	required by I aw (42 USC 1395g; 42 CFR 413.	CARE ONE AT VALLEY In L .20(b)). Failure to report can result in all interi period being deemed overpayments (42 USC 1395g).			u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315369	Period: From 01/01/2023 To 12/31/2023	
PART I - COST F	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost rep	port		Date: 5/10/20	24 Time: 11:50 am
use only	2. [] Manually prepared cost report				
5	3. [0] If this is an amended report en	ter the numbe	r of times the provide	r resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter '				
Contractor	4. [1]Cost Report Status	6. Contractor			
use only	(1) As Submitted	7 [N] Firs	t Cost Report for this	Provider CCN	
, and a g	(2) Settled without audit		Cost Report for this		
	(3) Settled with audit		COST REPORT FOR THIS	FIOVIDEI CON	
	(4) Reopened	9. NPR Date:			
	(5) Amended	10.[0][f]	ine 4, column 1 is "4"	: Enter number of	times reopened
		11.Contracto	r Vendor Code	4	
	5. Date Received:	12.[F] Medi	care Utilization. Ente	er "F" for full, '	'L" for 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 VALLEY (315369) 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	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Dav	vid Baruch	ř	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	David Baruch			2
3	Signatory Title	AUTHORI ZED SI GNOR			3
4	Date	(Dated when report is electronica			4

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-128, 010	-1, 803	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	-128, 010	-1, 803	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.

	ED NURSING FACILITY AND SKILLED NURSING FACILITY HEAU X INDENTIFICATION DATA	_TH CARE	Provider No.	: 315369	Period: From 01/01 To 12/31		Worksheet Part I Date/Time 5/10/2024	S-2 Prep	
	1.00	2.00		3.00					
00	Skilled Nursing Facility and Skilled Nursing Facili		dress:						1 00
00 00	Street: 300 OLD HOOK ROADPO BoxCi ty:WESTWOODState:		Zip Code: 076	575					1.00
00	5	ode: 35614	Urban/Rural:						3.00
01	CBSA C			0					3.00
01	CDON C		ent Name	Provi der	Date	Payme	ent System	(P	5.0
		Comport		CCN	Certified		0, or N)		
						V		KI X	
		1	. 00	2.00	3.00	4.00		. 00	
	SNF and SNF-Based Component Identification:			-	1	1			
00	SNF	CARE ONE AT	VALLEY	315369	09/01/1997	N	Р	Ν	4.00
00	Nursing Facility								5.00
00	I CF/IID								6.00
00	SNF-Based HHA								7.00
00	SNF-Based RHC								8.00
00	SNF-Based FQHC								9.00
0. 00	SNF-Based CMHC								10.00
. 00	SNF-Based OLTC SNF-Based HOSPICE								11.00
2.00	SNF-Based CORF								12.0 13.0
. 00	JNI -Dased CORI				From	.	To:		13.0
					1.00		2.00		
. 00	Cost Reporting Period (mm/dd/yyyy)				01/01/2		12/31/20	23	14.0
	Type of Control (See Instructions)					4			15.0
							Y/N		
							1.00		
. 00	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facility th	at meets the u	reguirements	set forth	in 42 CFR		Y		16. 00
. 00	section 483.5?					in	N		17.0
	42 CFR section 483.5? Are there any costs included in Worksheet A that re	5					Y		18.0
. 00	organizations as defined in CMS Pub. 15-1, chapter Miscellaneous Cost Reporting Information								10. 00
. 00	If this is a low Medicare utilization cost report,	indicate with	a "Y", for y	ves. or "N	" for no.		N	_	19.00
. 01	If line 19 is yes, does this cost report meet your utilization cost report, indicate with a "Y", for y	contractor's d	criteria for	filing a	low Medicar	e	Ν		19.0
	Depreciation - Enter the amount of depreciation rep			method ir	dicated on	Li nes	20 - 22.		
). 00	Straight Line							I, 133	20.0
. 00	Declining Balance							d	21.0
2.00	Sum of the Year's Digits								
								Q	
. 00	Sum of line 20 through 22						894	0 I, 133	22.0
	Sum of line 20 through 22 If depreciation is funded, enter the balance as of	the end of th	he period.				894	0 I, 133 0	22. 0 23. 0
. 00 5. 00	If depreciation is funded, enter the balance as of Were there any disposal of capital assets during th	e cost reporti	ing period?				894 N	0 I, 133 0	22. 0 23. 0 24. 0 25. 0
. 00	If depreciation is funded, enter the balance as of Were there any disposal of capital assets during th Was accelerated depreciation claimed on any assets	e cost reporti	ing period?		porting per	i od?		0 I, 133 0	22. 0 23. 0 24. 0 25. 0
. 00 . 00 . 00	If depreciation is funded, enter the balance as of Were there any disposal of capital assets during th Was accelerated depreciation claimed on any assets (Y/N)	e cost reporti in the curren ⁻	ing period? t or any prio	or cost re			N N	0 I, 133 0	22. 0 23. 0 24. 0 25. 0 26. 0
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Health Financial Systems	CARE ONE AT	VALLEY		In Lie	eu of Form C	MS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:		Period:	Worksheet	S-2
COMPLEX INDENTIFICATION DATA				rom 01/01/2023 o 12/31/2023		Prepared [.]
				0 12, 01, 2020	5/10/2024	
					Y/N	
					1.00	
42.00 Are malpractice premiums and paid loss					N	42.00
center? Enter Y or N. If yes, check bo	x, and submit supporti	ng schedule listin	g cost ce	nters and		
amounts.						
43.00 Are there any home office costs as def					Y	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and en	ter the name and a	ddress of	the home	HB0206	44.00
office on lines 45, 46 and 47.				0.00		_
1.00	2.00			3.00		
If this facility is part of a chain or	ganization, enter the	name and address o	of the hom	e office on th	e lines	
bel ow.	1					
45.00 Name: HEALTHBRIDGE	Contractor's Name: NOV	TAS SOLUTION	Contractor	r's Number: 120	21	45.00
46.00 Street: 173 BRIDGE PLAZA NORTH	PO Box:					46.00
47.00 City: FORT LEE	State: NJ	2	Zip Code:	070	24	47.00

MPLI	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	No.: 315369	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pr	repared
	· · · · · · · · · · · · · · · · · · ·				Y/N	5/10/2024 11 Date	:50 an
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in columr	ו 1, "Y" for	Yes or "N"	for No. For all	the date	
~~	Provider Organization and Operation				N		
00	Has the provider changed ownership immediated reporting period? If column 1 is "Y", enter instructions)				N		1.
			-	Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Progr	ram2 lf	1.00 N	2.00	3.00	2.
	column 1 is yes, enter in column 2 the date of						
00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or	., chain home offic d to the provider c l, or members of th	ces, drug or its ne board	Y			3.
	relationships? (see instructions)						_
				Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		I	1.00	2.00	3.00	
00	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" te copy or enter da	for ate	Y	A		4
0	Are the cost report total expenses and total those on the filed financial statements? If a reconciliation.			Ν			5
			L.		Y/N 1.00	Legal Oper. 2.00	
0	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2	2. Le the r	novidor the	N	N	6
			z. is the p	brovider the	IN	11	
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin	s? (Y/N) see instru ng the cost reporti	uctions.		N N		7.
	Were costs claimed for Allied Health Programs	s? (Y/N) see instru ng the cost reporti	uctions.		N	Y/N 1.00	7.
0	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts	s? (Y/N) see instrung the cost reporties instructions.	uctions. ing period 1	for Nursing	N	<u>Y/N</u> 1. 00	7 8
0	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad deb	s? (Y/N) see instrung the cost reporti ee instructions.	uctions. ing period 1	for Nursing	NN	Y/N	7 8 9
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Health Finan	cial Systems	CARE ONE A	T VAL	LEY		In	Lieu of Form CMS	-2540-10
	SING FACILITY AND SKILLED NURSING FAC	LITY HEALTH CARE		Provi der	No.: 315369	Peri od:	Worksheet S-	2
COMPLEX REIN	IBURSEMENT QUESTI ONNAI RE					From 01/01/2 To 12/31/2		enared
						10 12/31/.	5/10/2024 11	
				1.	00		2.00	
Cost	Report Preparer Contact Information							
19.00 Enter	the first name, last name and the ti	tle/position	CHARL	ES		REED		19.00
hel d	by the cost report preparer in column	is 1, 2, and 3,						
respe	ecti vel y.							
20.00 Enter	the employer/company name of the cos	t report	EXECU	CARE ASSO	CI ATES			20.00
prepa	irer.							
21.00 Enter	the telephone number and email addre	ss of the cost	(609)	738-3200		CRWASSC@NE	TSCAPE. NET	21.00
repor	t preparer in columns 1 and 2, respec	ti vel y.						

Heal th	Financial Systems	CARE ONE AT	VALLEY		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.:	1	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/10/2024 11:	pared:
		Part B					
		Date					
		4.00			· · · · ·		
	PS&R Data						
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/18/2024					13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.						14.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.						15.00
16.00	adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.						16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:						17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.						18.00
			3.00				
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title held by the cost report preparer in columns 7 respectively.		I CE-PRESI DENT				19.00
20.00	Enter the employer/company name of the cost r	report					20.00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						21.00

	ED NURSING FACILITY AND SKILLED NURSIN X STATISTICAL DATA	G FACILITY HEALTH CARE	Provi der	-	Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/10/2024 11:5	
				۱n	patient Days/Vis	sits	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	1	1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	120	43, 800		0 10, 003	11, 523	1.00
. 00	NURSING FACILITY	0	0		0	0	2.00 3.00
. 00	HOME HEALTH AGENCY COST	0	0		0 0	0	4.0
. 00	Other Long Term Care	0	0				5.0
. 00	SNF-Based CMHC						6.0
. 00 . 00	HOSPICE Total (Sum of lines 1-7)	120	43, 800		0 0 0 10,003	0 11, 523	7.0 8.0
. 00		Inpatient D			Di scharges	11,020	0.0
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	······	6.00	7.00	8.00	9.00	10.00	
. 00	SKILLED NURSING FACILITY	10, 052	31, 578		0 345	22	1.0
. 00 . 00	NURSING FACILITY	0	0		0	0	2.0 3.0
. 00	HOME HEALTH AGENCY COST	0	0			0	4.0
. 00	Other Long Term Care	0	0				5. C
. 00	SNF-Based CMHC						6.0
. 00 . 00	HOSPICE Total (Sum of lines 1-7)	0 10, 052	0 31, 578		0 0 0 345	0 22	7.C 8.C
. 00		Di scha			erage Length of		0.0
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	1	11.00	12.00	13.00	14.00	15.00	
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	242	609 0	0.0 0.0		523.77 0.00	1.0 2.0
. 00		0	0	0.0	0	0.00	3.0
. 00	HOME HEALTH AGENCY COST						4.C
. 00	Other Long Term Care	0	0				5. C
. 00 . 00	SNF-Based CMHC HOSPI CE	0	0	0.0	0.00	0.00	6. C 7. C
. 00	Total (Sum of Lines 1-7)	242	609	0.0			8.0
		Average Length		Admi	ssi ons		
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
. 00	SKILLED NURSING FACILITY	51.85	0	38	9 4	213	1.0
. 00 . 00	NURSING FACILITY	0. 00 0. 00	0		0	0	2.0 3.0
00	HOME HEALTH AGENCY COST	0.00			0	0	4. 0
00	Other Long Term Care	0.00				0	5.0
00	SNF-Based CMHC	0.00					6. (
. 00 . 00	HOSPICE Total (Sum of lines 1-7)	0. 00 51. 85	0		0 0 9 4		7.0 8.0
. 00		Admi ssi ons	Full Time		7 -	213	0.0
	Component	Total	Employees on	Nonpai d			
			Payrol I	Workers	_		
. 00	SKILLED NURSING FACILITY	21.00	22.00 118.88	23.00	0		1.0
. 00	NURSING FACILITY	0	0.00				2.0
. 00		0	0.00				3.0
. 00	HOME HEALTH AGENCY COST	0	0.00				4.C 5.C
. 00 . 00	Other Long Term Care SNF-Based CMHC	0	0.00 0.00				5. C 6. C
. 00	HOSPI CE	0	0.00				7. C
	Total (Sum of lines 1-7)						8. (

