Health Financial Systems CARE ONE AT WELLINGTON In Lieu of Form CMS-2540-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expires: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315152 Worksheet S Parts I, II & III Peri od. From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: То 5/10/2024 11:56 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/10/2024 Time: 11:56 am use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 3.01 [] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[0]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11.Contractor Vendor Code 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT WELLINGTON (315152) 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 provide in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Dav	id 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	AUTHORIZED SIGNOR			3
4	Date	(Dated when report is electronica			4

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-67, 107	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/IID				0	3.00
4.00 SNF - BASED HHA I	0	0	0		4.00
5.00 SNF - BASED RHC I	0		0		5.00
6.00 SNF - BASED FQHC I	0		0		6.00
7.00 SNF - BASED CMHC I	0		0		7.00
100. 00 TOTAL	0	-67, 107	0	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 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.

MPLE	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILIT X INDENTIFICATION DATA	<u>CARE ONE AT W</u> Y HEALTH CARE	Provider No	o.: 315152	Period: From 01/01, To 12/31,		Workshe Part I Date/Tii		
						2020	5/10/20		
	1.00	2.00		3.00					
00	Skilled Nursing Facility and Skilled Nursing F Street: 301 UNION STREET	<u>acility comple</u> 0 Box:	x Address:						1
00		state: NJ	Zip Code: 07	7601					2.0
00	3	BSA Code: 35614							3.0
01	3	BSA Code: 33014		. 0					3.0
			mponent Name	Provi der	Date	Pavme	nt Syste	em (P.	0.1
				CCN	Certified		0, or N)		
						V	XVIII	XI X	1
			1.00	2.00	3.00	4.00		6.00	
	SNF and SNF-Based Component Identification:								
	SNF	CARE ON	E AT WELLINGTON	315152	04/15/1974	N	P	Ν	4.0
00	Nursing Facility								5.0
00									6.0
	SNF-Based HHA								7.0
	SNF-Based RHC								8.0
00 . 00	SNF-Based FQHC SNF-Based CMHC								9.0
	SNF-Based OLTC								111. (
	SNF-Based HOSPICE								12. (
	SNF-Based CORF								13.
00					From:		To:		101
					1.00	1	2.0	C	1
00	Cost Reporting Period (mm/dd/yyyy)				01/01/2	023	12/31/	2023	14.
00	Type of Control (See Instructions)					4			15.
							Y/N		
							1.0	2	
00	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facili	ty that meets	the requirements	s set forth	in 42 CFR		Y		16.
00	section 483.5? Is this a composite distinct part skilled nurs	ing facility th	nat meets the re	equirements	set forth	in	Ν		17.
00	42 CFR section 483.5? Are there any costs included in Worksheet A th	at resulted fro	om transactions	with relat	ed		Y		18.
	organizations as defined in CMS Pub. 15-1, cha Miscellaneous Cost Reporting Information								
00	If this is a low Medicare utilization cost rep	ort, indicate v	with a "Y", for	ves. or "N	" for no.		N		19.
	If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y",	your contracto	's criteria fo			e	Ν		19.
	Depreciation - Enter the amount of depreciatio			e method in	dicated on	Li nes	20 - 22		1
00	Straight Line							(20.
00	Declining Balance							C	21.
	Sum of the Year's Digits							C	22.
	Sum of line 20 through 22							C	23.
	If depreciation is funded, enter the balance		•					C	24.
	Were there any disposal of capital assets duri	· ·	0.	• •			N		25.
00	Was accelerated depreciation claimed on any as	sets in the cu	rrent or any pri	ior cost re	porting per	i od?	N		26.
00	(Y/N) Did you coose to participate in the Medicare n	roarom at and	of the period to	o which this	s cost ropo	r+	N		27.
00	Did you cease to participate in the Medicare p applies? (Y/N)	0	·		·		IN		
	Was there a substantial decrease in health ins	urance proporti	on of allowable	e cost from	prior cost		N		28.
00	reports? (Y/N)					Part	APart B	0ther	
00	reports? (Y/N)							3 00	
00						1.00		5.00	
00	If this facility contains a public or non-publ					1.00 ne appl	i cati on	3.00	
00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y"					1.00 ne appl	i cati on	5.00	
	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption.					1.00 ne appl fies fo	ication or the	3.00	20
00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility					1.00 ne appl	i cati on		
00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility					1.00 ne appl fies fo	ication or the	<u>N</u>	30.
00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID					1.00 ne appl ies fo	ication or the		30. 31.
00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility					1.00 ne appl fies fo	ication or the		30. 31. 32.
00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA					1.00 ne appl ies fo	ication or the		30. 31. 32. 33.
00 00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC					1.00 ne appl ies fo	ication or the		30. 31. 32. 33. 34.
00 00 00 00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC				that qualif	1.00 ne appl ies fo	ication or the N		30. 31. 32. 33. 34. 35.
00 00 00 00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FOHC SNF-Based CMHC				that qualif	1.00 le appl i es fo N N	ication or the N N N	N	30. 31. 32. 33. 34. 35.
00 00 00 00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based FOHC SNF-Based CMHC SNF-Based OLTC	for each comp	onent and type	of service	Y/N 1.00	1.00 le appl i es fo N N	ication or the N	N	30. 31. 32. 33. 34. 35. 36.
00 00 00 00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based RHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a s	for each comp	fies the provid	of service	Y/N 1.00	1.00 le appl i es fo N N	ication or the N N N	N	30. 31. 32. 33. 34. 35. 36.
00 00 00 00 00 00 00 00 00	If this facility contains a public or non-publ of the lower of the costs or charges enter "Y" 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 s regardless of the level of care given for Titl	for each comp tate that certies V & XIX pati	fies the providents? (Y/N)	of service	That qualif	1.00 le appl i es fo N N	ication or the N N N	N	30. 31. 32. 33. 34. 35. 36. 37.
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Health Financial Systems	CARE ONE AT N	VELLI NGTON		In Li	eu of Form (CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:		Period:	Worksheet	S-2
COMPLEX INDENTIFICATION DATA				From 01/01/202 To 12/31/202		Prenared
	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	ox, and submit supporti	ng schedule listir	ng cost ce	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 er	iter the name and a	address of	the home	HB0206	44.00
office on lines 45, 46 and 47.		-				
1.00	2.0			3.00		
If this facility is part of a chain or	ganization, enter the	name and address	of the hor	me office on th	ne lines	
bel ow.	-					
45.00 Name: HEALTHBRIDGE	Contractor's Name: NO	VITAS SOLUTIONS	Contracto	or's Number: 120	001	45.00
46.00 Street: 173 BRIDGE PLAZA NORTH	PO Box:					46.00
47.00 City: FORT LEE	State: NJ		Zip Code:	070)24	47.00

