Heal th Financi	al Systems	CARE ONE AT W	A1 1	Inlia	u of Form CMS-2540-10
	s required by Law (42 USC 1395g; 42 CFR 413.				
	since the beginning of the cost reporting p				OMB NO. 0938-0463 Expires: 12/31/2021
	NG FACILITY AND SKILLED NURSING FACILITY HEA REPORT CERTIFICATION AND SETTLEMENT SUMMARY	ALTH CARE	Provider CCN: 315485	Period: From 01/01/2023 To 12/31/2023	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost re	port		Date: 5/10/20	24 Time: 11:54 am
use only	2. []Manually prepared cost report 3. [0]If this is an amended report en 3.01 []No Medicare Utilization. Enter			r resubmitted thi	s cost report
Contractor	4.[1]Cost Report Status	6. Contractor	No.		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	(2) Settled without audit	8.[N] Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened		ine 4, column 1 is "4"	· Enter number of	times reopened
	(5) Amended		r Vendor Code		
	E Data Dassivad				"I" for low or "N"
	5. Date Received:		care Utilization. Ente no utilization.	er F for full,	L TOT TOW, OF N

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT WALL (315485) 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	-153, 082	233	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	-153, 082	233	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.

	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH X INDENTIFICATION DATA	ONE AT WALL CARE Provide	~ No.: 315485	Period: From 01/01/ To 12/31/		Workshee Part I Date/Tim 5/10/2024	t S-2 e Prep	pared:
	1.00 2	. 00	3.00			0/ 10/ 202		
	Skilled Nursing Facility and Skilled Nursing Facility	Complex Address:						ļ
	Street: 2621 HI GHWAY 138 PO Box:							1.00
. 00	City: WALL State: NJ							2.00
. 00	County: MONMOUTH CBSA Code		ural:U					3.00
. 01	CBSA Code			_	-			3.01
		Component Name				ent System	n (P,	
			CCN	Certified		0, or N)		
		4 00			V		XIX	
	CNE and CNE Deced Component I dentification.	1.00	2.00	3.00	4.00	5.00	6.00	
. 00	SNF and SNF-Based Component Identification:	CARE ONE AT WALL	315485	09/10/2004	N	P	N	4.00
. 00	Nursing Facility	CARE UNE AT WALL	310460	09/10/2004		P	IN	5.00
. 00	ICF/IID							6.00
. 00	SNF-Based HHA							7.00
. 00 3. 00	SNF-Based RHC						-	8.00
	SNF-Based FQHC							9.00
	SNF-Based CMHC							10.00
	SNF-Based OLTC SNF-Based HOSPICE							11.00
								12.0
3.00	SNF-Based CORF			- Enor	l	То		13.0
				From: 1.00		To: 2.00		
4 00	Cost Reporting Period (mm/dd/yyyy)			01/01/2		12/31/2		14.0
	Type of Control (See Instructions)			01/01/2	4	12/31/2	023	15.0
5.00	Type of control (see that detrons)				4	Y/N		13.00
					ŀ	1.00		
	Type of Freestanding Skilled Nursing Facility					1.00		
6. 00	Is this a distinct part skilled nursing facility that section 483.5?	meets the requirem	ents set forth	in 42 CFR		Y		16. 0
7.00	Is this a composite distinct part skilled nursing faci 42 CFR section 483.5?	lity that meets th	e requirements	set forth i	in	Ν		17.0
8. 00	Are there any costs included in Worksheet A that resul organizations as defined in CMS Pub. 15-1, chapter 10?					Y		18.0
	Miscellaneous Cost Reporting Information	, ·						1
9.00	If this is a low Medicare utilization cost report, inc	licate with a "Y",	for yes, or "N	" for no.		N		19.00
9. 01	If line 19 is yes, does this cost report meet your cor utilization cost report, indicate with a "Y", for yes,	ntractor's criteria	for filing a	low Medicar	e	Ν		19. 0 [.]
	Depreciation - Enter the amount of depreciation report		the method in	ndicated on	Li nes	20 - 22.		
0.00	Straight Line						12, 831	20.00
	Declining Balance				ĺ		d	21.0
	Sum of the Year's Digits						d	22.0
	Sum of line 20 through 22					54	2, 831	
	If depreciation is funded, enter the balance as of th	e end of the neric	d			01	2,001	24.0
	Were there any disposal of capital assets during the c					Ν	Ĭ	
5 00				nortina neri	Sho i			25 0
	Was accelerated depreciation claimed on any assets in							25.0
	Was accelerated depreciation claimed on any assets in	the current of any	P	por tring por		N		
6. 00	(Y/N) Did you cease to participate in the Medicare program a	5						26. 0
6. 00 7. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p	at end of the perio	d to which thi	s cost repo	rt	N		25. 0 26. 0 27. 0 28. 0
6. 00 7. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N)	at end of the perio	d to which thi	s cost repo	rt	N N)thor	26. 0 27. 0
6. 00 7. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p	at end of the perio	d to which thi	s cost repo	rt Part	N N A Part B C		26. 0 27. 0
6. 00 7. 00 8. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N)	at end of the peric	d to which thi able cost from	s cost repon	rt Part 1.00	N N A Part B C 2.00		26. 0 27. 0
6. 00 7. 00 8. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	Part 1.00 e app	N N A Part B C 2.00		26. 0 27. 0
5. 00 7. 00 3. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption.	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	Part 1.00 e app i es fe	N N APart B C 2.00 Lication or the		26. 0 27. 0 28. 0
5. 00 7. 00 3. 00 9. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	Part 1.00 e app	N N A Part B C 2.00	3.00	26. 0 27. 0 28. 0 29. 0
5. 00 7. 00 3. 00 9. 00 0. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	Part 1.00 e app i es fe	N N APart B C 2.00 Lication or the		26. 0 27. 0 28. 0 28. 0 29. 0 30. 0
5. 00 7. 00 3. 00 9. 00 0. 00 1. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	rt <u>Part</u> 1.00 e app ies fo N	N N A Part B C 2.00 Lication for the N	3.00	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0
5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00 2. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	Part 1.00 e app i es fe	N N APart B C 2.00 Lication or the	3.00	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0
 5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	rt <u>Part</u> 1.00 e app ies fo N	N N A Part B C 2.00 Lication for the N	3.00	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0
5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	rt <u>Part</u> 1.00 e app ies fo N	N N A Part B C 2.00 Lication or the N N	3.00	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0
5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost	rt <u>Part</u> 1.00 e app ies fo N	N N A Part B C 2.00 Lication for the N	3.00	26.0 27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0 35.0
5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC	nt end of the perio proportion of allow der that qualifies	d to which thi able cost from	s cost report prior cost ion from th that qualif	rt <u>Part</u> 1.00 e app ies fo N	N N A Part B C 2.00 Lication or the N N	3.00	26.0 27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0 35.0
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6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 3. 00 4. 00 5. 00 6. 00	<pre>(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/ID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state tha regardless of the level of care given for Titles V & X</pre>	at end of the peric proportion of allow der that qualifies ch component and ty at certifies the pr (IX patients? (Y/N)	d to which thi able cost from for an exempt pe of service	s cost report prior cost tion from th that qualif Y/N 1.00 F N	Part 1.00 e app i es fo N N	N N N <u>A Part B C</u> 2.00 Lication or the N N N N	3.00 N	26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0
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6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00	<pre>(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based HHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state tha regardless of the level of care given for Titles V & X Are you legally-required to carry mal practice insuranc Is the mal practice a "claims-made" or "occurrence" pol</pre>	at end of the period proportion of allow der that qualifies ch component and ty at certifies the pr (IX patients? (Y/N) icy? (If the policy	d to which thi able cost from for an exempt ope of service	s cost report prior cost tion from th that qualif Y/N 1.00 F N	Part 1.00 e app i es fo N N	N N N <u>A Part B C</u> 2.00 Lication or the N N N N	3.00 N	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00	<pre>(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state that regardless of the level of care given for Titles V & X Are you legally-required to carry malpractice insurance </pre>	at end of the period proportion of allow der that qualifies ch component and ty at certifies the pr (IX patients? (Y/N) icy? (If the policy	d to which thi able cost from for an exempt pe of service ovider as a SN	s cost report prior cost ion from th that qualif	Part 1.00 e app i es fo N N	N N N 2.00 I i cati on or the N N N N 2.00	3.00 N	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	<pre>(Y/N) Did you cease to participate in the Medicare program a applies? (Y/N) Was there a substantial decrease in health insurance p reports? (Y/N) If this facility contains a public or non-public provi of the lower of the costs or charges enter "Y" for eac exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based HHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state tha regardless of the level of care given for Titles V & X Are you legally-required to carry mal practice insuranc Is the mal practice a "claims-made" or "occurrence" pol</pre>	at end of the period proportion of allow der that qualifies ch component and ty at certifies the pr (IX patients? (Y/N) icy? (If the policy	d to which thi able cost from for an exempt ope of service	s cost report prior cost tion from th that qualif <u>Y/N</u> F N Y	Part 1.00 e app i es fo N N	N N N <u>A Part B C</u> 2.00 Lication or the N N N N	3.00 N	26. 0 27. 0

Health Financial Systems	CARE ON	E AT WALL		In Li	eu of Form (CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CAR	E Provider No.:		Peri od:	Worksheet	S-2
COMPLEX INDENTIFICATION DATA				From 01/01/202 To 12/31/202		Prenared
				10 12/31/202	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 suppor	rting schedule listi	ng cost c	enters 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	enter the name and a	address o	f the home	HB0206	44.00
office on lines 45, 46 and 47.						
1.00		. 00		3.00		
If this facility is part of a chain or	ganization, enter tl	he name and address	of the ho	ome office on t	ne lines	
bel ow.	1					
45.00 Name: HEALTHBRIDGE	Contractor's Name:	NOVITAS SOLUTIONS	Contracto	or's Number: 12	201	45.00
46.00 Street: 173 BRIDGE PLAZA NORTH	PO Box:					46.00
47.00 City: FORT LEE	State:	NJ	Zip Code:	: 07	024	47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE	Provi der I	No.: 315485	Period:	u of Form CMS Worksheet S-	-2
OMPL	EX REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023 To 12/31/2023	Date/Time Pr	repared
					Y/N	5/10/2024 11 Date	1:54 ai
					1.00	2.00	
	General Instruction: For all column 1 respons	ses enter in column 1	, "Y" for	Yes or "N"	for No. For all	the date	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites						_
	Provider Organization and Operation						
00	Has the provider changed ownership immediated reporting period? If column 1 is "Y", enter				N		1.
	instructions)			1111 Z. (See			
			-	Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program	12 If	1.00 N	2.00	3.00	2.
00	column 1 is yes, enter in column 2 the date of						2.
~~	3, "V" for voluntary or "I" for involuntary.	tiono includina mono	acmont	Y			1
00	Is the provider involved in business transactions contracts, with individuals or entities (e.g.			ř			3.
	or medical supply companies) that are related	d to the provider or	its				
	officers, medical staff, management personnel of directors through ownership, control, or						
	relationships? (see instructions)		i ai				
				Y/N	Туре	Date	_
	Financial Data and Reports			1.00	2.00	3.00	
00	Column 1: Were the financial statements prepa	ared by a Certified F	Public	Y	A		4.
	Accountant? (Y/N) Column 2: If yes, enter "A'						
	Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If						
00	Are the cost report total expenses and total	revenues different f	rom	Ν			5.
	those on the filed financial statements? If a reconciliation.	column 1 is "Y", subm	nit				
					Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	nol? (Y/N) Column 2:	ls the r	provider the	N	N	6.
							1 0.
	legal operator of the program? (Y/N)	. ,			i v		
00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instruct	i ons.		N		
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00 00 00 00 00 00 00 00 00 00 00 00 00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debringeriod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data 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.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections. If line 13 or 14 is "Y", then were adjustments made to	s? (Y/N) see instruct ng the cost reporting ee instructions. d debts? (Y/N) see in t collection policy c d/or coinsurance waiv cost reporting peric Description 0	ions. g period 1 hstructior change dur ved? If "Y"	For Nursing hs. hing this cos (", see instru- P, Y/N 1.00 Y N N N	N N St reporting Fuctions. Justions. Justions. Justions. Justions. Justions. Justions. Justions.	Y/N 1.00 Y N N Part B Y/N 3.00 Y N N	8. 9. 10. 11. 12. 13. 14. 15. 16.

Heal th	Financial Systems	CARE ONE	AT WA	\LL		In Lie	eu of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HE	ALTH CARE		Provi der	No.: 315485	Peri od:	Worksheet S-2	2
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					From 01/01/2023 To 12/31/2023		nared
							5/10/2024 11:	
				1.	00	2.	00	
	Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the title/pos	ition	CHARL	ES		REED		19.00
	held by the cost report preparer in columns 1, 2,	and 3,						
	respecti vel y.							
20.00	Enter the employer/company name of the cost repor	t	EXECL	JCARE ASSO	CI ATES			20.00
	preparer.							
21.00	Enter the telephone number and email address of t	he cost	(609)	738-3200		CRWASSC@NETSCA	PE. NET	21.00
	report preparer in columns 1 and 2, respectively.							