2.00 Physician salaries-Part A 0 0 0.00 0.00 2. 3.00 Physician salaries-Part B 0 0 0.00 0.00 0.00 0.00 4.00 Home office personnel 0 0 0.00 0.00 0.00 4. 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 0.00 6.00 Revised wages (line 1 minus line 5) 8,074,893 0 8,074,893 247,279.00 32.65 6. 7.00 Other Long Term Care 0 0 0.00 <td< th=""><th>Heal th</th><th>Financial Systems</th><th>CARE ONE A</th><th>T VALLEY</th><th></th><th>In Lie</th><th>eu of Form CMS-:</th><th>2540-10</th></td<>	Heal th	Financial Systems	CARE ONE A	T VALLEY		In Lie	eu of Form CMS-:	2540-10
PART 11 - DIRECT SALARIES Reported Sal aries from Sal aries (col. 2) Worksheet A-6 Related to 1 ± col. 2) Related to Salary in col. 4) Wage (col. 3 ± col. 4) 1.00 2.00 3.00 4.00 5.00 SALARIES	SNF WA	IGE INDEX INFORMATION				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/10/2024 11:	pared: 50 am
PART 11 - DIRECT SALARIES Solution Solu								
PART 11 - DIRECT SALARIES SALARIES 1.00 2.00 3.00 4.00 5.00 SALARIES 5.00 0 3.00 4.00 5.00 1.00 Total salaries (See Instructions) 8.074.893 0 8.074.893 247.279.00 32.65 1. 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2.00 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 0.00 2.300 4.00 Home office personnel 0 0 0 0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
PART II - DIRECT SALARIES SALARIES SALARIES SALARIES SALARIES SALARIES Salaries (See Instructions) 8,074,893 0 8,074,893 247,279.00 32.65 1. 2.00 Physician salaries-Part A 0 0 0 0.00 <t< td=""><td></td><td></td><td></td><td>Worksheet A-6</td><td>1 ± col. 2)</td><td>5</td><td>col. 4)</td><td></td></t<>				Worksheet A-6	1 ± col. 2)	5	col. 4)	
SALARIES 1.00 Total salaries (Se Instructions) 8,074,893 0 8,074,893 247,279.00 32.65 1. 2.00 Physician salaries-Part A 0 0 0.00 0.00 0.00 3.00 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0.00 0.00 0.00 4.00 5.00 Sum of Lines 2 through 4 0 0 0 0.00			1.00	2.00	3.00	4.00	5.00	
1.00 Total salaries (See Instructions) 8,074,893 0 8,074,893 247,279.00 32.65 1. 2.00 Physician salaries-Part A 0 0 0 0.00 0.00 0.00 0.00 32.65 1. 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 0.00 0.00 0.00 32.65 1. 3.00 Physician salaries-Part B 0 0 0 0.00 0.00 0.00 0.00 32.65 6. 4.00 Home office personnel 0 0 0 0 0.00 0.00 0.00 0.00 4. 5.00 Sum of lines 2 through 4 0 0 0 0.00								
2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2. 3.00 Physician salaries-Part B 0 0 0.00			1		1			
3.00 Phýsician salaries-Part B 0 0 0 0.00 0.00 3. 4.00 Home office personnel 0 0 0 0.00 0.00 4. 5.00 Sum of Lines 2 through 4 0 0 0.00 0.00 0.00 4. 6.00 Revised wages (Line 1 minus Line 5) 8.074, 893 0 8.074, 893 247, 279.00 32.65 6. 7.00 Other Long Term Care 0 0 0 0.00 0.00 7. 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 7. 9.00 CMHC 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 10.00 10.00 10.00 10.00 0 0.00 0.00 0.00 0.00 10.00 11.00 11.00 0 0 0.00 0.00 0.00 11.20 12.00 Subtotal Excluded areas 0 0 0.00 0.00 12.00 11.21 12.00 <td></td> <td></td> <td>8, 074, 893</td> <td>C</td> <td>8, 074, 89</td> <td></td> <td></td> <td></td>			8, 074, 893	C	8, 074, 89			
4.00 Home office personnel 0 0 0 0.00 0.00 4. 5.00 Sum of lines 2 through 4 0 0 0 0.00 <td< td=""><td></td><td>5</td><td>0</td><td>C</td><td></td><td></td><td></td><td></td></td<>		5	0	C				
5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 5. 6.00 Revised wages (line 1 minus line 5) 8,074,893 0 8,074,893 247,279.00 32.65 6. 7.00 Other Long Term Care 0 0 0 0.00 0.00 7. 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00		5	0	C				
6.00 Revised wages (line 1 minus line 5) 8,074,893 0 8,074,893 247,279.00 32.65 6. 7.00 Other Long Term Care 0 0 0 0.00 0.00 7. 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 7. 9.00 CMHC 0 0 0 0.00 0.00 8. 10.00 HOSPICE 0 0 0 0.00 0.00 10. 11.00 Other excluded areas 0 0 0 0.00 0.00 11. 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 8.074,893 0 8,074,893 247,279.00 32.65 13. 12. 0 0 0 0 0.00 0.00 12. 0 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 14.00 Contract Labor: Physician services-Part A 0 0			0	C				
7.00 Other Long Term Care 0 0 0 0.00 0.00 7. 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 8. 9.00 CMHC 0 0 0 0.00 0.00 0.00 8. 9.00 CMHC 0 0 0 0.00 0.00 9. 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 10. 11.00 Other excluded areas 0 0 0 0.00 0.00 10. 11. 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 18, 074, 893 0 8, 074, 893 247, 279.00 32.65 13. 14.00 Contract Labor: Physician services-Part A 0 0 0.00 0.00 15. 14.00 Contract Labor: Physician services-Part A 0 0 0.00 0.00 16. WAGE-RELATED COSTS 1 1.214, 969 1.214			0	C				
8.00 HOME HEALTH AGENCY COST 0 0 0.00 0.00 0.00 0.00 8. 9.00 CMHC 0 0 0 0.00 0.00 0.00 9. 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 0.00 11. 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,074,893 247,279.00 32.65 13. 14.00 Contract Labor: Patient Related & Mgmt 53,960 0 53,960 931.00 57.96 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 16. WAGE-RELATED COSTS 0 0 0 0 0.00 16. WAGE-RELATED COSTS 0 0 0 0 0.00 16. Wage-related costs core (See Part			8,074,893	C	8,074,89			
9.00 CMHC 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 10.01 11.00 Other excluded areas 0 0 0 0.00 0.00 0.00 10.01 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,074,893 0 8,074,893 247,279.00 32.65 13. 12.0 Other excluder: Patient Related & Mgmt 53,960 0 53,960 931.00 57.96 14. 14.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 14. 16.00 Home office salaries & wage related costs 0 0 0 0 16. Wage-related costs core (See Part IV) 1, 214, 969 0 1, 214, 969 18. 19. 19.00<			0	C				
10.00 HOSPICE 0 0 0.00 0.00 10. 11.00 Other excluded areas 0 0 0 0.00 0.00 11. 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,074,893 0 8,074,893 247,279.00 32.65 13. 14.00 Contract Labor: Patient Related & Mgmt 53,960 0 53,960 931.00 57.96 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16.00 Home office salaries & wage related costs 0 0 0.00 0.00 16. WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1, 214, 969 0 1, 214, 969 17. 18.00 Wage-related costs (excluded units) 0 0 0 19. 19.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0<			0					
11.00 Other excluded areas 0 0 0 0.00 0.00 11. 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 8,074,893 0 8,074,893 247,279.00 32.65 13. 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 0 0 0 0 0.00 0.00 12. 0 OTHER WAGES & RELATED COSTS 0 53,960 0 53,960 931.00 57.96 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16.00 Home office salaries & wage related costs 0 0 0 0.00 16. WAGE-RELATED COSTS Tr.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 17. 18.00 Wage-related costs (excluded units) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 20. 20. 20.			0					
12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12. 13.00 Total Adjusted Salaries (Line 6 minus Line 8,074,893 0 8,074,893 247,279.00 32.65 13. 12.0 OTHER WAGES & RELATED COSTS 0 0 53,960 931.00 57.96 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16.00 Home office salaries & wage related costs 0 0 0 0.00 16. WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 16. NAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,214,969 0 17. 18.00 Wage-related costs (excluded units) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 0 19. 20.00 Physician Part A - WRC 0 0 0 20. 21. 21.00 Physician Part B - WRC <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
13. 00 through 11) Total Adjusted Salaries (line 6 minus line 8, 074, 893 0 8, 074, 893 247, 279. 00 32. 65 13. 13. 00 OTHER WAGES & RELATED COSTS OTHER WAGES & RELATED COSTS 14. 00 0 53, 960 0 53, 960 931. 00 57. 96 14. 15. 00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16. 00 Home office salaries & wage related costs 0 0 0 0.00 16. WAGE-RELATED COSTS Tr. 00 Wage-related costs core (See Part IV) 1, 214, 969 0 1, 214, 969 17. 17. 00 Wage-related costs (excluded units) 0 0 0 18. 19. 00 Wage related costs (excluded units) 0 0 0 18. 19. 00 Physician Part A - WRC 0 0 0 20. 21. 00 Physician Part B - WRC 20.			0					
12) OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 53,960 0 53,960 931.00 57.96 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16.00 Home office salaries & wage related costs 0 0 0 0.00 16. WAGE-RELATED COSTS 11, 214, 969 0 1, 214, 969 17. 18.00 Wage-related costs other (See Part IV) 1, 214, 969 0 18.00 19.00 19.00 19.00 20.00 19.91 10 10 20.00		through 11)	0					
14.00 Contract Labor: Patient Related & Mgmt 53,960 0 53,960 931.00 57.96 14. 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16. WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 17. 18.00 Wage-related costs other (See Part IV) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 0 19. 20.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0 0 0 21.	13.00		8, 074, 893	C	8, 074, 89	247, 279. 00	32.65	13.00
15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15. 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16. WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 17. 18.00 Wage-related costs other (See Part IV) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 18. 20.00 Physician Part A - WRC 0 0 20. 21.00 Physician Part B - WRC 0 0 21.		OTHER WAGES & RELATED COSTS						
16.00 Home office salaries & wage related costs 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 17.00 1,214,969 17.00 1,214,969 17.00 1,214,969 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.00 0 0 18.00 18.00 19.00 19.00 19.00 19.00 10.00 18.00 19.00 19.00 10.00 18.00 19.00 <td>14.00</td> <td></td> <td>53, 960</td> <td>C</td> <td>53, 96</td> <td></td> <td></td> <td></td>	14.00		53, 960	C	53, 96			
WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 17. 18.00 Wage-related costs other (See Part IV) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 0 19. 20.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0 0 0 21.	15.00		0	C				
17.00 Wage-related costs core (See Part IV) 1,214,969 0 1,214,969 17. 18.00 Wage-related costs other (See Part IV) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 0 19. 20.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0 0 0 21.	16.00		0	C		0 0.00	0.00	16.00
18.00 Wage-related costs other (See Part IV) 0 0 0 18. 19.00 Wage related costs (excluded units) 0 0 0 19. 20.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0 0 0 21.								
19.00 Wage related costs (excluded units) 0 0 0 19. 20.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0 0 0 21.			1, 214, 969	C	1, 214, 96	9		17.00
20.00 Physician Part A - WRC 0 0 0 20. 21.00 Physician Part B - WRC 0 0 0 21.		5	0	C		0		18.00
21.00 Physician Part B - WRC 0 0 0 21.			0	C		0		19.00
			0	C		0		20.00
22 OD Total Adjusted Ware Related cost (see $1.1214.969$ OL $1.214.969$ OL $1.214.969$ 22			0	C		0		21.00
instructions)	22.00	Total Adjusted Wage Related cost (see instructions)	1, 214, 969	C	1, 214, 96	99		22.00

Heal th	Financial Systems	CARE ONE A	T VALLEY		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period: From 01/01/2023 To 12/31/2023		
						5/10/2024 11:	<u>50 am</u>
		Amount	Reclass. of			Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	[I	1			
1.00	Employee Benefits	0	0		0.00		1.00
2.00	Administrative & General	528, 060		528, 06			2.00
3.00	Plant Operation, Maintenance & Repairs	44, 233		44, 23			
4.00	Laundry & Linen Service	96, 405	0	96, 40	5 5, 771. 00	16. 71	4.00
5.00	Housekeepi ng	293, 425	0	293, 42	5 14, 819. 00	19.80	5.00
6.00	Dietary	548, 633	0	548, 63	3 27, 803. 00	19.73	6.00
7.00	Nursing Administration	584, 133	0	584, 13	3 10, 839. 00	53.89	7.00
8.00	Central Services and Supply	15, 787	0	15, 78	7 826.00	19. 11	8.00
9.00	Pharmacy	0	0		0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	42, 258	0	42, 25	B 2, 040. 00	20. 71	10.00
11.00	Social Service	103, 040	0	103, 04	3, 172. 00	32.48	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	191, 177	0	191, 17	7 9, 906. 00	19.30	13.00
14.00	Total (sum lines 1 thru 13)	2, 447, 151	0	2, 447, 15	1 90, 274. 00	27.11	14.00
	•		•				-

ealth Financial Systems	CARE ONE AT V	ALLEY	In Lie	u of Form CMS-2	2540-1
NF WAGE RELATED COSTS		Provider No.: 315369	Period: From 01/01/2023 To 12/31/2023		pared:
				Amount Reported	
				1.00	
PART IV - WAGE RELATED COSTS					
Part A - Core List					1
RETI REMENT COST					1
.00 401K Employer Contributions				42, 497	1.0
.00 Tax Sheltered Annuity (TSA) Employe	r Contribution			0	2.0
.00 Qualified and Non-Qualified Pension	Plan Cost			0	3.0
.00 Prior Year Pension Service Cost				0	4.0
PLAN ADMINISTRATIVE COSTS (Paid to E	External Organization)				1
.00 401K/TSA Plan Administration fees				0	5.0
.00 Legal /Accounting/Management Fees-Pe	nsion Plan			0	6.0
.00 Employee Managed Care Program Admin	istration Fees			0	7.0
HEALTH AND INSURANCE COST					1
.00 Health Insurance (Purchased or Self	Funded)			409, 939	8.0
.00 Prescription Drug Plan				0	9.0
0.00 Dental, Hearing and Vision Plan				0	10.0
1.00 Life Insurance (If employee is owne	r or beneficiary)			1, 601	11. C
2.00 Accident Insurance (If employee is	owner or beneficiary)			0	12.0
3.00 Disability Insurance (If employee is	s owner or beneficiary)			0	13.0
4.00 Long-Term Care Insurance (If employ	ee is owner or beneficiary)			0	14.0
5.00 Workers' Compensation Insurance				62, 705	15. C
6.00 Retirement Health Care Cost (Only c	urrent year, not the extrao	rdinary accrual require	ed by FASB 106.	0	16. C
Non cumulative portion)	-		-		
TAXES					
7.00 FICA-Employers Portion Only				601, 909	17.0
8.00 Medicare Taxes - Employers Portion	Onl y			0	18.0
9.00 Unemployment Insurance				0	19. C
0.00 State or Federal Unemployment Taxes				95, 720	20. C
OTHER					
1.00 Executive Deferred Compensation				0	
2.00 Day Care Cost and Allowances				0	
3.00 Tuition Reimbursement				598	
4.00 Total Wage Related cost (Sum of line	es 1 - 23)			1, 214, 969	24.0
				Amount	
				Reported	
				1.00	
Part B - Other than Core Related Cos	st				
5.00 OTHER WAGE RELATED COST				0	25.0

Heal th	Financial Systems	CARE ONE AT	VALLEY		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to	5/10/2024 11: Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	851, 436	137, 813	989, 24	9 15, 528. 00	63.71	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 653, 877	267, 696				2.00
3.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	2, 025, 550	327, 855	2, 353, 40	5 78, 337. 00	30.04	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4, 530, 863	733, 364				4.00
5.00	Physical Therapists	469, 990	76, 072	546, 06			5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	443, 119	71, 723	514, 84			8.00
9.00	Occupational Therapy Assistants	0	0		0 0.00		9.00
10.00	Occupational Therapy Aides	0	0		0 0.00		
11.00	Speech Therapists	90, 352	14, 624	104, 97			11.00
12.00	Respi ratory Therapi sts	0	0		0 0.00		12.00
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations				1		
14.00	Registered Nurses (RNs)	1, 020		1, 02			
15.00	Licensed Practical Nurses (LPNs)	15, 086		15, 08			
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	11, 400		11,40			16.00
17.00	Total Nursing (sum of lines 14 through 16)	27, 506		27, 50			
18.00	Physical Therapists	0			0 0.00		
19.00	Physical Therapy Assistants	0			0 0.00		
20.00	Physical Therapy Aides	0			0 0.00		
21.00	Occupational Therapists	0			0 0.00		21.00
22.00	Occupational Therapy Assistants	0			0 0.00		
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapists	6,000		6, 00			
25.00	Respiratory Therapists	20, 454		20, 45			25.00
26.00	Other Medical Staff	0		I	0 0.00	0.00	26.00

		From 01/01/2023	
		To 12/31/2023	Date/Time Prepa 5/10/2024 11:50
	· · · · · · · · · · · · · · · · · · ·	Group	Days
00	· · · · · · · · · · · · · · · · · · ·	1.00 RUX	2.00
00		RUL	
00		RVX	
00		RVL	
00		RHX	
00 00 00 00 00 00 00 00 00 00 00 00 00		RHL RMX	
00		RML	
00		RLX	
0. 00		RUC	1
1. 00 2. 00		RUB RUA	1
3. 00		RVC	1
4.00		RVB	
5. 00		RVA	1
5. 00		RHC	1
7.00		RHB	1
3. 00 9. 00		RHA RMC	1
2. 00 D. 00		RMB	
1.00		RMA	
2. 00		RLB	2
3. 00		RLA	2
4.00		ES3	
5. 00		ES2 ES1	
7.00		HE2	
3. 00		HE1	2
9. 00		HD2	2
0.00		HD1	
1. 00 2. 00		HC2 HC1	
3. 00		HB2	
4.00		HB1	
5. 00		LE2	3
5. 00		LE1	3
7.00		LD2	3
3. 00 9. 00		LD1 LC2	
). 00		LC1	
1.00		LB2	4
2. 00		LB1	4
3. 00		CE2	4
4. 00 5. 00		CE1 CD2	
5. 00		CD2 CD1	
7.00		CC2	4
3. 00		CC1	4
9.00		CB2	4
0. 00 1. 00		CB1 CA2	Ę
2.00		CA2 CA1	E
8.00		SE3	5
l. 00		SE2	5
5.00		SE1	3
0. 00 7. 00		SSC SSB	E
. 00		SSA	3
. 00		I B2	E
. 00		I B1	6
. 00		I A2	6
. 00 . 00		I A1 BB2	
. 00		BB2 BB1	
. 00		BA2	
. 00		BA1	6
. 00		PE2	e
. 00		PE1	e
. 00 . 00		PD2 PD1	
. 00		PD1 PC2	
		PC1	، I
2. 00 3. 00		PC1 PB2	7

Health Financial Systems	CARE ONE AT VA	LLEY		In Lie	u of Form C	MS-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315369	Period:	Worksheet	S-7
				From 01/01/2023 To 12/31/2023		
				Group	Days	
				1.00	2.00	
76.00				PA1		76.00
99.00				AAA		99.00
100. 00 TOTAL						100.00
			Expenses	Percentage	Y/N	
			1.00	2.00	3.00	
A notice published in the Federal Register payments beginning 10/01/2003. Congress exp expenses. For lines 101 through 106: Enter column 2 the percentage of total expenses 1 line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expens (See instructions)	bected this increase in column 1 the amou for each category to for yes or "N" for r	to be used int of the total SNF io if the s	l for direct expense for d revenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, 1	ine 1, column 3)					101. 00 102. 00 103. 00 104. 00 105. 00 106. 00

