00	Heal th Insurance (Purchased or Self Funded)	281, 977	8. 00
9. 00	Prescription Drug Plan	201, 777	9. 00
10. 00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 328	11. 00
12. 00		1, 320	12.00
13. 00	, , , ,	0	13. 00
14. 00		0	14.00
15. 00	Workers' Compensation Insurance	51, 716	15.00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	31, 710	16.00
16.00	Non cumulative portion)	0	16.00
	TAXES		
17 00	FICA-Employers Portion Only	423, 100	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	0	19.00
	State or Federal Unemployment Taxes	74, 062	20. 00
20.00	OTHER	74,002	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 - 23)	860, 038	
24.00	Total mage herated cost (sum of fines i - 23)	Amount	24.00
		Reported	
		1. 00	
	Part B - Other than Core Related Cost	1.00	
25. 00	OTHER WAGE RELATED COST	0	25. 00
20.00	Tarrier more meetings and the control of the contro	1	

				Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:4	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	10 4
	3. 3	Reported		Salaries (col.		Wage (col. 3 ÷	
		'		1 + col. 2)	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)	374, 516	61, 643		i i		1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 166, 790	192, 047		· ·		2.00
3.00	Certified Nursing Assistant/Nursing	999, 887	164, 576	1, 164, 463	44, 161. 00	26. 37	3.00
	Assi stants/Ai des	0.544.400		0 050 450	70 /0/ 00	07.44	
4.00	Total Nursing (sum of lines 1 through 3)	2, 541, 193	418, 266		i i		4. 00
5.00	Physical Therapists	463, 284	76, 254	539, 538			5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		6. 00
7.00	Physical Therapy Aides	440.440	7/ 0/0	500 000	0.00	0.00	7. 00
8.00	Occupational Therapists	462, 160	76, 069	538, 229			8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	172 027	20.217	200 252	0.00	0.00	10.00
11. 00 12. 00	Speech Therapists Respiratory Therapists	172, 037	28, 316	200, 353	3, 607. 00 0. 00	55. 55 0. 00	11. 00 12. 00
12.00	Other Medical Staff	0	0	1	0.00		
13.00	Contract Labor	U U		<u> </u>	0.00	0.00	13.00
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	0		0	0.00	0.00	14. 00
15. 00	Licensed Practical Nurses (LPNs)	29, 127		29, 127	388.00		15. 00
16. 00	Certified Nursing Assistant/Nursing	126		126		42.00	
	Assi stants/Ai des	. = 3					
17.00	Total Nursing (sum of lines 14 through 16)	29, 253		29, 253	391.00	74. 82	17.00
18.00	Physical Therapists	o		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	o		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	o		0	0.00	0.00	20.00
21.00	Occupational Therapists	4, 449		4, 449	68. 00	65. 43	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23. 00	Occupational Therapy Aides	0		0	0.00		
24. 00	Speech Therapists	1, 750		1, 750			24.00
25. 00	Respi ratory Therapi sts	11, 596		11, 596			
26. 00	Other Medical Staff	0		0	0.00	0.00	26.00

	To 12/31/2023	Date/Time Prepared: 5/10/2024 11:43 am
	Group	Days
1.00	 1.00	2.00
1. 00 2. 00	RUX RUL	1. 00 2. 00
3.00	RVX	3. 00
4.00	RVL	4. 00
5. 00	RHX	5. 00
6. 00 7. 00	RHL RMX	6. 00 7. 00
8. 00	RML	8.00
9. 00	RLX	9. 00
10. 00	RUC	10.00
11. 00	RUB	11.00
12. 00 13. 00	RUA RVC	12. 00 13. 00
14. 00	RVB	14. 00
15. 00	RVA	15. 00
16. 00	RHC	16.00
17. 00 18. 00	RHB RHA	17. 00 18. 00
19. 00	RMC	19. 00
20. 00	RMB	20. 00
21. 00	RMA	21. 00
22. 00 23. 00	RLB RLA	22. 00 23. 00
24. 00	ES3	24. 00
25. 00	ES2	25. 00
26. 00	ES1	26. 00
27. 00 28. 00	HE2 HE1	27. 00 28. 00
29. 00	HD2	29. 00
30. 00	HD1	30.00
31. 00	HC2	31.00
32. 00 33. 00	HC1 HB2	32. 00 33. 00
34.00	HB1	34.00
35. 00	LE2	35. 00
36. 00	LE1	36.00
37. 00	LD2	37.00
38. 00 39. 00	LD1 LC2	38. 00 39. 00
40. 00	LC1	40. 00
41. 00	LB2	41.00
42. 00 43. 00	LB1 CE2	42. 00 43. 00
44. 00	CE1	44. 00
45. 00	CD2	45. 00
46. 00	CD1	46.00
47. 00 48. 00	CC2 CC1	47. 00 48. 00
49. 00	CB2	49. 00
50. 00	CB1	50.00
51. 00	CA2	51.00
52. 00 53. 00	CA1 SE3	52. 00 53. 00
54. 00	SE2	54. 00
55. 00	SE1	55. 00
56. 00	SSC	56. 00 57. 00
57. 00 58. 00	SSB SSA	58.00
59. 00	I B2	59. 00
60. 00	I B1	60.00
61. 00	I A2	61.00
62. 00 63. 00	I A1 BB2	62. 00 63. 00
64. 00	BB1	64. 00
65. 00	BA2	65. 00
66. 00	BA1	66.00
67. 00 68. 00	PE2 PE1	67. 00 68. 00
69. 00	PD2	69. 00
70. 00	PD1	70.00
71. 00	PC2	71.00
72. 00 73. 00	PC1 PB2	72. 00 73. 00
74. 00	PB1	74. 00
75. 00	PA2	75. 00

Health Financial Systems	CARE ONE AT PARSI	PPANY		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315468	Peri od:	Worksheet S-	7
				From 01/01/2023 To 12/31/2023	Date/Time Pr	enared.
				10 127 017 2020	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 V payments beginning 10/01/2003. Congress expe expenses. For lines 101 through 106: Enter i column 2 the percentage of total expenses fo line 1, column 3. Indicate in column 3 "Y" if with direct patient care and related expense (See instructions)	cted this increase to n column 1 the amour r each category to or yes or "N" for no	to be used not of the cotal SNF of the solutions.	for direct pexpense for erevenue from pending refle	aatient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101. 00 Staffi ng						101. 00 102. 00
102.00 Recruitment 103.00 Retention of employees						102.00
104. 00 Training						104. 00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne 1, column 3)					106.00
	•		•			•

	Financial Systems	CARE ONE AT PA	ARSI PPANY		In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	1 Reclassi fi cati	5/10/2024 11: Reclassi fi ed	43 am
	oost contor boson per on		0 (1.10)	+ col . 2)	ons	Trial Balance	
					Increase/Decre	,	
					ase (Fr Wkst A-6)	col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		4 (77 404	4 (77 40	4	4 (77 404	1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 677, 184 186, 937				1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	0	977, 872			977, 872	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	489, 298	2, 008, 096			2, 497, 394	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	110, 107	519, 894			630, 001	5. 00 6. 00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	69, 297 279, 109	54, 176 37, 998			123, 473 317, 107	7.00
8. 00	00800 DI ETARY	407, 720	266, 751			674, 471	ł
9. 00	00900 NURSING ADMINISTRATION	595, 694	77, 482			673, 176	1
10.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	10, 100	145, 990			140, 616	
11. 00 12. 00	01200 MEDI CAL RECORDS & LI BRARY	47, 523	33, 520 0	1		33, 520 47, 523	
13. 00	01300 SOCIAL SERVICE	17, 465	54			17, 519	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	14. 00
15. 00	01500 ACTI VI TES	128, 194	10, 637	138, 83	1 0	138, 831	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	2, 541, 193	110, 739	2, 651, 93	2 0	2, 651, 932	30.00
31. 00	03100 NURSING FACILITY	2, 341, 173	0 110,737	2,031,73	0 0	0	31.00
	03200 CF/IID	0	0		0 0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. 00
40. 00	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY	0	19, 541	19, 54	1 0	19, 541	40. 00
41. 00	04100 LABORATORY	O	56, 092			56, 092	1
42.00	04200 I NTRAVENOUS THERAPY	O	173, 003	1			1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	,,,,	0	0	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	611, 206 462, 160	18, 157 4, 449	1		629, 363 466, 609	1
46. 00	04600 SPEECH PATHOLOGY	172, 037	1, 750	1		173, 787	ł
47. 00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.40 0.4	0 15, 474	15, 474	1
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	348, 967	348, 96	7 0	348, 967 0	1
51. 00	05100 SUPPORT SURFACES	O	0		0 10, 710		51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0 0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0		0	0	
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 0	0	52. 02
60.00	06000 CLINIC	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	
	06200 FQHC						62.00
63.00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	0	1	0 0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	0	118, 070	118, 07	0 0	118, 070	1
73. 00	07300 CMHC	0	0		0	0	
74.00	O7400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	l	0 0	0	74. 00
80. 00			0		0 0	0	80.00
81. 00	08100 I NTEREST EXPENSE		0		0 0	0	
82. 00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST	0	0		0 0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	o o	0		0 0	0	ı
89. 00	SUBTOTALS (sum of lines 1-84)	5, 941, 103	6, 847, 359	12, 788, 46	2 0	12, 788, 462	89. 00
00 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		2 1/2	2.14	2 0	2 1/2	00.00
90. 00 91. 00	1 1 1	0	3, 163 0	1	0 0	3, 163	90. 00 91. 00
	09200 PHYSI CI ANS PRI VATE OFFI CES		Ö		o o	0	ı
	09300 NONPAI D WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0		0	0	
95. 00 100. 00	l l	5, 941, 103	6, 850, 522	12, 791, 62	5 0	12, 791, 625	
	1 - 1	2, , . 30	2, 300, 322	,,,,,,,,	-1	, , , , , , , , , , , , , , , , , , ,	