Heal th	Financial Systems	CARE ONE AT	F WALL	In Lie	u of Form CMS-2540	40-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.: 315485	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepart 5/10/2024 11:54	
		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.)	03/19/2024			13	3.00
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	4.00
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	5.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.				16	6.00
	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:				17	7.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18	8.00
			3.00			
	Cost Report Preparer Contact Information	, h				
19.00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		CE-PRESI DENT		19	9. 00
20.00	Enter the employer/company name of the cost r	report			20	0.00
	preparer.					
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv				21	1. 00

(I LLE	Financial Systems ED NURSING FACILITY AND SKILLED NURSI EX STATISTICAL DATA	CARE ONE / NG FACILITY HEALTH CARE		F	Period: From 01/01/2023 To 12/31/2023		pared:
				l np	oatient Days/Vis		
	Component	Number of Beds	Bed Days Avai Labl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	138	50, 370	C		10, 061	1.0
00 00	NURSING FACILITY	0	0	Ĺ)	0	2.0 3.0
00	HOME HEALTH AGENCY COST	U. U	0	C	0	0	4.0
00	Other Long Term Care	0	0				5. C
00	SNF-Based CMHC		0				6.0
00 00	HOSPICE Total (Sum of lines 1-7)	138	0 50, 370			0 10, 061	7.0
00		Inpatient D		, c	Di scharges	10, 001	0.0
					3		
	Component	Other 6 00	Total	Title V	Title XVIII	Title XIX	
00	SKILLED NURSING FACILITY	<u> </u>	7.00 34,528	8.00 C	9.00	10.00	1. (
00	NURSING FACILITY	0	01, 020	C)	0	2.0
00	ICF/IID	0	0			0	3.
00	HOME HEALTH AGENCY COST	0	0				4.
00 00	Other Long Term Care SNF-Based CMHC	0	0				5. 6.
00	HOSPICE	0	0	C	0	0	7.
00	Total (Sum of lines 1-7)	10, 700	34, 528	C	459	42	
		Di scha	arges	Ave	rage Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
00	SKILLED NURSING FACILITY	374	875	0.00		239.55	1.0
00 00	NURSING FACILITY	0	0	0.00)	0.00 0.00	2. (3. (
00	HOME HEALTH AGENCY COST	0	0			0.00	4. (
00	Other Long Term Care	0	0				5.0
00	SNF-Based CMHC						6. (
00	HOSPICE	0 374	0	0.00			7.0
00	Total (Sum of lines 1-7)	Average Length	875	0.00 Admi s	29.99 ssions	239.55	8.
		of Stay					
	Component	Total 16.00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
00	SKILLED NURSING FACILITY	39.46	0	498		371	1.0
00	NURSING FACILITY	0.00	0		0	0	2.
00	ICF/IID	0.00			0	0	3.
00 00	HOME HEALTH AGENCY COST Other Long Term Care	0.00				0	4. 5.
00 00	SNF-Based CMHC	0.00				0	6.
00	HOSPI CE	0.00	0	C	0 0	0	
00	Total (Sum of lines 1-7)	39.46	0		3 17	371	8. (
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d	-		
		21.00	Payrol I	Workers	-		
00	SKILLED NURSING FACILITY	21.00	22.00	23.00)		1. (
00	NURSING FACILITY	0	0.00				2.0
00	ICF/IID	0	0.00				3.
00	HOME HEALTH AGENCY COST		0.00	0.00			4.
00 00	Other Long Term Care	0	0.00				5.
	SNF-Based CMHC		0.00	0.00			6.0
00	HOSPI CE		0.00	0.00)	1	7.0

SNF WAGE IN	NDEX INFORMATION						2540-10
					Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	II – DIRECT SALARIES						
SALAF				1			
	l salaries (See Instructions)	8, 737, 958	C	8, 737, 95			1.00
	ician salaries-Part A	0	C		0 0.00		2.00
, , ,	ician salaries-Part B	0	C		0 0.00		3.00
	office personnel	0	0		0 0.00		4.00
	of lines 2 through 4	0	0		0 0.00		5.00
	sed wages (line 1 minus line 5)	8, 737, 958	0	8, 737, 95			6.00
	r Long Term Care	0	0		0 0.00		7.00
	HEALTH AGENCY COST	0	0		0 0.00		
9.00 CMHC		0	0		0 0.00		
10.00 HOSP		0	0		0 0.00		
	r excluded areas	0	0		0 0.00		
thro	otal Excluded salary (Sum of lines 7 nugh 11)	0	U		0 0.00		
13.00 Tota 12)	I Adjusted Salaries (line 6 minus line	8, 737, 958	C	8, 737, 95	58 255, 926. 00	34.14	13.00
OTHER	R WAGES & RELATED COSTS	-					
14.00 Cont	ract Labor: Patient Related & Mgmt	1, 408, 514	C	1, 408, 51	18, 065. 00	77.97	14.00
	ract Labor: Physician services-Part A	0	C)	0 0.00	0.00	15.00
	office salaries & wage related costs	0	0		0 0.00	0.00	16.00
	-RELATED COSTS						
	e-related costs core (See Part IV)	1, 725, 021	0	1, 725, 02	21		17.00
18.00 Wage	-related costs other (See Part IV)	0	0		0		18.00
	related costs (excluded units)	0	C		0		19.00
	ician Part A - WRC	0	0		0		20.00
	ician Part B - WRC	0	0		0		21.00
	I Adjusted Wage Related cost (see ructions)	1, 725, 021	C	1, 725, 02	21		22.00

Heal th	Financial Systems	CARE ONE	AT WALL		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 01/01/2023 To 12/31/2023		nared
			_			5/10/2024 11:	
		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			1			
1.00	Employee Benefits	0	0		0.00		1.00
2.00	Administrative & General	697, 817	0	697, 81	7 15, 807. 00	44.15	2.00
3.00	Plant Operation, Maintenance & Repairs	89, 810	0	89, 81	0 3, 107. 00	28. 91	3.00
4.00	Laundry & Linen Service	72, 710	0	72, 71	0 4, 215. 00	17.25	4.00
5.00	Housekeepi ng	354, 167	0	354, 16	7 18, 629. 00	19.01	5.00
6.00	Dietary	678, 940	0	678, 94	0 29, 162. 00	23. 28	6.00
7.00	Nursing Administration	804, 025	0	804, 02	5 17, 363. 00	46.31	7.00
8.00	Central Services and Supply	43, 082	0	43, 08	2 1, 946. 00	22.14	8.00
9.00	Pharmacy	0	0		0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	11, 877	0	11, 87	7 549.00	21.63	10.00
11.00	Social Service	143, 213	0	143, 21	3 3, 919. 00	36.54	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	171, 202	0	171, 20	2 8, 404. 00	20.37	13.00
14.00	Total (sum lines 1 thru 13)	3, 066, 843	0	3, 066, 84	3 103, 101. 00	29.75	14.00

lealth Financial Systems	CARE ONE	AT WALL	In Lie	u of Form CMS-2	2540-1
SNF WAGE RELATED COSTS		Provider No.: 315485	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Pre 5/10/2024 11:	pared:
				Amount Reported	
				1.00	
PART IV - WAGE RELATED CO	TS				
Part A - Core List					1
RETI REMENT COST					1
1.00 401K Employer Contributio	IS			37, 152	1.0
2.00 Tax Sheltered Annuity (TS	 Employer Contribution 			0	2.0
3.00 Qualified and Non-Qualifi	d Pension Plan Cost			0	3.0
4.00 Prior Year Pension Servic	e Cost			0	4.0
PLAN ADMINISTRATIVE COSTS	(Paid to External Organization)				
5.00 401K/TSA Plan Administrat				0	5.0
. 00 Legal /Accounting/Manageme				0	6. C
2.00 Employee Managed Care Pro	ram Administration Fees			0	7.0
HEALTH AND INSURANCE COST					
.00 Health Insurance (Purchas	d or Self Funded)			786, 624	
.00 Prescription Drug Plan				0	
0.00 Dental, Hearing and Visio				0	10. (
	e is owner or beneficiary)			1, 808	
	oloyee is owner or beneficiary)			0	
	employee is owner or beneficiary)			0	13.0
	If employee is owner or benefici	ary)		0	
5.00 Workers' Compensation Ins				130, 528	
	st (Only current year, not the ex	traordinary accrual require	ed by FASB 106.	0	16. (
Non cumulative portion)					
7.00 FICA-Employers Portion On				649, 504	17. (
8.00 Medicare Taxes - Employer				049, 504	
9.00 Unemployment Insurance	, POLETOIL OIL Y			0	10.0
0.00 State or Federal Unemploy	ant Taxas			110, 557	
OTHER				110, 557	20.1
1.00 Executive Deferred Compen	ation			0	21.0
2.00 Day Care Cost and Allowan				0	
3.00 Tuition Reimbursement				8, 848	
4.00 Total Wage Related cost (jum of lines 1 - 23)			1, 725, 021	
	,			Amount	
				Reported	
				1.00	
Part B - Other than Core	elated Cost				
5.00 OTHER WAGE RELATED COST				0	25.0

Heal th	Financial Systems	CARE ONE A	AT WALL		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	oared:
	Occupational Category	Amount Reported	Fringe Benefits	Adj usted Sal ari es (col 1 + col . 2)	. Related to	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 257, 976	259, 384				1.00
2.00	Licensed Practical Nurses (LPNs)	1, 135, 963	234, 226				2.00
3.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	1, 699, 338	350, 389	2, 049, 72	65, 059. 00	31. 51	3.00
4.00	Total Nursing (sum of lines 1 through 3)	4, 093, 277	843, 999	4, 937, 27	6 116, 900. 00	42.24	4.00
5.00	Physical Therapists	637, 605	131, 469	769, 07	4 16, 333.00	47.09	5.00
6.00	Physical Therapy Assistants	0	0		0 0.00		6.00
7.00	Physical Therapy Aides	0	0		0 0.00	0.00	7.00
8.00	Occupational Therapists	652, 607	134, 562	787, 16	9 15, 174. 00	51.88	8.00
9.00	Occupational Therapy Assistants	0	0)	0 0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0		0 0.00	0.00	10.00
11.00	Speech Therapists	128, 865	26, 571				11.00
12.00	Respi ratory Therapi sts	56, 266	11, 602	67,86			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)	33, 370		33, 37			14.00
15.00	Licensed Practical Nurses (LPNs)	960, 683		960, 68			15.00
16.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	395, 661		395, 66	6, 594. 00	60.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	1, 389, 714		1, 389, 71	4 17, 814.00	78.01	17.00
18.00	Physical Therapists	0			0 0.00	0.00	18.00
19.00	Physical Therapy Assistants	0			0 0.00	0.00	19.00
20.00	Physical Therapy Aides	0			0 0.00	0.00	20.00
21.00	Occupational Therapists	0			0 0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0			0 0.00	0.00	
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapists	18, 800		18, 80			
25.00	Respiratory Therapists	0			0 0.00		25.00
26.00	Other Medical Staff	0			0 0.00	0.00	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider No.: 315485 Period: Worksheet	MS-2540-10 S-7
	From 01/01/2023 To 12/31/2023 Date/Time	Prepared:
	5/10/2024 Group Days	11:54 am
1.00	1.00 2.00	1.00
1.00 2.00	RUX RUL	1.00
3.00	RVX	3.00
4.00	RVL	4.00
5.00	RHX	5.00
6. 00 7. 00	RHL RMX	6.00 7.00
8.00	RML	8.00
9.00	RLX	9.00
10. 00 11. 00	RUC RUB	10.00
12.00	RUA	12.00
13. 00	RVC	13.00
14.00	RVB	14.00
15. 00 16. 00	RVA RHC	15.00 16.00
17.00	RHB	17.00
18.00	RHA	18.00
19.00	RMC	19.00
20.00 21.00	RMB RMA	20.00
22.00	RIA	21.00
23. 00	RLA	23.00
24.00	ES3	24.00
25. 00 26. 00	ES2 ES1	25.00 26.00
27.00	HE2	28.00
28.00	HE1	28.00
29.00	HD2	29.00
30. 00 31. 00	HD1 HC2	30.00
32.00	HC1	31.00
33. 00	HB2	33.00
34. 00	HB1	34.00
35. 00 36. 00	LE2 LE1	35.00 36.00
37.00	LD2	37.00
38. 00	LD1	38.00
39. 00	LC2	39.00
40. 00 41. 00	LC1 LB2	40.00
42.00	LB1	42.00
43. 00	CE2	43.00
44.00	CE1	44.00
45. 00 46. 00	CD2 CD1	45.00 46.00
47.00	CC2	47.00
48. 00	CC1	48.00
49.00	CB2	49.00
50.00 51.00	CB1 CA2	50.00 51.00
52. 00	CA1	52.00
53. 00	SE3	53.00
54.00 55.00	SE2 SE1	54.00 55.00
56.00	SSC	55.00
57. 00	SSB	57.00
58.00	SSA	58.00
59. 00 60. 00	I B2 I B1	59.00 60.00
61.00	I A2	61.00
62.00	I A1	62.00
63. 00	BB2	63.00
64.00 65.00	BB1 BA2	64.00 65.00
66.00	BA2 BA1	66.00
67. 00	PE2	67.00
68.00	PE1	68.00
69. 00 70. 00	PD2 PD1	69. 00 70. 00
71.00	PC2	70.00
72.00	PC1	72.00
73.00	PB2 PB1	73.00 74.00
74.00		

Health Financial Systems CARE ONE AT	WALL		In Lie	eu of Form CN	IS-2540-10		
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315485	Peri od:	Worksheet S	5-7		
			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 Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)							
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00		

Fram Difference Fram Difference Fram Difference Properate Cost Cent Cent Cent Cent Difference Properate Properat Properate		Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	CARE ONE AT EXPENSES			Period:	u of Form CMS-2 Worksheet A	2540-10
Cost Center Description Sal uries Other Table (col.) Reclassified (col. 2) Reclassified (col. 2) Reclassified (col. 2) 1.00 2.00 3.00 4.00 5.00 5.00 1.00 0.00 1.01/10						From 01/01/2023 To 12/31/2023		
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90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 2,860 2,860 0 2,860 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 7,496 7,496 0 7,496 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 95.00	89.00		8, 737, 958	10, 557, 701	19, 295, 65	9 0	19, 295, 659	89.00
91.00 09100 BARBER AND BEAUTY SHOP 0 7,496 7,496 91.00 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 95.00	00.00					-	0.015	00.00
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 94.00 95.00 0 0 0 0 94.00 94.00 94.00 94.00 95.00 0 0 0 0 95.00 0 0 0 95.00 0 0 0 95.00 0 0 0 0 95.00 0 0 0 0 0 0 95.00			0					
93.00 09300 NONPAI D WORKERS 0 0 0 0 93.00 94.00 94.00 94.00 94.00 95.00			0	7, 470 N	7,49			
94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 94.00 94.00 94.00 95.00 0 0 0 0 95.00 0 0 0 0 95.00 0 0 0 0 95.00 95.00 0 0 0 0 0 95.00 100			0	0		0 0		
	94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
100.00 101AL 8, 737, 958 10, 568, 057 19, 306, 015 0 19, 306, 015 100.00			0	0		0 0		
	100.00	IOTAL	8, 737, 958	10, 568, 057	19, 306, 01	5 0	19, 306, 015	100. 00