CLAS	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	CARE ONE AT			eriod:	u of Form CMS-: Worksheet A	
				F	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst	Reclassified Trial Balance (col. 3 +- col. 4)	
					A-6)	-	
		1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		2, 435, 942	2, 435, 942	0	2, 435, 942	1.00
00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		251, 460	251, 460	-422	251,038	
00	00300 EMPLOYEE BENEFITS	0	1, 306, 999	1, 306, 999	0	1, 306, 999	3.00
00	00400 ADMINISTRATIVE & GENERAL	528, 060	2, 356, 974	2, 885, 034	0	2, 885, 034	
00 00	00500 PLANT OPERATION, MAINT. & REPAIRS	44, 233 96, 405	390, 778	435, 011	0	435, 011	5.00
00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	293, 425	72, 535 45, 992	168, 940 339, 417	0	168, 940 339, 417	7.00
00	00800 DI ETARY	548, 633	328, 224	876, 857	0	876, 857	8.00
00	00900 NURSI NG ADMI NI STRATI ON	584, 133	105, 360	689, 493	0	689, 493	9.00
0. 00	01000 CENTRAL SERVICES & SUPPLY	15, 787	193, 050	208, 837	-405	208, 432	
. 00		0	37, 696	37, 696	0	37, 696	
2.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	42, 258 103, 040	0	42, 258 103, 040	0	42, 258 103, 040	
I. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	103, 040	0	0103,040	0	103, 040	14.00
5.00	01500 ACTI VI TES	191, 177	12, 672	203, 849	0	203, 849	
	INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00	03000 SKILLED NURSING FACILITY	4, 530, 863	103, 021	4, 633, 884	0	4, 633, 884	30.00
. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
2.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0	0	0	0	32.00 33.00
. 00	ANCI LLARY SERVICE COST CENTERS	<u>Ч</u>	0	0	0	0	33.00
0. 00	04000 RADI OLOGY	0	26, 114	26, 114	0	26, 114	40.00
. 00	04100 LABORATORY	0	70, 752	70, 752	0	70, 752	
2.00	04200 I NTRAVENOUS THERAPY	0	145, 029	145, 029	0	145, 029	
. 00	04300 OXYGEN (INHALATION) THERAPY	0 E42 409	10 927	E02 22E	0	E02 22E	43.00 44.00
5.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	563, 408 443, 119	19, 827 0	583, 235 443, 119	0	583, 235 443, 119	
b. 00	04600 SPEECH PATHOLOGY	90, 352	6,000	96, 352	0	96, 352	
. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
8. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	405	405	
9.00	04900 DRUGS CHARGED TO PATIENTS	0	437, 812	437, 812	0	437, 812	49.00
0.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	422	0 422	50.00 51.00
2.00	05200 COMPLEX MEDICAL EQUI PMENT	0	0	0	422	422	52.00
2. 01	05201 OTHER ANCI LLARY SERVICES COST	0	0	0	0	0	
2. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52.02
	OUTPATIENT SERVICE COST CENTERS		0		0	0	1 / 0 . 00
0.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60.00 61.00
	06200 FQHC	0	0	0	0	0	62.00
	06300 DI ALYSI S	0	0	0	0	0	1
	OTHER REIMBURSABLE COST CENTERS	1					
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	
	07100 AMBULANCE	0	37, 347	37, 347	0	37, 347	
3.00 4.00	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0	0	0	0	
F. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	0	0	74.00
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	0	0	0	80.00
. 00	08100 INTEREST EXPENSE		0	0	0	0	81.00
2.00	08200 UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
3.00 1.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I	0	0	0	0	0	83.00 84.00
. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	
0.00	SUBTOTALS (sum of lines 1-84)	8,074,893	8, 383, 584	16, 458, 477	0	16, 458, 477	89.00
	NONREI MBURSABLE COST CENTERS						
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	4, 953		0	4, 953	
	09100 BARBER AND BEAUTY SHOP	0	15, 898	15, 898	0	15, 898	
2.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0	0	92.00 93.00
1. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
	09500 OTHER NONREI MBURSABLE COST	o o	0	0	0	0	95.00

	n Financial Systems SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	CARE ONE A		No.: 315369		u of Form CMS Worksheet A	6-2540-10
RECER	STITISATION AND ADJUSTMENT OF TRIAL DALANCE OF	EXT ENGES	11 OVI del	10	From 01/01/2023 To 12/31/2023	Date/Time Pr	renared
					10 12/31/2023	5/10/2024 1	
	Cost Center Description	Adjustments to	Net Expenses For Allocation				
		Wkst A-8)	(col. 5 +-				
		(00	col. 6)	-			
	GENERAL SERVICE COST CENTERS	6.00	7.00		<u> </u>		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-5, 181	2, 430, 761				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	251,038				2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	-838, 719	1, 306, 999 2, 046, 315	1			3.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-030,719	435, 011				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	-645	168, 295				6.00
7.00	00700 HOUSEKEEPI NG	0	339, 417	1			7.00
8.00		0	876, 857	1			8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	-2, 595	686, 898 208, 432	1			9.00
11.00		-3, 016	34, 680	1			11.00
12.00		0	42, 258				12.00
13.00		0	103, 040	1			13.00
14.00 15.00		0	0 203, 849				14.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	203, 847	1			15.00
30.00		-24, 410	4, 609, 474				30.00
31.00		0	C				31.00
32.00		0	0				32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	1			33.00
40.00		0	26, 114				40.00
41.00	04100 LABORATORY	0	70, 752				41.00
42.00		-11, 602	133, 427	1			42.00
43.00 44.00		0	0 583, 235				43.00
44.00		0	443, 119	1			44.00
46.00		0	96, 352	1			46.00
47.00		0	C				47.00
48.00		0	405	•			48.00
49.00 50.00		-35, 025	402, 787 0	1			49.00 50.00
51.00		0	422				51.00
52.00		0	C				52.00
52.01		0	C	•			52.01
52.02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	C				52. 02
60.00		0	C)			60.00
61.00		0	0	1			61.00
62.00							62.00
63.00		0	C				63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	C				70.00
71.00		0	37, 347				71.00
73.00		0	C				73.00
74.00		0	C				74.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C				80.00
81.00		0	0				81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0				82.00
83.00		0	C				83.00
84.00		0	0				84.00
84. 01 89. 00		-921, 193	15, 537, 284				84. 01 89. 00
27.00	NONREI MBURSABLE COST CENTERS	721,173	.0,007,204	1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	4, 953	1			90.00
91.00		0	15, 898				91.00
	09200 PHYSI CLANS PRIVATE OFFICES 09300 NONPALD WORKERS	0	0				92.00 93.00
	09300 NONPATE WORKERS 09400 PATIENTS LAUNDRY	0					93.00
	09500 OTHER NONREI MBURSABLE COST	0	C C				95.00
100.0	0 TOTAL	-921, 193	15, 558, 135				100.00

Health Financial Systems	CARE ONE AT VALLEY			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provider No.: 315369		Period: From 01/01/2023	Worksheet A-6)	
				To 12/31/2023			
			Increases				
	Cost Center	r i i	Line #	Sal ary	Non Salary		
	2.00		3.00	4.00	5.00		
(1) A - RECLASS MED SUPP CHARGED							
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		48.0	0 00	405	1.00	
(1) C - RECLASS SUPPORT SURFACES	·					1	
2.00	SUPPORT SURFACES		51.0	0 0	422	2.00	
TOTALS							
100.00	Total Reclassificat	ions (Sum		0	827	100.00	
	of columns 4 and 5 must						
	equal sum of column	s 8 and					
	9)						

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

Health Financial Systems	CARE ONE AT VALLEY			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provider No.: 315369		Period: From 01/01/2023	Worksheet A-6		
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 50 am	
	Decreases						
	Cost Center		Line # Salary		Non Salary		
	6.00		7.00	8.00	9.00		
(1) A - RECLASS MED SUPP CHARGED							
1.00	CENTRAL SERVICES &	SUPPLY	10. C	0 0	405	1.00	
(1) C - RECLASS SUPPORT SURFACES						1	
2.00	CAP REL COSTS - MOV	ABLE	2.0	0 0	422	2.00	
	EQUI PMENT						
TOTALS							
100.00				0	827	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.

	Financial Systems	CARE ONE A				In Lie	u of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315369		i od:	Worksheet A-7	
					Fro	01/01/2023 12/31/2023	Date/Time Pre	arad
					10	12/ 31/ 2023	5/10/2024 11:	50 am
				Acqui si ti on	s			
	Description	Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALA	NCES		_				
1.00	Land	1, 680, 000	0		0	0	0	1.00
2.00	Land Improvements	1, 915, 797	25, 469		0	25, 469	0	2.00
3.00	Buildings and Fixtures	15, 895, 136	10, 898, 425		0	10, 898, 425	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	1, 089, 049	455, 986		0	455, 986	0	5.00
6.00	Movable Equipment	2, 842, 017	611, 316		0	611, 316	0	6.00
7.00	Subtotal (sum of lines 1-6)	23, 421, 999	11, 991, 196		0	11, 991, 196	0	7.00
8.00	Reconciling Items	0	0		0	0	0	8.00
9.00	Total (line 7 minus line 8)	23, 421, 999	11, 991, 196		0	11, 991, 196	0	9.00
	Description	Endi ng Bal ance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALA							
1.00	Land	1, 680, 000	0					1.00
2.00	Land Improvements	1, 941, 266	0					2.00
3.00	Buildings and Fixtures	26, 793, 561	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	1, 545, 035	0					5.00
6.00	Movable Equipment	3, 453, 333	0					6.00
7.00	Subtotal (sum of lines 1-6)	35, 413, 195	0					7.00
8.00	Reconciling Items	0	0					8.00
9.00	Total (line 7 minus line 8)	35, 413, 195	0					9.00

	Financial Systems MENTS TO EXPENSES	CARE ONE AT		No.: 315369	Period:	u of Form CMS-2	
DJ021	MENTS TO EXPENSES		Provi der	NO.: 315369	From 01/01/2023	Worksheet A-8	
					To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared 50 am
					lassification on ch the Amount is	Worksheet A	
					in the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Adjustment 1.00	2.00		3.00	4.00	
. 00	Investment income on restricted funds	В		CAP REL COST		1.00	1.0
00	(chapter 2) Trade, quantity, and time discounts (chapter		0	FI XTURES		0.00	2.
00	8) Defunds and rebates of expenses (chapter 9)		0			0.00	3.
00 00	Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers		0			0.00 0.00	
00	(chapter 8) Telephone services (pay stations excluded)		0)		0.00	5.
00	(chapter 21)					0.00	,
00	Television and radio service (chapter 21) Parking lot (chapter 21)		0			0.00 0.00	
00	Remuneration applicable to provider-based physician adjustment	A-8-2	0				8.
00	Home office cost (chapter 21)		0			0.00	9.
0.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
. 00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	11.
2. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-304, 786				12.
3. 00	Laundry and Linen service	В	-645	LAUNDRY & LI	NEN SERVICE	6.00	13.
1.00	Revenue - Employee meals		0			0.00	
5.00 5.00	Cost of meals - Guests Sale of medical supplies to other than		0			0.00 0.00	
	patients		C C			0100	
7.00	5 1		0			0.00	
3.00 9.00	Sale of medical records and abstracts Vending machines		0			0. 00 0. 00	
). 00	Income from imposition of interest, finance		0			0.00	
	or penalty charges (chapter 21)		-				
I. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21.
2.00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON		82.00	22
2.00	(chapter 21)						
3.00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.
1. 00	Depreciationmovable equipment		0	CAP REL COST	S - MOVABLE	2.00	24.
6. 00	FACILITY MARKETING	А	-6, 490	ADMI NI STRATI	VE & GENERAL	4.00	25.
5. 01	RESIDENT REPLACEMENT ITEMS	A	-1, 463	ADMI NI STRATI	VE & GENERAL	4.00	
. 02	MARKETING EXPENSE	A		ADMI NI STRATI		4.00	
6.03	MARKETING CORP EXPENSE	A		ADMI NI STRATI		4.00	
. 04	MARKETING - MEALS	A		ADMI NI STRATI		4.00	
. 05	SHOWS & CONFERENCES	A		ADMI NI STRATI		4.00	
. 06	SPONSORSHI PS OTHER DONATI ONS	A		ADMINI STRATI		4.00 4.00	
5. 07	BAD DEBT EXPENSE	A		ADMI NI STRATI		4.00	
5.08	BAD DEBT EXPENSE - MEDI CARE	A		ADMI NI STRATI		4.00	
5. 10	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURS		30.00	
5. 11	OTHER REVENUE	B		ADMI NI STRATI		4.00	
5. 12	OTHER INCOME	B		ADMI NI STRATI		4.00	
	Total (sum of lines 1 through 99) (Transfer	5	-921, 193		. u General	4.00	100.
	to Worksheet A, col. 6, line 100)		,21,170				

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

	Financial Systems	CARE ONE A			In Lie	u of Form CMS-	2540-10
	ENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOMI		No.: 315369	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-II Date/Time Pre 5/10/2024 11:	epared:
		Line No.	Cost (Center	Expense	e Items	
		1.00		00		00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:						
1.00			ADMI NI STRATI VE		MANAGEMENT FEES		1.00
2.00			NURSING ADMINI		PHARMACY CONSUL		2.00
3.00			CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPE	ENSE	3.00
4.00		11.00	00 PHARMACY DRUGS-NON-PRESCRI PTI ON, NON-LEGEND				4.00
5.00		11.00	PHARMACY		PHARMACY SUPPLI	ES	5.00
6.00		42.00	INTRAVENOUS TH	ERAPY	I V EXPENSE		6.00
7.00		49.00	DRUGS CHARGED	TO PATI ENTS	DRUGS-PRESCRI P DRUGS OTH	FION, LEGEND	7.00
8.00		49.00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI P DRUGS MAN	FION, LEGEND	8.00
9.00		49.00	DRUGS CHARGED	TO PATI ENTS	DRUGS-PRESCRI P	FION, MEDICARE	9.00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.						10.00
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minu	s		
		Cost	Wkst. A, col.	col. 5)			
		4.00	5.00	6,00	_		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:				ED ORGANI ZATI ONS	OR	
1.00		605, 966	858, 514	-252, 54	18		1.00
2.00		29, 843			95		2.00
3.00		90, 082	90, 082		0		3.00
4.00		33, 094			78		4.00
5.00		1, 586					5.00
6.00		133, 427					6.00
7.00		19, 623					7.00
8.00		122, 948					8.00
9.00		260, 216	282, 844	-22, 62	28		9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 296, 785					10.00

Health Financial Systems	CARE ONE AT VAL			In Lieu of Form CMS-2540-10			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME	Ξ	Provider No.: 315369	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-II Date/Time Pre 5/10/2024 11:	pared:	
	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	A	DANI EL STRAUS	41.00	1.00
2.00	A	DANI EL STRAUS	41.00	2.00
3.00	A	DES HOLDING CO. INC.	22.00	3.00
4.00	F	PARTNERS PHARMACY SERVICES	0.00	4.00
		LLC		
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)	1		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.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

Director, officer, administrator, or key person of related organization or relative of such person has financial

nterest	in	provi der.	
---------	----	------------	--

Rel ated Organi	zation(s) and/	or Home Office	
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
ATLONICS AND OD HOME OFFICE			

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

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

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

· · · · · · · · · · · · · · · · · · ·			
1.00	HEALTHBRIDGE MANAGEMENT LLC	100. 00 MANAGEMENT	1.00
2.00	TOTALCARE LLC	99. OOWOUND CARE	2.00
3.00	TOTALCARE LLC	1. OOWOUND 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.

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CARE ONE AT			In Lie Period: From 01/01/2023 To 12/31/2023	u of Form CMS-: Worksheet B Part I Date/Time Pre	
			CAPI TAL REL		1	5/10/2024 11:	50 am
			CAPITAL REL	LATED CUSTS			
	Cost Center Description	Net Expenses for Cost	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
		Allocation (from Wkst A col. 7)					
		0	1.00	2.00	3.00	3A	
4 00	GENERAL SERVICE COST CENTERS	0 400 7 4	0.400.7/4				1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	2, 430, 761 251, 038	2, 430, 761	251, 03	9		1.00 2.00
3.00	00300 EMPLOYEE BENEFITS	1, 306, 999	0		0 1, 306, 999		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 046, 315	398, 343	41, 13		2, 571, 269	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	435, 011	91, 452	9, 44		543, 068	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	168, 295	120, 328			316, 654	6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	339, 417 876, 857	15, 566 191, 933			404, 085 1, 177, 414	7.00 8.00
9.00	00900 NURSING ADMINI STRATI ON	686, 898	17, 746			801, 025	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	208, 432	0		0 2, 555	210, 987	10.00
11.00	01100 PHARMACY	34, 680	0		0 0	34, 680	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	42, 258	15, 177	1, 56		65, 842	12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	103, 040	5, 526 0	57	1 16,678 0 0	125, 815 0	13.00 14.00
14.00	01500 ACTI VI TES	203, 849	0		0 30, 944	234, 793	
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	2007017		<u> </u>	00,711	2011/1/0	10100
30.00	03000 SKILLED NURSING FACILITY	4, 609, 474	1, 443, 466	149, 07	5 733, 362	6, 935, 377	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00 33.00	03200 I CF/I I D 03300 OTHER LONG TERM CARE	0	0		0 0 0 0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		0 0	0	33.00
40.00	04000 RADI OLOGY	26, 114	0		0 0	26, 114	40.00
41.00	04100 LABORATORY	70, 752	0		0 0	70, 752	
42.00	04200 I NTRAVENOUS THERAPY	133, 427	0		0 0	133, 427	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 583, 235	0 25, 607	2, 64	0 0 5 91, 193	0 702, 680	43.00 44.00
44.00	04500 OCCUPATI ONAL THERAPY	443, 119	13, 231	1, 36		529, 439	44.00
46.00	04600 SPEECH PATHOLOGY	96, 352	13, 231	1, 36		125, 573	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	405	35, 569	3, 67		39, 647	48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	402, 787	31, 133 0			437, 135 0	49.00 50.00
51.00	05100 SUPPORT SURFACES	422	0		0 0	422	51.00
52.00	05200 COMPLEX MEDICAL EQUI PMENT	0	0		0 0	0	52.00
52.01	05201 OTHER ANCI LLARY SERVICES COST	0	0		0 0	0	52.01
52.02	05202 MEDI CAL SERVI CES	0	0		0 0	0	52.02
60 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 DI ALYSI S	0	0		0 0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	37, 347	0		0 0	37, 347	71.00
73.00	07300 CMHC	0	0		0 0	0	73.00
74.00	07400 OTHER REI MBURSEMENT	0	0		00	0	74.00
00 00	SPECIAL PURPOSE COST CENTERS	1					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	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	15 527 204	0	240 75	0 0	15 522 545	84.01
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	15, 537, 284	2, 418, 308	249, 75	2 1, 306, 999	15, 523, 545	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	4, 953	0		0 0	4, 953	90.00
91.00	09100 BARBER AND BEAUTY SHOP	15, 898	12, 453	1, 28	6 0	29, 637	91.00
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0 0	0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST		0			0	94.00 95.00
93.00 98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	TOTAL	15, 558, 135	2, 430, 761	251, 03	8 1, 306, 999	15, 558, 135	100.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CARE ONE A		No.: 315369 P	In Lie eriod:	u of Form CMS-: Worksheet B	2540-10
CUST P			PI OVI dei	F	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/10/2024 11:	pared: 50 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS			1			
1.00 2.00 3.00 4.00 5.00 6.00 7.00	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	2, 571, 269 107, 522 62, 694 80, 005	650, 590 40, 333 5, 218	419, 681 0	489, 308	1 507 000	1.00 2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	233, 116 158, 595 41, 773 6, 866	64, 334 5, 948 C	0	52, 028 4, 810 0 0	1, 526, 892 0 0 0	9.00 10.00
12.00 13.00 14.00	01200 MEDI CAL RECORDS & LIBRARY 01300 SOCI AL SERVI CE 01400 NURSI NG AND ALLI ED HEALTH EDUCATI ON 01500 ACTI VI TES	13, 036 24, 910 0 46, 487	5, 087 1, 852 C	0	1, 498 0	0 0 0 0 0	12.00 13.00 14.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
30.00 31.00 32.00 33.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	1, 373, 135 0 0 0	483, 834 C C C	0 0	0	1, 526, 892 0 0 0	31.00 32.00
	ANCI LLARY SERVICE COST CENTERS						
40.00 41.00 42.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	5, 170 14, 008 26, 417	C C C	0		0 0 0	
43.00 44.00 45.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY	0 139, 124 104, 824	C 8, 583 4, 435	0		0 0 0	43.00 44.00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	24, 862 0	4, 435 C	0	3, 587 0	0	46.00 47.00
48.00 49.00 50.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	7, 850 86, 548 0	11, 922 10, 435 C	0	9, 642 8, 439 0	0 0 0	49.00 50.00
51.00 52.00 52.01	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	84 0 0	C C C			0 0 0	51.00 52.00 52.01
52.02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	C	0	0	0	52.02
60.00	06000 CLINIC	0	C	0	0	0	60.00
61.00 62.00 63.00	06100 RURAL HEALTH CLINIC 06200 FOHC 06300 DIALYSIS	0	c	0	0	0	62.00
00.00	OTHER REIMBURSABLE COST CENTERS			<u>ı</u> 0	0		00.00
71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 7, 394 0	C C C	0	0	0 0 0	71.00
	07400 OTHER REIMBURSEMENT	0	C			0	
80. 00 81. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82.00 83.00 84.00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I	0	C	0 0	0	0 0	
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 2, 564, 420	0 646, 416	0 419, 681	0 485, 932	0 1, 526, 892	
90.00 91.00 92.00 93.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	981 5, 868 0 0	C 4, 174 C C		0 3, 376 0 0	0 0 0 0	
94.00 95.00 98.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0 0 0	C C C		0 0 0	0 0 0	94.00 95.00 98.00
99. 00 100. 00	Negative Cost Centers TOTAL	0 2, 571, 269	0 650, 590	0 0 419, 681	0 489, 308	0 1, 526, 892	