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

 Heal th Financial
 Systems
 CARE ON

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315468

				To 12/31/2023 Date/Ti me	Prepared: 11:43 am
	Cost Center Description	Adjustments to	Net Expenses	3/10/2024	11.43 alli
	·		For Allocation	n	
		Wkst A-8)	(col. 5 +-		
		6. 00	col . 6) 7.00	-	
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-1, 069	1, 676, 115	5	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0		·	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	977, 872	•	3. 00
4.00	00400 ADMI NI STRATI VE & GENERAL	-251, 194 0		•	4.00
5. 00 6. 00	OO500 PLANT OPERATION, MAINT. & REPAIRS OO600 LAUNDRY & LINEN SERVICE	0	630, 001 123, 473		5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	0	317, 107	·	7. 00
8.00	00800 DI ETARY	o o	674, 471	l .	8. 00
9.00	00900 NURSING ADMINISTRATION	-2, 079	671, 097	7	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	140, 616	1	10. 00
11. 00	01100 PHARMACY	-2, 682		l .	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0			12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	17, 519 0	l .	13. 00 14. 00
15. 00	01500 ACTIVITES	0			15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		100,001	1	
30.00	03000 SKILLED NURSING FACILITY	-19, 818	2, 632, 114	1	30.00
31.00	03100 NURSING FACILITY	0	0		31.00
32. 00	03200 CF/ I D	0		1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0)	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	19, 541	Л	40.00
41. 00	04100 LABORATORY	0	56, 092		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	-13, 840		l .	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	l e e e e e e e e e e e e e e e e e e e	43.00
44.00	04400 PHYSI CAL THERAPY	0	629, 363	3	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	466, 609	•	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	173, 787	l .	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY	0	1	1	47. 00 48. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	-27, 918	15, 474 321, 049	•	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	-27, 910	321,047		50.00
	05100 SUPPORT SURFACES	Ö	10, 710		51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0			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
	06300 DI ALYSI S	0	0		63. 00
	OTHER REIMBURSABLE COST CENTERS				
70. 00	07000 HOME HEALTH AGENCY COST	0	-	1	70. 00
71. 00	07100 AMBULANCE	0	1		71.00
	07300 CMHC 07400 OTHER REIMBURSEMENT	0 0			73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS)	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	0		80. 00
	08100 NTEREST EXPENSE	0	Ō		81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		82. 00
	08300 H0SPI CE	0	0		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0		84. 00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	318 600	1	1	84. 01 89. 00
07.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	-318, 600	12, 469, 862		09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	3, 163	3	90.00
	09100 BARBER AND BEAUTY SHOP	0	0,133	I .	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
	09300 NONPALD WORKERS	0	0		93. 00
	09400 PATIENTS LAUNDRY	0	0		94. 00
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST	-318, 600	1	5	95. 00 100. 00
100.00	I I I I I I I I I I I I I I I I I I I	-310,000	12,4/3,025	'I	1100.00

Health Financial Systems	CARE ONE AT PARSI	PPANY		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 43 am
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
(1) A - RECLASS MED SUPP CHARGED						
1.00	MEDICAL SUPPLIES CH PATIENTS	IARGED TO	48. 0	00 0	15, 474	1. 00
(1) C - RECLASS SUPPORT SURFACES				<u> </u>		
2. 00	SUPPORT SURFACES		51. (0 0	10, 710	2.00
TOTALS						
100. 00	Total Reclassificat	ions (Sum		0	26, 184	100. 00
	of columns 4 and 5	must				
	equal sum of column 9)	ns 8 and				

⁽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 PARSI	PPANY		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315468	Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 43 am
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - RECLASS MED SUPP CHARGED						
1. 00	CENTRAL SERVICES &	SUPPLY	10. (00	15, 474	1. 00
(1) C - RECLASS SUPPORT SURFACES						
2.00	CAP REL COSTS - MOV EQUIPMENT	'ABLE	2. (00 0	10, 710	2. 00
TOTALS						
100. 00				0	26, 184	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 PARSIPPANY In Lieu of Form CMS-2540-10

				To	0 12/31/2023	Date/Time Prep 5/10/2024 11:4	
	·			Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2, 322, 092	0	0	0	0	1. 00
2.00	Land Improvements	42, 500	0	0	0	0	2.00
3.00	Buildings and Fixtures	9, 431, 278	7, 420	0	7, 420	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	344, 380	43, 636		43, 636		5. 00
6.00	Movable Equipment	2, 458, 393	33, 168	0	33, 168	0	6.00
7.00	Subtotal (sum of lines 1-6)	14, 598, 643	84, 224	0	84, 224	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	14, 598, 643	84, 224	0	84, 224	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1. 00	Land	2, 322, 092	0				1. 00
2.00	Land Improvements	42, 500	0				2. 00
3.00	Buildings and Fixtures	9, 438, 698	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	388, 016	0				5. 00
6. 00	Movable Equipment	2, 491, 561	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	14, 682, 867	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	14, 682, 867	0				9. 00

Provi der No.: 315468 Peri od: Worksheet A-8 Period: | WULKSHEEL A-0 | From 01/01/2023 | Date/Time Prepared: | 5/10/2024 | 11:43 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, 069	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		C)	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
5.00	(chapter 8) Tel ephone services (pay stations excluded)		C		0.00	5. 00
3.00	(chapter 21)				0.00	3.00
6.00	Television and radio service (chapter 21)		C		0.00	6. 00
7. 00	Parking lot (chapter 21)		Č		0.00	
8. 00	Remuneration applicable to provider-based	A-8-2	Č		0.00	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	60, 401			12. 00
	related organizations (chapter 10)					
13. 00	Laundry and linen service	В	C	LAUNDRY & LINEN SERVICE		13. 00
14. 00	Revenue - Employee meals	_	C	1	0.00	
15. 00	Cost of meals - Guests	В		DI ETARY	8. 00	
16. 00	Sale of medical supplies to other than		C)	0.00	16. 00
17 00	pati ents				0.00	17.00
17. 00	Sale of drugs to other than patients		C			17. 00
18. 00 19. 00	Sale of medical records and abstracts		C		0. 00 0. 00	
	Vending machines		C		1	
20. 00	Income from imposition of interest, finance or penalty charges (chapter 21)			,	0.00	20. 00
21. 00	Interest expense on Medicare overpayments		C		0.00	21. 00
21.00	and borrowings to repay Medicare			,	0.00	21.00
	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
				EQUI PMENT		
25. 00	MI SCELLANEOUS EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 01	RESIDENT REPLACEMENT ITEMS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	REFERAL FEES	A		ADMINISTRATIVE & GENERAL	4.00	
25. 03	MARKETING EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	MARKETING CORP EXPENSE	A		ADMINISTRATIVE & GENERAL		25. 04
25. 05	MARKETING - MEALS PUBLIC RELATIONS	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL		25. 05
25. 06 25. 07	SHOWS & CONFERENCES	A A		ADMINISTRATIVE & GENERAL	4. 00 4. 00	•
25. 07	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL	4.00	•
25. 08	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 10	BAD DEBT EXPENSE - MEDICARE	A		BADMINI STRATI VE & GENERAL	4.00	
25. 10	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	
25. 12	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	4. 00	
25. 13	OTHER I NCOME	В		ADMINISTRATIVE & GENERAL	4. 00	
	Total (sum of lines 1 through 99) (Transfer		-318, 600			100. 00
	to Worksheet A, col. 6, line 100)					

⁽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 PARSIPPANY

| Peri od: | Worksheet A-8-1 | From 01/01/2023 | Parts I-II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems CARE ONE AT PARTICLE STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315468 OFFICE COSTS