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	CARE ONE		No.: 315485	In Lie Period:	u of Form CMS Worksheet A	-2540-10
RECERC	STITISTICS AND ADJUSTMENT OF TRIAL DALANCE OF	EXTENSES	i i ovrder	10010400	From 01/01/2023 To 12/31/2023		epared.
	Cost Conton Description	Adiustmente to	Not Experses			5/10/2024 11	
	Cost Center Description	Adjustments to Expenses (Fr	For Allocation				
		Wkst A-8)	(col. 5 +-				
		6.00	col. 6) 7.00	-			
	GENERAL SERVICE COST CENTERS	0.00	7.00				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-3, 196		1			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0		1			2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	-689, 979	1, 801, 693 2, 799, 245				3.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	567, 835	1			5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	145, 191	1			6.00
7.00	00700 HOUSEKEEPING	0		1			7.00
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	-705 -2,430		1			8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	2,430	335, 502	1			10.00
11.00	01100 PHARMACY	-3, 207	36, 881	1			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	11, 877	1			12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION		143, 213 0	1			13.00
14.00	01500 ACTIVITES		177, 256	1			15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	-15, 994		1			30.00
31.00	03100 NURSING FACILITY	0	0				31.00
32.00 33.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0				32.00 33.00
55.00	ANCI LLARY SERVICE COST CENTERS		0	1			- 55.00
40.00	04000 RADI OLOGY	0	43, 514				40.00
41.00	04100 LABORATORY	0	95, 461	1			41.00
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	-16, 798	193, 172 0	1			42.00
44.00	04400 PHYSI CAL THERAPY	0	762, 282				44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	652, 607	1			45.00
46.00	04600 SPEECH PATHOLOGY	0	147, 665	1			46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 198	1			47.00 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	-58, 222					49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1			50.00
51.00	05100 SUPPORT SURFACES	0	0	1			51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0	0	1			52.00 52.01
	05202 MEDICAL SERVICES		0	1			52.01
02.02	OUTPATIENT SERVICE COST CENTERS			1			
	06000 CLI NI C	0		1			60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0				61.00 62.00
62.00 63.00	06300 DI ALYSI S	0	0				63.00
00100	OTHER REIMBURSABLE COST CENTERS			1			
70.00	07000 HOME HEALTH AGENCY COST	0	0				70.00
71.00	07100 AMBULANCE	0	67, 181	1			71.00
	07300 CMHC 07400 OTHER REI MBURSEMENT	0	0	1			73.00 74.00
71.00	SPECIAL PURPOSE COST CENTERS			1			/ 1.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0		1			80.00
81.00	08100 I NTEREST EXPENSE	0	0	1			81.00
82.00 83.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE		0				82.00 83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I		0				84.00
84.01	08401 OTHER SPECIAL PURPOSE COST II	0	0				84.01
89.00	SUBTOTALS (sum of Lines 1-84)	-790, 531	18, 505, 128				89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	2, 860				90.00
90.00 91.00	09100 BARBER AND BEAUTY SHOP		2,800	1			90.00
	09200 PHYSI CLANS PRI VATE OFFI CES		0	1			92.00
93.00	09300 NONPAI D WORKERS	0	0	1			93.00
	09400 PATIENTS LAUNDRY	0	0				94.00
95.00 100.00	09500 OTHER NONREIMBURSABLE COST	-790, 531	18, 515, 484				95.00 100.00
100.00		1 170, 331	1 10, 515, 404	I			1.00.00

Health Financial Systems	CARE ONE AT WALL			In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS		Provider No.: 315485		Period: From 01/01/2023	Worksheet A-6	
					Date/Time Pre	pared:
					5/10/2024 11:	54 am
			Increases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
(1) A - RECLASS MED SUPP CHARGED						
1.00	MEDICAL SUPPLIES CH	IARGED TO	48.0	0 0	198	1.00
	PATI ENTS					
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	198	100.00
	of columns 4 and 5	must				
	equal sum of column	is 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 W	ALL		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS			No.: 315485	Period: From 01/01/2023	Worksheet A-6	
				To 12/31/2023		pared: 54 am
	Decreases					
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
(1) A - RECLASS MED SUPP CHARGED						
1.00	CENTRAL SERVICES &	SUPPLY	10.	0 00	198	1.00
TOTALS						
100.00				0	198	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			In Lie	eu of Form CMS-2	2540-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315485	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		narod
					10 12/31/2023	5/10/2024 11:	54 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 BALANCE					-	
1.00	Land	1, 202, 467	0		0 0	0	1.00
2.00	Land Improvements	24, 393			0 0	0	2.00
3.00	Buildings and Fixtures	9, 367, 664	12, 815		0 12, 815		3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	378, 514	90, 769		0 90, 769		5.00
6.00	Movable Equipment	2, 979, 289			0 0	0	6.00
7.00	Subtotal (sum of lines 1-6)	13, 952, 327	103, 584		0 103, 584		7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	13, 952, 327	103, 584		0 103, 584	. 0	9.00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE						
1.00	Land	1, 202, 467	0				1.00
2.00	Land Improvements	24, 393	0				2.00
3.00	Buildings and Fixtures	9, 380, 479	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	469, 283					5.00
6.00	Movable Equipment	2, 979, 289	0				6.00
7.00	Subtotal (sum of lines 1-6)	14, 055, 911	0				7.00
8.00	Reconciling Items	14 055 011	0				8.00
9.00	Total (line 7 minus line 8)	14, 055, 911	0				9.00

T2III (MENTS TO EXPENSES		Provi der	No.: 315485	Peri od:	Worksheet A-8	2540-
5031	WENTS TO EAFENSES		FIOVIDEI	NO 315465	From 01/01/2023 To 12/31/2023	Date/Time Pre	pare
				Evinence C	lassification on	5/10/2024 11:	<u>54 ar</u> 1
					ch the Amount is		
	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.
00	(chapter 2) Trade, quantity, and time discounts (chapter		0	FI XTURES		0.00	2.
	8)		0			0.00	
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) (chapter 21)		0			0.00	5
00	Television and radio service (chapter 21)		0			0.00	6
00	Parking lot (chapter 21)		0			0.00	7
00	Remuneration applicable to provider-based physician adjustment	A-8-2	0				8
00	Home office cost (chapter 21)		0			0.00	
. 00 . 00	Sale of scrap, waste, etc. (chapter 23) Nonallowable costs related to certain		0			0.00	
. 00	Capital expenditures (chapter 24)		0			0.00	''
. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-183, 319				12
8.00	Laundry and Linen service		0			0.00	
. 00	Revenue - Employee meals	В		DI ETARY		8.00	
. 00 . 00	Cost of meals - Guests Sale of medical supplies to other than	В	- 666 - 0	DI ETARY		8.00 0.00	
	patients		-				
. 00	Sale of drugs to other than patients		0			0.00	
. 00 . 00	Sale of medical records and abstracts Vending machines		0			0.00	
. 00	Income from imposition of interest, finance		0			0.00	
	or penalty charges (chapter 21)						
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21
. 00	overpayments Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW - SNE	82.00	22
. 00	(chapter 21) Depreciation-buildings and fixtures			CAP REL COST		1.00	
. 00	Depreciationmovable equipment			FIXTURES CAP REL COST		2.00	
				EQUI PMENT ADMI NI STRATI			
. 00 . 01	RESIDENT REPLACEMENT ITEMS MARKETING EXPENSE	A		ADMINI STRATI		4.00 4.00	
. 02	MARKETING CORP EXPENSE	A		ADMI NI STRATI		4.00	
. 03	MARKETING - MEALS	А		ADMI NI STRATI		4.00	
. 04	SHOWS & CONFERENCES	A		ADMI NI STRATI		4.00	25
. 05	BAD DEBT EXPENSE	A		ADMI NI STRATI		4.00	
6. 06	BAD DEBT EXPENSE - MEDICARE	A		ADMI NI STRATI		4.00	
5. 07	OTHER MEDICAL SERVICES EXPENSE	А		SKILLED NURS		30.00	
5. 08	OTHER REVENUE	В		ADMI NI STRATI		4.00	
	OTHER INCOME	В		ADMI NI STRATI	VE & GENERAL	4.00	
10 00	Total (sum of lines 1 through 99) (Transfer	1 1	-790, 531	1			100

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

	Financial Systems	CARE ONE			In Lie	u of Form CMS-	2540-10
STATEM OFFICE	ENT OF COSTS OF SERVICES FROM RELATED ORGANIZ. COSTS	ATIONS AND HOMI			Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-II Date/Time Pre 5/10/2024 11:	epared:
		Line No.		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		10.00	CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPE	ENSE	3.00
4.00		11.00	PHARMACY		DRUGS-NON-PRESONON-LEGEND	CRIPTION,	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	TION, LEGEND	7.00
8.00		49.00	DRUGS CHARGED	TO PATI ENTS	DRUGS-PRESCRI P DRUGS MAN	TION, LEGEND	8.00
9.00		49.00	DRUGS CHARGED	TO PATI ENTS	DRUGS-PRESCRI P	TION, 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. 5	col. 5)			
		4.00	5.00	6,00	_		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:				ED ORGANI ZATI ONS	G OR	
1.00		799, 612	902, 274	-102, 66	2		1.00
2.00		27, 946	30, 376	-2, 43	0		2.00
3.00		93, 168	93, 168		0		3.00
4.00		35, 201	38, 262	-3, 06	51		4.00
5.00		1, 680	1, 826	-14	6		5.00
6.00		193, 172			8		6.00
7.00		43, 849					7.00
8.00		230, 467					8.00
9.00		395, 235					9.00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	1, 820, 330					10.00
	12.						

Health Financial Systems	AT WALL	In Lie	u of Form CMS-2	2540-10	
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGA	NIZATIONS AND HOME	Provider No.: 315485	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8- Parts I-II Date/Time Prep 5/10/2024 11:5	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 1 5	1	1			
1.00	A	DANI EL STRAUS	41.00	1.	. 00
2.00	A	DANI EL STRAUS	41.00	2.	. 00
3.00	A	DES HOLDING CO. INC.	22.00	3.	. 00
4.00	F	PARTNERS PHARMACY SERVICES	0.00	4.	. 00
		LLC			
5.00			0.00	5.	. 00
6.00			0.00	6.	. 00
7.00			0.00	7.	. 00
8.00			0.00	8.	. 00
9.00			0.00	9.	. 00
10.00			0.00	10.	. 00
100.00 G. Other (financial or non-financial)			0.00	100.	. 00
speci fy:					

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

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

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

interest in provider.			
	Rel ated Organi	zation(s) and/	or Home Office
	-		
	Name	Percentage of	Type of Business
		Ownershi p	

4 00

5.00

6 00

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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.