	Financial Systems	CARE ONE A				u of Form CMS-	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/10/2024 11:	pared: 50 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00 4.00 5.00 6.00 7.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	970, 378 0	252, 760				8.00 9.00 10.00
11.00	01100 PHARMACY	0	252,700		6		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	C		88, 079		12.00
13.00	01300 SOCIAL SERVICE	0	C		0 0	154, 075	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0 0	0	
15.00	01500 ACTIVITES	0	C		0 0	0	15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS	970, 378	252, 760	41, 54	6 88, 079	154, 075	30.00
30.00	03100 NURSING FACILITY	970, 378	252,700		0 0	0154,075	1
32.00	03200 I CF/I I D	0	C		0 0	0	1
33.00	03300 OTHER LONG TERM CARE	0	C		0 0	0	1
	ANCI LLARY SERVI CE COST CENTERS			1			
40.00	04000 RADI OLOGY	0	C		0 0	0	1
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	C		0 0	0	
42.00	04300 OXYGEN (INHALATION) THERAPY	0				0	
44.00	04400 PHYSI CAL THERAPY	0	C		0 0	0	
45.00	04500 OCCUPATI ONAL THERAPY	0	C		0 0	0	1
46.00	04600 SPEECH PATHOLOGY	0	C		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	C		0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0				0	49.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	C		0 0	0	52.00
52.01	05201 OTHER ANCI LLARY SERVICES COST	0	C		0 0	0	52.01
52.02	05202 MEDI CAL SERVI CES	0	C)	0 0	0	52.02
(0.00	OUTPATIENT SERVICE COST CENTERS			1			1 / 0 . 00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	C		0 0 0 0	0	1
62.00	06200 FQHC	0	C		0 0	0	62.00
63.00	06300 DI ALYSI S	0	C		0 0	0	1
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	C		0 0	0	1
71.00 73.00	07100 AMBULANCE 07300 CMHC	0	C		0 0 0 0	0	
73.00	07400 OTHER REI MBURSEMENT	0			0 0	0	1
74.00	SPECIAL PURPOSE COST CENTERS	V		,,,	0 0	0	74.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF		-		-	-	82.00
83.00		0	C		0 0	0	1
84.00 84.01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0				0	1
89.00	SUBTOTALS (sum of lines 1-84)	970, 378	252, 760	41, 54	6 88,079		
27.00	NONREI MBURSABLE COST CENTERS		232,700		30, 017		1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	C		0 0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	C		0 0	0	
93.00 94.00	09300 NONPALD WORKERS	0	C			0	
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0				0	1
98.00	Cross Foot Adjustments	0	0			0	98.00
99.00	Negative Cost Centers	0	C		0 0	0	99.00
100.00	TOTAL	970, 378	252, 760	41, 54	6 88, 079	154, 075	100.00

From From <th></th> <th>Financial Systems</th> <th>CARE ONE A</th> <th></th> <th></th> <th></th> <th>u of Form CMS-</th> <th>2540-10</th>		Financial Systems	CARE ONE A				u of Form CMS-	2540-10
Cost Center Description NURFINE AD LLED (#ALT) (BULLED (#ALT) (BULLED (#ALT)) (BULLED	COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315369		Date/Time Pre	epared:
Cost Curtur Description NREN AND ALLED UNITS ACTIVITES Subtocled Post Support Total CENERAL SERVICE COST CENTERS 100 15.00 16.00 17.00 18.00 1.00 CONTROL COST - ELLOSS & FUTURES 1.00 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>371072024 11.</th> <th></th>							371072024 11.	
Introduct StavPrice Cost CANTRES 11.00 15.00 16.00 17.00 18.00 100 GOTOR CAP RT. ORSTS - BLOS & LITURES 1 <		Cost Center Description	ALLI ED HEALTH		Subtotal		Total	
1.00 DOTOG CAP REL COSTS - BLORS & FIXINES 1.00 3.00 DOXOG LAR OVE REL COSTS - BLORS & FIXINES 2.00 3.00 DOXOG LAR OVE REL COSTS - BLORS & FIXINES 5.00 3.00 DOXOG LAR OVE REL COSTS - BLORS & FIXINES 5.00 3.00 DOXOG LAR OVE ALL NEW SERVICE 7.00 3.00 DOXOG LAR OVE ALL NEW SERVICE 1.00 3.00 DOXOG LAR OVE ALL NEW SING ALL NEW SIN				15.00	16.00	17.00	18.00	
2.00 DOXDO CAP, FREL COSTS - MOVABLE EQUIPMENT 2.00 3.00 4.00 DOXDO CAP, FREL COSTS - MOVABLE EQUIPMENT 3.00 4.00 DOXDO CAP, TURN OPEANT ON, MAIN TO REPAIRS 3.00 7.00 DOXDO CAP, TURN OPEANT ON, MAIN TO REPAIRS 7.00 7.00 DOXDO CAP, MAIN STRATE ON 7.00 7.00 DOXDO MUSSING AMINI STRATE ON 7.00 0.00 DOXDO MUSSING AMINI STRATE ON 7.00 0.00 DOXDO MUSSING AMINI STRATE ON 7.00 0.00000 MUSSING AMD ALLERD WINKING AS ALMONDY 11.00 1.00 DIACOLONIANS STRATE ON 11.00 0.01000 CHILLAR STRATE ON 0 2.01 0.00000 MUSSING AMD ALLED WINKING AND AL	1 00		1		1			1 1 00
4.00 ODOROG ADMIN INSTRUTUSE & CENERAL 4.00 5.00 OBOSCIP LINARY 5.00 6.00 ODOROG DLENARY 5.00 8.000 DOROSCIP LINARY 5.00 8.000 DOROSCIP LINARY 5.00 10.00 OTICO PARAMACY 10.00 11.00 OTICO PARAMACY 10.00 11.00 OTICO PARAMACY 10.00 11.00 OTICO PARAMACY 10.00 11.00 OTICO PARAMACY 0 281.280 11.00 OTICO PARAMACY 0 281.280 12.918.323 30.00 11.00 OTICO PARAMACY 0 281.280 12.918.323 30.00 11.00 OTICO PARAMACY 0 281.280 12.918.323 30.00 11.00 OTICO PARAMACY 0 0 0 0 0 31.284 11.00 OTICO PARAMACY 0 281.280 12.918.323 30.00 31.284 30.00 31.284 31.284 31.284 31.284 31.284 31	2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
6.00 DOCKOT LUNDRY & LINEN SERVICE 6.00 6.00 S.00 7.00 8.00 S.00 8.00 S.00	4.00	00400 ADMINISTRATIVE & GENERAL						4.00
8.00 00000 DETARY 8.00 9.00 9.00 000000 DETARY 8.00 9.00 10.00 CENTRAL SERVICES & SUPPLY 10.00 11.00 110.00 11.00 01100 DETADAMACY 12.00 11.00 11.00 01100 DETADAMACY 12.00 12.00 11.00 01100 DETADAMACY 12.00 12.00 11.00 01500 ACTI VITES 0 281.280 12.918.323 0 12.918.323 0 12.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.00 32.00 12.918.323 0 0 31.20 32.00		00600 LAUNDRY & LINEN SERVICE						
9.00 00700 UREN IG ADM IN STRATION 9.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 1100 PARMACY 11.00 11								
11.00 00 11.00 01100 PHARMACY 11.00 <td< td=""><td>9.00</td><td>00900 NURSING ADMINISTRATION</td><td></td><td></td><td></td><td></td><td></td><td>9.00</td></td<>	9.00	00900 NURSING ADMINISTRATION						9.00
12.00 01300 SOCIAL SERVICE 13.00 14.00 13.00 01400 NURSING AND ALLED HEALTH EDUCATION 281.280 15.00 IMPATIENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0.00 03000 SKILLED NURSING FACILITY 0 281.280 12.918.323 0 12.918.323 0<		01100 PHARMACY						
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 281,280 15.00 10.00 01500,0111 ME, SERVICE COST CENTERS 0 281,280 15.00 00 03000,011 ME, SERVICE COST CENTERS 0 0 0.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Inpart ENT BOUTINE SERVICE COST CENTERS 21 21 21 21 23 0 12 91 23 0	14.00	01400 NURSING AND ALLIED HEALTH EDUCATION		201 200				14.00
31:00 03100 NURSING FACLLITY 0 0 0 0 31:00 32:00 03200 OTHER LONG TERM CARE 0 0 0 0 33:00 40:00 03300 OTHER LONG TERM CARE 0 0 0 0 33:00 40:00 04000 RADICLARY SERVICE COST CENTERS 0 0 31:284 0 33:284 0 33:00 40:00 04200 INTRAVENUUS THERAPY 0 0 84:760 0 42:00 0 42:00 0 42:00 0 42:00 0 42:00 0 42:00 0 64:22:00 64:7.328 0 64:7.328 0 64:00 42:00 0 40:00 0 0 0 0 0 0 0 40:00 0	15.00		0	281, 280	2			15.00
32. 00 03200 [CF/110] 0			1					
ANCI LLARY SERVICE COST CENTERS Image: Control of the co	32.00	03200 I CF/I I D	0	C		0 0	0	32.00
40:00 04000 RADIOLOGY 0 0 31.284 0 31.284 0 31.284 0 31.284 0 31.284 0 31.284 0 31.284 0 31.284 0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 40.00 0.0 0.0 0.0 0.0 31.284 40.00 40.00 30.0<	33.00		0	C		0 0	0	33.00
42:00 04200 INTRAVENUUS THERAPY 0 0 159;844 0 159;844 42:00 44:00 04400 DVYGEN (INHALATION) THERAPY 0 0 857;328 0 857;328 44:00 50:00 04500 DVYGEN (INHALATION) THERAPY 0 0 857;328 0 642;285 0 642;285 0 642;285 0 642;285 0 642;285 0 642;285 0 642;285 0 640;01 650;01 650;01 650;01 650;01 650;01 650;01 650;01 650;01 650;01 652;01 652;01 652;01 650;01 652;01		04000 RADI OLOGY	1	C				
43.00 04300 0YGEN (1NHALATION) THERAPY 0 0 0 0 43.00 44.00 04400 04500 0CUPATIONAL THERAPY 0 0 642.285 0 642,285 0 650.0 542,557 0 542,557 0 542,557 0 550.0 0 0 0 0 0 0 0 52.0 0 0 0 0 0 0 52.0 0 0 0 0 0 52.0 0 0 0 0 <			1					
45.00 04500 CCUPATIONAL THERAPY 0 0 642,285 0 642,285 45.00 46.00 04600 SPECEH PATHOLOGY 0 0 0 158.457 0 158.457 0 158.457 0 0 47.00 48.00 04800 DEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 69.061 0 69.061 0 69.061 80.07 49.00 05000 DENIGS CHARGED TO PATIENTS 0 0 0 0 542.557 0 542.557 49.00 51.00 DS100 SUPPORT SURFACES 0 0 0 0 55.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 60.00 61.00 61.00 61.00 62.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00	43.00	04300 OXYGEN (INHALATION) THERAPY	0	C		0 0	0	43.00
46.00 04600 SPECCH PATHOLOGY 0 158,457 0 158,457 0 158,457 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 69,061 0 69,061 69,061 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 542,557 0 542,557 49.00 0.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 50.00 0.00 05100 SUPPORT SURFACES 0 0 0 0 0 52.00 20.00 DS200 COMPLEX MEDICAL SERVICES 0 0 0 0 0 52.00 20.00 DOCOO CLINIC 0 0 0 0 0 60.00 61.00 62.00 62.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 74.00 74.00 74.00 74.00 74.00			0	0				
48. 00 004800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 69,061 69,061 48.00 49.00 49.00 Ad900 DRUGS CHARGED TO PATIENTS 0 0 542,557 0 542,557 0 542,557 49,00 00 05100 SUPPORT SURFACES 0 0 0 0 0 506 51,00 52,01 52,01 52,01 0 0 0 0 0 52,00 52,01 0 0 0 0 0 52,02 <	46.00	04600 SPEECH PATHOLOGY	0	C		57 0	158, 457	46.00
50.00 OSOOO DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 50.00 60.00 60.00 <t< td=""><td></td><td></td><td>0</td><td>C</td><td>69,0</td><td>-</td><td></td><td></td></t<>			0	C	69,0	-		
51.00 OS100 SUPPORT SURFACES O O 506 51.00 52.00 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>542, 5</td><td></td><td></td><td></td></t<>			0	0	542, 5			
52.01 OTHER ANCILLARY SERVICES COST 0		05100 SUPPORT SURFACES	0	0	5	-	-	
52.02 05202 MEDICAL SERVICES 0 0 0 0 0 0 52.02 001PATIENT SERVICE COST CENTERS 0			-	-		-		
60.00 06000 CLINIC 0		05202 MEDI CAL SERVI CES	-					
61.00 06100 RURAL HEALTH CLINIC 0 0 0 61.00 62.00 0 0 61.00 62.00	60 00		0	0		0 0	0	60 00
63.00 06300 01 0	61.00	06100 RURAL HEALTH CLINIC						61.00
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HMUE HEALTH AGENCY COST 0			0	C)	0 0	0	
71.00 07100 AMBULANCE 0 44,741 0 44,741 71.00 73.00 07300 CMHC 0 0 0 0 73.00 74.00 OTHER REIMBURSEMENT 0 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 80.00 81.00 0 0 0 0 81.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 82.00 83.00 84.00		OTHER REIMBURSABLE COST CENTERS					0	
74.00 OT400 OTHER REIMBURSEMENT 0 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 80.00 90.00 90.00 90.00 90.00			1			-		
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 08100 INTEREST EXPENSE 80.00 82.00 08200 UTI LI ZATI ON REVIEW - SNF 82.00 83.00 08300 HOSPI CE 0 0 82.00 84.00 08400 OTHER SPECI AL PURPOSE COST I 0 0 0 83.00 84.01 08401 OTHER SPECI AL PURPOSE COST II 0 0 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 0 281,280 15,509,146 0 15,509,146 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 5,934 0 5,934 90.00 91.00 09000 BABER AND BEAUTY SHOP 0 0 43,055 0 43,055 91.00 92.00 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.00 93.00 09300 NONREL MBURSABLE COST 0 0 0			-	-		-		
81.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 0 0 82.00 83.00 08300 HOSPICE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 0 281,280 15,509,146 0 15,509,146 84.00 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 43,055 90.00 91.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 43,055 91.00 92.00 09000 BABBER AND BEAUTY SHOP 0 0 0 0 92.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 0 92.00 94.00 09	74.00						0	74.00
82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 HOSPICE 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 0 281,280 15,509,146 0 15,509,146 84.01 90.00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0<								
84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 84.01 89.00 SUBTOTALS (sum of lines 1-84) 0 281,280 15,509,146 0 15,509,146 89.00 NONREI MBURSABLE COST CENTERS 0 0 0 64,01 89.00 90.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 5,934 0 5,934 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 43,055 91.00 92.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONREI MBURSABLE COST 0 0 0 92.00 93.00 92.00 93.00 94.00 92.00 92.00 93.00 92.00 93.00 94.00 92.00 92.00 92.00 93.00 92.00	82.00	08200 UTILIZATION REVIEW - SNF						82.00
84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 84.01 89.00 SUBTOTALS (sum of lines 1-84) 0 281,280 15,509,146 0 15,509,146 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 5,934 0 5,934 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 43,055 0 43,055 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 92.00 94.00 PATIENTS LAUNDRY 0 0 0 0 92.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 93.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 98.00 97.00 Nogative Cost Centers 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>•</td>			0	0		0 0		•
NONRE IMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 5, 934 0 5, 934 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 43, 055 0 43, 055 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 0 0 99.00	84.01	08401 OTHER SPECIAL PURPOSE COST II	0	0		0 0	0	84.01
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 5,934 0 5,934 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 43,055 0 43,055 91.00 92.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 0 99.00	89.00		0	281, 280	15, 509, 1	46 0	15, 509, 146	89.00
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 94.00 93.00 94.00 95.00 95.00 0 0 0 95.00 95.00 95.00 95.00 95.00 98.00 98.00 98.00 98.00 98.00 99.00		09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1	0				
93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 0 0 0 0 95.00 95.00 95.00 0 0 0 0 95.00 95.00 98.00 98.00 0 0 0 98.00 98.00 99.00 0 0 0 0 99.00 99.00 0 0 0 0 99.00			0	0 0	43,0	55 0 0 0		
95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00	93.00	09300 NONPAI D WORKERS	0	Ö		0 0	0	93.00
98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00			0	0		0 0	-	
	98.00	Cross Foot Adjustments	0	0		0 0		98.00
			0	281, 280	15, 558, 1	35 0		