				Т	o 12/31/2023 Date/Time Pro 5/10/2024 11:	
		Li ne No.	Cost (Center	Expense Items	
		1. 00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1 00	CLAIMED HOME OFFICE COSTS:	4.00	ADMINI CEDATINE	O CENEDAL	MANACEMENT FEEC	1 00
1. 00 2. 00			ADMINISTRATIVE NURSING ADMINI		MANAGEMENT FEES PHARMACY CONSULTANT	1.00
3.00			CENTRAL SERVIC		WOUND CARE EXPENSE	3.00
4. 00			PHARMACY	LS & SUITE	DRUGS-NON-PRESCRI PTI ON,	4.00
4.00		11.00	I TIANWAO I		NON-LEGEND	4.00
5.00		11. 00	PHARMACY		PHARMACY SUPPLIES	5.00
6.00		42. 00	INTRAVENOUS TH	ERAPY	IV EXPENSE	6.00
7.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	7.00
					DRUGS OTH	
8.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	8. 00
0.00		40.00	DDUGG GUADGED	TO DATI FAITO	DRUGS MAN	0.00
9. 00		49.00	DRUGS CHARGED	10 PATTENTS	DRUGS-PRESCRIPTION, MEDICARE	9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column				A	10.00
10.00	6, line 100 to Worksheet A-8, column 3, line					10.00
	12.					
		Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
		4.00	5 5. 00	(00	-	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	4.00		6.00	D ODCANI ZATI ONE OD	
	CLAIMED HOME OFFICE COSTS:	KED AS A KESULI	OF TRANSACTIO	NS WITH KELATE	D ORGANIZATIONS OR	
1.00	CENTIMED HOME OFFICE COSTS.	756, 200	649, 280	106, 920		1.00
2.00		23, 903				2.00
3.00		30, 158	30, 158	C		3. 00
4.00		25, 516				4. 00
5.00		5, 322				5. 00
6.00		159, 163				6. 00
7. 00		23, 170				7. 00
8.00		101, 679				8. 00
9.00	TOTALS (sum of lines 1-9). Transfer column	196, 200 1, 321, 311	213, 261 1, 260, 910			9. 00
10. 00	6, line 100 to Worksheet A-8, column 3, line		1, 200, 910	00, 401		10.00
	12.					
	II.	1	1	1	T. Control of the con	

OFFICE COSTS

From 01/01/2023

Parts I-II Date/Time Prepared: 12/31/2023 5/10/2024 11:43 am

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2. 00	3. 00	

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

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

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

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

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

	Related Organi	zation(s) and/	or Home Office	
		-		
	Name	Percentage of	Type of Business	
		Ownershi p		
	4. 00	5. 00	6. 00	
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/OR HOME OFFICE:			

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

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

1.00		HEALTHBRIDGE MANAGEMENT LLC	100.00	MANAGEMENT	1.00
2.00		TOTALCARE LLC	99.00	WOUND CARE	2. 00
3.00		TOTALCARE LLC	1.00	WOUND CARE	3. 00
4.00		PARTNERS PHARMACY LLC	100.00	PHARMACY	4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10. 00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	speci fy:				

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

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315468

					To	12/31/2023	Date/Time Prep 5/10/2024 11:4	
				CAPI TAL REI	LATED COSTS		37 107 2024 11.	+3 alli
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	FI XTURES	EQUI PMENT	BENEFITS	Subtotal	
			Allocation					
			(from Wkst A col. 7)					
			0	1. 00	2. 00	3. 00	3A	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	1, 676, 115	1, 676, 115				1. 00
2. 00	1	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	176, 227	1, 676, 115	176, 227			2. 00
3.00	00300	EMPLOYEE BENEFITS	977, 872	0	0	977, 872		3. 00
4.00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	2, 246, 200	168, 388 49, 893		80, 536	2, 512, 828	4. 00 5. 00
5. 00 6. 00		LAUNDRY & LINEN SERVICE	630, 001 123, 473	49, 693 11, 073		18, 123 11, 406	703, 263 147, 116	6. 00
7.00	00700	HOUSEKEEPI NG	317, 107	11, 582		45, 940	375, 847	7. 00
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON	674, 471 671, 097	155, 278 130, 077		67, 108 98, 048	913, 183 912, 898	8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	140, 616	130, 077	13, 070	1, 662	142, 278	10. 00
11. 00		PHARMACY	30, 838	0	0	0	30, 838	11.00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	47, 523 17, 519	0	0	7, 822 2, 875	55, 345 20, 394	12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	0	1	2, 0, 3	0	14. 00
15. 00		ACTI VI TES	138, 831	0	0	21, 100	159, 931	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	2, 632, 114	1, 064, 421	111, 914	418, 266	4, 226, 715	30. 00
31. 00		NURSING FACILITY	0	0		110, 200	4, 220, 713	31. 00
32.00		I CF/IID	0	0		0	0	32.00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS] 0]	0	0	0	0	33. 00
40.00		RADI OLOGY	19, 541	0	0	0	19, 541	40. 00
41. 00		LABORATORY	56, 092	0		0	56, 092	41.00
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	159, 163	0	0	0	159, 163 0	42. 00 43. 00
44. 00		PHYSI CAL THERAPY	629, 363	62, 366	6, 557	100, 601	798, 887	44. 00
45.00	1	OCCUPATIONAL THERAPY	466, 609	2, 164		76, 069	545, 069	45. 00
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	173, 787	4, 009 0		28, 316 0	206, 534 0	46. 00 47. 00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 474	8, 018		0	24, 335	48. 00
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	321, 049	8, 846 0		0	330, 825 0	49. 00 50. 00
51.00		SUPPORT SURFACES	10, 710	0		0	10, 710	
52. 00		COMPLEX MEDICAL EQUIPMENT	0	0	1	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	<u> </u>		0	32. 02
60.00	1	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	06300	DIALYSIS	0	0	0	0	0	
70.00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST		0	0	ما	0	70. 00
70. 00 71. 00		AMBULANCE	118, 070	0	1	0	118, 070	
73. 00	07300		0	0		0	0	73. 00
74. 00		OTHER REIMBURSEMENT AL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	1	INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0		0	0	82. 00 83. 00
84. 00	1	OTHER SPECIAL PURPOSE COST I	0	0	o	o	0	84. 00
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	12, 469, 862	1, 676, 115	176, 227	977, 872	12, 469, 862	89. 00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	3, 163	0	0	0	3, 163	90. 00
91.00		BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS		0	0	0 nl	0	92. 00 93. 00
94.00	09400	PATIENTS LAUNDRY		0	ō	o	0	94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	0	0	0	95. 00 98. 00
98.00		Negative Cost Centers		0	0	ol	0	98. 00 99. 00
100.00)	TOTAL	12, 473, 025	1, 676, 115	176, 227	977, 872	12, 473, 025	100. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315468

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

5/10/2024 11:43 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATI ON, & GENERAL LINEN SERVICE MAINT. & REPAIRS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 2, 512, 828 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 177, 424 880, 687 5.00 00600 LAUNDRY & LINEN SERVICE 37.115 190, 920 6.00 6, 689 6.00 7.00 00700 HOUSEKEEPI NG 94, 821 6, 997 C 477, 665 7.00 8.00 00800 DI ETARY 230, 384 93, 805 0 51, 681 1, 289, 053 8.00 9.00 00900 NURSING ADMINISTRATION 230, 312 78, 581 0 43, 293 9.00 01000 CENTRAL SERVICES & SUPPLY 35, 895 0 10.00 10.00 Λ 11.00 01100 PHARMACY 7, 780 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 13, 963 0 0 0 12.00 01300 SOCIAL SERVICE 0 0 13.00 13.00 5.145 C 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 0 14.00 01500 ACTI VI TES 40, 349 0 15.00 15.00 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 1, 066, 345 190, 920 1, 289, 053 30.00 03000 SKILLED NURSING FACILLTY 643 022 354 267 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 32.00 0 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 4,930 0 0 0 0 40.00 41.00 04100 LABORATORY 14, 151 0 0 41.00 0 42 00 04200 I NTRAVENOUS THERAPY 40, 155 0 0 42 00 Ω 0 43.00 04300 OXYGEN (INHALATION) THERAPY C 0 0 0 43.00 04400 PHYSI CAL THERAPY 201, 549 37, 676 20, 757 44.00 44.00 0 04500 OCCUPATIONAL THERAPY 45.00 137, 514 1, 307 0 720 45.00 0 04600 SPEECH PATHOLOGY 46 00 46 00 52, 106 2.422 1, 334 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 139 4, 844 2, 669 48.00 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 83, 463 5. 344 2,944 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50 00 C 0 0 51.00 05100 SUPPORT SURFACES 2,702 C 0 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 52.00 52.01 05201 OTHER ANCILLARY SERVICES COST 0 C 0 ol 0 52.01 05202 MEDICAL SERVICES 52.02 0 0 0 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 60 00 06000 CLI NI C 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 61.00 0 0 0 0 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 0 0 0 70.00 29, 788 71.00 07100 AMBULANCE C 0 0 0 71.00 73.00 07300 CMHC 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 84.00 08401 OTHER SPECIAL PURPOSE COST II 84.01 84.01 0 880, 687 477, 665 1, 289, 053 89.00 SUBTOTALS (sum of lines 1-84) 2, 512, 030 190, 920 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 o 09100 BARBER AND BEAUTY SHOP 0 91.00 91.00 0 0 0 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 C 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 94.00 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST 95 00 0 O 0 95 00 Ω 0 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 99.00 0 0 0 100.00 TOTAL 2, 512, 828 880, 687 190, 920 477, 665 1, 289, 053 100. 00