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	CARE ONE A		F	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	ATED COSTS		5/10/2024 11:	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
	col. 7)					
GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	3A	
1.00 00100 CAP REL COSTS - BLDGS & FIXTURE	S 1, 613, 910	1, 613, 910				1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PME			334, 094	-		2.00
3.00 00300 EMPLOYEE BENEFITS	1, 801, 693	0	C		0.054.700	3.00
4. 00 00400 ADMINI STRATI VE & GENERAL 5. 00 00500 PLANT OPERATI ON, MAINT. & REPAI	2, 799, 245 RS 567, 835	258, 212 64, 541	53, 452 13, 361		3, 254, 793 664, 255	4.00 5.00
6.00 00600 LAUNDRY & LINEN SERVICE	145, 191	80, 688	16, 703		257, 574	6.00
7.00 00700 HOUSEKEEPI NG	397, 711	9, 688	2,006		482, 431	7.00
8.00 00800 DI ETARY	1, 027, 379	129, 082	26, 721		1, 323, 174	8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY	918, 499 335, 502	11, 256 0	2, 330		1, 097, 869 344, 385	
11. 00 01100 PHARMACY	36, 881	0	C		36, 881	11.00
12.00 01200 MEDI CAL RECORDS & LI BRARY	11, 877	9, 688	2,006		26, 020	12.00
13.00 01300 SOCIAL SERVICE	143, 213	3, 229	669		176, 640	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCA 15.00 01500 ACTIVITES	TI ON 0 177, 256	0			0 212, 556	14.00 15.00
INPATIENT ROUTINE SERVICE COST CENTER		0		55, 500	212, 330	15.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	5, 563, 211	968, 643	200, 517	855, 600	7, 587, 971	30.00
31. 00 03100 NURSI NG FACI LI TY	0	0	C	-	0	31.00
32.00 03200 ICF/IID 33.00 03300 OTHER LONG TERM CARE	0	0			0	32.00 33.00
ANCI LLARY SERVICE COST CENTERS	0	0		, 0	0	33.00
40. 00 04000 RADI OLOGY	43, 514	0	C	0	43, 514	40.00
41. 00 04100 LABORATORY	95, 461	0	C		95, 461	41.00
42.00 04200 INTRAVENOUS THERAPY 43.00 04300 0XYGEN (INHALATION) THERAPY	193, 172	0		, s	193, 172 0	42.00 43.00
44. 00 04400 PHYSI CAL THERAPY	762, 282	17, 714	3, 667	, s	936, 266	
45.00 04500 OCCUPATI ONAL THERAPY	652, 607	8, 026	1, 661		796, 856	
46.00 04600 SPEECH PATHOLOGY	147, 665	8, 026	1, 661		183, 923	46.00
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PAT	0 TENTS 198	0 24, 173	C 5, 004	-	0 29, 375	47.00 48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	669, 551	24, 173	4, 336		694, 831	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	C		0	50.00
51.00 05100 SUPPORT SURFACES	0	0	C	0	0	51.00
52. 00 05200 COMPLEX MEDICAL EQUIPMENT 52. 01 05201 OTHER ANCILLARY SERVICES COST	0	0			0	52.00 52.01
52. 02 05202 MEDI CAL SERVI CES	0	0	C		0	
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLINIC 61. 00 06100 RURAL HEALTH CLINIC	0	0	C		0	
62. 00 06200 FQHC	0	0	Ĺ	0	0	61.00 62.00
63. 00 06300 DI ALYSI S	0	0	C	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70. 00 07000 HOME HEALTH AGENCY COST 71. 00 07100 AMBULANCE	0 67, 181	0	C	-	0 67, 181	70.00 71.00
73. 00 07300 CMHC	07, 181	0			07, 181	73.00
74.00 07400 OTHER REIMBURSEMENT	0	0	C	0	0	74.00
SPECIAL PURPOSE COST CENTERS	2050					
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOS 81. 00 08100 I NTEREST EXPENSE	DSES					80.00 81.00
82.00 08200 UTILIZATION REVIEW - SNF						82.00
83. 00 08300 HOSPI CE	0	0	C	0	0	83.00
84.00 08400 OTHER SPECIAL PURPOSE COST I	0	0	C	0	0	84.00
84.01 08401 OTHER SPECIAL PURPOSE COST II 89.00 SUBTOTALS (sum of lines 1-84)	19 505 129	0 1 612 010	224 004	0 1 201 602	19 505 129	84.01
89.00 SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	18, 505, 128	1, 613, 910	334, 094	1, 801, 693	18, 505, 128	89.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CA	NTEEN 2, 860	0	C	0 0	2, 860	90.00
91.00 09100 BARBER AND BEAUTY SHOP	7, 496	0	C	0	7, 496	91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 93. 00 09300 NONPAID WORKERS	0	0		0	0	92.00 93.00
94. 00 09400 PATIENTS LAUNDRY	0	0			0	93.00
95.00 09500 OTHER NONREIMBURSABLE COST	0	0	C) Ö	0	95.00
98.00 Cross Foot Adjustments	0	0	C	0	0	98.00
99.00Negative Cost Centers100.00TOTAL	0 18, 515, 484	0 1, 613, 910	334, 094	0 1, 801, 693	0 18, 515, 484	99.00
	10, 515, 464	1,013,710	004,074	1,001,093	10, 313, 404	1.00.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CARE ONE A		F	Period: From 01/01/2023 Fo 12/31/2023	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/10/2024 11:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	<u>54 am</u>
		4.00	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
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL	3, 254, 793	005 007				4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	141,672	805, 927				5.00
8.00 7.00	00700 HOUSEKEEPING	54, 935 102, 893	50, 365 6, 047				7.00
7.00 8.00	00800 DI ETARY	282, 207	80, 572			1, 749, 525	
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	232, 207	7, 026		5, 543	1, 749, 525	1
10.00	01000 CENTRAL SERVICES & SUPPLY	73, 450	7,020			0	10.00
11.00	01100 PHARMACY	7,866	0		Ű	0	11.00
	01200 MEDICAL RECORDS & LIBRARY	5, 550	6, 047	-	-	0	12.00
13.00	01300 SOCIAL SERVICE	37,674	2,016		.,	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0,,0,1	2,010			0	14.00
	01500 ACTI VI TES	45, 334	Ő	-	-	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	10,001			<u> </u>		1 101 00
30.00	03000 SKILLED NURSING FACILITY	1, 618, 354	604, 615	362, 874	477, 045	1, 749, 525	30.00
31.00	03100 NURSING FACILITY	0	C			0	31.00
	03200 CF/I D	0	C	C	0	0	•
33.00	03300 OTHER LONG TERM CARE	0	C	C	0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS			•			1
40.00	04000 RADI OLOGY	9, 281	C	C	0 0	0	40.00
41.00	04100 LABORATORY	20, 360	0	C	0 0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	41, 200	C	C	0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	C	0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	199, 687	11, 057	C		0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	169, 953	5, 010		0,,00	0	45.00
46.00	04600 SPEECH PATHOLOGY	39, 227	5, 010			0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	C	-	, u	0	47.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	6, 265	15, 089		,	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	148, 194	13, 073	C		0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	05200 COMPLEX MEDICAL EQUIPMENT	0	0			0	52.00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES	0	0			0	52.01 52.02
52. UZ	OUTPATIENT SERVICES	0	0			0	52.02
60.00	06000 CLINIC	0	C	C		0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0			0	61.00
	06200 FQHC	Ŭ	0		,	0	62.00
	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	V					1
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0 0	0	70.00
	07100 AMBULANCE	14, 328	0	C	0	0	
	07300 CMHC	0	C	C		0	73.00
	07400 OTHER REIMBURSEMENT	0	0	C	00	0	
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	08100 INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	C	C	0 0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	(C	0 0	0	84.00
84.01	08401 OTHER SPECIAL PURPOSE COST II	0	C	C	0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	3, 252, 584	805, 927	362, 874	591, 371	1, 749, 525	89.00
00.00	NONREI MBURSABLE COST CENTERS		-	-		_	00.07
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	610	0			0	90.00
	09100 BARBER AND BEAUTY SHOP	1, 599	0			0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0			0	92.00
	09300 NONPALD WORKERS	0	0			0	93.00
	09400 PATIENTS LAUNDRY	0	0			0	94.00
	09500 OTHER NONREI MBURSABLE COST	0	0			0	95.00
00 00	Cross Foot Adjustments	0	0	1 (ין U	0	98.00
98.00			0			0	00 00
98.00 99.00 100.00	Negative Cost Centers	0 3, 254, 793	0 805, 927	C 362, 874	0 0 I 591, 371	0 1, 749, 525	99.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CARE ONE A		No.: 315485	Peri od:	u of Form CMS-2 Worksheet B	2040-10
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/10/2024 11:	
	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	
	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						1.00 2.00 3.00
4.00 5.00 6.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						4.00 5.00 6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY						7.00
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	1, 344, 592					9.00
	01000 CENTRAL SERVICES & SUPPLY	0	417, 835				10.00
	01100 PHARMACY	0	C	44, 7			11.00
	01200 MEDI CAL RECORDS & LI BRARY	0	C		0 42, 388	217 020	12.00
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0			0 0	217, 920 0	
	01500 ACTIVITES	0	0		0 0	0	
101 00	INPATIENT ROUTINE SERVICE COST CENTERS						10100
	03000 SKILLED NURSING FACILITY	1, 344, 592	417, 835	44, 7	47 42, 388	217, 920	30.00
	03100 NURSING FACILITY	0	C		0 0	0	
	03200 ICF/IID	0	C		0 0 0 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
	04100 LABORATORY	0	C		0 0	0	41.00
	04200 I NTRAVENOUS THERAPY	0	C		0 0	0	
	04300 OXYGEN (INHALATION) THERAPY	0	C		0 0	0	
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0			0 0	0	
	04600 SPEECH PATHOLOGY	0				0	
	04700 ELECTROCARDI OLOGY	0	C		0 0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0 0	0	50.00
	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUI PMENT	0				0	51.00 52.00
	05200 OTHER ANCILLARY SERVICES COST	0			0 0	0	
	05202 MEDI CAL SERVI CES	0	C		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
	06000 CLI NI C	0	C		0 0	0	
	06100 RURAL HEALTH CLINIC	0	C)	0 0	0	
	06200 FQHC 06300 DI ALYSI S	0	C		0 0	0	62.00 63.00
	OTHER REIMBURSABLE COST CENTERS	V		<u>'</u>	0 0	0	00.00
	07000 HOME HEALTH AGENCY COST	0	C)	0 0	0	70.00
	07100 AMBULANCE	0	C		0 0	0	
	07300 CMHC	0	C		0 0	0	
74.00	07400 OTHER REIMBURSEMENT	0	C		0 0	0	74.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW - SNF						82.00
	08300 HOSPI CE	0	C		0 0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	C		0 0	0	
	08401 OTHER SPECIAL PURPOSE COST II	1 244 502	417 025		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	1, 344, 592	417, 835	44, 7	47 42, 388	217, 920	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	ſ		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	C		0 0	0	
	09200 PHYSICIANS PRIVATE OFFICES	0	C		0 0	0	92.00
92.00	09300 NONPALD WORKERS	0	C)	0 0	0	93.00
92. 00 93. 00		-					
92.00 93.00 94.00	09400 PATIENTS LAUNDRY	0	C		0 0	0	
92.00 93.00 94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0			0 0 0 0	0 0	95.00
92.00 93.00 94.00	09400 PATIENTS LAUNDRY	0 0 0	0 0 0 0			-	95.00 98.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CARE ONE A		No.: 315485	Peri od:	u of Form CMS- Worksheet B	2340-10
					From 01/01/2023 To 12/31/2023		epared:
			OTHER GENERAL			371072024 11.	
	Cost Center Description	NURSING AND ALLIED HEALTH	SERVICE ACTIVITES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION 14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS			1	T		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00							8.00
9.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY						9.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTI VI TES	0	257, 890)			15.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	257, 890	14, 725, 7	56 0	14, 725, 756	30.00
31.00	03100 NURSING FACILITY	0	237,090		0 0	0	1
32.00	03200 I CF/I I D	0	C		0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCI LLARY SERVICE COST CENTERS	-1					
40.00 41.00	04000 RADI OLOGY	0	C			52, 795	
41.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0) 115, 8 234, 3		115, 821 234, 372	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C) 204, 0	0 0	0	1
44.00	04400 PHYSI CAL THERAPY	0	C	1, 155, 7	34 0	1, 155, 734	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	C	975, 7		975, 772	
46.00		0	C	232, 1		232, 113	
47.00 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		62,6	0 0	0 62, 634	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C	866, 4		866, 413	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0 0	0	1
51.00	05100 SUPPORT SURFACES	0	C		0 0	0	
52.00	05200 COMPLEX MEDICAL EQUI PMENT	0	0	0	0 0	0	
52. 01 52. 02	05201 OTHER ANCI LLARY SERVICES COST 05202 MEDI CAL SERVICES	0	C		0 0	0	
JZ. UZ	OUTPATIENT SERVICE COST CENTERS	0	Ĺ	<u>/</u>	0 0	0	52.02
60.00	06000 CLINIC	0	C	D	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	C		0 0	0	61.00
	06200 FQHC					_	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	(b	0 0	0	70.00
71.00	07100 AMBULANCE	0	C	81, 5		81, 509	
		0	C		0 0	0	73.00
74.00	07400 OTHER REI MBURSEMENT	0			0 0	0	74.00
00.00	SPECIAL PURPOSE COST CENTERS	1		T	-		00.00
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	C	þ	0 0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	C)	0 0	0	
84.01	08401 OTHER SPECIAL PURPOSE COST II	0	0	10 500 -	0 0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	257, 890	18, 502, 9	19 0	18, 502, 919	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	3, 4	70 0	3, 470	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	C	9,0		9, 095	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C		0 0	0	92.00
93.00	09300 NONPAI D WORKERS	0	C	D	0 0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	
95.00 98.00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	(Ś		0	
99.00 99.00	Negative Cost Centers	0	(þ	0 0	0	
100.00	S S	0	257, 890	18, 515, 4	84 0		
							•

	Financial Systems TION OF CAPITAL RELATED COSTS	CARE ONE A		No.: 315485 Pe	In Lie eriod:	u of Form CMS-: Worksheet B	2540-10
ALLOUA	THON OF CALLER RELATED COSTS		TTOVIDEI		om 01/01/2023	Part II Date/Time Pre	epared.
					12/01/2020	5/10/2024 11:	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FI XTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		0	1.00	2.00	2A	3.00	
1 00	GENERAL SERVICE COST CENTERS						1 4 00
1.00 2.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0 0	0 258, 212 64, 541	0 53, 452 13, 361	0 311, 664 77, 902	0 0 0	4.00 5.00
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	0	80, 688 9, 688	16, 703 2, 006	97, 391 11, 694	0	7.00
8.00 9.00 10.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	000000000000000000000000000000000000000	129, 082 11, 256 0	26, 721 2, 330 0	155, 803 13, 586 0 0	0 0 0	9.00 10.00
11.00 12.00 13.00 14.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	9, 688 3, 229 0	0 2, 006 669 0	0 11, 694 3, 898 0	0 0 0 0	12.00 13.00
15.00	01500 ACTIVITES	0	0	0	0	0	1
30.00 31.00 32.00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY 03200 I CF/I I D	0 0	968, 643 0 0	200, 517 0 0	1, 169, 160 0 0	0 0 0	31.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	1
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00		0	0	0	0	0	
42.00 43.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	42.00
44.00	04400 PHYSI CAL THERAPY	0	17, 714	3, 667	21, 381	0	
45.00	04500 OCCUPATI ONAL THERAPY	0	8, 026	1, 661	9, 687	0	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	8, 026 0	1, 661 0	9, 687 0	0	
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24, 173	5,004	29, 177	0	1
49.00	04900 DRUGS CHARGED TO PATIENTS	0	20, 944	4, 336	25, 280	0	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	51.00
52.00 52.01	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	
52.02	05202 MEDI CAL SERVI CES	0	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
		0	0	0	0	0	
	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	0	0	0	61.00 62.00
63.00	06300 DI ALYSI S	0	0	0	0	0	
70.00	OTHER REIMBURSABLE COST CENTERS						
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	0	0	1
73.00	07300 CMHC	0	0	0	0	0	1
	07400 OTHER REIMBURSEMENT	0	0	0	0	0	
~~ ~~	SPECIAL PURPOSE COST CENTERS						
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	1
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	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	1, 613, 910	334, 094	1, 948, 004	0	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	1
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	1
93.00	09300 NONPAID WORKERS	0	0	0	0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
95.00	09500 OTHER NONREIMBURSABLE COST		0	0	0	0	
	Cross Foot Adjustments Negative Cost Centers		0	0	0	0	98.00