	Financial Systems	CARE ONE A				u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2023	Worksheet B Part II	
				Тс		Date/Time Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS		371072024 11.	
	Cast Castas Description	Discontinu			Cultated		
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		Capi tal					
		Related Costs	1 00	2.00	24	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 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	0	0 398, 343	0 41, 139	0 439, 482	0	3.00 4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	91, 452	41, 139 9, 445	439, 482 100, 897	0	4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	120, 328		132, 755	0	6.00
7.00	00700 HOUSEKEEPI NG	0	15, 566		17, 174	0	7.00
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	191, 933		211, 755	0	8.00 9.00
9.00 10.00	01000 CENTRAL SERVICES & SUPPLY	0	17, 746 0	1, 833 0	19, 579 0	0	9.00
11.00	01100 PHARMACY	0	0	0	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	15, 177		16, 744	0	12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	5, 526 0	571 0	6, 097 0	0	13.00 14.00
15.00	01500 ACTI VI TES	0	0	0	0	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-			-		
30.00	03000 SKILLED NURSING FACILITY	0	1, 443, 466		1, 592, 541	0	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 ICF/IID	0	0	0	0	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE	0	0	-	0	0	33.00
	ANCI LLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY 04100 LABORATORY	0	0	0	0	0	40.00
41.00 42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	41.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	Ō	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	25, 607		28, 252	0	44.00
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	13, 231 13, 231	1, 366 1, 366	14, 597 14, 597	0	45.00 46.00
40.00	04700 ELECTROCARDI OLOGY	0	13, 231	0	14, 597	0	40.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35, 569		39, 242	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	31, 133		34, 348	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50.00 51.00
52.00	05200 COMPLEX MEDICAL EQUI PMENT	0	0	0	0	0	52.00
52.01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	52.02
60.00	06000 CLINIC	0	0	0	0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0	0	
62.00	06200 FQHC					0	62.00
63.00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	0		0	0	
73.00 74.00	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0		0	0	
74.00	SPECIAL PURPOSE COST CENTERS	0	0	0	V	0	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00 83.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0	0	0	0	82.00 83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	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) NONREIMBURSABLE COST CENTERS	0	2, 418, 308	249, 752	2, 668, 060	0	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	o	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	12, 453	1, 286	13, 739	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00 94.00	09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY	0	0	0	0	0	93.00 94.00
94.00 95.00	09500 OTHER NONRELMBURSABLE COST	0	0	0	0	0	
98.00	Cross Foot Adjustments				0		98.00
99.00	Negative Cost Centers TOTAL	0	0	0	0 2, 681, 799	0	99.00 100.00
100.00		ı ol	2, 430, 761	251, 038	2,001,199	0	1100.00

Heal th	Financial Systems	CARE ONE A	T VALLEY		In Lie	u of Form CMS-2	2540-10
	TION OF CAPITAL RELATED COSTS				eriod: rom 01/01/2023	Worksheet B Part II	
					o 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 50 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	REPAI RS 5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
2.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINI STRATI VE & GENERAL	439, 482					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	18, 377	119, 274				5.00
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	10, 716 13, 674	7, 394 957				6.00 7.00
8.00	00800 DI ETARY	39,844	11, 794			266, 775	•
9.00	00900 NURSI NG ADMI NI STRATI ON	27, 107	1, 090		313	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	7, 140	0		0	0	10.00
11.00		1, 174	0		0	0	11.00
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	2, 228 4, 258	933 340		267 97	0	12.00 13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	4,230	0+0			0	14.00
15.00	01500 ACTI VI TES	7, 945	0	0	0	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			150.0/5	05.404		
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	234, 698	88, 702 0			266, 775 0	30.00 31.00
31.00	03200 I CF/I I D	0	0	-	-	0	
33.00	03300 OTHER LONG TERM CARE	0	0			0	
	ANCI LLARY SERVICE COST CENTERS			1			
40.00	04000 RADI OLOGY	884	0		-	0	
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	2, 394 4, 515	0		0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	4, 313	0	-	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	23, 779	1, 574	0	451	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	17, 916	813		233	0	45.00
46.00 47.00		4, 249	813 0		233 0	0	46.00
47.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 342	2, 186	-	627	0	47.00
49.00	04900 DRUGS CHARGED TO PATIENTS	14, 793	1, 913		549	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	14	0	0	0	0	51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCI LLARY SERVICES COST	0	0	0	-	0	52.00 52.01
52.02	05202 MEDI CAL SERVI CES	0	0		-	0	
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1			
60.00	06000 CLINIC	0	0			0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61.00 62.00
	06300 DI ALYSI S	0	0	о	0	0	•
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	-	0	
71.00 73.00	07100 AMBULANCE 07300 CMHC	1, 264	0	-		0	
	07400 OTHER REIMBURSEMENT	0	0	-		0	
/ 11 00	SPECIAL PURPOSE COST CENTERS						1.1.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00 83.00	08200 UTI LI ZATI ON REVIEW - SNF 08300 HOSPI CE	0	0	0	0	0	82.00 83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84.01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	438, 311	118, 509	150, 865	31, 586	266, 775	89.00
00.00	NONREIMBURSABLE COST CENTERS	1/0				^	00.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	168 1, 003	0 765		0 219	0	
92.00	09200 PHYSI CLANS PRI VATE OFFICES	0	, 33	0	0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 98.00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0		0	0	95.00 98.00
98.00 99.00	Negative Cost Centers	0	0	0	0	0	
100.00	5	439, 482	119, 274	150, 865	31, 805	266, 775	

-	Financial Systems	CARE ONE A				u of Form CMS-	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/10/2024 11:	pared: 50 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1		1			1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - BEDGS & TEXTORES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	48, 089					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	7, 140	þ			10.00
11.00	01100 PHARMACY	0	C	1, 17	4		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	C		0 20, 172		12.00
13.00	01300 SOCIAL SERVICE	0	C		0 0		
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	C		0 0 0 0	-	14.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	(/	0 0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	48, 089	7, 140) 1, 17	4 20, 172	10, 792	30.00
31.00	03100 NURSING FACILITY	0	C		0 0		•
32.00	03200 I CF/I I D	0	C		0 0	-	
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0)	0 0	0	33.00
40.00	04000 RADI OLOGY	0	C		0 0	0	40.00
41.00	04100 LABORATORY	0	C		0 0		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	C		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	(0 0 0 0	0	
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	(0 0	0	45.00
47.00	04700 ELECTROCARDI OLOGY	0	(0 0	0	47.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0 0	0	50.00
51.00 52.00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	0	(0 0 0 0	0	51.00 52.00
52.00	05201 OTHER ANCI LLARY SERVICES COST	0	C		0 0	0	
52.02	05202 MEDI CAL SERVI CES	0	C		0 0	0	52.02
	OUTPATIENT SERVICE COST CENTERS	1 1		İ.	1		
60.00		0	0		0 0		
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	C		0 0	0	61.00 62.00
63.00	06300 DI ALYSI S	0	C		0 0	0	
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	C		0 0		•
71.00 73.00	07100 AMBULANCE 07300 CMHC	0	((0 0 0 0		
73.00	07400 OTHER REIMBURSEMENT	0	0		0 0		74.00
71.00	SPECIAL PURPOSE COST CENTERS			/	0 0	0	/ 1. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF						82.00
83.00 84.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I	0	(0 0 0 0	0	•
84.00	08401 OTHER SPECIAL PURPOSE COST I	0	0		0 0	0	•
89.00	SUBTOTALS (sum of lines 1-84)	48, 089	7, 140				•
	NONREI MBURSABLE COST CENTERS	· · · · · ·		· ·			1
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0		•
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	-	91.00
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0			0 0	0	
93.00 94.00	09400 PATIENTS LAUNDRY	0	(0 0	0	1
95.00	09500 OTHER NONREI MBURSABLE COST	0	C		0 0	0	•
98.00	Cross Foot Adjustments	0	C		0		98.00
99.00	Negative Cost Centers	0	0		0 0	0	
100.00	TOTAL	48, 089	7, 140	1, 17	4 20, 172	10, 792	100.00

	I Financial Systems ATION OF CAPITAL RELATED COSTS	CARE ONE A		No.: 315369	Period: From 01/01/2023 To 12/31/2023	u of Form CMS- Worksheet B Part II Date/Time Pre 5/10/2024 11:	epared:
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	OTHER GENERAL SERVI CE ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS			1			1
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	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						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 14.00 15.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	7, 945				12.00 13.00 14.00 15.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	7, 740	· · · · · · · · · · · · · · · · · · ·			1 .0.00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0	7, 945 C C		27 0 0 0 0 0 0 0	2, 454, 327 C C C	31.00 32.00
40.00 41.00 42.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0 0			94 0	884 2, 394 4, 515	41.00
43.00 44.00 45.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	0		54, 05 33, 55	59 0	0 54, 056 33, 559	44.00 45.00
46.00 47.00 48.00 49.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0) 19, 89) 43, 39) 51, 60	0 0 97 0	19, 892 C 43, 397 51, 603	47.00 48.00
50.00 51.00 52.00 52.01 52.02	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES				0 0 14 0 0 0 0 0 0 0	0 14 0 0 0 0	51.00 52.00 52.01
	OUTPATI ENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	C		0 0 0 0	C	
63.00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	C)	0 0	C	63.00
71.00 73.00	07100 AMBULANCE 07300 CMHC 07400 OTHER REI MBURSEMENT SPECI AL PURPOSE COST CENTERS	0 0 0	C C C		54 0 0 0 0 0	1, 264 0 0	71.00 73.00
81. 00 82. 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 0 0	C C C 7, 945	2, 665, 90	0 0 0 0 0 0 0 0 5 0	0 0 0 2, 665, 905	84. 00 84. 01
91.00 92.00 93.00 94.00 95.00 98.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments			16 15, 72		168 15, 726 0 0 0 0 0 0 0 0 0 0	91.00 92.00 93.00 94.00 95.00 98.00
99.00 100.00	Negative Cost Centers TOTAL	0	C 7, 945	2, 681, 79	0 0 99 0	0 2, 681, 799	

COST A	Financial Systems LOCATION - STATISTICAL BASIS	CARE ONE A			Period: From 01/01/2023	u of Form CMS-2 Worksheet B-1	2010 1
					o 12/31/2023	Date/Time Pre 5/10/2024 11:	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES	21 221		1			1 1 00
2.00 3.00 4.00 5.00 5.00 7.00 3.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	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 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	31, 231 0 5, 118 1, 175 1, 546 200 2, 466 228 0 0 195 71 0 0 0	31, 231 0 5, 118 1, 175 1, 546 200 2, 466 228 0 0 195 71 0 0 0	8, 074, 893 528, 060 44, 233 96, 405 293, 425 548, 633 584, 133 15, 787 0 42, 258 103, 040	-2, 571, 269 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 986, 866 543, 068 316, 654 404, 085 1, 177, 414 801, 025 210, 987 34, 680 65, 842 125, 815 0 234, 793	9.00 10.00 11.00 12.00 13.00 14.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	18, 546	18, 546	4, 530, 863	0	6, 935, 377	30. 00
	03100 NURSING FACILITY 03200 ICF/IID	0	0		-	0	31.00 32.00
	03200 OTHER LONG TERM CARE	0	0		-	0	
40.00	ANCI LLARY SERVICE COST CENTERS					2/ 114	
	04000 RADI OLOGY 04100 LABORATORY	0			-	26, 114 70, 752	40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	c c	0	133, 427	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43.00
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	170	329 170			702, 680 529, 439	
	04600 SPEECH PATHOLOGY	170	170			125, 573	
	04700 ELECTROCARDI OLOGY	0	0		0	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	457 400	457 400		0	39, 647 437, 135	48.00 49.00
	05000 DENTAL CARE - TITLE XIX ONLY	400	400		0	437, 135	50.00
	05100 SUPPORT SURFACES	0	0	c c	0	422	51.0
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.0
	05201 OTHER ANCI LLARY SERVICES COST 05202 MEDI CAL SERVICES	0				0	52.0 52.0
JZ. UZ	OUTPATIENT SERVICE COST CENTERS	0	0	η (/0	0	52.0
	06000 CLI NI C	0	0			0	
	06100 RURAL HEALTH CLINIC	0	0	C	0 0	0	
	06200 FQHC 06300 DI ALYSI S	0	0	, c	0	0	62.00 63.00
	OTHER REIMBURSABLE COST CENTERS		-		-		
	07000 HOME HEALTH AGENCY COST	0	0			0	
	07100 AMBULANCE 07300 CMHC	0	0		-	37, 347 0	
	07400 OTHER REIMBURSEMENT	0	0		-	0	
	SPECIAL PURPOSE COST CENTERS	1	L	1			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.0
	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW – SNF						81.0 82.0
	08300 HOSPI CE	0	0	c c	0	0	
	08400 OTHER SPECIAL PURPOSE COST I	0	0	C	0	0	
84.01 89.00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0	0	0 074 903	0		84.0
	NONREI MBURSABLE COST CENTERS	31,071	31, 071	8, 074, 893	-2, 571, 269	12, 952, 276	89.0
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	4, 953	
	09100 BARBER AND BEAUTY SHOP	160	160	0	0	29, 637	91.0
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS					0	92.00 93.00
	09400 PATIENTS LAUNDRY	0	0		0	0	94.00
	09500 OTHER NONREI MBURSABLE COST	0	0	C	0	0	95.00
98.00	Cross Foot Adjustments						98.0
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 430, 761	251, 038	1, 306, 999		2, 571, 269	99.00 102.0
. 52. 00	Part I)	2,400,701	201,000	1, 300, 77		2, 371, 207	02.0
103.00 104.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	77. 831674	8. 038103	0. 161860 (0. 197990 439, 482	