Provi der No.: 315468

				'`	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		
		9.00	10.00	11. 00	12.00	13. 00	
4 00	GENERAL SERVICE COST CENTERS						4 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00 6. 00
7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSING ADMINISTRATION	1, 265, 084					9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	1, 203, 004	178, 173				10. 00
11. 00	01100 PHARMACY	0	170, 175	38, 618			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	00,010	69, 308		12. 00
13. 00	01300 SOCI AL SERVI CE	0	0	o o	0,7,000	25, 539	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	o o	0	0	14. 00
15. 00	01500 ACTI VI TES	0	0	Ö	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30.00	03000 SKILLED NURSING FACILITY	1, 265, 084	178, 173	38, 618	69, 308	25, 539	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDI CAL EQUI PMENT	0	0	0	0	0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCIELARY SERVICES COST	0	0	0	0	0	52. 01
32. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		U	U	0	32.02
60. 00	06000 CLINIC	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	Ö	61. 00
62. 00	06200 FQHC		Ŭ	Ĭ	J		62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS	-1	-		-		
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	1, 265, 084	178, 173	38, 618	69, 308	25, 539	89. 00
00.00	NONREI MBURSABLE COST CENTERS		51				00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0	0	0	0	93. 00 94. 00
94. 00 95. 00	09500 OTHER NONREIMBURSABLE COST		0	0	0	0	94. 00 95. 00
95. 00 98. 00	Cross Foot Adjustments		0		U	0	95. 00 98. 00
99. 00	Negative Cost Centers		0		0	0	99. 00
100.00	1 1 0	1, 265, 084	178, 173	38, 618	69, 308		
100.00	1.01112	1, 200, 004	170, 175	30,010	07, 300	20, 007	

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315468

				-	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			37 107 2024 11.	45 4111
			SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION			Auj us tillerits		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12. 00
13.00	01300 SOCIAL SERVICE						13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	l .				14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		200, 280	71			15.00
30.00	03000 SKILLED NURSING FACILITY	0	200, 280	9, 547, 32	4 0	9, 547, 324	30.00
31. 00	03100 NURSING FACILITY	0			0 0	0	31. 00
32. 00	03200 CF/IID	0	1		0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0))	0	0	33. 00
40. 00	04000 RADI OLOGY	0		24, 47	1 0	24, 471	40. 00
41. 00	04100 LABORATORY	0) (70, 24	3 0	70, 243	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0		199, 31		199, 318	1
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0		1	0	0 1, 058, 869	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	1 0		684, 61		684, 610	45. 00
46. 00	04600 SPEECH PATHOLOGY	0		262, 39		262, 396	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0			0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0		37, 98 422, 57		37, 987 422, 576	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	1 0		422, 37	0	422, 576	50.00
51. 00	05100 SUPPORT SURFACES			13, 41	2 0	13, 412	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0) (0 0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	 		0	0	52. 01
52. 02	O5202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0) ()	0	0	52. 02
60. 00	06000 CLINIC	0			0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0) (0 0	0	61. 00
62.00	06200 FQHC						62.00
63. 00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0) ()	0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0			0 0	0	70. 00
71. 00	07100 AMBULANCE	0) (147, 85	8 0	147, 858	71. 00
73.00	07300 CMHC	0			0	0	73.00
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0))	0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	0			0	0	83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I	1 0			0	0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)		1	12, 469, 06	4 0	12, 469, 064	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	l .	3, 96	1 0	3, 961	1
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0			0	0	91. 00 92. 00
93. 00	09300 NONPAID WORKERS			ő		0	93. 00
94.00	09400 PATIENTS LAUNDRY	0			0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	0			0	0	95. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers				0	0	98. 00 99. 00
100.00	1 1 0		200, 280	12, 473, 02	5 0	12, 473, 025	•
	1	'			, ,		

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315468

				T	12/31/2023		
			CAPI TAL REL	ATED COSTS		5/10/2024 11:	43 alli
	Cost Conton Dogonintian	Di mantlu	DI DCC 0	MOVABLE	Cubtatal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal					
		Related Costs	1 00	2.00	2.4	2.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	3. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1(0, 200	17.704	107 000	0	3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS		168, 388 49, 893	17, 704 5, 246	186, 092 55, 139	0	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE		11, 073	1, 164		0	6. 00
7. 00	00700 HOUSEKEEPI NG	0	11, 582	1, 218		0	
8.00	00800 DI ETARY	0	155, 278	16, 326	171, 604	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	130, 077	13, 676	143, 753	0	
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0	0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13. 00	01300 SOCI AL SERVI CE	o	o	0	Ö	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	o	0	0	0	14. 00
15. 00	01500 ACTIVITES	0	0	0	0	0	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	l ol	1, 064, 421	111 014	1 17/ 225	0	20.00
30. 00 31. 00	03100 NURSING FACILITY		1, 064, 421	111, 914 0	1, 176, 335	0	30. 00 31. 00
32. 00	03200 CF/11D	o	ő	0	Ö	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	Ō	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	62, 366	6, 557	68, 923	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	2, 164	227	2, 391	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	4, 009	422	4, 431	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	8, 018 8, 846	843 930	8, 861 9, 776	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0, 040	0	9, 770	0	50.00
51. 00	05100 SUPPORT SURFACES	O	O	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 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52. 02
60. 00	06000 CLINIC	0	O	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	o	0	Ö	0	61.00
62.00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		٥	0	٥	0	70.00
		0	0	0	0	0	70. 00 71. 00
73. 00	07300 CMHC	0	ő	0	o	0	73.00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
81.00	08200 UTI LI ZATI ON REVI EW - SNF						81.00
83. 00	08300 HOSPI CE	0	o	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	O	0	0	0	
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 676, 115	176, 227	1, 852, 342	0	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	ما	0	O	0	90.00
90.00	09100 BARBER AND BEAUTY SHOP		ol Ol	0	0	0	
92. 00	09200 PHYSI CLANS PRI VATE OFFICES		ol	0	ol	0	
93. 00	09300 NONPALD WORKERS	0	o	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
95.00	09500 OTHER NONREI MBURSABLE COST		0	0	0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0	0	O O	0	98. 00 99. 00
100.00	1 1 9	0	1, 676, 115	176, 227	1, 852, 342		100.00
	1	, 91	,	-,			

Provi der No.: 315468

				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	43 alli
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
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	186, 092					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	13, 140	68, 279				5. 00
6. 00 7. 00	O0600 LAUNDRY & LINEN SERVICE O0700 HOUSEKEEPING	2, 749 7, 022	519 542		20, 364		6. 00 7. 00
7. 00 8. 00	00800 DI ETARY	17, 062	7, 273		20, 364	198, 142	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	17, 052	6, 092		1, 846	170, 142	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	2, 658	0	o	0	0	10.00
11. 00	01100 PHARMACY	576	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	1, 034	0	0	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	381	0	0	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00	O1500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	2, 988	0	0	U	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	78, 968	49, 853	15, 505	15, 102	198, 142	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	o	0	o	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	365	0		0	0	40.00
41.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	1, 048	0	0	0	0	41.00
42. 00 43. 00	04300 OXYGEN (INHALATION) THERAPY	2, 974	0		0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	14, 926	2, 921		885	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	10, 184	101	l ő	31	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	3, 859	188	o	57	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	455	376		114	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	6, 181	414	0	126	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	200	0		0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	200	0		0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST		0	0	0	Ö	52. 01
52. 02	05202 MEDI CAL SERVI CES	o	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0		0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200 FQHC 06300 DI ALYSI S		0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	ı o		<u> </u>	U _I	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	2, 206	0	0	0	0	71. 00
	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE	o	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	o	0	o	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)	186, 033	68, 279	15, 505	20, 364	198, 142	89. 00
00.00	NONREI MBURSABLE COST CENTERS		0		٥	0	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	59	0		0	0	90. 00 91. 00
91.00	09200 PHYSICIANS PRIVATE OFFICES		0	0	0	0	91.00
93. 00	09300 NONPALD WORKERS		n	o o	o o	Ö	93. 00
94. 00	09400 PATIENTS LAUNDRY		0	Ō	O	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments			0	0	0	98. 00
99.00	Negative Cost Centers	104 000	(0.270	15 505	0 24	100 142	99.00
100.00	TOTAL	186, 092	68, 279	15, 505	20, 364	198, 142	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315468 Peri od:

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

5/10/2024 11:43 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 168, 748 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 2,658 10.00 01100 PHARMACY 11.00 0 576 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 C 1,034 12.00 13.00 01300 SOCIAL SERVICE 0 0 381 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 C 0 0 01500 ACTI VI TES 15.00 C 0 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 168, 748 576 1, 034 381 30.00 2.658 03100 NURSING FACILITY 31.00 0 0 31.00 32.00 03200 | CF/IID 0 C 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 04000 RADI OLOGY 40.00 0 Ω 0 0 0 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000000 0 0 0 0 42.00 0 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 04400 PHYSI CAL THERAPY 0 44.00 0 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY O 50 00 0 05100 SUPPORT SURFACES 0 51.00 0 0 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 52.00 52.00 52. 01 0 ol 05201 OTHER ANCILLARY SERVICES COST 0 0 0 52.01 0 05202 MEDICAL SERVICES 0 o 52.02 0 Ω 52.02 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0 0 60.00 60.00 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 o 0 61.00 06200 FOHC 62.00 62.00 63.00 06300 DI ALYSI S 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 C 07100 AMBULANCE 0 71.00 0 C 0 Ω 71.00 73.00 07300 CMHC 0 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 ol 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 H0SPLCE 83.00 0 C 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 C 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 84.01 SUBTOTALS (sum of lines 1-84) 168, 748 2,658 1,034 89.00 576 381 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 C 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 91.00 0 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 95.00 0 0 0 Cross Foot Adjustments 0 98.00 C 0 98 00 99.00 Negative Cost Centers C 0 99.00 381 100.00 100.00 168, 748 2, 658 576 1, 034