Heal th	Financial Systems	CARE ONE A	AT WALL		In Lie	u of Form CMS-:	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2023 p 12/31/2023	Worksheet B Part II Date/Time Pre 5/10/2024 11:	pared: 54 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					
1.00 2.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	311, 664 13, 566	91, 468				1.00 2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	5, 260 9, 853 27, 023 22, 422	5, 716 686 9, 144 797	0 0 0	22, 233 2, 390 208	194, 360 0	6.00 7.00 8.00 9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	7, 033 753	0		0	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	531	686	-	179	0	12.00
13.00	01300 SOCIAL SERVICE	3, 608	229	0	60	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15.00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	4, 341	0	0	0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	154, 965	68, 621	108, 367	17, 934	194, 360	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	31.00
32.00	03200 I CF/I I D	0	0		0	0	
33.00	O3300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	889	0	0	0	0	40.00
41.00	04100 LABORATORY	1, 950	0		0	0	
42.00	04200 I NTRAVENOUS THERAPY	3, 945	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	-	0	0	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	19, 121 16, 274	1, 255 569		328 149	0	44.00 45.00
46.00	04600 SPEECH PATHOLOGY	3, 756	569		149	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	600	1, 712		448	0	
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS	14, 191	1, 484		388	0	49.00 50.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50.00
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	
52.02	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	
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	1, 372	0		0	0	
73.00	07300 CMHC	0	0	0	0	0	•
74.00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74.00
00.00	SPECIAL PURPOSE COST CENTERS	1 1					00.00
80. 00 81. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	311, 453	0 91, 468	108, 367	0 22, 233	0 194, 360	
07.00	NONREI MBURSABLE COST CENTERS	511, 403	71,400	100, 307	22,233	174, 300	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	58	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	153	0	0	0	0	91.00
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	92.00 93.00
93.00 94.00	09400 PATIENTS LAUNDRY	0	0	0 0	0	0	
95.00	09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments			0	0	0	
99.00	Negative Cost Centers	0	01 440	100 247	0	104 260	
100.00	TOTAL	311, 664	91, 468	108, 367	22, 233	194, 360	100.00

	Financial Systems	CARE ONE A		N 045405		u of Form CMS-	2540-10
ALLOC/	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315485	Period: From 01/01/2023 To 12/31/2023		
	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					1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINI STRATI VE & GENERAL 00500 PLANT OPERATI ON, 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 10.00 11.00 12.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	37, 013 0 0 0	7, 033 C C	7	53 0 13, 090		9.00 10.00 11.00 12.00
13. 00 14. 00 15. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0	C C C			7, 795 0 0	13.00 14.00
30.00 31.00 32.00 33.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	37, 013 0 0 0	7, 033 C C C		53 13,090 0 0 0 0 0 0	0 0	31.00
55.00	ANCI LLARY SERVICE COST CENTERS			<u>'I</u>	<u> </u>		33.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	C		0 0 0 0	0	40. 00 41. 00
42.00 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0	C		0 0	0	42.00
43.00	04400 PHYSI CAL THERAPY	0	C		0 0	0	43.00
45.00	04500 OCCUPATIONAL THERAPY	0	C		0 0	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	C		0 0	0	46.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	47.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	C		0 0	0	50.00
52.00	05200 COMPLEX MEDICAL EQUI PMENT	0	C		0 0	0	52.00
52. 01 52. 02	05201 OTHER ANCI LLARY SERVICES COST 05202 MEDI CAL SERVICES	0	C		0 0 0 0	0	
60.00	OUTPATI ENT SERVI CE COST CENTERS	0	С		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	C		0 0		61.00
62.00 63.00	06200 FQHC 06300 DI ALYSI S	0	C		0 0	0	62.00 63.00
03.00	OTHER REIMBURSABLE COST CENTERS			/	0 0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	C		0 0	-	•
71.00 73.00	07100 AMBULANCE 07300 CMHC	0	C		0 0 0 0		
74.00		0	C		0 0		
00.00	SPECIAL PURPOSE COST CENTERS						
80.00 81.00 82.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						80.00 81.00 82.00
83.00 84.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I	0	C		0 0 0 0	0	
84.00 84.01	08400 OTHER SPECIAL PURPOSE COST I	0	C		0 0	0	84.00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	37, 013	7, 033	1	53 13, 090	· · · ·	89.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	C		0 0		
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C		0 0	0	1
93.00	09300 NONPAI D WORKERS	0	C		0 0	-	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	C		0 0	0	
93.00 98.00	Cross Foot Adjustments	0	C	1	0	0	98.00
99.00	Negative Cost Centers	0	C	_	0 0	0	99.00
100.00	D TOTAL	37, 013	7, 033	il 7	53 13, 090	7, 795	100.00

	Financial Systems TION OF CAPITAL RELATED COSTS	CARE ONE A		No.: 315485	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 SERVICE ACTIVITES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS	<u>т</u> т		1			1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	000	4, 341				1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS			1 700 40		4 700 400	
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	4, 341 0 0		32 0 0 0 0 0 0 0	1, 783, 432 0 0 0	31.00 32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	88	39 0	889	40.00
41.00	04100 LABORATORY	0	0			1, 950	
42.00	04200 I NTRAVENOUS THERAPY	0	0	3, 94		3, 945	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0)	0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	42, 08		42, 085	
45.00	04500 OCCUPATI ONAL THERAPY	0	0	26, 67		26, 679	
46.00	04600 SPEECH PATHOLOGY	0	0	14, 16		14, 161	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	31, 93		31, 937	
49.00		0	0	41, 34		41, 343	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0 0	0	
51.00 52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0 0	0	
52.00 52.01	05201 OTHER ANCILLARY SERVICES COST	0	0		0 0	0	
52.01		0	0		0 0	0	
02.02	OUTPATIENT SERVICE COST CENTERS						02.02
60.00		0	0)	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
	06200 FQHC						62.00
63.00	06300 DI ALYSI S	0	0		0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	1 1		1			
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0 0 72 0	0	
		0	0	1, 37	0 0	1, 3/2	71.00
	07400 OTHER REIMBURSEMENT	0	0		0 0	0	
/ 1. 00	SPECIAL PURPOSE COST CENTERS						/ / 1.00
80.00							80.00
81.00	08100 INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83.00		0	0		0 0	0	
84.00		0	0		0 0	0	
84.01	08401 OTHER SPECIAL PURPOSE COST II	0	0	1 0 1 7 7	0 0	0	
00 00	SUBTOTALS (sum of lines 1-84)	0	4, 341	1, 947, 79	93 0	1, 947, 793	89.00
89.00			0	F	58 0	58	90.00
	NONREI MBURSABLE COST CENTERS	0			/U U	50	1 20.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			152	91 00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 0	0	15		153 0	
90.00 91.00 92.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0 0 0	0 0 0		53 0	0	92.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0 0 0 0 0			53 0		92.00 93.00
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 09400 PATIENTS LAUNDRY	0 0 0 0 0			53 0	0 0	92.00 93.00 94.00
90.00 91.00 92.00 93.00 94.00 95.00 98.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments		0 0 0 0 0 0 0 0 0		53 0	0 0 0	 92.00 93.00 94.00 95.00 98.00
90.00 91.00 92.00 93.00 94.00 95.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15	3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	92.00 93.00 94.00 95.00 98.00 99.00