Health Financial Systems	CARE ONE AT VALLEY			In Lieu of Form CMS-2540-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023	Worksheet B-1	
				To 12/31/2023		
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDGS & FLXTURES	MOVABLE FOULPMENT	EMPLOYEE BENEFLTS	Reconciliation	ADMI NI STRATI VE & GENERAL	
	(SQUARE FEET)	(SQUARE FEET)			(ACCUM COST)	
	1.00	2.00	3.00	4A	4.00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 00000	0	0. 033840	105.00

					rom 01/01/2023		
				Т	0 12/31/2023	Date/Time Pre	parec
	Cast Captor Decarintian	PLANT			DI ETARY	5/10/2024 11: NURSI NG	<u>50 ar</u>
	Cost Center Description	OPERATION,	LAUNDRY &	HOUSEKEEPING (SQUARE FEET)	(MEALS SERVED)		
			(PATIENT DAYS)	((
		REPAI RS				(PATIENT DAYS)	
		(SQUARE FEET) 5.00	6.00	7.00	8.00	9.00	-
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
	00100 CAP REL COSTS - BLDGS & FIXTURES						1.
	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.
	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3.
	00500 PLANT OPERATION, MAINT. & REPAIRS	24, 938					4. 5.
	00600 LAUNDRY & LINEN SERVICE	1, 546					6.
00	00700 HOUSEKEEPI NG	200	0	23, 192			7.
	00800 DI ETARY	2, 466		_,			8.
	00900 NURSI NG ADMI NI STRATI ON	228		228		31, 578	
	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0			-	0	
	01200 MEDI CAL RECORDS & LI BRARY	195	-	195		0	
	01300 SOCIAL SERVICE	71	0	71	0	0	13.
	01400 NURSING AND ALLIED HEALTH EDUCATION	0				0	
	01500 ACTI VI TES	0	0	0	0	0	15.
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	18, 546	31, 578	18, 546	94, 734	31, 578	30.
	03100 NURSING FACILITY	18, 340	0			0	
	03200 I CF/I I D	0				0	
3.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.
	ANCI LLARY SERVICE COST CENTERS		1	I			4
	04000 RADI OLOGY	0			-	0	
1	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0			0	
	04300 OXYGEN (INHALATION) THERAPY	0	0			0	
	04400 PHYSI CAL THERAPY	329		329		0	
	04500 OCCUPATI ONAL THERAPY	170	0	170	0	0	45.
	04600 SPEECH PATHOLOGY	170		170		0	
	04700 ELECTROCARDI OLOGY	0		0		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	457 400		457 400		0	
	05000 DENTAL CARE - TITLE XIX ONLY	400	0	400		0	
		0	0	0	0	0	
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	
	05201 OTHER ANCI LLARY SERVICES COST	0	-		-	0	
	05202 MEDI CAL SERVI CES	0	0	0	0	0	52.
	OUTPATIENT SERVICE COST CENTERS	0	0	0		0	60.
		0	0			0	
	06200 FQHC						62.
	06300 DI ALYSI S	0	0	0	0	0	63.
	OTHER REIMBURSABLE COST CENTERS						
1	07000 HOME HEALTH AGENCY COST	0				0	
			-			0	
	07400 OTHER REIMBURSEMENT	0	0			0	
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.
	08100 I NTEREST EXPENSE	1					81.
1	08200 UTI LI ZATI ON REVIEW - SNF	-	_			0	82.
	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I				0	0	
1	08401 OTHER SPECIAL PURPOSE COST II	0	0		0	0	
9.00	SUBTOTALS (sum of lines 1-84)	24, 778	31, 578	23, 032	94, 734	31, 578	
	NONREI MBURSABLE COST CENTERS	1	1	1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	-	0	
	09100 BARBER AND BEAUTY SHOP	160	0	160	0	0	
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS				0	0	
	09400 PATIENTS LAUNDRY	0	0	0	0	0	
	09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	
3. 00	Cross Foot Adjustments						98.
9.00	Negative Cost Centers					l	99.
02.00		650, 590	419, 681	489, 308	1, 526, 892	970, 378	102.
03. 00	Part I) nit cost multiplier (West B Part I)	26. 088299	13. 290297	21. 098137	16 117677	30. 729559	102
03.00		26. 088299				48, 089	
	Part II)	, 2/4		31,003	200, 773	10, 007	
1	Unit cost multiplier (Wkst. B, Part	4. 782821	4. 777535	1. 371378	2.816043	1. 522864	100

ST AL	Financial Systems LOCATION – STATISTICAL BASIS	CARE ONE A				Period: From 01/01/2023	u of Form CMS-2 Worksheet B-1	
						From 01/01/2023 Fo 12/31/2023	Date/Time Pre	
	Cost Center Description	CENTRAL	PH	ARMACY	MEDI CAL	SOCIAL SERVICE	5/10/2024 11: NURSI NG AND	50 8
		SERVICES &	(PATI	ENT DAYS)			ALLI ED HEALTH	
		SUPPLY				(PATI ENT DAYS)	EDUCATI ON	
		(PATIENT DAYS)			(PATIENT DAYS)	,	(ASSIGNED TIME)	
		10.00	· ·	11.00	12.00	13.00	14.00	
1	GENERAL SERVICE COST CENTERS							
	00100 CAP REL COSTS - BLDGS & FIXTURES							1
	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS							2
	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL							
	00500 PLANT OPERATION, MAINT. & REPAIRS							5
	00600 LAUNDRY & LINEN SERVICE							1
00	00700 HOUSEKEEPI NG							
	00800 DI ETARY							8
	00900 NURSI NG ADMI NI STRATI ON	21 570						10
	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	31, 578		31, 578				10
	01200 MEDICAL RECORDS & LIBRARY			01, 570	31, 578	3		12
	01300 SOCIAL SERVICE	C	b	0	(13
00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	D	0	(0 0	0	14
		C		0	(0 0	0	15
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	31, 578		31, 578	31, 578	3 31, 578	0	30
	03100 NURSING FACILITY	31, 576		31, 378	31, 376		0	
	03200 CF/I D			0		-	0	32
00	03300 OTHER LONG TERM CARE	0	D	0	(0 0	0	33
	ANCI LLARY SERVICE COST CENTERS	-	1		1			
	04000 RADI OLOGY	0	1	0	(0	
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY			0			0	1 ·
	04300 OXYGEN (INHALATION) THERAPY		Ď	0			0	
	04400 PHYSI CAL THERAPY	C	þ	0	(0 0	0	
	04500 OCCUPATI ONAL THERAPY	C	D	0		0 0	0	45
	04600 SPEECH PATHOLOGY	C	D D	0	(0 0	0	46
	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			0			0	
	04900 DRUGS CHARGED TO PATIENTS			0			0	
	05000 DENTAL CARE - TITLE XIX ONLY			0		0 0	0	1
	05100 SUPPORT SURFACES	C	D	0		0 0	0	5
	05200 COMPLEX MEDICAL EQUIPMENT	C	D	0	(0 0	0	
	05201 OTHER ANCI LLARY SERVICES COST		2	0		- -	0	
	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS		<u>и</u>	0	1 (0	1 04
	06000 CLINIC	0				0 0	0	60
	06100 RURAL HEALTH CLINIC	C	D	0	0	0 0	0	6
	06200 FQHC							62
		C		0	(0 0	0	63
	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	1	0		0 0	0	70
	07100 AMBULANCE			0			0	
	07300 CMHC	0	Ď	0		-	0	
	07400 OTHER REIMBURSEMENT	C		0		0 0	0	74
H H	SPECIAL PURPOSE COST CENTERS		1		1	1		1
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80
	08200 UTILIZATION REVIEW - SNF							82
	08300 HOSPI CE	c	þ	0		0 0	0	
	08400 OTHER SPECIAL PURPOSE COST I	0	D	0		0 0	0	84
	08401 OTHER SPECIAL PURPOSE COST II	C	D	0	(0 0	0	84
00	SUBTOTALS (sum of lines 1-84)	31, 578	3	31, 578	31, 578	3 31, 578	0	8
	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN			0		0 0	0	90
	09100 BARBER AND BEAUTY SHOP		b	0			0	
	09200 PHYSICIANS PRIVATE OFFICES	0	D	0	0		0	
	09300 NONPAID WORKERS	0	D	0	(0 0	0	
	09400 PATIENTS LAUNDRY		2	0		0	0	94
00 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments		"	0		ן ע	0	95
00	Negative Cost Centers							90
2.00	Cost to be allocated (per Wkst. B,	252, 760	þ	41, 546	88, 079	9 154, 075	0	102
	Part I)							
3. 00	Unit cost multiplier (Wkst. B, Part I)	8. 004307		1. 315663			0. 000000	
4. 00	Cost to be allocated (per Wkst. B,	7,140	P	1, 174	20, 172	2 10, 792	0	104
5. 00	Part II)	0 224107	,	0 027170	0 420700	0 241757	0 00000	10
J. UUI	Unit cost multiplier (Wkst. B, Part II)	0. 226107		0. 037178	0. 638799	0. 341757	0.000000	1,02

	Financial Systems LLOCATION - STATISTICAL BASIS	CARE ONE AT V	/ALLEY Provider No.: 315369	Peri od:	u of Form CMS-2540-10 Worksheet B-1
				From 01/01/2023 To 12/31/2023	Date/Time Prepared:
	· · · · ·	OTHER GENERAL			5/10/2024 11:50 am
		SERVI CE			
	Cost Center Description	ACTI VI TES (PATI ENT DAYS)			
		15.00			
	GENERAL SERVICE COST CENTERS				
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT				1.00
2.00	00300 EMPLOYEE BENEFITS				3.00
4.00	00400 ADMINI STRATI VE & GENERAL				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING				6. 00 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
12.00	01300 SOCIAL SERVICE				13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION				14.00
15.00		31, 578			15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	31, 578			30.00
	03100 NURSING FACILITY	31, 578			30.00
32.00	03200 I CF/I I D	0			32.00
33.00	O3300 OTHER LONG TERM CARE	0			33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0			40.00
	04000 RADI OLOGI 04100 LABORATORY	0			40.00
42.00	04200 I NTRAVENOUS THERAPY	0			42.00
	04300 OXYGEN (INHALATION) THERAPY	0			43.00
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0			44. 00 45. 00
46.00	04600 SPEECH PATHOLOGY	0			46.00
	04700 ELECTROCARDI OLOGY	0			47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0			49.00 50.00
51.00	05100 SUPPORT SURFACES	0			51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0			52.00
	05201 OTHER ANCI LLARY SERVICES COST	0			52.01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0			52. 02
60.00	06000 CLINIC	0			60.00
	06100 RURAL HEALTH CLINIC	0			61.00
	06200 FQHC 06300 DI ALYSI S	0			62.00 63.00
03.00	OTHER REIMBURSABLE COST CENTERS	0			03.00
	07000 HOME HEALTH AGENCY COST	0			70.00
	07100 AMBULANCE	0			71.00
	07300 CMHC 07400 OTHER REIMBURSEMENT	0			73.00 74.00
00	SPECIAL PURPOSE COST CENTERS				
	08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
	08100 INTEREST EXPENSE				81.00
	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0			82. 00 83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	Ő			84.00
84.01	08401 OTHER SPECIAL PURPOSE COST II	0			84.01
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	31, 578			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.00
	09100 BARBER AND BEAUTY SHOP	0			91.00
92.00	09200 PHYSI CLANS PRI VATE OFFICES	0			92.00
	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0			93.00 94.00
94.00 95.00	09500 OTHER NONREIMBURSABLE COST	0			94.00
98.00	Cross Foot Adjustments				98.00
99.00	Negative Cost Centers				99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	281, 280			102.00
103.00		8. 907467			103.00
104.00		7, 945			104. 00
105.00	Part II)				105
	Unit cost multiplier (Wkst. B, Part	0. 251599			105.00

Health Financial Systems	CARE ONE AT VALLE	ΞY		In	Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT (COST CENTERS PI	rovi der	No.: 315369	Peri od:		Worksheet C	
				From 01/01/2 To 12/31/2		Date/Time Pre	narod
				10 12/31/2	2023	5/10/2024 11:	
Cost Center Description			Total (from	n Total Char	ges	Ratio (col. 1	
			Wkst. B, Pt	Ι,	-	di vi ded by	
			col. 18)			col. 2	
			1.00	2.00		3.00	
ANCI LLARY SERVI CE COST CENTERS				1			
40. 00 04000 RADI OLOGY			31, 2		285	0. 479191	•
41.00 04100 LABORATORY			84, 7		880	0. 479195	•
42.00 04200 I NTRAVENOUS THERAPY			159, 8		572	0. 440861	
43.00 04300 OXYGEN (INHALATION) THERAPY				0	0	0.00000	•
44. 00 04400 PHYSI CAL THERAPY			857, 3			0. 390338	•
45. 00 04500 OCCUPATIONAL THERAPY			642, 2			0. 289295	•
46. 00 04600 SPEECH PATHOLOGY			158, 4		495	0. 374165	
47.00 04700 ELECTROCARDI OLOGY			(0.0	0	010	0.00000	•
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			69,0		013	68. 174729	•
49.00 04900 DRUGS CHARGED TO PATIENTS			542, 5		530	0. 495699	•
50.00 05000 DENTAL CARE - TITLE XIX ONLY 51.00 05100 SUPPORT SURFACES			E.	0 06 1,	054	0. 000000 0. 480076	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT			5	0	054	0. 480078	•
52.00 05200 COMPLEX MEDICAL EQUIPMENT 52.01 05201 OTHER ANCILLARY SERVICES COST				0	0	0.000000	•
52. 02 05202 MEDICAL SERVICES				0	0	0.000000	•
OUTPATIENT SERVICES				0	9	0.00000	JZ. 0Z
60. 00 06000 CLINIC				0	0	0. 000000	60.00
61. 00 06100 RURAL HEALTH CLINIC				Ũ	Ŭ	0.000000	61.00
62. 00 06200 FQHC							62.00
63. 00 06300 DI ALYSI S				o	o	0.000000	
71. 00 07100 AMBULANCE			44, 7	41 93	368	0. 479190	•
100.00 Total			2, 590, 8			2	100.00

Health Financial Systems	CARE ONE A	T VALLEY		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315369	Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII (1)	Skilled Nursing		
			. ,	Facility		
		Heal th Care Pi	rogram Charge	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col 1	Part B (col. 1	
	to Charges		i di t b	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X 0011 2)		
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENT COST					
ANCI LLARY SERVI CE COST CENTERS						1
40. 00 04000 RADI OLOGY	0. 479191	12, 604		0 6, 040		40.00
41. 00 04100 LABORATORY	0. 479195	45, 870		0 21, 981	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 440861	38, 024		0 16, 763	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 390338			0 489, 442	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 289295	1, 241, 029		0 359, 023	0	
46.00 04600 SPEECH PATHOLOGY	0. 374165			0 92, 262	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	68. 174729			0 69, 061	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0. 495699	167, 989		0 83, 272	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51.00 05100 SUPPORT SURFACES	0. 480076			0 506	0	
52.00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000	0		0 0	0	
52.01 05201 OTHER ANCI LLARY SERVICES COST	0. 000000			0 0	0	
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52.02
OUTPATIENT SERVICE COST CENTERS	-					
60. 00 06000 CLINIC	0. 000000	0		0 0	0	
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
63. 00 06300 DI ALYSI S	0. 000000			0 0	0	
71.00 07100 AMBULANCE (2)	0. 479190			0	0	
100.00 Total (Sum of lines 40 - 71)		3, 008, 058		0 1, 138, 350	0	100.00
(1) For title V and XIX use columns 1 2 and 4 onl	V					

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

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

Heal th	Financial Systems	CARE ONE A	T VALLEY		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/10/2024 11:	
			Ti tl	e XVIII	Skilled Nursing	PPS	
					Facility		
	Cost Center Description					1 00	
						1.00	
1.00 2.00 3.00	PART II - APPORTIONMENT OF VACCINE COST Drugs charged to patients - ratio of cc Program vaccine charges (From your reco Program costs (Line 1 x line 2) (Title E, Part I, line 18)	ords, or the PS	&R)		,	0. 495699 3, 648 1, 808	1.00 2.00 3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
			Allied Health		Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,	Allied Healt	n Wkst. D Part	Health Costs	
		18	Part I, Col.	Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col. 2 / Col	•	3 x Col. 4)	
		1.00	2.00	1) 3.00	4.00	5.00	
	PART III - CALCULATION OF PASS THROUGH COSTS			5.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS						1
40.00	04000 RADI OLOGY	31, 284	C	0.00000	6,040	0	40.00
41.00	04100 LABORATORY	84, 760	c c	0. 00000	0 21, 981	0	41.00
42.00	04200 INTRAVENOUS THERAPY	159, 844	c	0.00000	16, 763	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	c	0.00000	0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	857, 328	0	0. 00000	489, 442	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	642, 285	0	0. 00000	0 359, 023	0	45.00
46.00	04600 SPEECH PATHOLOGY	158, 457	0	0. 00000	92, 262	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 061	0	0. 00000	69, 061	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	542, 557	0	0. 00000	0 83, 272	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	0 0	0	50.00
51.00	05100 SUPPORT SURFACES	506	C	0.00000		0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0.00000		0	
52.01	05201 OTHER ANCILLARY SERVICES COST	0	0	0.00000		0	
		0	0	0.00000		0	02.02
100.00	Total (Sum of lines 40 - 52)	2, 546, 082	0	1	1, 138, 350	0	100. 00