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315468

Cost Center Description						-	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
Cost Center Description								07 107 202 1 11.	TO CITI
CEREPAL SERVICE COST CENTERS			Cost Contor Doscription	NUIDSI NG AND		Subtotal	Post Stop Down	Total	
SEREMAL SERVICE COST CENTERS			cost center bescription		ACTIVITES	Subtotal		Total	
CEMERAL SERVICE COST CENTERS									
1.00		GENER	AL SERVICE COST CENTERS	14.00	15.00	16.00	17. 00	18. 00	
0.000 DUPLOYEE BENEFITS	1.00								1.00
0.0400 AMM INSTRATIVE & CENERAL									1
5.00 00000 AUTO OFFRATION, MAINT, & REPAIRS									1
0.0700 IOUSELECEPTING		1							1
0.000 0.000 DETARY									1
9.00 00000 MURSI NO. ADMINISTRATION									1
10.00 10000 CENTRAL SERVICES & SUPPLY									1
12.00 01200 MEDICAL, RECORDS & LIBRARY	10.00	01000	CENTRAL SERVICES & SUPPLY						1
13.00 01300 SOCIAL SERVICE		1							1
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 2, 988		1							1
INPATI ENT ROUTINE SERVICE COST CENTERS		1		0					1
30. 00	15. 00			0	2, 988				15. 00
31 00 03100 NURSING FACILITY	30 00			0	2 988	1 710 290	0	1 710 290	30.00
33.00				Ö	_,	1			1
MOCILLARY SERVICE COST CENTERS				0	l e	1			1
40. 00 04000 ABOILOGY	33. 00			0	0) (0	0	33.00
A2 00 04200 INTRAVENOUS THERAPY 0 0 2,974 0 2,974 0 0 0 0 0 0 0 0 0	40. 00			0	0	36!	5 0	365	40. 00
43. 00 04300 OXYCEN (INHALATION) THERAPY 0 0 0 0 0 0 0 0 0		1		0	1				1
44. 00 04400 PHYSI CAL THERAPY 0 0 87,655 0 87,655 0 12,707 0 12,707 0 12,707 0 12,707 0 12,707 0 12,707 0 12,707 0 12,707 0 0 0 0 0 0 0 0 0				0	0	1			1
46.00 04600 SPEECH PATHOLOGY 0 0 0 8,535 0 8,535 46.00 47.00 04700 ELECTROCARD IOLOGY 0 0 0 0 0 0 0 0 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 50.00 05000 DRITAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 51.00 05100 DRITAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 52.00 05200 COMPLEX MEDI CAL EQUIPMENT 0 0 0 0 0 0 0 52.01 05200 COMPLEX MEDI CAL EQUIPMENT 0 0 0 0 0 0 0 52.01 05201 OTHER ANCI LLARY SERVI CES COST 0 0 0 0 0 0 0 0 52.02 052020 MEDI CAL SERVI CES 0 0 0 0 0 0 0 0 52.02 052020 MEDI CAL SERVI CES 0 0 0 0 0 0 0 0 52.02 052020 MEDI CAL SERVI CES 0 0 0 0 0 0 0 0 52.02 052020 MEDI CAL SERVI CES 0 0 0 0 0 0 0 0 0 61.00 06000 CLINIC 0 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 0 61.00 06000 LINIC 0 0 0 0 0 0 0 61.00 06000 0 0 0 0 0 0 0		1		0			٦ - ١		ı
A7, 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0				1
AB. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 16,497 0 16,497 0 16,497 0 16,497 0 16,497 10 10 10 10 10 10 10 1				0	0	i .	0		1
49.00 04900 DRUSC CHARGED TO PATIENTS 0 0 16, 497 0 16, 497 0 50.00							5 0		1
51.00 05100 SUPPORT SURFACES 0 0 200 0 200 51.00		04900	DRUGS CHARGED TO PATIENTS	0	0				49. 00
S2.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 52.00				0	0	1		_	1
52.01 05201 OTHER ANCI LLARY SERVI CES						1			1
OUTPATIENT SERVICE COST CENTERS				0	l .			0	52. 01
60. 00 06000 CLINIC 0 0 0 0 0 0 0 0 0	52. 02			0	0) (0	0	52. 02
61. 00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 62. 00 62. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 63. 00 07000 RURAL HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0	60. 00			0	0		0	0	60.00
63.00 06.300 DIALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	l	1			1
OTHER REIMBURSABLE COST CENTERS O									ı
70. 00	63.00			0			<u>) </u>	0	63.00
73. 00 07300 CMHC	70.00	07000	HOME HEALTH AGENCY COST	0	0				
74.00 07400 OTHER REIMBURSEMENT O O O O O O O O O				0	0				
SPECIAL PURPOSE COST CENTERS SO. 00 MALPRACTICE PREMIUMS & PAID LOSSES SO. 00 SO. 00 MALPRACTICE PREMIUMS & PAID LOSSES SO. 00 SO. 00 INTEREST EXPENSE SO. 00 SO. 00 UTILIZATION REVIEW - SNF SO. 00 SO.				0		1			
81. 00	7 11 00						, ,		7 00
82. 00									
83.00 08300 HOSPICE 0 0 0 0 0 0 0 0 83.00									1
84. 01		1		0	О		0	0	
89. 00 SUBTOTALS (sum of lines 1-84) 0 2,988 1,852,283 0 1,852,283 89. 00				0	0		0		
NONRE MBURSABLE COST CENTERS		08401		0	0 2 988	1 852 28	-		ı
91. 00	07.00	NONRE			2,700	1,002,200	51 0	1, 002, 200	07.00
92. 00				0	ľ	1			
93. 00				0	0				
95. 00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 95. 00 98. 00 0 0 0 0 98. 00 99. 00 0 0 0 0 0 0 0 0 0				0	Ö		o o		1
98.00 Cross Foot Adjustments				0	0		0		
99.00 Negative Cost Centers 0 0 0 99.00		09500		0	0		م اد	_	
100. 00 TOTAL 0 2, 988 1, 852, 342 0 1, 852, 342 100. 00			,	0	0			0	99. 00
	100.00)	TOTAL	0	2, 988	1, 852, 342	2 0	1, 852, 342	100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315468

					lo 12/31/2023	Date/lime Pre 5/10/2024 11:	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconci I i ati or	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1 0,000	T		T		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	26, 338 0 2, 646 784 174 182 2, 440 2, 044 0 0	26, 338 (2, 646 784 174 182 2, 440	5, 941, 103 489, 298 110, 10 69, 29 279, 10 407, 720 595, 69	3 -2, 512, 828 7 (7) 7 (7) 9 (7) 10 (7) 4 (7) 10 (7) 10 (7)	9, 960, 197 703, 263 147, 116 375, 847 913, 183 912, 898 142, 278 30, 838 55, 345	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0					1
15. 00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0	(128, 19	4 (159, 931	15. 00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	16, 726 0 0				0 0	31.00
41.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0 0 0 0 980 34	(((980) () () () () () (19, 541 56, 092 159, 163 0 798, 887 545, 069	41. 00 42. 00 43. 00 44. 00
46. 00 47. 00 48. 00 49. 00 50. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	63 0 126 139 0	126 139		7	206, 534 0 24, 335 330, 825	47. 00 48. 00 49. 00 50. 00
	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES 0UTPATIENT SERVICE COST CENTERS	000000000000000000000000000000000000000	(0	52. 00 52. 01 52. 02
60. 00 61. 00 62. 00 63. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC 06300 DIALYSIS OTHER REIMBURSABLE COST CENTERS	0	(0	61. 00 62. 00
71. 00 73. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC 07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	000000000000000000000000000000000000000	(0 118,070 0 0 0	71. 00 73. 00
81. 00 82. 00 83. 00 84. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0 0 0 26, 338	26, 338))) 3 5, 941, 10:)))) 3 -2, 512, 828	0 0 0 0 0 9, 957, 034	84. 00 84. 01
91. 00 92. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 0 0	())))		3, 163 0 0 0 0 0 0 0 0 0 0 0 0	91. 00 92. 00 93. 00 94. 00 95. 00 98. 00 99. 00
	Part I)						
103. 00 104. 00	1	63. 638659	6. 690979	0. 16459	4 D	0. 252287 186, 092	1

Health Financial Systems	CARE ONE AT	PARSI PPANY		In Lie	eu of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				rom 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/10/2024 11:	<u>43 am</u>
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			SALARI ES)			
	1.00	2. 00	3. 00	4A	4. 00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 018684	105. 00