.00 001 .00 002 .00 003 .00 004 .00 005 .00 006 .00 007 .00 008 .00 007 .00 010 .00 011 .00 012 .00 012 .00 012 .00 012 .00 014 5.00 015 .00 031 .00 032 .00 033 .00 040 .00 041 .00 041 .00 042 .00 042 .00 044 .00 042 .00 042 .00 042 .00 052 .01 052 .01 052 .02 010 .00	Cost Center Description VERAL SERVICE COST CENTERS 100 CAP REL COSTS - BLDGS & FIXTURES 200 CAP REL COSTS - MOVABLE EQUIPMENT 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS 600 LAUNDRY & LINEN SERVICE	BLDGS & FI XTURES (SOUARE FEET) 1.00 33,983	LATED COSTS MOVABLE EQUI PMENT (SQUARE FEET) 2.00		rom 01/01/2023 o 12/31/2023 Reconciliation	5/10/2024 11:	
.00 001 .00 002 .00 003 .00 004 .00 005 .00 006 .00 007 .00 008 .00 007 .00 010 .00 011 .00 012 .00 012 .00 012 .00 012 .00 014 5.00 015 .00 031 .00 032 .00 033 .00 040 .00 041 .00 041 .00 042 .00 042 .00 044 .00 042 .00 042 .00 042 .00 052 .01 052 .01 052 .02 010 .00	VERAL SERVICE COST CENTERS 100 CAP REL COSTS - BLDGS & FIXTURES 200 CAP REL COSTS - MOVABLE EQUIPMENT 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS	BLDGS & FI XTURES (SOUARE FEET) 1.00 33,983	MOVABLE EQUI PMENT (SQUARE FEET)	BENEFI TS (GROSS	Reconciliation,		
.00 001 .00 002 .00 003 .00 004 .00 005 .00 006 .00 007 .00 008 .00 007 .00 010 .00 011 .00 012 .00 012 .00 012 .00 012 .00 014 5.00 015 .00 031 .00 032 .00 033 .00 040 .00 041 .00 041 .00 042 .00 042 .00 044 .00 042 .00 042 .00 042 .00 052 .01 052 .01 052 .02 010 .00	VERAL SERVICE COST CENTERS 100 CAP REL COSTS - BLDGS & FIXTURES 200 CAP REL COSTS - MOVABLE EQUIPMENT 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS	FI XTURES (SOUARE FEET) 1.00 33,983	EQUI PMENT (SQUARE FEET)	BENEFI TS (GROSS	Reconciliation.		
.00 001 .00 002 .00 003 .00 004 .00 005 .00 006 .00 007 .00 008 .00 007 .00 010 .00 011 .00 012 .00 012 .00 012 .00 012 .00 014 5.00 015 .00 031 .00 032 .00 033 .00 040 .00 041 .00 041 .00 042 .00 042 .00 044 .00 042 .00 042 .00 042 .00 052 .01 052 .01 052 .02 010 .00	100 CAP REL COSTS - BLDGS & FIXTURES 200 CAP REL COSTS - MOVABLE EQUIPMENT 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS	33, 983	2.00	<u>JALAN LOJ</u>		(ACCUM COST)	
.00 001 .00 002 .00 003 .00 004 .00 005 .00 006 .00 007 .00 008 .00 007 .00 010 .00 011 .00 012 .00 012 .00 012 .00 012 .00 014 5.00 015 .00 031 .00 032 .00 033 .00 040 .00 041 .00 041 .00 042 .00 042 .00 044 .00 042 .00 042 .00 042 .00 052 .01 052 .01 052 .02 010 .00	100 CAP REL COSTS - BLDGS & FIXTURES 200 CAP REL COSTS - MOVABLE EQUIPMENT 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS			3.00	4A	4.00	
.00 002 .00 003 .00 004 .00 005 .00 006 .00 006 .00 007 .00 007 .00 007 .00 010 1.00 011 2.00 012 3.00 033 4.00 041 5.00 032 0.00 030 2.00 032 3.00 033 0.00 040 2.00 042 3.00 043 4.00 044 5.00 045 6.00 046 9.00 049 0.00 050 1.00 051 2.01 052 2.02 052 0.00 060 1.00 061 2.01 052 3.00 063	200 CAP REL COSTS - MOVABLE EQUIPMENT 300 EMPLOYEE BENEFITS 400 ADMINISTRATIVE & GENERAL 500 PLANT OPERATION, MAINT. & REPAIRS				T		
0.00 030 1.00 031 2.00 032 3.00 033 ANC 0.00 0.00 040 1.00 041 2.00 042 3.00 043 4.00 044 5.00 045 6.00 046 7.00 047 8.00 048 9.00 050 2.00 052 0.00 050 2.00 052 0.00 060 1.00 051 2.01 052 0.00 060 1.00 061 2.00 062 3.00 063 0.00 070 1.00 071 3.00 081 2.00 082 3.00 083 4.00 084 9.00 084 084	700 HOUSEKEEPING 800 DI ETARY 900 NURSING ADMINISTRATION 000 CENTRAL SERVICES & SUPPLY 100 PHARMACY 200 MEDICAL RECORDS & LIBRARY 300 SOCIAL SERVICE 400 NURSING AND ALLIED HEALTH EDUCATION 500 ACTIVITES PATIENT ROUTINE SERVICE COST CENTERS	0 5, 437 1, 359 204 2, 718 237 0 0 0 204 68 0 0	33, 983 0 5, 437 1, 359 1, 699 204	354, 167	-3, 254, 793 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 260, 691 664, 255 257, 574 482, 431 1, 323, 174 1, 097, 869 344, 385 36, 881 26, 020 176, 640 0 212, 556	9.0 10.0 11.0 12.0 13.0 14.0
2.00 032 3.00 033 ANC 033 ANC 043 0.00 040 3.00 043 4.00 044 5.00 045 6.00 046 7.00 047 8.00 048 9.00 049 0.00 050 1.00 051 2.01 052 2.02 052 0.00 060 1.00 061 2.01 052 3.00 063 0.00 060 1.00 071 3.00 070 1.00 071 3.00 074 SPE 0.00 1.00 081 2.00 082 3.00 083 4.01 084	000 SKILLED NURSING FACILITY	20, 396	20, 396	4, 149, 543	0	7, 587, 971	30. 0
3. 00 033 ANC 0. 00 040 1. 00 041 2. 00 042 3. 00 043 4. 00 044 5. 00 045 6. 00 046 7. 00 047 8. 00 048 9. 00 049 0. 00 050 1. 00 051 2. 01 052 2. 01 052 2. 01 052 0. 00 060 1. 00 061 2. 00 062 3. 00 070 1. 00 070 1. 00 071 3. 00 073 4. 00 080 1. 00 081 2. 00 082 3. 00 083 4. 01 084 9. 00 084	100 NURSING FACILITY	0	0	0	-	0	31.0
ANC 0.00 040 1.00 041 2.00 042 3.00 043 4.00 044 5.00 043 5.00 044 5.00 045 6.00 046 7.00 047 8.00 048 9.00 050 1.00 051 2.01 052 2.02 052 0.011 0.00 0.00 060 1.00 061 2.00 062 3.00 063 0.011 0.00 1.00 071 3.00 073 4.00 074 5PE(0.00 0.00 080 1.00 081 2.00 082 3.00 083 4.01 084 9.00	200 I CF/I I D 300 OTHER LONG TERM CARE	0	0	0	-	0	32.0 33.0
1. 00 041 2. 00 042 3. 00 043 4. 00 044 5. 00 045 6. 00 046 7. 00 047 8. 00 048 9. 00 049 0. 00 050 2. 00 052 2. 01 052 2. 02 052 0. 00 060 1. 00 061 2. 00 062 3. 00 063 0. 100 071 3. 00 073 4. 00 074 5. 00 082 3. 00 084 1. 00 071 3. 00 082 3. 00 083 4. 01 084 9. 00 084	CILLARY SERVICE COST CENTERS	1					
2.00 042 3.00 043 4.00 044 5.00 045 6.00 046 7.00 047 8.00 048 9.00 049 0.00 050 1.00 051 2.01 052 2.02 052 0.00 060 1.00 061 2.00 062 3.00 063 0.00 070 1.00 071 3.00 073 4.00 074 5.00 070 1.00 071 3.00 073 4.00 074 5.00 081 2.00 082 3.00 083 4.01 084 9.00 049	000 RADI OLOGY 100 LABORATORY	0	0	0	-	43, 514 95, 461	40. C
4. 00 044 5. 00 045 6. 00 046 7. 00 047 8. 00 049 9. 00 049 0. 00 050 1. 00 051 2. 01 052 2. 02 052 0. 00 060 0. 00 061 2. 00 063 0. 00 070 1. 00 071 3. 00 073 4. 00 074 5. 00 080 1. 00 084 4. 00 084 4. 01 084 9. 00	200 I NTRAVENOUS THERAPY	0	0	0	0	193, 172	
5.00 045 6.00 046 7.00 047 8.00 048 9.00 050 1.00 051 2.01 052 2.01 052 2.02 052 0.00 060 0.00 061 1.00 061 2.00 063 0.00 070 1.00 071 0.00 070 1.00 071 0.00 070 1.00 071 0.00 070 1.00 071 0.00 080 1.00 071 0.00 081 2.00 082 3.00 083 4.01 084 9.00	300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.0
6. 00 046 7. 00 047 8. 00 048 9. 00 050 0. 00 052 2. 01 052 2. 02 052 0.00 060 0. 00 060 0. 00 061 1. 00 061 2. 00 062 3. 00 063 0.00 070 1. 00 071 3. 00 073 4. 00 074 SPE(0.00 0.00 080 1. 00 081 2. 00 082 3. 00 083 4. 01 084 9. 00 9.00	400 PHYSI CAL THERAPY 500 OCCUPATI ONAL THERAPY	373		740, 100 652, 607		936, 266 796, 856	
8. 00 048 9. 00 049 0. 00 050 1. 00 051 2. 00 052 2. 01 052 2. 02 052 0. 00 060 1. 00 061 1. 00 063 0. 00 063 0. 00 070 1. 00 071 3. 00 073 4. 00 074 SPE(0.00 1. 00 081 2. 00 082 3. 00 083 4. 01 084 9. 00 984	600 SPEECH PATHOLOGY	169	169	128, 865		183, 923	
9.00 049 0.00 050 1.00 051 2.01 052 2.01 052 2.02 052 0.00 060 1.00 061 2.00 062 3.00 063 0.01 0.00 1.00 070 1.00 071 3.00 074 SPE 0.00 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 4.01 084 9.00	700 ELECTROCARDI OLOGY	0	0	0	0	0	47.0
0. 00 050 1. 00 051 2. 00 052 2. 01 052 2. 01 052 2. 02 052 0UTI 0. 00 060 1. 00 061 2. 00 063 0TH 0. 00 070 1. 00 071 3. 00 073 4. 00 074 SPE(0. 00 080 1. 00 081 2. 00 082 3. 00 084 4. 00 084 4. 00 084 4. 01 084	800 MEDICAL SUPPLIES CHARGED TO PATIENTS 900 DRUGS CHARGED TO PATIENTS	509 441	509 441			29, 375 694, 831	48. (49. (
2.00 052 2.01 052 2.02 052 0UTI 0.00 060 3.00 063 0TH 0.00 070 1.00 074 5PE 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 4.01 084 9.00	DOO DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.0
2. 01 052 2. 02 052 0UTI 0. 00 060 1. 00 061 2. 00 062 3. 00 070 1. 00 071 1. 00 071 1. 00 074 5PE 0. 00 080 1. 00 081 2. 00 082 3. 00 083 4. 00 084 4. 01 084 9. 00	100 SUPPORT SURFACES	0	0	0	0	0	51.0
2. 02 052 0UTI 0. 00 060 1. 00 061 2. 00 062 3. 00 063 0. 100 070 1. 00 071 3. 00 073 4. 00 074 5. 00 080 1. 00 881 2. 00 082 3. 00 083 4. 01 084 9. 00	200 COMPLEX MEDICAL EQUIPMENT 201 OTHER ANCILLARY SERVICES COST	0	0			0	52. (52. (
0. 00 060 1. 00 061 2. 00 062 3. 00 063 0TH 0. 00 070 1. 00 071 3. 00 073 4. 00 074 SPE 0. 00 080 1. 00 081 2. 00 083 4. 00 084 4. 00 084 4. 01 084 9. 00	202 MEDI CAL SERVI CES	0	0	0	0	0	
1. 00 061 2. 00 062 3. 00 063 0TH 0. 00 070 1. 00 071 3. 00 073 4. 00 074 SPE 0. 00 080 1. 00 081 2. 00 082 3. 00 084 4. 00 084 4. 01 084	TPATIENT SERVICE COST CENTERS	0	0	0	0	0	60.0
2.00 062 3.00 063 0TH 0.00 070 1.00 071 3.00 073 4.00 074 SPE 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 4.01 084 9.00	100 RURAL HEALTH CLINIC	0				0	
0.00 070 1.00 071 3.00 073 4.00 074 5.00 080 1.00 080 1.00 082 3.00 083 4.01 084 9.00	200 FQHC			1			62. (
0.00 070 1.00 071 3.00 073 4.00 074 SPE 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 4.01 084 9.00	300 DI ALYSI S HER REI MBURSABLE COST CENTERS	0	0	0	0 0	0	63. (
3.00 073 4.00 074 SPE 0.00 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 9.00 084	DOO HOME HEALTH AGENCY COST	0	0	0	0 0	0	70.
4.00 074 <u>SPE</u> 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 4.01 084 9.00	100 AMBULANCE	0	0	0	-	67, 181	
SPE 0.00 080 1.00 081 2.00 082 3.00 083 4.00 084 9.00 084	300 CMHC 400 OTHER REIMBURSEMENT	0	0	0	-	0	
1.00 081 2.00 082 3.00 083 4.00 084 9.00 0	ECIAL PURPOSE COST CENTERS	0	0	0	<u> </u>	0	/4.
2.00 082 3.00 083 4.00 084 4.01 084 9.00	000 MALPRACTICE PREMIUMS & PAID LOSSES						80.
3.00 083 4.00 084 4.01 084 9.00	100 INTEREST EXPENSE 200 UTILIZATION REVIEW - SNF						81. 82.
4. 01 084 9. 00	300 HOSPI CE	0	0	0	0	0	
9.00	400 OTHER SPECIAL PURPOSE COST I	0	0	0	, O	0	
	401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0 33, 983	0 33, 983	0 8, 737, 958	0 -3, 254, 793	0 15, 250, 335	84. 89.
14014	VREIMBURSABLE COST CENTERS	55,705	55, 705	0, 737, 730	-3, 234, 773	13, 230, 333	07.
	000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	2, 860	
	100 BARBER AND BEAUTY SHOP 200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	7, 496 0	91. 92.
	300 NONPAID WORKERS	0	0		0	0	92. 93.
	400 PATIENTS LAUNDRY	0	0	0	0	0	94.
5.00 095 8.00	500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	0	0	0	95. 98.
8.00 9.00	Negative Cost Centers	1		1			98. 99.
02.00	Cost to be allocated (per Wkst. B,	1, 613, 910	334, 094	1, 801, 693	,	3, 254, 793	
03 00	Part I) Unit cost multiplier (Wkst. B, Part I)	17 101407	0 001010	0 204102		0 212200	102
03.00 04.00	TOTEL COSCINULTOFIEL LWKST B PARTIN	47. 491687	9. 831210	0. 206192 0	,	0. 213280 311, 664	

Health Financial Systems	CARE ONE	AT WALL		In Lieu of Form CMS-2540-10		
COST ALLOCATION - STATISTICAL BASIS			Period: From 01/01/2023	Worksheet B-1		
				To 12/31/2023		
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDGS & FLXTURES	MOVABLE FOULPMENT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM COST)	
	1.00	2.00	3.00	4A	4.00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 00000	0	0. 020423	105.00

OST A	LLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/10/2024 11: NURSI NG	54 ai
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)		
			(PATIENT DAYS)				
		REPAI RS (SQUARE FEET)				(PATIENT DAYS)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	T	1	Γ			
. 00 . 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.
. 00	00300 EMPLOYEE BENEFITS						3.
. 00	00400 ADMI NI STRATI VE & GENERAL						4.
00	00500 PLANT OPERATION, MAINT. & REPAIRS	27, 187					5.
. 00	00600 LAUNDRY & LINEN SERVICE	1, 699					6.
00	00700 HOUSEKEEPING	204		,			7.
00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	2, 718		2, 718		34, 528	8. 9.
	01000 CENTRAL SERVICES & SUPPLY	0		0		01,020	
1.00	01100 PHARMACY	0	0	C	0	0	11.
	01200 MEDI CAL RECORDS & LI BRARY	204		204		0	1
	01300 SOCIAL SERVICE	68		68		0	
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0				0	
0.00	INPATIENT ROUTINE SERVICE COST CENTERS						10.
	03000 SKILLED NURSING FACILITY	20, 396	34, 528	20, 396	103, 584	34, 528	30.
	03100 NURSING FACILITY	0	-		-	0	
	03200 I CF/I I D	0				0	
3.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	C	0 0	0	33.
0. 00	04000 RADI OLOGY	0	0	C) 0	0	40.
1.00	04100 LABORATORY	0	0	C	0	0	41.
	04200 I NTRAVENOUS THERAPY	0	0	C		0	
	04300 OXYGEN (INHALATION) THERAPY	0		0		0	
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	373		373		0	
	04600 SPEECH PATHOLOGY	169		169		0	
	04700 ELECTROCARDI OLOGY	0		C		0	1
	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	509		509	-	0	
	04900 DRUGS CHARGED TO PATIENTS	441	0	441		0	
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0	
	05200 COMPLEX MEDICAL EQUI PMENT	0	0		0	0	
	05201 OTHER ANCILLARY SERVICES COST	0	0	C	0	0	52.
2. 02	05202 MEDI CAL SERVI CES	0	0	C	0 0	0	52.
0 00	OUTPATIENT SERVICE COST CENTERS	0				0	1 (0
	06100 RURAL HEALTH CLINIC		0			0	
	06200 FQHC				0	0	62.
	06300 DI ALYSI S	0	0	C	0	0	
	OTHER REIMBURSABLE COST CENTERS	-	-	-	-	-	1
	07000 HOME HEALTH AGENCY COST	0				0	
	07100 AMBULANCE 07300 CMHC	0	0			0	
	07400 OTHER REI MBURSEMENT	0	0			0	
	SPECIAL PURPOSE COST CENTERS	1	-				
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF						81. 82.
	08200 HOSPICE	0	n	0		0	1
	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	
4. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	C	0	0	84.
9.00	SUBTOTALS (sum of lines 1-84)	27, 187	34, 528	25, 284	103, 584	34, 528	89.
0. 00	NONREIMBURSABLE COST CENTERS		0	C	0	0	00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		0 0			0	
	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	0	
3.00	09300 NONPAI D WORKERS	0	0	C	0	0	93.
	09400 PATIENTS LAUNDRY	0	0	C	0	0	
	09500 OTHER NONREI MBURSABLE COST	0	0	C	0	0	
3.00 9.00	Cross Foot Adjustments Negative Cost Centers						98. 99.
9.00 02.00		805, 927	362, 874	591, 371	1, 749, 525	1, 344, 592	
	Part I)						
03.00		29.643837				38. 942076	
04.00		91, 468	108, 367	22, 233	194, 360	37, 013	104.
	Part II) Unit cost multiplier (Wkst. B, Part	3. 364402	3. 138525	0. 879331	1. 876352	1.071971	105
05.00							