00 Private room days 0 2 00 Inpatient days including private room days applicable to the Program 10,003 3 00 Inpatient days including private room days applicable to the Program 10,003 4 00 Total general inpatient routine service cost 12,918,323 5 01 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 0.762347 7 01 Enter private room charges from your records 0 0 0 02 Enter semi-private room charges from your records 0 0 0 03 Average per diem private room charges from your records 0 0 0 0 04 Average per diem private room charges from your records 0 0 0 0 05 Out Average per diem private room cost differential (Line 9 minus line 11) 0.00 0 0 06 Private room cost differential (Line 2 times line 13) 0 0 14 06 Program routine service cost per diem (Line 15 divided by line 1) 409.09 14 07 Overage per diem private room cost differential (Line 7 plus line 13) 0 14	UMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315369	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	pared
PART 1 CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS 00 Inpatient days including private room days 31,578 01 Private room days 0 02 Inpatient days including private room days applicable to the Program 0 03 Inpatient days including private room days applicable to the Program 0 04 Total general inpatient routine service cost 12,918,323 05 General inpatient routine service cost /charge ratio (Line 5 divided by line 6) 0.762347 06 General inpatient routine service cost /charge ratio 0 16,945,464 6 07 General inpatient routine service cost /charge ratio 0.10 0.00 10 08 Average private room charges from your records 0 0 10 09 Private room days 0 11 0.00 12 00 Average per diem private room charge differential (Line 9 minus line 11) 0.00 12 00 Average per diem private room cost differential (Line 7 times line 12) 0 12 01 0 0 12 <td< th=""><th></th><th></th><th>Title XVIII</th><th></th><th>PPS</th><th></th></td<>			Title XVIII		PPS	
PART 1 CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS 00 Inpatient days including private room days 31,578 01 Private room days 0 02 Inpatient days including private room days applicable to the Program 0 03 Inpatient days including private room days applicable to the Program 0 04 Total general inpatient routine service cost 12,918,323 05 General inpatient routine service cost /charge ratio (Line 5 divided by line 6) 0.762347 06 General inpatient routine service cost /charge ratio 0 16,945,464 6 07 General inpatient routine service cost /charge ratio 0.10 0.00 10 08 Average private room charges from your records 0 0 10 09 Private room days 0 11 0.00 12 00 Average per diem private room charge differential (Line 9 minus line 11) 0.00 12 00 Average per diem private room cost differential (Line 7 times line 12) 0 12 01 0 0 12 <td< td=""><td></td><td></td><td></td><td></td><td>1.00</td><td></td></td<>					1.00	
00 Inpatient days including private room days 31,578 1 00 Private room days 01 01 private room days 01 02 01 private room days 01 02 01 private room days 01 02 01 Medically necessary private room days applicable to the Program 0 02 Total general inpatient routine service cost 12,918,323 03 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 0.762347 04 General inpatient routine service cost/charge ratio (Line 5 divided by private room days, line 0. 05 Enter private room charges from your records 0 0 05 Mercage perivate room charges from your records 0 0 06 Enter semi-private room cost differential (Line 9 minus line 11) 0.00 0 07 Average per diem private room cost differential (Line 7 times line 12) 0.00 0 08 Average per diem private room cost differential (Line 7 times line 13) 0 0 08 Average per diem private room cost differential (Line 7 times line 13) 0 0 09 <td></td> <td>PART I CALCULATION OF INPATIENT ROUTINE COSTS</td> <td></td> <td></td> <td></td> <td></td>		PART I CALCULATION OF INPATIENT ROUTINE COSTS				
00 Private room days 0 2 00 Inpatient days including private room days applicable to the Program 10,003 3 00 Total general inpatient routine service cost 12,918,323 6 00 General inpatient routine service charges 16,945,464 6 00 General inpatient routine service charges room ocharges from your records 0 0 00 Average private room charges from your records 0 0 01 Average private room charges from your records 0 0 02 Average private room charges from your records 0 0 03 Average private room charges from your records 0 0 04 Average private room days) 0 0 0 05 Derivate room days 0 0 0 06 Average peri diem private room charge differential (Line 9 minus line 11) 0 0 07 Derivate room cost differential ajustment (Line 2 times line 12) 0 0 08 Average peri diem private room cost end forential ajustment (Line 2 times line 13) 0 14 08 Of cla program routine service		I NPATI ENT DAYS				1
00Inpatient days including private room days applicable to the Program10,003300Medically necessary private room days applicable to the Program001Total general inpatient routine service cost12,918,32301General Inpatient routine service charges16,945,46402General Inpatient routine service cost/charge ratio (Line 5 divided by line 6)0.76234703Enter private room charges from your records004Average private room charges from your records005Enter semi-private room charges from your records006Average per diem private room charge differential (Line 9 minus line 11)0.00100Average per diem private room cost differential (Line 7 times line 12)0.00100Average per diem private room cost differential (Line 7 times line 13)01110.0012,918,32301120014,928,3231130014114012,918,3230115.00Average per diem private room cost differential (Line 7 times line 12)0.001100012,918,323111001411112,918,323011112,918,3230120014120014120014120014120014120014120014120014120<	. 00	Inpatient days including private room days			31, 578	1.C
00 Medically necessary private room days applicable to the Program 0 4 00 Total general inpatient routine service cost 12,918,323 00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 16,945,464 6 00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 0 7 00 Average private room charges from your records 0 0 01 Average semi-private room charges from your records 0 0 02 O Enter semi-private room charges from your records 0 0 0 00 Average per diem private room charge differential (Line 9 minus line 11) 0.00 10 00 Average per diem private room cost differential (Line 7 times line 12) 0.00 13 01 O General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12,918,323 01 O Average per diem private room cost applicable to program (line 4 times line 13) 0.00 01 Average per diem private room cost applicable to program (line 4 times line 13) 0 14,992,127 02 O Adjusted general inpatient routine service cost (Line 15 divided	. 00	Private room days			0	2.0
00 Total general inpatient routine service cost 12,918,323 5 00 General inpatient routine service charges 16,945,464 6 00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 0.762347 7 00 Enter private room charges from your records 0 0 0 01 Enter semi-private room charges from your records 0 0 0 02 Deter semi-private room charges from your records 0 0 0 0 02 Observate room days) 0 0 0 0 0 0 0.0 Average semi-private room cost differential (Line 9 minus line 11) 0.00 12 0.00 1.00 Average per diem private room cost differential (Line 2 times line 12) 0.00 14 0.0 Private room cost differential diustment (Line 2 times line 13) 0 14 0.00 Forgam routine service cost net of private room cost differential (Line 2 times line 13) 0 14 0.00 Forgam routine service cost (Line 3 times line 16) 4,092,127 17 0.00 Forgam routine service cost (Line 3 times line 12) 0 <t< td=""><td>. 00</td><td>Inpatient days including private room days appli</td><td>cable to the Program</td><td></td><td>10, 003</td><td>3.0</td></t<>	. 00	Inpatient days including private room days appli	cable to the Program		10, 003	3.0
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT00General inpatient routine service charges16,945,464601General inpatient routine service cost/charge ratio (Line 5 divided by line 6)0.762347702Enter private room charges from your records0.8903Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)0.00004Enter semi-private room charges from your records0.100005Enter semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)0.00006Average per diem private room charge differential (Line 7 times line 12)0.00007Average per diem private room cost differential (Line 7 times line 12)0.00008General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)12,918,32309Private room cost differential diustment (Line 15 divided by line 1)4090,0900Redically necessary private room cost applicable to program (line 4 times line 13)001OAverage per diem cost cost (Line 3 times line 16)4,092,12709OCapital related cost (Line 3 times line 11)4,092,12700Medically necessary private room cost applicable to program (line 4 times line 13)001Capital related cost (Line 3 times line 21)777,43300Redically necessary private room cost for CF/IDD777,7300Nedically necessary private room cost for ICF/IDD777,7430	. 00		to the Program		0	4. C
00General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6)16,945,464 0.762347600General inpatient routine service cost/charge ratio (Line 5 divided by line 6)0.76234701Enter private room charges from your records Average per ivate room charges from your records002Oter private room charges from your records semi-private room charges from your records001Average semi-private room charges from your records semi-private room cost differential (Line 9 minus line 11)0.0002OA verage per diem private room charge differential (Line 7 times line 12)0.0003OA verage per diem private room cost differential (Line 7 times line 13)0.0004OP rivate room cost differential djustment (Line 2 times line 13)0.0005OA djusted general inpatient service cost per diem (Line 15 divided by line 1)409.0906Medically necessary private room cost applicable to program (line 4 times line 13)007OP rogram routine service cost (Line 3 times line 16)4.092, 12708OP rogram capital related cost (Line 3 times line 21)777, 43300Inpatient routine service cost (Line 15 for vice records)000Inpatient routine service costs for comparison to the cost limitation (Line 23 minus line 24)3.314, 69409101027100Per diem capital related cost (Line 19 minus line 22)777, 43311000Per diem capital related cost (Line 3 times line 21)777, 7231110	. 00	Total general inpatient routine service cost			12, 918, 323	5.0
00General inpatient routine service cost/charge ratio (Line 5 divided by line 6)0.762347701Enter private room charges from your records0802Average private room per diem charge (Private room charges line 8 divided by private room days, line0.00020Enter semi-private room per diem charge (Private room charges line 8 divided by private room days, line00.00Enter semi-private room charges from your records00.01Average semi-private room days)0.000.02Average per diem private room charge differential (Line 9 minus line 11)0.000.03Average per diem private room cost differential (Line 7 times line 12)0.000.04Private room cost differential (Line 2 times line 13)0.000General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)12,918,3230Adjusted general inpatient service cost per diem (Line 15 divided by line 1)409.090Adjusted general inpatient routine service cost (Line 3 times line 16)4,092,1270Copian routine service cost (Line 3 times line 14)4,092,1271.00Program general inpatient routine service cost (Line 17 plus line 18)4,092,1271.00Per diem capital related costs (Line 3 times line 21)77.721.00Program capital related cost (Line 3 times line 12)77.721.00Program capital related cost (Line 19 minus line 22)3,314,6941.00Per diem capital related cost (Line 3 times line 22)3,314,6941.00Inpatient rou		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00Enter private room charges from your records001Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)002Enter semi-private room charges from your records003Average semi-private room charges from your records004Average semi-private room charges from your records005Average semi-private room charge (Semi-private room charges line 10, divided by semi-private room cost differential (Line 9 minus line 11)0.0005Average per diem private room cost differential (Line 7 times line 12)0.0006Average per diem private room cost differential djustment (Line 2 times line 13)000Average per al inpatient routine service cost net of private room cost differential (Line 5 minus line 14)12,918,32301PROGRAM INPATIENT ROUTINE SERVICE COSTS409,0901Adjusted general inpatient service cost per diem (Line 15 divided by line 1)409,0901Adjusted general inpatient routine service cost (Line 17 plus line 18)4,092,12702Or program routine service cost (Line 3 times line 16)4,092,12703On tal program general inpatient routine service costs (Line 17 plus line 18)4,092,12704Or program capital related costs (Line 20 divided by line 1)77,743305On program capital related costs (Line 3 times line 21)77,43304Or program capital related costs (Line 19 minus line 22)3,314,69405On program routine service costs for comparison to the cost limitation (Line 23 minus line 24) <t< td=""><td>. 00</td><td>General inpatient routine service charges</td><td></td><td></td><td>16, 945, 464</td><td>6. (</td></t<>	. 00	General inpatient routine service charges			16, 945, 464	6. (
00 Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 0.00 00 Enter semi-private room charges from your records 0 1.00 Average semi-private room days) 0.00 2.00 Average per diem private room charge differential (Line 9 minus line 10, divided by semi-private room days) 0.00 2.00 Average per diem private room cost differential (Line 7 times line 12) 0.00 3.00 Average per diem private room cost differential (Line 2 times line 13) 0.00 6.00 Private room cost differential adjustment (Line 2 times line 13) 0.00 7.00 Program routine service cost per diem (Line 15 divided by line 1) 12,918,323 7.00 Program routine service cost (Line 3 times line 16) 4,092,127 8.00 Medically necessary private room cost applicable to program (line 4 times line 13) 0 9.00 Total program general inpatient routine service cost (Line 17 plus line 18) 4,092,127 9.00 Program capital related cost (Line 3 times line 21) 77.72 9.00 Capital related cost (Line 3 times line 21) 77.72 9.00 Program capital related cost (Line 19 minus line 22) 3,314,694 9.00 Inpatient routine s	. 00	General inpatient routine service cost/charge ra	tio (Line 5 divided by line 6)		0. 762347	7.
2)2)2)00102)Enter semi-private room charges from your records00100Average semi-private room days)002.00Average per diem private room charge differential (Line 9 minus line 11)00100Average per diem private room cost differential (Line 7 times line 12)0010100011102001201030Average per diem private room cost differential (Line 7 times line 12)00101000120102001412,918,323151030001412,918,32315104001412,918,3231510500Adjusted general inpatient service cost net of private room cost differential (Line 5 minus line 14)12,918,323104001412,918,3231510500Adjusted general inpatient service cost per diem (Line 15 divided by line 1)409,091041414,092,12717161050016161718106001617181810701210101412,918,323108109100161001618109100100100100100100100100101100 </td <td>. 00</td> <td></td> <td></td> <td></td> <td>0</td> <td>8.</td>	. 00				0	8.
1.00Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)0.00112.00Average per diem private room cost differential (Line 9 minus line 11) 0.000.00123.00Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) 00.00144.00Private room cost differential adjustment (Line 2 times line 13) PROGRAM INPATIENT ROUTINE SERVICE COSTS0.00145.00Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) 	. 00		om charges line 8 divided by private	room days, line	0.00	9.
semi-private room days)	0. 00	Enter semi-private room charges from your record	S		0	10.
3.00Average per diem private room cost differential (Line 7 times line 12)0.00134.00Private room cost differential adjustment (Line 2 times line 13)0145.00General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)12,918,323155.00Adjusted general inpatient service cost per diem (Line 15 divided by line 1)409.09167.00Program routine service cost (Line 3 times line 16)4,092,127178.00Medically necessary private room cost applicable to program (line 4 times line 13)0189.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,127199.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)77.722110.00Program capital related costs (Line 3 times line 21)777,433223.00Inpatient routine service costs (From provider records)0244.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service cost for comparison to the cost limitation (Line 23 minus line 24)3,314,694255.00Total program routine service costs (Line 3 times the per diem limitation line 26) (1)267.00Inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	1.00		-private room charges line 10, divide	d by	0.00	11.
4.00Private room cost differential adjustment (Line 2 times line 13)06.00General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)12,918,3237.00Program routine service cost per diem (Line 15 divided by line 1)409.097.00Program routine service cost (Line 3 times line 16)4,092,1278.00Medically necessary private room cost applicable to program (line 4 times line 13)09.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,1279.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)77.721.00Per diem capital related cost (Line 3 times line 21)777,4332.00Program capital related cost (Line 19 minus line 22)3,314,6944.00Aggregate charges to beneficiaries for excess costs (From provider records)02.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3,314,6943.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)3,314,6944.00Aggregate charges to beneficiaries for excess costs (From provider records)02.00Enter the per diem limitation (1)273.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)3,314,6943.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)3	2.00	Average per diem private room charge differentia	l (Line 9 minus line 11)		0.00	12.
5.00General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)12,918,32315PROGRAM INPATIENT ROUTINE SERVICE COSTSAdjusted general inpatient service cost per diem (Line 15 divided by line 1)409.09167.00Program routine service cost (Line 3 times line 16)4,092,127178.00Medically necessary private room cost applicable to program (line 4 times line 13)0189.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,127199.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)4,092,127191.00Per diem capital related costs (Line 20 divided by line 1)77.72212.00Program capital related cost (Line 3 times line 21)777,433223.00Inpatient routine service costs (From provider records)03,314,6945.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3,314,694236.00Enter the per diem limitation (1)26243,314,694257.00Inpatient routine service cost (Line 3 times the per diem limitation line 26) (1)26267.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28					0.00	13.
PROGRAM INPATIENT ROUTINE SERVICE COSTS6.00Adjusted general inpatient service cost per diem (Line 15 divided by line 1)409.097.00Program routine service cost (Line 3 times line 16)4,092,1278.00Medically necessary private room cost applicable to program (line 4 times line 13)08.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,1279.00Total program general inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)4,092,1271.00Per diem capital related costs (Line 20 divided by line 1)77.722.00Program capital related cost (Line 3 times line 21)777,4333.00Inpatient routine service costs (From provider records)04.00Aggregate charges to beneficiaries for excess costs (From provider records)02.00Enter the per diem limitation (1)3,314,6947.00Inpatient routine service cost for comparison to the cost limitation (Line 23 minus line 24)3,314,6943.00Reimbursable inpatient routine service costs (Line 2 plus the lesser of line 25 or line 27)28	4.00	Private room cost differential adjustment (Line :	2 times line 13)		0	14.
7.00Program routine service cost (Line 3 times line 16)4,092,127173.00Medically necessary private room cost applicable to program (line 4 times line 13)4,092,127173.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,127193.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18,4,092,127191.00Per diem capital related costs (Line 20 divided by line 1)77.72212.00Program capital related cost (Line 3 times line 21)777,433223.00Inpatient routine service cost (Line 19 minus line 22)3,314,694234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service cost limitation (1)26247.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)268.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	5.00		ivate room cost differential (Line 5	minus line 14)	12, 918, 323	15.
3.00Medically necessary private room cost applicable to program (line 4 times line 13)0189.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,127190.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)2,454,327201.00Per diem capital related costs (Line 20 divided by line 1)77.72212.00Program capital related cost (Line 3 times line 21)777,433223.00Inpatient routine service cost for excess costs (From provider records)3,314,694235.00Total program routine service cost for comparison to the cost limitation (Line 23 minus line 24)3,314,694256.00Enter the per diem limitation (1)2026267.00Inpatient routine service cost (Line 3 times the per diem limitation line 26) (1)268.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	6. 00	Adjusted general inpatient service cost per diem	(Line 15 divided by line 1)		409.09	16.
9.00Total program general inpatient routine service cost (Line 17 plus line 18)4,092,1279.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)4,092,1271.00Per diem capital related costs (Line 20 divided by line 1)77.722.00Program capital related costs (Line 3 times line 21)777.4333.00Inpatient routine service cost (Line 19 minus line 22)3,314,6944.00Aggregate charges to beneficiaries for excess costs (From provider records)05.00Total program routine service cost limitation (Line 3 times the per diem limitation line 26)3,314,6945.00Reimbursable inpatient routine service costs (Line 2 plus the lesser of line 25 or line 27)26	7.00	Program routine service cost (Line 3 times line	16)		4, 092, 127	17.
0.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)2,454,327201.00Per diem capital related costs (Line 20 divided by line 1)77.72212.00Program capital related cost (Line 3 times line 21)777,433223.00Inpatient routine service cost (Line 19 minus line 22)3,314,694234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Enter the per diem limitation (1)3,314,694257.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)3,314,694258.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	8.00	Medically necessary private room cost applicable	to program (line 4 times line 13)		0	18.
line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)1.00Per diem capital related costs (Line 20 divided by line 1)2.00Program capital related cost (Line 3 times line 21)3.003.00Inpatient routine service cost (Line 19 minus line 22)4.00Aggregate charges to beneficiaries for excess costs (From provider records)5.005.005.00Enter the per diem limitation (1)7.007.007.008.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	9.00	Total program general inpatient routine service	cost (Line 17 plus line 18)		4, 092, 127	19.
22.00Program capital related cost (Line 3 times line 21)777,433223.00Inpatient routine service cost (Line 19 minus line 22)3,314,694234.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3,314,694236.00Enter the per diem limitation (1)2626267.00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)268.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	0. 00			t II column 18,	2, 454, 327	20.
3. 00Inpatient routine service cost (Line 19 minus line 22)3, 314, 694234. 00Aggregate charges to beneficiaries for excess costs (From provider records)0245. 00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3, 314, 694235. 00Enter the per diem limitation (1)267. 00Inpatient routine service costs (Line 3 times the per diem limitation line 26) (1)273. 00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	1.00	Per diem capital related costs (Line 20 divided	by line 1)		77.72	21.
4.00Aggregate charges to beneficiaries for excess costs (From provider records)0245.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3,314,694255.00Enter the per diem limitation (1)2626267.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)27283.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	2. 00	Program capital related cost (Line 3 times line	21)		777, 433	22.
5.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3,314,694255.00Enter the per diem limitation (1)267.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)273.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	3. 00	Inpatient routine service cost (Line 19 minus I	ine 22)		3, 314, 694	23.
6.00Enter the per diem limitation (1)267.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)273.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	4.00	Aggregate charges to beneficiaries for excess co	sts (From provider records)		0	24.
7.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)273.00Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)28	5.00	Total program routine service costs for comparis	on to the cost limitation (Line 23 mi	nus line 24)	3, 314, 694	25.
3.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) 28	5. 00	Enter the per diem limitation (1)				26.
	7.00	Inpatient routine service cost limitation (Line	3 times the per diem limitation line	26) (1)		27.
	3. 00			line 27)		28.