Provi der No.: 315468

				Т	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DIETARY	NURSI NG	
		OPERATION, MAINT. &	LINEN SERVICE (PATIENT DAYS)		(MEALS SERVED)	ADMI NI STRATI ON	
		REPAI RS	(PATTENT DATS)			(PATIENT DAYS)	
		(SQUARE FEET)				, ,	
	CENEDAL CEDIALCE COCT CENTEDO	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS - BLDGS & FIXTURES	I	I	I			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	22, 908	1				5.00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	174 182					6. 00 7. 00
8. 00	00800 DI ETARY	2, 440	1	2, 440			8.00
9.00	00900 NURSING ADMINISTRATION	2, 044	l .	2, 044		26, 566	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	C	0	0	0	0	10.00
11. 00 12. 00	01100 PHARMACY				0	0	11. 00 12. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE				0	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION				Ö	ő	14. 00
15.00	01500 ACTI VI TES	C	0) c	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					1	
30.00	03000 SKILLED NURSING FACILITY	16, 726	1	16, 726	79, 698		30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID		Ί "		0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		1				33.00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	C	1	1		_	40.00
41.00	04100 LABORATORY	C	1		_	0	41.00
42. 00 43. 00	04200 NTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY		1		_	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	980	1	980	1	Ö	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	34	l e	34	. 0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	63	B .	63		0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	12/	1	0	_	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	126		126		0	48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	137	1		Ö	ő	50.00
51.00	05100 SUPPORT SURFACES	C	0	o c	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	C	0) c	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C	Ί "		0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	C)) <u> </u>	0	0	52. 02
60. 00	06000 CLINIC		0)	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0) c	0	0	61.00
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S		0) <u> </u>	0	0	63.00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST) C	0	0	70.00
	07100 AMBULANCE				Ö	ő	
73. 00	07300 CMHC	C	0) c	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	C	0) <u> </u>	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	1	1	T		I	80.00
81.00	08100 NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	c	0) c	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	C	0) C	0	0	84. 00
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	22, 908	0 24 544) 22 552	79, 698	0	84. 01 89. 00
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	22, 900	26, 566	22, 552	. 79,090	26, 566	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0) c	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	c	0) c	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	C	0	0	0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY				0	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST					0	95.00
98. 00	Cross Foot Adjustments						98.00
99. 00	Negative Cost Centers						99. 00
102.00		880, 687	190, 920	477, 665	1, 289, 053	1, 265, 084	102. 00
103. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	38. 444517	7. 186630	21. 180605	16. 174220	47. 620417	103 00
103.00		68, 279	1	1		l .	
	Part II)	33, 27,	.5, 500	25, 30			50
105.00		2. 980574	0. 583641	0. 902980	2. 486160	6. 352029	105. 00
	1)	1	1	I	1	<u> </u>	I

Provi der No.: 315468

				'	0 12/31/2023	Date/lime Pre 5/10/2024 11:	
	Cost Center Description	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATLENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)		
		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	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 ADMINI STRATI ON						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	26, 566					10.00
11. 00	01100 PHARMACY	20, 300	26, 566				11.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	20, 300	26, 566			12.00
13. 00	01300 SOCI AL SERVI CE	0	0	20, 300	26, 566		13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	20, 000	0	14. 00
	01500 ACTI VI TES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			-	-,1		1
30.00	03000 SKILLED NURSING FACILITY	26, 566	26, 566	26, 566	26, 566	0	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						1
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41.00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 INTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50. 00 51. 00	O5000 DENTAL CARE - TITLE XIX ONLY O5100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52.00
52. 00	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 00
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
02.02	OUTPATIENT SERVICE COST CENTERS	J	U		<u> </u>		02.02
60.00	06000 CLINI C	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	0		0	
	07100 AMBULANCE	0	0	0	0	·	
	07300 CMHC	0	0	0	0	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74.00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF	-					81. 00 82. 00
82.00	08300 HOSPI CE		^	_	0	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	26, 566	26, 566	26, 566	26, 566	0	89.00
_ , . 50	NONREI MBURSABLE COST CENTERS	20,000	20,000		20, 000		1 55
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	Ō	Ō	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	1
93.00	09300 NONPALD WORKERS	0	0	0	О	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
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						99. 00
102. 00		178, 173	38, 618	69, 308	25, 539	0	102. 00
100.00	Part I)	, 70,000	1 450//0	2 (00000	0.0/40:0	0.000000	100 00
103.00	Unit cost multiplier (Wkst. B, Part I)	6. 706806	1. 453663	1	0. 961342	0.000000	
104. 00		2, 658	576	1, 034	381	0	104. 00
105. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 100053	0. 021682	0. 038922	0. 014342	0. 000000	105 00
103.00		0. 100053	0.021082	0.030922	0.014342	0.000000	105.00
		l .	<u> </u>	I		<u> </u>	ı

CARE ONE AT PARSI PPANY In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Ti me Prepared: 5/10/2024 11: 43 am Provi der No.: 315468

			10 12/31/2023	5/10/2024 11: 43 am
		OTHER GENERAL		
		SERVI CE		
	Cost Center Description	ACTI VI TES		
		(PATIENT DAYS) 15.00		
	GENERAL SERVICE COST CENTERS	15.00	 	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6. 00
7. 00	00700 HOUSEKEEPI NG			7. 00
8. 00	00800 DI ETARY			8.00
9.00	00900 NURSI NG ADMI NI STRATI ON			9.00
10.00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY			11. 00
13. 00	01300 SOCIAL SERVICE			13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	01500 ACTIVITES	26, 566		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	20,000		.0.00
30.00	03000 SKILLED NURSING FACILITY	26, 566		30.00
31.00	03100 NURSING FACILITY	0		31.00
32.00	03200 CF/IID	0		32. 00
33. 00	03300 OTHER LONG TERM CARE	0		33. 00
	ANCILLARY SERVICE COST CENTERS			
40. 00	04000 RADI OLOGY	0		40.00
41. 00	04100 LABORATORY	0		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		43. 00 44. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00	04600 SPEECH PATHOLOGY			46.00
47. 00	04700 ELECTROCARDI OLOGY			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS			49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	O		50.00
51.00	05100 SUPPORT SURFACES	0		51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0		52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0		52. 01
52. 02		0		52. 02
(0.00	OUTPATIENT SERVICE COST CENTERS			/0.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0		60.00
62. 00	06200 FQHC	U		62.00
63. 00	06300 DI ALYSI S	o		63.00
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		33. 33
70. 00	07000 HOME HEALTH AGENCY COST	0		70.00
71. 00		0		71. 00
73.00	07300 CMHC	0		73. 00
74.00	07400 OTHER REIMBURSEMENT	0		74. 00
	SPECIAL PURPOSE COST CENTERS			
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		83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0		84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	26, 566		89.00
07.00	NONREI MBURSABLE COST CENTERS	20, 500		84.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0		91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	o		92. 00
93. 00	09300 NONPALD WORKERS	O		93. 00
94.00	09400 PATIENTS LAUNDRY	0		94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0		95. 00
98. 00	Cross Foot Adjustments			98. 00
99. 00	Negative Cost Centers			99. 00
102.00		200, 280		102. 00
100 0	Part I)	7 5000/0		100.00
103.00		7. 538960		103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	2, 988		104. 00
105.00		0. 112475		105. 00
. 55. 50	II)	3 12 17 3		100.00
		. '		1

Health Financial Systems	CARE ONE AT PARS	PPANY		In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FO	OR ANCILLARY AND OUTPATIENT COST CENTERS	Provider No.: 315468	Peri od:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:43 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 24, 471 48, 853 0.500911 40.00 04100 LABORATORY 70, 243 140, 230 0.500913 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 199, 318 432, 507 0.460843 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 058, 869 2, 463, 481 0.429826 44.00 04500 OCCUPATIONAL THERAPY 45.00 684, 610 2, 436, 990 0. 280924 45.00 04600 SPEECH PATHOLOGY 46.00 262, 396 704, 448 0.372485 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 37, 987 38, 686 0. 981931 48.00 04900 DRUGS CHARGED TO PATIENTS 0. 484374 49.00 49.00 872, 417 422, 576 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 50.00 51.00 05100 SUPPORT SURFACES 13, 412 26, 776 0.500896 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 52.01 0 05202 MEDICAL SERVICES 0.000000 52.02 0 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 63.00 147, 858 295, 175 0.500916 71. 00 07100 AMBULANCE 71.00

2, 921, 740

7, 459, 563

100. 00

100.00

Total

Health Financial Systems	CARE ONE AT	PARSI PPANY			eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	epared: 43 am
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pr	rogram Charge:	s Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0. 500911			0 5, 961		
41. 00 04100 LABORATORY	0. 500913			0 18, 831		
42. 00 04200 I NTRAVENOUS THERAPY	0. 460843			0 12, 129	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0	0	1 .0.00
44. 00 O4400 PHYSI CAL THERAPY	0. 429826			0 420, 561	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 280924			0 302, 385		
46. 00 04600 SPEECH PATHOLOGY	0. 372485			0 116, 180	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	l .		0	1	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 981931			0 37, 987		
49. 00 O4900 DRUGS CHARGED TO PATIENTS	0. 484374			0 66, 480	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 500896			0 13, 412	0	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000			0	0	
52. 01 05201 OTHER ANCILLARY SERVICES COST	0. 000000			0	0	
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52. 02
OUTPATIENT SERVICE COST CENTERS	_					
60. 00 06000 CLI NI C	0. 000000	0		0	0	00.00
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
63. 00 06300 DI ALYSI S	0. 000000			0	1	
71. 00 07100 AMBULANCE (2)	0. 500916	l .		0	0	
100.00 Total (Sum of lines 40 - 71)		2, 645, 269		0 993, 926	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	у.					