MPL	ED NURSING FACILITY AND SKILLED NURSING FACILI EX REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Pro	ovider I		Period: From 01/01/2023 To 12/31/2023	Date/Time Pr	epared
					Y/N	5/10/2024 11 Date	: 50 81
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column 1,	"Y" for	Yes or "N"	for No. For all	the date	_
00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.
			-	Y/N	Date	V/I	_
00	Has the provider terminated participation in	the Medicare Program?	lf	1.00 N	2.00	3.00	2.
00	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g.	of termination and in o tions, including manage ., chain home offices,	column ement drug	Ŷ			3.
	or medical supply companies) that are related officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	l, or members of the bo	oard	V /N	Turna	Data	
			-	Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports				2.00	01.00	
00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If Are the cost report total expenses and total	" for Audited, "C" for te copy or enter date no, see instructions.		Y	A		4.
	those on the filed financial statements? If						
	reconciliation.				Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	nol2 (Y/N) Column 2: 1		mavidan the	N	N	6.
			is the p	brovider the	N	IN	0.
	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained during	s? (Y/N) see instruction ng the cost reporting p	ons.		N N N	N	7.
	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so	s? (Y/N) see instruction ng the cost reporting p	ons.		N	Y/N 1.00	7.
00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bac	s? (Y/N) see instruction ng the cost reporting p ee instructions. d debts? (Y/N) see inst	ons. period f	For Nursing	NN	Y/N 1.00 Y	7. 8. 9.
00	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	s? (Y/N) see instruction ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha	ons. period f tructior ange dur	for Nursing ns. ning this cos	N N t reporting	Y/N 1. 00	7. 8. 9. 10.
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) so Bad Debts Is the provider seeking reimbursement for baa If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.	s? (Y/N) see instruction ng the cost reporting p ee instructions. d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived	ons. period f tructior ange dur d? lf ")	for Nursing ns. ng this cos (", see instr	N N t reporting uctions.	Y/N 1.00 Y N	9. 10. 11.
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	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? 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 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 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	s? (Y/N) see instruction ng the cost reporting period d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period Description 0	ons. period f tructior ange dur d? lf ")	for Nursing ns. ring this cos (", see instru Pa Y/N 1.00	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00	7. 8. 9. 10. 11. 12. 13.
	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 deb period? 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	s? (Y/N) see instruction ng the cost reporting period d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period Description 0	ons. period f tructior ange dur d? lf ")	For Nursing ns. ring this cos (", see instru Pa Y/N 1.00 Y	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	7. 8. 9. 10. 11.
	<pre>legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin 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 deb period? 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 cols 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 Report information? If yes, see instructions.</pre>	s? (Y/N) see instruction ng the cost reporting period d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period Description 0	ons. period f tructior ange dur d? lf ")	For Nursing hs. ring this cos (", see instru Pa Y/N 1.00 Y N N N	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y N N	7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
200 200 200 200 200 200 200 200	<pre>legal operator of the program? (Y/N) Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained durin 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 deb period? 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. </pre>	s? (Y/N) see instruction ng the cost reporting period d debts? (Y/N) see inst t collection policy cha d/or coinsurance waived cost reporting period Description 0	ons. period f tructior ange dur d? lf ")	For Nursing hs. ring this cos (", see instru Pa Y/N 1.00 Y N N	N N t reporting uctions. ctions. rt A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y N	7. 8. 9. 10. 11. 12. 13. 14.