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	31, 578	1.00
2.00	Program inpatient days (see instructions)	10, 003	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. 316771	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

		E ONE AT VALLEY		u of Form CMS-2	<u>2540-10</u>
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No. : 315369	Period: From 01/01/2023 To 12/31/2023		
		Title XIX	Skilled Nursing Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
1.00	Inpatient days including private room days			31, 578	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicabl	e to the Program		11, 523	3.00
4.00	Medically necessary private room days applicable to	the Program		0	4.00
5.00	Total general inpatient routine service cost			12, 918, 323	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges			16, 945, 464	6.00
7.00	General inpatient routine service cost/charge ratio	(Line 5 divided by line 6)		0. 762347	7.00
8.00	Enter private room charges from your records			0	8.00
9.00	Average private room per diem charge (Private room c 2)	charges line 8 divided by private	room days, line	0.00	9.00
10.00	Enter semi-private room charges from your records			0	10.00
11.00	Average semi-private room per diem charge (Semi-pri semi-private room days)	vate room charges line 10, divid	ed by	0.00	11.00
12.00	Average per diem private room charge differential (L	ine 9 minus line 11)		0.00	12.00
40.00					40.00

12.00	Average per drem private room charge differential (Line 9 minus fine fi)	0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	12, 918, 323	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	409.09	16.00
17.00	Program routine service cost (Line 3 times line 16)	4, 713, 944	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	4, 713, 944	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18,	2, 454, 327	20.00
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		
21.00	Per diem capital related costs (Line 20 divided by line 1)	77.72	21.00
22.00	Program capital related cost (Line 3 times line 21)	895, 568	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	3, 818, 376	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	3, 818, 376	25.00
26.00	Enter the per diem limitation (1)	0.00	26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0	27.00
20.00		4 740 044	00 00

 28.00
 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)
 4,713,944
 28.00

 (1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX
 4,713,944
 28.00

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	31, 578	1.00
2.00	Program inpatient days (see instructions)	11, 523	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)	0.364906	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

	Financial Systems CARE ONE A			u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315369	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prep 5/10/2024 11:5	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
		DUDOFUENT		1.00	
1 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIM	BURSEMENT		0.007.0(0	1 00
1.00	Inpatient PPS amount (See Instructions)	h normanta)		8, 907, 869	1.00
2.00	Nursing and Allied Health Education Activities (pass throug	n payments)		0	2.00
3.00 4.00	Subtotal (Sum of lines 1 and 2)			8, 907, 869	3.00 4.00
4.00 5.00	Primary payor amounts Coinsurance			1 055 900	4.00
5.00 6.00				1, 055, 800 106, 786	5.00 6.00
7.00	Allowable bad debts (From your records) Allowable Bad debts for dual eligible beneficiaries (See in	etructione)		76, 078	7.00
8.00	5	istructrons)			8.00
8.00 9.00	Adjusted reimbursable bad debts. (See instructions) Recovery of bad debts - for statistical records only			69, 411 0	9.00
9.00 10.00	Utilization review			0	9.00
				-	
11.00	Subtotal (See instructions)			7, 921, 480 7, 891, 061	12.00
12.00	Interim payments (See instructions)				12.00
14.00	Tentative adjustment OTHER adjustment (See instructions)			0	14.00
14.00	Demonstration payment adjustment amount before sequestratio	n an		0	14.00
14.55	Demonstration payment adjustment amount after sequestration			0	14.50
14. 55	Sequestration for non-claims based amounts (see instruction				14. 75
14.75	Sequestration amount (see instructions)	(5)		157,041	
	Balance due provider/program (see Instructions)			-128, 010	
	Protested amounts (Nonallowable cost report items in accord	ance with CMS Pub 15-2 s	action 115 2	- 128, 010	16.00
10.00	PART B - ANCI LLARY SERVICE COMPUTATION OF REIMBURSEMENT LES			0	10.00
17.00	Ancillary services Part B			0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			1, 808	
19.00	Total reasonable costs (Sum of Lines 17 and 18)			1, 808	
20.00	Medicare Part B ancillary charges (See instructions)			3, 648	
21.00	Cost of covered services (Lesser of line 19 or line 20)			1, 808	
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 in	structions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	,		0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			1, 808	25.00
26.00	Interim payments (See instructions)			3, 575	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestratio	n		0	28.50
28.55	Demonstration payment adjustment amount after sequestration			0	28.55
28.99	Sequestration amount (see instructions)			36	28.99
29.00	Balance due provider/program (see instructions)			-1, 803	
29.00					

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provi der	No.: 315369	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prep 5/10/2024 11:5	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	<u>, , , , , , , , , , , , , , , , , , , </u>
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		7, 695, 0 192, 5		3, 575 0	1.0 2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER	05/31/2023	3, 4	42	0	3. (
02			5, 1	0	0	3.0
03				0	0	3.0
04				0	0	3.
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
50 51	ADJUSTMENTS TO PROGRAM			0	0	3. 3.
52				0	0	3.
53				0	Ő	3.
54				0	0	3.
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		3, 4	42	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		7, 891, 0	61	3, 575	4.
~~	TO BE COMPLETED BY CONTRACTOR					-
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER		[0	0	5.
02	TENTATIVE TO PROVIDER			0	0	5.
03				0	Ö	5.
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	5.
52				0	0	5.
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	PROGRAM TO PROVIDER			0	0	6.
02	PROVI DER TO PROGRAM		128, 0		1, 803	6.
00	Total Medicare program liability (see instructions)		7, 763, 0		1, 772	7.
				actor Name	Contractor	
					Number	
				1.00	2.00	

	are nonproprietary and do not maintain ecords, complete the "General Fund" column	Provi der	F	eriod: rom 01/01/2023	Worksheet G
y)				0 12/31/2023	Date/Time Pre 5/10/2024 11:
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1.00	2.00	3.00	4.00
Assets CURRENT ASSETS					
0 Cash on hand ar	d in banks	31, 406	0	0	0
0 Temporary inves		0	0	0	0
0 Notes receivabl		0	0	0	0
0 Accounts receiv		2, 124, 762	0	0	0
0 Other receivabl 0 Less: allowance	es s for uncollectible notes and accounts	-482, 250		0	0
recei vabl e		102,200			0
0 Inventory		0	0	0	0
0 Prepaid expense		51, 667	0	0	0
0 Other current a 00 Due from other		89,067		0	0
	SSETS (Sum of lines 1 - 10)	1, 814, 652	0		0
FIXED ASSETS	, , , , , , , , , , , , , , , , , , ,				
00 Land		1, 680, 000	0		0
00 Land improvemen 00 Less: Accumulat		1, 941, 266	0	0	0
00 Buildings		-776, 259 26, 793, 561		0	0
00 Less Accumulate	d depreciation	-10, 598, 326	0	0	0
00 Leasehold impro		0	0	0	0
00 Less: Accumulat	ed Amortization	0	0	0	0
00 Fixed equipment 00 Less: Accumulat	ad danraciation	1, 545, 035		0	0
00 Automobiles and		14, 254		0	0
00 Less: Accumul at		-14, 254	0	0	0
00 Major movable e		3, 439, 079	0	0	0
00 Less: Accumulat		-2, 032, 200	0	0	0
00 Minor equipment 00 Minor equipment		0	0	0	0
00 Other fixed as	•	2, 925, 861		0	0
	ETS (Sum of lines 12 - 27)	23, 486, 679	0		Ő
OTHER ASSETS		l			
00 Investments		0	0	0	0
00 Deposits on lea 00 Due from owners				0	0
00 Other assets		877, 579	0	0	0
00 TOTAL OTHER ASS	ETS (Sum of lines 29 - 32)	877, 579	0	0	0
	um of lines 11, 28, and 33)	26, 178, 910	0	0	0
Liabilities and CURRENT LIABILI					
00 Accounts payabl		1, 422, 247	0	0	0
	, and fees payable	104, 142	0		0
00 Payroll taxes p		34, 707	0	0	0
	ayable (Short term)	0	0	0	0
00 Deferred income 00 Accelerated pay				0	0
00 Due to other fu		89, 067	0	0	0
00 Other current I	i abi l i ti es	40, 845, 871	0	0	0
	IABILITIES (Sum of lines 35 - 42)	42, 496, 034	0	0	0
00 Mortgage payabl			0	o	0
00 Mortgage payabl 00 Notes payable	2			0	0
00 Unsecured Loans		0	0	0	0
00 Loans from owne		0	0	0	0
00 Other long term	liabilities	-47, 951, 371	0	0	0
00 OTHER (SPECIFY) 00 TOTAL LONG TERM	LIABILITIES (Sum of lines 44 - 49	-47, 951, 371		0	0
	ES (Sum of Lines 43 and 50)	-5, 455, 337		0	0
CAPI TAL ACCOUNT		1	1	, - <u>,</u>	
00 General fund ba		31, 634, 247			
00 Specific purpos			0		
	endowment fund balance - restricted endowment fund balance - unrestricted			0	
	created - endowment fund balance			0	
0 3	nce - invested in plant				0
00 Plant fund bala	nce - reserve for plant improvement,				0
replacement, ar		21 / 24 047	_		~
	NCES (Sum of lines 52 thru 58) ES AND FUND BALANCES (Sum of lines 51 and	31, 634, 247 26, 178, 910		0	0
OU LINDITI	LO AND FUND DALANGED (JUII OF FITTES OF AND	20, 170, 910	I	- U	0

Heal th Financi	ial Systems	CARE ONE A	T VALLEY				In Lie	u of Form CM	S-2	540-10
STATEMENT OF	CHANGES IN FUND BALANCES		Pro	vi der	No.: 315369		eriod: com 01/01/2023 b 12/31/2023	Worksheet G Date/Time F 5/10/2024 1	rep	
		General	Fund		Speci al	Pur	rpose Fund	Endowment Fu		
		1.00	2.00)	3,00		4.00	5.00	_	
2.00 Net ind 3.00 Total 4.00 Additio 5.00 6.00 7.00 8.00 9.00 Total 4.00 Additio 10.00 Total 4.00 Additio 11.00 Subtota 12.00 Deducti 13.00 DRAW 14.00 IS.00 IS.00 IS.00 IS.00 IS.00 IS.00 Total 4.00 IS.00 Total 4.00 IS.00 Total 4.00 IS.00	alances at beginning of period come (loss) (from Wkst. G-3, line 31) (sum of line 1 and line 2) ons (credit adjustments) additions (sum of line 5 - 9) al (line 3 plus line 10) ions (debit adjustments) deductions (sum of lines 13 - 17)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31, 08 69 31, 78 31, 78	37, 215 96, 772 33, 987 0 33, 987 49, 740		0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
	alance at end of period per balance (Line 11 – line 18)		31, 63	34, 247			0			19.00
		Endowment Fund		Pl ant	Fund					
1.00 Fund ba	alances at beginning of period	6.00	7.00)	8.00	0			_	1.00
2.00 Net ind 3.00 Total	come (loss) (from Wkst. G-3, line 31) (sum of line 1 and line 2) ons (credit adjustments)	0		0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
11.00 Subtota 12.00 Deducti 13.00 DRAW 14.00 15.00 16.00 17.00 18.00 Total of 19.00 Fund bar Fund bar	additions (sum of line 5 - 9) al (line 3 plus line 10) ions (debit adjustments) deductions (sum of lines 13 - 17) alance at end of period per balance (Line 11 - line 18)	0 0 0 0		0 0 0 0		0 0 0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Heal th	Financial Systems	CARE ONE AT VAL	_LEY			In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315369	Peri From To		Worksheet G-2 Parts I-II Date/Time Pre 5/10/2024 11:	pared:
	Cost Center Description			I npati ent	C)utpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services			_				
1.00	SKILLED NURSING FACILITY			16, 945, 40	64		16, 945, 464	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE				0		0	4.00
5.00	Total general inpatient care services (Sum of I	ines 1 - 4)		16, 945, 40	64		16, 945, 464	5.00
	All Other Care Services							
6.00	ANCI LLARY SERVI CES			6, 634, 7	47	0	6, 634, 747	6.00
7.00						0	0	7.00
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9,00	AMBULANCE					0	0	9.00
	RURAL HEALTH CLINIC					0	0	10.00
10.00	FQHC					0	0	10.10
	СМНС					0	0	11.00
	HOSPICE				0	0	0	12.00
	OTHER (SPECIFY)				0	0	0	12.00
	Total Patient Revenues (Sum of lines 5 - 13) (T	renefer column 2	+ 0	22 500 2	11	0	-	13.00
14.00	Worksheet G-3, Line 1)	ransier corumn 3	10	23, 580, 2		0	23, 580, 211	14.00
	Cost Center Description			1				
						1.00	2.00	
	PART II - OPERATING EXPENSES						2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Li	ne 100)					16, 479, 328	1.00
2.00	Add (Specify)					0	10/ 17 / 020	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	0	8.00
8.00 9.00	Deduct (Specify)					0	0	8.00 9.00
	Deduct (Specify)					0		
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0	_	13.00
	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8,	minus line 14)					16, 479, 328	15.00

Hoal th	Financial Systems	CARE ONE AT VA	LIEV	Inlie	eu of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	OARE ONE AT VA	Provider No.: 31536		Worksheet G-3	
STATEN				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/10/2024 11:	50 am
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,				23, 580, 211	1.00
2.00	Less: contractual allowances and discounts on pa	atients accounts			6, 444, 506	2.00
3.00	Net patient revenues (Line 1 minus line 2)		. = >		17, 135, 705	3.00
4.00	Less: total operating expenses (From Worksheet (ne 15)		16, 479, 328	4.00
5.00	Net income from service to patients (Line 3 minu	us 4)			656, 377	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				5, 181	7.00
8.00	Revenues from communications (Telephone and In-	ternet service)			0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen service				645	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 suppli		n patients		0	16.00
17.00	Revenue from sale of drugs to other than patien				0	17.00
18.00	Revenue from sale of medical records and abstrac				0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.	,			0	19.00
20.00	Revenue from gifts, flower, coffee shops, cantee	en			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of skilled nursing space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	BARBER AND BEAUTY				16, 118	24.00
24.01	OTHER REV				1, 601	24.01
24.02	NJ PROVIDER TAX				12, 277	24.02
24.03	OTHER INCOME				4, 573	24.03
24.50	COVID-19 PHE Funding				0	24.50
25.00	Total other income (Sum of lines 6 - 24)				40, 395	25.00
26.00	Total (Line 5 plus line 25)				696, 772	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
	Total other expenses (Sum of lines 27 - 29)				0	30.00
31.00	Net income (or loss) for the period (Line 26 min	nus line 30)			696, 772	31.00