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

Health Financial Systems		CARE ONE AT	PARSI PPANY		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY	AND OUTPATIENT COSTS				Period: From 01/01/2023 To 12/31/2023	5/10/2024 11:4	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Des	scription		·		,	1.00	
PART II - APPORTIONM	ENT OF VACCINE COST					1. 00	
	to patients - ratio of co	ost to charges	(From Workshee	t C, column 3	, line 49)	0. 484374	1.00
2.00 Program vacci no	e charges (From your reco	ords, or the PS	R)		•	250	2. 00
3.00 Program costs E, Part I, line	(Line 1 x line 2) (Title	XVIII, PPS prov	viders, transfe	er this amoun	t to Worksheet	121	3. 00
Cost Center Des		Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,	Allied Healt	h Wkst. D Part	Health Costs	
		18		Costs to Tota		for Pass	
				Costs - Part		Through (Col.	
				(Col . 2 / Col		3 x Col. 4)	
		1.00	2.00	3, 00	4. 00	5. 00	
PART III - CALCULATI	ON OF PASS THROUGH COSTS			0.00	1. 00	0.00	
ANCILLARY SERVICE CO							
40. 00 04000 RADI OLOGY		24, 471	0	0.00000	5, 961	0	40. 00
41. 00 04100 LABORATORY		70, 243	0	0. 00000	18, 831	0	41.00
42. 00 04200 I NTRAVENOUS THI	ERAPY	199, 318	0	0. 00000	12, 129	0	42.00
43.00 04300 0XYGEN (I NHALA		0	0	0.00000		0	43. 00
44. 00 04400 PHYSI CAL THERAI		1, 058, 869	0	0. 00000		0	44. 00
45. 00 04500 OCCUPATI ONAL TI		684, 610	0	0. 00000		0	45. 00
46.00 04600 SPEECH PATHOLO		262, 396	0	0. 00000		0	46. 00
47. 00 04700 ELECTROCARDI OLO		0	0	0. 00000		0	47. 00
	ES CHARGED TO PATIENTS	37, 987	0	0. 00000		0	48. 00
49. 00 04900 DRUGS CHARGED		422, 576	0	0. 00000		0	49. 00
50. 00 05000 DENTAL CARE -		0	0	0. 00000		0	50.00
51. 00 05100 SUPPORT SURFACI		13, 412	0	0.00000		0	51.00
52. 00 05200 COMPLEX MEDICAL		0	0	0.00000		0	52.00
52. 01 05201 OTHER ANCILLARY		0	0	0.00000		0	52. 01
52. 02 05202 MEDI CAL SERVI CI		2, 773, 882	0	0.00000	993, 926	0	52. 02 100. 00
100.00 Total (Sum of I	THEN 4U - 071						

	Financial Systems CARE ONE AT ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315468	Peri od: From 01/01/2023 To 12/31/2023		pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			26, 566	1.
00	Private room days			0	2.
00	Inpatient days including private room days applicable to			7, 966	
OC	Medically necessary private room days applicable to the P	rogram		0	4.
00	Total general inpatient routine service cost			9, 547, 324	5.
20	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			44.074.450	,
00	General inpatient routine service charges	- F divided by 11 ()		14, 274, 653	6
00	General inpatient routine service cost/charge ratio (Line	e 5 divided by line 6)		0. 668831	7
00	Enter private room charges from your records	- 1: 0 divided by		0	8
00	Average private room per diem charge (Private room charge: 2)	s line 8 divided by private	room days, line	0. 00	9
00	'				
00	Average semi-private room per diem charge (Semi-private	room charges line 10. divide	ed by	0.00	10 11
	semi-private room days)	, i i j	,		
00	Average per diem private room charge differential (Line 9	minus line 11)		0.00	12
00	Average per diem private room cost differential (Line 7 t	mes line 12)		0.00	13
00	Private room cost differential adjustment (Line 2 times I	ne 13)		0	14
00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	n cost differential (Line 5	minus line 14)	9, 547, 324	15
00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		359. 38	16
00	Program routine service cost (Line 3 times line 16)	,		2, 862, 821	17
00	Medically necessary private room cost applicable to progra	am (line 4 times line 13)		0	18
00	Total program general inpatient routine service cost (Li	ne 17 plus line 18)		2, 862, 821	19
00	Capital related cost allocated to inpatient routine servioline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ce costs (From Wkst. B, Par	t II column 18,	1, 710, 290	20
00	Per diem capital related costs (Line 20 divided by line	1)		64. 38	21
00	Program capital related cost (Line 3 times line 21)			512, 851	
00	Inpatient routine service cost (Line 19 minus line 22)			2, 349, 970	
00	Aggregate charges to beneficiaries for excess costs (Fro			0	
00	Total program routine service costs for comparison to the	cost limitation (Line 23 mi	nus line 24)	2, 349, 970	
00	Enter the per diem limitation (1)				26
. 00	Inpatient routine service cost limitation (Line 3 times the				27
00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instruction		line 27)		28

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	26, 566	1.00
2.00	Program inpatient days (see instructions)	7, 966	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. 299857	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 ATION OF INPATIENT ROUTINE COSTS	PRRSI PPANY Provi der No.: 315468	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:4	pare
		Title XIX	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			26, 566	
00	Private room days	D.		0	
0	Inpatient days including private room days applicable to the			12, 760 0	
00	Medically necessary private room days applicable to the Pro Total general inpatient routine service cost	ogram		9, 547, 324	
iU	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			9, 347, 324	۱ ۳
0	General inpatient routine service charges			14, 274, 653	1 6
0	General inpatient routine service cost/charge ratio (Line	5 divided by Line 6)		0. 668831	
0	Enter private room charges from your records	· · · · · · · · · · · · · · · · ·		0	
0	Average private room per diem charge (Private room charges line 8 divided by private room days, line				
	2)	3 .	, .	 -	
00					
00	Average semi-private room per diem charge (Semi-private rosemi-private room days)		d by	0. 00	
00	Average per diem private room charge differential (Line 9 m	•		0. 00	
00	Average per diem private room cost differential (Line 7 tim			0.00	1
00	Private room cost differential adjustment (Line 2 times lin			0 547 004	1
00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus line 14)	9, 547, 324	15
00	Adjusted general inpatient service cost per diem (Line 15	divided by Line 1)		359. 38	16
00	Program routine service cost (Line 3 times line 16)	divided by Title 1)		4, 585, 689	1
00	Medically necessary private room cost applicable to program	n (line 4 times line 13)		4, 303, 007	1
00	Total program general inpatient routine service cost (Line	,		4, 585, 689	
00	Capital related cost allocated to inpatient routine service		t II column 18,	1, 710, 290	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		·		
00	Per diem capital related costs (Line 20 divided by line 1))		64. 38	21
00	Program capital related cost (Line 3 times line 21)			821, 489	
00	Inpatient routine service cost (Line 19 minus line 22)			3, 764, 200	
00	Aggregate charges to beneficiaries for excess costs (From			0	1
00	Total program routine service costs for comparison to the o	cost limitation (Line 23 mi	nus line 24)	3, 764, 200	
00	Enter the per diem limitation (1)		0() (4)	0.00	
00	Inpatient routine service cost limitation (Line 3 times the			0	1 -
00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instruction		rine 2/)	4, 585, 689	28

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	26, 566	1.00
2.00	Program inpatient days (see instructions)	12, 760	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. 480313	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 PARSI	PPANY	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SET	TTLEMENT FOR TITLE XVIII	Provi der No.: 315468	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:43 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS	
			Taciffty		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			6, 181, 397	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)			6, 181, 397	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coi nsurance			809, 435	5. 00
6.00	Allowable bad debts (From your records)			311, 441	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		171, 553	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			202, 437	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)			5, 574, 399	11. 00
12.00	Interim payments (See instructions)			5, 430, 882	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)			4, 049	
14. 99	Sequestration amount (see instructions)			107, 439	
15. 00	Balance due provider/program (see Instructions)			32, 029	
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	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			121	
19.00	Total reasonable costs (Sum of lines 17 and 18)			121	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			250	20.00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			121	
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)	-+:>		0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	CTIONS)		- 1	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			121	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50 28. 55	Demonstration payment adjustment amount before sequestration			0	28. 50 28. 55
	Demonstration payment adjustment amount after sequestration				
28. 99 29. 00	Sequestration amount (see instructions) Balance due provider/program (see instructions)			2 119	28. 99 29. 00
	Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 115 2	0	30. 00
30.00	processed amounts (Nonarrowable cost report realis) ill accordance	e with two rub. 10-2,	36011011 113. 2	U	30.00

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider No.: 315468 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11:43 am

Title XVIII Skilled Nursing PPS Facility Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3. 00 2.00 5, 264, 523 1.00 Total interim payments paid to provider 1.00 2.00 Interim payments payable on individual bills, either 214, 792 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, 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 3. 01 0 0 3.02 0 3.02 0 3 03 3.03 0 0 3.04 0 3.04 3.05 0 0 3.05 Provider to Program 3 50 ADJUSTMENTS TO PROGRAM 06/05/2023 3.50 48.433 0 3.51 0 0 3.51 0 3. 52 3.52 0 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 -48, 433 0 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 5, 430, 882 0 4.00 (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVIDER 0 0 5.01 0 5.02 0 5.02 5.03 5.03 0 0 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5.51 0 5 52 0 5 52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 Determined net settlement amount (balance due) based on 6.00 6.00 the cost report. (1) 6.01 PROGRAM TO PROVIDER 32, 029 119 6.01 PROVIDER TO PROGRAM 6.02 Λ 6.02 Total Medicare program liability (see instructions) 5, 462, 911 119 7.00 Contractor Name Contractor Number 1.00 2 00

8.00

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.