	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: rom 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES & SUPPLY	(PATIENT DAYS)	RECORDS & LI BRARY	(PATIENT DAYS)	ALLIED HEALTH EDUCATION	
		(PATIENT DAYS)		(PATIENT DAYS)		(ASSI GNED	
						TIME)	
	Г <u> </u>	10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS		1				
	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1
	00300 EMPLOYEE BENEFITS						
	00400 ADMINISTRATIVE & GENERAL						
	00500 PLANT OPERATION, MAINT. & REPAIRS						5
	00600 LAUNDRY & LINEN SERVICE						6
0	00700 HOUSEKEEPI NG						7
	00800 DI ETARY						8
	00900 NURSING ADMINISTRATION						9
	01000 CENTRAL SERVICES & SUPPLY	34, 528					10
			34, 528				11
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE			34, 528	34, 528		12
	01400 NURSING AND ALLIED HEALTH EDUCATION				0 34, 320	0	
	01500 ACTI VI TES		o o		0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
	03000 SKILLED NURSING FACILITY	34, 528	34, 528	34, 528	34, 528	0	30
00	03100 NURSING FACILITY	C	0	C	0	0	31
	03200 CF/I D	C		C		0	
	03300 OTHER LONG TERM CARE	0	0 0	C	0	0	33
	ANCI LLARY SERVICE COST CENTERS					0	
	04000 RADI OLOGY 04100 LABORATORY				-	0	
	04200 I NTRAVENOUS THERAPY				0	0	
	04300 OXYGEN (INHALATION) THERAPY				0	0	
	04400 PHYSI CAL THERAPY		o o		0	0	
00	04500 OCCUPATI ONAL THERAPY	C	0	c	0	0	45
00	04600 SPEECH PATHOLOGY	C	0	c c	0	0	46
	04700 ELECTROCARDI OLOGY	C	0 0	C	0	0	
	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	1
	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	1
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES				0	0	
	05200 COMPLEX MEDICAL EQUIPMENT				0	0	-
	05201 OTHER ANCI LLARY SERVICES COST				0	0	
	05202 MEDI CAL SERVI CES		0	C C	0	0	
ĺ	OUTPATIENT SERVICE COST CENTERS						
	06000 CLI NI C	C		C	-	0	60
	06100 RURAL HEALTH CLINIC	C	0 0	C	0	0	
	06200 FQHC		_	_		_	62
		0	0 0	C	0	0	63
	OTHER REIMBURSABLE COST CENTERS	0	0			0	70
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE		-		0	0	
	07300 CMHC				0	0	
	07400 OTHER REIMBURSEMENT		-		0	0	
	SPECIAL PURPOSE COST CENTERS						1
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80
	08100 I NTEREST EXPENSE						8
	08200 UTI LI ZATI ON REVI EW - SNF	-	-	-		-	82
	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I		0		0	0	
	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II					0	
00	SUBTOTALS (sum of lines 1-84)	34, 528	34, 528	34, 528	34, 528	0	
	NONREI MBURSABLE COST CENTERS	. 01,020	51, 320	51, 520	51, 520	0	1
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	C	0	0	90
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	
	09300 NONPALD WORKERS		0		0	0	
	09400 PATIENTS LAUNDRY		0		0	0	
00 00	09500 OTHER NONREI MBURSABLE COST		0		0	0	1
00	Cross Foot Adjustments Negative Cost Centers						98
. 00	0	417, 835	44, 747	42, 388	217, 920	n	102
. 50	Part I)	-17,030		+2, 500	211,720	0	['02
. 00		12. 101338	1. 295963	1. 227641	6. 311399	0. 000000	103
. 00		7,033					104
	Part II)						
1	Unit cost multiplier (Wkst. B, Part						

	nancial Systems DCATION - STATISTICAL BASIS	CARE ONE AT	Provider No.: 315485	Peri od:	u of Form CMS-25 Worksheet B-1
				From 01/01/2023 To 12/31/2023	Date/Time Prepa
		OTHER GENERAL		I	5/10/2024 11:54
		SERVI CE			
	Cost Center Description	ACTI VI TES			
		(PATIENT DAYS)			
CEN	NERAL SERVICE COST CENTERS	15.00		<u> </u>	
	100 CAP REL COSTS - BLDGS & FIXTURES				
	200 CAP REL COSTS - MOVABLE EQUIPMENT				
003	300 EMPLOYEE BENEFITS				
	400 ADMINISTRATIVE & GENERAL				
	500 PLANT OPERATION, MAINT. & REPAIRS				
	600 LAUNDRY & LI NEN SERVI CE 700 HOUSEKEEPI NG				
	800 DI ETARY				
	900 NURSI NG ADMI NI STRATI ON				
	000 CENTRAL SERVICES & SUPPLY				1
	100 PHARMACY				1
	200 MEDI CAL RECORDS & LI BRARY				1
	300 SOCIAL SERVICE 400 NURSING AND ALLIED HEALTH EDUCATION				1
	500 ACTI VI TES	34, 528			1
	PATIENT ROUTINE SERVICE COST CENTERS				
	000 SKILLED NURSING FACILITY	34, 528			3
	100 NURSING FACILITY	0			3
	200 I CF/I I D 300 OTHER LONG TERM CARE	0			
	CILLARY SERVICE COST CENTERS	0			
	000 RADI OLOGY	0			4
00 04	100 LABORATORY	0			4
	200 I NTRAVENOUS THERAPY	0			4
1	300 OXYGEN (INHALATION) THERAPY	0			4
	400 PHYSI CAL THERAPY 500 OCCUPATI ONAL THERAPY	0			2
	600 SPEECH PATHOLOGY	0			2
1	700 ELECTROCARDI OLOGY	0			4
00 048	800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			4
	900 DRUGS CHARGED TO PATIENTS	0			4
	000 DENTAL CARE - TITLE XIX ONLY	0			5
	100 SUPPORT SURFACES 200 COMPLEX MEDICAL EQUIPMENT	0			Ę
	201 OTHER ANCI LLARY SERVICES COST	0			E
02 052	202 MEDI CAL SERVI CES	0			5
	TPATIENT SERVICE COST CENTERS				
	000 CLINIC 100 RURAL HEALTH CLINIC	0			
	200 FQHC	0			
	300 DI ALYSI S	0			
	HER REIMBURSABLE COST CENTERS				
	000 HOME HEALTH AGENCY COST	0			7
	100 AMBULANCE	0			7
	300 CMHC 400 OTHER REIMBURSEMENT	0			
	ECIAL PURPOSE COST CENTERS				/
	000 MALPRACTI CE PREMI UMS & PAI D LOSSES				8
	100 INTEREST EXPENSE				8
	200 UTILIZATION REVIEW - SNF				8
	300 HOSPI CE 400 OTHER SPECIAL PURPOSE COST I	0			8
	400 OTHER SPECIAL PURPOSE COST I 401 OTHER SPECIAL PURPOSE COST II				8
00	SUBTOTALS (sum of lines 1-84)	34, 528			8
	NREI MBURSABLE COST CENTERS				
	000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			ç
	100 BARBER AND BEAUTY SHOP	0			, , , , , , , , , , , , , , , , , , ,
1	200 PHYSICIANS PRIVATE OFFICES 300 NONPAID WORKERS	0			
	400 PATIENTS LAUNDRY	0			0
1	500 OTHER NONREI MBURSABLE COST	Ő			ç
00	Cross Foot Adjustments				ç
00	Negative Cost Centers				9
00	Cost to be allocated (per Wkst. B,	257, 890			10
00	Part I) Unit cost multiplier (Wkst. B, Part I)	7. 469011			10
	Cost to be allocated (per Wkst. B,	4, 341			10
00	1000 LO NO ULI DULLOU (PEL WKSL. D.	7, 341			
00	Part II)				I

Health Financial Systems	CARE ONE AT WA	ALL		١r	ı Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT	COST CENTERS	Provi der	No.: 315485	Period:		Worksheet C	
				From 01/01/ To 12/31/		Date/Time Pre	narod
				10 12/31/	2023	5/10/2024 11:	
Cost Center Description			Total (from	Total Char	ges	Ratio (col. 1	
			Wkst. B, Pt 🛛	,	-	divided by	
			col. 18)			col. 2	
			1.00	2.00		3.00	
ANCI LLARY SERVI CE COST CENTERS							
40. 00 04000 RADI OLOGY			52, 7		, 785		•
			115, 8		, 653		•
42.00 04200 I NTRAVENOUS THERAPY			234, 3	/2 524	, 925		
43.00 04300 OXYGEN (INHALATION) THERAPY			4 455 7	0	0	0.00000	•
44.00 04400 PHYSI CAL THERAPY			1, 155, 7			0. 407290	
45. 00 04500 OCCUPATI ONAL THERAPY			975, 7				•
46. 00 04600 SPEECH PATHOLOGY			232, 1	13 //8	, 968	0. 297975	
47. 00 04700 ELECTROCARDI OLOGY 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			(2.4)	0	404	0.00000	•
48.00 04900 DRUGS CHARGED TO PATIENTS			62, 63 866, 4		496	126. 278226 0. 476199	•
50. 00 05000 DENTAL CARE - TITLE XIX ONLY			800, 4	13 1, 819	, 433	0. 478199	•
51. 00 05100 SUPPORT SURFACES				0	0	0. 000000	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT				0	0	0. 000000	
52. 01 05201 OTHER ANCI LLARY SERVICES COST				0	0	0. 000000	•
52. 02 05202 MEDI CAL SERVICES				0	0	0. 000000	•
OUTPATIENT SERVICE COST CENTERS			1			0.00000	02.02
60. 00 06000 CLINIC				0	0	0. 000000	60.00
61. 00 06100 RURAL HEALTH CLINIC				-	-		61.00
62.00 06200 FQHC							62.00
63. 00 06300 DI ALYSI S				0	o	0.000000	•
71.00 07100 AMBULANCE			81, 50	09 167	, 952		•
100. 00 Total			3, 777, 10	63 9, 425	, 579		100. 00
							•

Health Financial Systems	CARE ONE	AT WALL			In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315485		od: 01/01/2023 12/31/2023		pared: 54 am
		Title	XVIII (1)	Skill	ed Nursing		
			. ,		acility		
		Heal th Care Pr	rogram Charge	es H	ealth Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B		t A (col. 1 col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00		4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	0.00		1.00	0.00	
ANCI LLARY SERVICE COST CENTERS							1
40. 00 04000 RADI OLOGY	0. 485315	27, 980		0	13, 579	0	1 40. 00
41. 00 04100 LABORATORY	0. 485311	64, 238		0	31, 175	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0. 446487	0		0	0	0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0	1	0	0	0	43.00
44.00 04400 PHYSI CAL THERAPY	0. 407290	1, 828, 466		0	744, 716	0	44.00
45.00 04500 OCCUPATI ONAL THERAPY	0. 330911	1, 884, 406		0	623, 571	0	45.00
46.00 04600 SPEECH PATHOLOGY	0. 297975	489, 384		0	145, 824	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	126. 278226	496		0	62, 634	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0. 476199	194, 155		0	92, 456	0	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0			0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000			0	0	0	51.00
52.00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000			0	0	0	52.00
52.01 05201 OTHER ANCILLARY SERVICES COST	0. 000000			0	0	0	
52. 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. 485311			0		0	
100.00 Total (Sum of lines 40 - 71)		4, 489, 125	l	0	1, 713, 955	0	100.00
(1) For title V and XIX use columns 1, 2, and 4 on	Iу.						

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

Health Financial Systems	CARE ONE	AT WALL		In Lie	eu of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315485	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III	pared:
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST						
1.00 Drugs charged to patients - ratio of co			t C, column 3	, line 49)	0. 476199	1.00
2.00 Program vaccine charges (From your reco					500	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	er this amoun	t to Worksheet	238	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,			Heal th Costs	
	18	Part I, Col.			for Pass	
		14)	Costs - Part		Through (Col.	
			(Col. 2 / Col 1)	•	3 x Col. 4)	
	1.00	2.00	3.00	4,00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS			0.00		0100	
ANCI LLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	52, 795	0	0,0000	13, 579	0	40.00
41. 00 04100 LABORATORY	115, 821	0	0,0000	31, 175	0	41.00
42.00 04200 INTRAVENOUS THERAPY	234, 372	0	0.0000		0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0.0000		0	43.00
44.00 04400 PHYSI CAL THERAPY	1, 155, 734	0	0.0000	744, 716	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	975, 772	0	0.0000	623, 571	0	45.00
46.00 04600 SPEECH PATHOLOGY	232, 113	0	0.0000	145, 824	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0.0000		0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	62, 634	0	0.0000	62, 634	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	866, 413	0	0.0000			49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.0000	0 0	0	50.00
51.00 05100 SUPPORT SURFACES	0	0	0.0000	0 0	0	51.00
52.00 05200 COMPLEX MEDICAL EQUIPMENT	0	0	0,0000		0	
52. 01 05201 OTHER ANCI LLARY SERVICES COST	0	0	0.0000		0	
52. 02 05202 MEDI CAL SERVI CES	0	0	0.0000		0	
100.00 Total (Sum of Lines 40 - 52)	3, 695, 654	0		1, 713, 955	0	100.00
				1		

)MPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315485	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	pared
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			34, 528	1.
00	Private room days			0	2.
00	Inpatient days including private room days applicable to th	ne Program		13, 767	3.
00	Medically necessary private room days applicable to the Pro	ogram		0	4.
00	Total general inpatient routine service cost			14, 725, 756	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges			18, 548, 809	6.
00	General inpatient routine service cost/charge ratio (Line	5 divided by line 6)		0. 793892	7.
00	Enter private room charges from your records			0	8
00	Average private room per diem charge (Private room charges 2)	line 8 divided by private	room days, line	0.00	9
. 00	Énter semi-private room charges from your records			0	10
. 00	Average semi-private room per diem charge (Semi-private ro semi-private room days)	oom charges line 10, divide	d by	0.00	11
. 00	Average per diem private room charge differential (Line 9 m	ninus line 11)		0.00	12
. 00	Average per diem private room cost differential (Line 7 tim	nes line 12)		0.00	13
. 00	Private room cost differential adjustment (Line 2 times lir	ne 13)		0	14
. 00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus line 14)	14, 725, 756	15
. 00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		426.49	16
	Program routine service cost (Line 3 times line 16)			5, 871, 488	
	Medically necessary private room cost applicable to program	m (line 4 times line 13)		0	18
	Total program general inpatient routine service cost (Line			5, 871, 488	19
	Capital related cost allocated to inpatient routine service		t II column 18.	1, 783, 432	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)				
. 00	Per diem capital related costs (Line 20 divided by line 1))		51.65	21
	Program capital related cost (Line 3 times line 21)			711,066	
	Inpatient routine service cost (Line 19 minus line 22)			5, 160, 422	
	Aggregate charges to beneficiaries for excess costs (From	provider records)		0	
	Total program routine service costs for comparison to the c		nus line 24)	5, 160, 422	
	Enter the per diem limitation (1)	·····			26
	Inpatient routine service cost limitation (Line 3 times the	e per diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus				28
	(Transfer to Worksheet E, Part II, line 4) (See instruction		,		1 -0

		1.00	Í
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	34, 528	1.00
2.00	Program inpatient days (see instructions)	13, 767	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. 398720	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00
		-	

Health Financial Systems	CARE ONE AT WALL	In Lie	u of Form CMS-2540-10
COMPUTATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315485	From 01/01/2023	Worksheet D-1 Parts I-II Date/Time Prepared: 5/10/2024 11:54 am
	Title XIX	Skilled Nursing Facility	

Т

		ļ	
		1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS		
	I NPATI ENT DAYS		
1.00	Inpatient days including private room days	34, 528	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	10, 061	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	14, 725, 756	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	18, 548, 809	
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0. 793892	7.00
8.00	Enter private room charges from your records	0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00	Enter semi-private room charges from your records	0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by	0.00	11.00
	semi-private room days)		
12.00	Average per diem private room charge differential (Line 9 minus line 11)	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)	14, 725, 756	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00		426.49	
17.00		4, 290, 916	
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, 290, 916	
20.00	Capital 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)	1, 783, 432	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	51.65	21.00
22.00	Program capital related cost (Line 3 times line 21)	519, 651	22.00
23.00		3, 771, 265	23.00
24.00		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	3, 771, 265	25.00
26.00	Enter the per diem limitation (1)	0.00	
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	0	27.00
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, 290, 916	28.00
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX		

		1.00	Í
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	34, 528	1.00
2.00	Program inpatient days (see instructions)	10, 061	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. 291387	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	o	5.00
		•	

	Financial Systems CARE ONE A ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	T WALL Provider No.: 315485	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	pare
				5/10/2024 11:	
		Title XVIII	Skilled Nursing Facility	PPS	
			Tacifity		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMB	URSEMENT			
. 00	Inpatient PPS amount (See Instructions)			10, 424, 467	1.
. 00	Nursing and Allied Health Education Activities (pass through	n payments)		0	
. 00	Subtotal (Sum of lines 1 and 2)			10, 424, 467	3.
. 00	Primary payor amounts			0	
. 00	Coinsurance			1, 508, 200	
. 00	Allowable bad debts (From your records)			366, 785	
. 00	Allowable Bad debts for dual eligible beneficiaries (See ins	structions)		156, 270	
. 00	Adjusted reimbursable bad debts. (See instructions)			238, 410	
. 00	Recovery of bad debts - for statistical records only			0	
0. 00	Utilization review			0	
I. 00	Subtotal (See instructions)			9, 154, 677	
2.00				8, 791, 919	
8. 00	Tentati ve adjustment			0	
1.00	OTHER adjustment (See instructions)			0	
1.50	Demonstration payment adjustment amount before sequestration	1		0	
1.55	Demonstration payment adjustment amount after sequestration			332, 747	
4. 75	Sequestration for non-claims based amounts (see instructions	5)		4, 768	
1. 99	Sequestration amount (see instructions)			178, 325	
	Balance due provider/program (see Instructions)			-153, 082	
5.00	Protested amounts (Nonallowable cost report items in accorda			0	16
7.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESS Ancillary services Part B	ER OF COST OR CHARGES - I	IILE XVIII UNLY	0	1 17
3.00	Vaccine cost (From Wkst D, Part II, line 3)			238	
<i>7.</i> 00	Total reasonable costs (Sum of Lines 17 and 18)			238	
). 00	Medicare Part B ancillary charges (See instructions)			500	
. 00	Cost of covered services (Lesser of line 19 or line 20)			238	
2.00	Primary payor amounts			230	
3. 00	Coinsurance and deductibles			0	
I. 00	Allowable bad debts (From your records)			0	
	Allowable Bad debts for dual eligible beneficiaries (see ins	structions)		0	
1. 02	Adjusted reimbursable bad debts (see instructions)			0	
	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			238	
5.00				0	
7.00	Tentati ve adjustment			0	
3.00	Other Adjustments (See instructions) Specify			0	
3. 50	Demonstration payment adjustment amount before sequestration	1		0	
3.55	Demonstration payment adjustment amount after sequestration	-		0	
8.99	Sequestration amount (see instructions)			5	
9.00	Balance due provider/program (see instructions)			233	
	Protested amounts (Nonallowable cost report items) in accord		antion 115 0	0	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No.: 3154		Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Pre 5/10/2024 11:	pare
		Ti tl	e XVIII	Skilled Nursing Facility		01 01
		Inpatien	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		8, 405, 1 296, 2		0	1. 2.
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	09/12/2023	90, 4	<u>on</u>	0	3.
)2	ADJUSTMENTS TO TROVIDER	077 127 2023	, 7 0, 4	0	0	3
03				0	0	
)4				0	0	3
)5				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0] 3
51				0	0	
52				0	0	
53				0	0	
54				0	0	
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		90, 4	80	0	3
_	- 3.98)					
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)		8, 791, 9	19	0	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
	Program to Provider					1
)1	TENTATI VE TO PROVI DER			0	0] 5
)2				0	0	
)3				0	0	5
	Provider to Program		I	T	I.	
50	TENTATIVE TO PROGRAM			0	0	
51				0	0	
52				0	0	
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
)1	PROGRAM TO PROVIDER			0	233	6
02	PROVI DER TO PROGRAM		153, 0	82	0	
00	Total Medicare program liability (see instructions)		8, 638, 8		233	
				actor Name	Contractor	
					Number	

 8.00
 Name of Contractor

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

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	F	Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Pre	epar
,,		General Fund	Speci fi c	Endowment Fund	5/10/2024 11: Plant Fund	54
		1.00	Purpose Fund			
	Assets	1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
2	Cash on hand and in banks	28, 687	0		0	
))	Temporary investments Notes receivable	0	0	0	0	
))	Accounts receivable	2,084,274			0	
5	Other receivables	0		0	0	
C	Less: allowances for uncollectible notes and accounts	-377, 472	0	0	0	
	recei vabl e					
2	Inventory	0		0	0	
2	Prepaid expenses	34, 736			0	
))0	Other current assets Due from other funds	19, 794			0	
)0)0	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	1, 790, 019			0	
00	FIXED ASSETS	1,770,017				4'
00	Land	1, 202, 467	(0	0	12
00	Land improvements	24, 393	c	0	0) 13
00	Less: Accumulated depreciation	-10, 222	0	0	0	
00	Buildings	9, 380, 479	0	0	0	
00	Less Accumulated depreciation	-6, 541, 871		0	0	
00 00	Leasehold improvements	0		0	0	
	Less: Accumulated Amortization Fixed equipment	469, 283			0	
00	Less: Accumulated depreciation	-338, 802			0	
00	Automobiles and trucks	000,002		0	0	
00	Less: Accumulated depreciation	0	C	0	0	
00	Major movable equipment	2, 979, 289	(C	0	0	23
00	Less: Accumulated depreciation	-2, 603, 155	0	0	0) 24
00	Minor equipment - Depreciable	0	C	0	0	
	Minor equipment nondepreciable	0	0	0	0	
00	Other fixed assets	959, 230			0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	5, 521, 091	(0 0	0	2
00	Investments	0	0	0	0	2
00	Deposits on Leases	0		o o	0	
00	Due from owners/officers	0	C	0	0	
00	Other assets	113, 817	(c	0	0) 32
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	113, 817	0		0	
00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	7, 424, 927	(0 0	0) 34
	Liabilities and Fund Balances					-
00	CURRENT LI ABI LI TI ES Accounts payabl e	2, 699, 114	0	0	0	3!
)0)0	Salaries, wages, and fees payable	2, 099, 114			0	
	Payroll taxes payable	-12, 754			0	
	Notes & Loans payable (Short term)	0	0	0	0	
00	Deferred income	0	0	0	0) 3'
00	Accelerated payments	0				40
00	Due to other funds	19, 794		0	0	
00	Other current liabilities	2, 152, 205		0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 123, 353		0 0	0	43
00	LONG TERM LIABILITIES Mortgage payable	12, 482, 002		0	0	0 44
00 00	Notes payable	12, 402, 002			0	
00	Unsecured Loans	0			0	
00	Loans from owners:	0		0	0	
00	Other long term liabilities	-38, 912, 976	0	0	0	48
00	OTHER (SPECIFY)	0	с с	0	0) 49
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-26, 430, 974	0	0 0	0) 50
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-21, 307, 621	(0 0	0) 5'
	CAPI TAL ACCOUNTS	00 700 540	1			1 -
00	General fund balance	28, 732, 548				5
00 00	Specific purpose fund Donor created - endowment fund balance - restricted		0			5
00 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		5
	Governing body created - endowment fund balance - unrestricted			0		56
)()	Plant fund balance - invested in plant			0	0	
00 00	Plant fund balance - reserve for plant improvement,				0	
00 00 00						1.1.1
00	replacement, and expansion					
00		28, 732, 548 7, 424, 927		0	0	

Heal th	Financial Systems	CARE ONE A	AT WALL			In Lie	u of Form CMS-	2540-10
STATEM	ENT OF CHANGES IN FUND BALANCES			der No.: 3154	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet G- Date/Time Pro 5/10/2024 11	epared:
		General	Fund	Spec	ial Pu	irpose Fund	Endowment Fund	
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	1.00	<u>2.00</u> 29,998, -1,265,	450	0	4.00	5.00	1.00 2.00
3.00 4.00 5.00	Total (sum of line 1 and line 2) Additions (credit adjustments)	0	28, 732,	550	C	0	(3.00 4.00 5.00
6.00 7.00		0			C		(6.00 7.00
8.00 9.00 10.00	Total additions (sum of line 5 - 9)	0		0	C		(
11. 00 12. 00 13. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	2	28, 732,	550	C	0	(11.00 12.00 13.00
14. 00 15. 00		0			C		(14.00 15.00
16.00 17.00 18.00	Total deductions (sum of lines 13 - 17)	0		2	C		(
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)		28, 732,			0		19.00
		Endowment Fund		ant Fund		_		
1.00	Fund balances at beginning of period	6.00	7.00	8.00	<u>с</u>			1.00
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0			C			2.00 3.00 4.00
5.00 6.00 7.00 8.00				0 0 0				5.00 6.00 7.00 8.00
9. 00 10. 00	Total additions (sum of line 5 - 9)	0		0	C			9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	0		0 0 0 0	C)		11.00 12.00 13.00 14.00 15.00 16.00 17.00
	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0			C			17.00 18.00 19.00

Hoal th	Financial Systems	CARE ONE AT WA	NE 1			Inlia	u of Form CMS-:	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES			No.: 315485		riod: om 01/01/2023	Worksheet G-2 Parts I-II	pared:
	Cost Center Description			I npati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services			1				
1.00	SKILLED NURSING FACILITY			18, 548, 80	29		18, 548, 809	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 li	nes 1 - 4)		18, 548, 80	29		18, 548, 809	5.00
	All Other Care Services			T		-		
	ANCI LLARY SERVI CES			9, 425, 5	79	0	9, 425, 579	6.00
7.00						0	0	7.00
	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	
	RURAL HEALTH CLINIC					0	0	
	FQHC					0	0	10.10
	CMHC				~	0	0	11.00
	HOSPI CE				0	0	0	12.00
	OTHER (SPECIFY)	с I о		07 074 0	0	0	0	13.00
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Tr Worksheet G-3, Line 1)	ansfer column 3	to	27, 974, 38	38	0	27, 974, 388	14.00
	Cost Center Description	· · · · · · · · · · · · · · · · · · ·						
	'					1.00	2.00	
	PART II - OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3, Lir	ne 100)					19, 306, 015	1.00
2.00	Add (Specify)					0		2.00
3.00						0		3.00
4.00						0		4.00
5.00						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
	Total Deductions (Sum of lines 9 - 13)						0	
15.00	Total Operating Expenses (Sum of lines 1 and 8,	minus line 14)					19, 306, 015	15.00

Heal th	Financial Systems	CARE ONE AT WA	ALL	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES			Provider No.: 315485	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Prep 5/10/2024 11:5	
	· · · · · · · · · · · · · · · · · · ·				1 57 107 2024 11. 0	<u>14 alii</u>
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col. 3, line 1.	4)		27, 974, 388	1.00
2.00	Less: contractual allowances and discounts on pa				9, 948, 544	2.00
3.00	Net patient revenues (Line 1 minus line 2)				18, 025, 844	3.00
4.00	Less: total operating expenses (From Worksheet G	-2, Part II, li	ne 15)		19, 306, 015	4.00
5.00	Net income from service to patients (Line 3 minus	s 4)			-1, 280, 171	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				3, 196	7.00
8.00	Revenues from communications (Telephone and Inte	ernet 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	
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and guests				705	
15.00	Revenue from rental of living quarters				0	
16.00	Revenue from sale of medical and surgical supplic		n patients		0	
17.00	Revenue from sale of drugs to other than patients				0	17.00
18.00	Revenue from sale of medical records and abstrac				0	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)				0	
20.00	Revenue from gifts, flower, coffee shops, canteel	n			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	
24.00	BARBER AND BEAUTY					24.00
24.01	OTHER REV				4, 243	
24.02	OTHER INCOME				3, 210	
24.50	COVI D-19 PHE Funding				0	
25.00	Total other income (Sum of lines 6 - 24)				14, 721	
26.00	Total (Line 5 plus line 25)				-1, 265, 450	
27.00	Other expenses (specify)				0	
28.00					0	
29.00	Total athan averages (Sum of Lines 27 20)				0	29.00 30.00
30.00	Total other expenses (Sum of Lines 27 - 29) Net income (or Loss) for the period (Line 26 min	us lino 20)			-1, 265, 450	
31.00	Iner medine (or ross) for the period (Line 20 min	us IIIle 30)		I	-1, 200, 450	31.00