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.: 315468 | Peri od: From 01/01/2023 To 12/31/2023

Period: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 43 am

oni y)				12,01,2020	5/10/2024 11:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	Assets					4
1. 00	CURRENT ASSETS Cash on hand and in banks	28, 053		0	0	1.00
2.00	Temporary investments	20,033			l	
3. 00	Notes recei vabl e	0			l	
4.00	Accounts receivable	1, 626, 009		0	0	
5.00	Other recei vabl es	0	(0	0	
6.00	Less: allowances for uncollectible notes and accounts	-299, 866	(0	0	6.00
7 00	recei vabl e					7 00
7. 00 8. 00	Inventory Prepai d expenses	21, 324			0	
9. 00	Other current assets	68, 887			0	
10.00	Due from other funds	00,007		, 	Ö	
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 444, 407		0	0	11.00
	FIXED ASSETS	_				
12.00	Land	2, 322, 092			1	1
13.00	Land improvements	42, 500		-	1	
14.00	Less: Accumulated depreciation	-19, 833	•	-	0	1
15. 00 16. 00	Buildings Less Accumulated depreciation	9, 438, 698 -5, 859, 134			0	
17. 00	Leasehold improvements	-5, 657, 134			0	
18. 00	Less: Accumulated Amortization	0		-	Ö	
19. 00	Fi xed equipment	388, 016		o o	Ō	
20.00	Less: Accumulated depreciation	-215, 894	(0	0	20.00
21. 00	Automobiles and trucks	0	(0	0	21.00
22. 00	Less: Accumulated depreciation	0	(0	0	
23. 00	Major movable equipment	2, 491, 561	(0	0	
24. 00	Less: Accumulated depreciation	-1, 937, 037		0	0	1
25. 00 26. 00	Minor equipment - Depreciable Minor equipment nondepreciable	0			0	
27. 00	Other fixed assets	107		-	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	6, 651, 076		-	Ö	
	OTHER ASSETS	2/22//2/2		-		1
29. 00	Investments	0	(0	0	29.00
30.00	Deposits on Leases	0	(0	1	
31. 00	Due from owners/officers	0	(٥	0	
32.00	Other assets	1, 953, 281		, i	0	1
33. 00 34. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)	1, 953, 281 10, 048, 764		-	0	
34.00	Liabilities and Fund Balances	10,046,764		<u>J</u>	0	34.00
	CURRENT LIABILITIES					1
35. 00	Accounts payable	1, 201, 330	(0	0	35.00
36. 00	Salaries, wages, and fees payable	151, 225	(0	0	36.00
37. 00	Payroll taxes payable	-2, 849	(0	0	
38. 00	Notes & Loans payable (Short term)	0	(0	0	
39.00	Deferred income	0	(O O	0	
40. 00 41. 00	Accel erated payments Due to other funds	69, 387			0	40.00
42. 00	Other current liabilities	4, 038, 234		-	l	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 457, 327			1	
	LONG TERM LIABILITIES					1
44.00	Mortgage payable	13, 167, 683	(0	0	44.00
45.00	Notes payable	0	(0	1	
46. 00	Unsecured Loans	0	(0	0	
47.00	Loans from owners:	0	(0	0	1
48. 00	Other long term liabilities	-18, 458, 845	1	0	0	
49. 00 50. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-5, 291, 162		-	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	166, 165		-	l	
01.00	CAPITAL ACCOUNTS	100, 100		<u> </u>	Ŭ.	3 0 1. 00
52.00	General fund balance	9, 882, 599				52.00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
	Coverning hady areated andowment fund halance			0	_	56. 00
56. 00	Governing body created - endowment fund balance					57.00
56. 00 57. 00	Plant fund balance - invested in plant				0	
56. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
56. 00 57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	0 892 500	,		0	58.00
56. 00 57. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	9, 882, 599 10, 048, 764	•	0		58.00

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

Provi der No.: 315468

				1	Го 12/31/2023	B Date/Time Pre 5/10/2024 11:	
		General	Fund	Speci al Pu	urpose Fund	Endowment Fund	TO GIII
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	9, 697, 003	3.00		0.00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		185, 596				2. 00
3.00	Total (sum of line 1 and line 2)		9, 882, 599			ol	3. 00
4.00	Additions (credit adjustments)						4. 00
5.00	•	0		()	0	5.00
6.00		0		(0	6. 00
7.00		0		(0	7. 00
8.00		0		(0	8. 00
9.00	T. I.	0		(0	9. 00
10.00	Total additions (sum of line 5 - 9)		0				10.00
11.00	Subtotal (line 3 plus line 10)		9, 882, 599				11.00
12. 00 13. 00	Deductions (debit adjustments)	0		(0	12.00
14. 00					-	0	13. 00 14. 00
15. 00		0				0	15. 00
16. 00						0	16. 00
17. 00		0			o l	0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)	1	o				18. 00
19. 00	Fund balance at end of period per balance		9, 882, 599				19. 00
	sheet (Line 11 - line 18)						
		Endowment Fund	PI ant	Fund			
		4.00	7.00	0.00	_		
1.00	Fund balances at beginning of period	6.00	7. 00	8. 00			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3.00	Total (sum of line 1 and line 2)	0		(3. 00
4. 00	Additions (credit adjustments)			Ì			4. 00
5. 00	That trong (or our trady as timorite)		o				5. 00
6.00			o				6. 00
7.00			o				7. 00
8.00			o				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 5 - 9)	0		(-		10. 00
11. 00	Subtotal (line 3 plus line 10)	0		(11. 00
12. 00	Deductions (debit adjustments)						12. 00
13. 00			0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16.00
17. 00	Total deductions (sum of lines 12 17)		O	,			17. 00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0		(18. 00 19. 00
19.00	sheet (Line 11 - Line 18)	١					19.00
	Silect (Line II - IIIIe IO)	1 1	ı	I	T		l

11001 + b	Financial Cystems	CADE ONE AT DADELDDANN		lm lio	u of Form CMC 2)E40 10
	Financial Systems (MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet G-2 Parts I-II Date/Time Prep 5/10/2024 11:4	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		14, 274, 65	i3	14, 274, 653	1.00
2.00	NURSING FACILITY			0	0	2.00
3.00	ICF/IID			0	o	3.00
4.00	OTHER LONG TERM CARE			0	o	4.00
5.00	Total general inpatient care services (Sum of I	ines 1 - 4)	14, 274, 65	53	14, 274, 653	5.00
	All Other Care Services		•			
, 00	ANGLI LADV. CEDVI CEC		7 450 54	0	7 450 540	/ 00

	All other care services				
6.00	ANCI LLARY SERVI CES	7, 459, 563	0	7, 459, 563	6. 00
7.00	CLI NI C		o	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	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to	21, 734, 216	0	21, 734, 216	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)			12, 791, 625	1. 00
2.00	Add (Specify)		0		2. 00
3.00			0		3. 00
4.00			0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7.00			0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)			0	8. 00
9.00	Deduct (Specify)		0		9. 00
10.00			0		10.00
11.00			0		11. 00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			12, 791, 625	15. 00
		'	·	'	•

Heal th	Financial Systems	CARE ONE AT PARSI	PPANY	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES			Provi der No.: 315468	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/10/2024 11:	43 am
					1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part	I, col. 3, line 1-	4)		21, 734, 216	1. 00
2.00	Less: contractual allowances and discounts on	patients accounts			8, 770, 604	2. 00
3.00	Net patient revenues (Line 1 minus line 2)				12, 963, 612	3.00

	To 12/	/31/2023	Date/Time Prep 5/10/2024 11:4	
			37 107 2024 11.	45 aiii
			1. 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)		21, 734, 216	1. 00
2.00	Less: contractual allowances and discounts on patients accounts		8, 770, 604	2.00
3.00	Net patient revenues (Line 1 minus line 2)		12, 963, 612	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	İ	12, 791, 625	4.00
5.00	Net income from service to patients (Line 3 minus 4)		171, 987	5.00
	Other income:			
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		1, 069	7. 00
8.00	Revenues from communications (Telephone and Internet service)		0	8. 00
9.00	Revenue from television and radio service		0	9. 00
10.00	Purchase discounts		0	10.00
11. 00	Rebates and refunds of expenses		0	11. 00
12.00	Parking Lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		0	14.00
15. 00	Revenue from rental of living quarters		0	15.00
16. 00	Revenue from sale of medical and surgical supplies to other than patients	1	0	16.00
17. 00	Revenue from sale of drugs to other than patients		0	17. 00
18. 00	Revenue from sale of medical records and abstracts	1	0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	1	0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen		0	20.00
21. 00	Rental of vending machines		0	21. 00
22. 00	Rental of skilled nursing space		0	22. 00
23. 00	Governmental appropriations		0	23. 00
24. 00	OTHER REV		3, 398	
24. 01	OTHER INCOME		9, 142	
24. 50	COVI D-19 PHE Funding		0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)		13, 609	25.00
26. 00	Total (Line 5 plus line 25)		185, 596	26. 00
27. 00	Other expenses (specify)		0	27. 00
28. 00			0	28. 00
29. 00		ļ	0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	ļ	0	30.00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)		185, 596	31. 00