Health Fin	ancial Systems	CARE ONE AT	WELLI	NGTON			In Lieu	u of Form CMS-	2540-10
	JRSING FACILITY AND SKILLED NURSING FACILIT	TY HEALTH CARE		Provi der	No.: 315152	Per		Worksheet S-2	
COMPLEX RE	I MBURSEMENT QUESTI ONNAI RE					Fro	m 01/01/2023 12/31/2023	Part II Date/Time Pre	nared
							12/ 51/ 2023	5/10/2024 11:	<u>56 am</u>
				1.	00		2.0	00	
Cost	t Report Preparer Contact Information								
19.00 Ent	er the first name, last name and the title	e/position	CHARL	ES		RE	ED		19.00
hel	d by the cost report preparer in columns 1	, 2, and 3,							
res	pecti vel y.								
20.00 Ent	er the employer/company name of the cost r	report	EXECL	ICARE ASSC	CI ATES				20.00
pre	parer.								
21.00 Ent	er the telephone number and email address	of the cost	(609)	738-3200		CR	RWASSC@NETSCAP	E. NET	21.00
rep	ort preparer in columns 1 and 2, respectiv	vel y.							

Heal th	Financial Systems	CARE ONE AT W	ELLI NGTON	In Lie	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der No. : 315152	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/10/2024 11:	pared:
		Part B				
		Date				
		4.00				
10.00	PS&R Data	00 (40 (000 4				10.00
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	03/19/2024				13.00
14.00	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					14.00
15.00	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					15. 00
16. 00	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					16. 00
17.00	information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00			
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title held by the cost report preparer in columns of respectively.		I CE-PRESI DENT			19.00
20.00	Enter the employer/company name of the cost i	report				20. 00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems D NURSING FACILITY AND SKILLED NURSI X STATISTICAL DATA		VELLI NGTON Provi der		eriod: rom 01/01/2023	Worksheet S-3 Part I	
				l npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	128	46, 720	0	9, 332	9, 963	1.00
00	NURSING FACILITY	0	0	0		0	2.00
00		0	0	0	0	0	3.00
00 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0	0	0	0	4.0 5.0
00	SNF-Based CMHC	0	0				6.0
00	HOSPI CE	0	0	0	0	0	7.0
00	Total (Sum of lines 1-7)	128	46, 720	0	9, 332	9, 963	8.0
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
00	SKILLED NURSING FACILITY	14, 915	34, 210	0	271	73	1.0
00 00	NURSING FACILITY	0	0	0		0	2.0 3.0
00	HOME HEALTH AGENCY COST	0	0			0	4. C
00	Other Long Term Care	0	0				5.0
00	SNF-Based CMHC						6.0
00	HOSPI CE	0	0	0	0	0	7.0
00	Total (Sum of lines 1-7)	14, 915 Di scha	34, 210 arges	0 Aver	271 age Length of 1	73 Stav	8.0
			il ges		3 3	, 	
	Component	0ther 11.00	Total 12,00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
00	SKILLED NURSING FACILITY	311	655	0.00	34.44	136.48	1.0
00	NURSING FACILITY	0	0	0.00	01111	0.00	2.0
00	ICF/IID	0	0			0.00	3.0
00	HOME HEALTH AGENCY COST						4.0
00	Other Long Term Care	0	0				5.0
00 00	SNF-Based CMHC HOSPI CE	0	0	0.00	0.00	0.00	6.0 7.0
00	Total (Sum of Lines 1-7)	311	655	0.00		136.48	8.0
00		Average Length			sions	100.10	0.0
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
	component	16.00	17.00	18.00	19.00	20.00	
00	SKILLED NURSING FACILITY	52. 23	0	303	39	301	1. (
00	NURSING FACILITY	0.00	0		0	0	2.0
00		0.00			0	0	3.0
00 00	HOME HEALTH AGENCY COST Other Long Term Care	0.00				0	4. (5. (
00	SNF-Based CMHC	0.00				0	6.0
00	HOSPICE	0.00	0	0	0	0	7.0
00	Total (Sum of lines 1-7)	52. 23	0	303	39	301	8. (
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22.00	Workers 23.00			
00	SKILLED NURSING FACILITY	643	129.95	0.00			1. C
00	NURSING FACILITY	0	0.00	0.00			2.0
00	ICF/IID	0	0.00	0.00			3. (
00	HOME HEALTH AGENCY COST		0.00	0.00			4.0
00	Other Long Term Care	0	0.00				5.0
00	SNF-Based CMHC HOSPI CE		0.00 0.00	0. 00 0. 00			6.0 7.0
00		0					

	Financial Systems	CARE ONE AT		N 045450		u of Form CMS-2	
SNF WA	AGE INDEX INFORMATION		Provi der	1	Period: From 01/01/2023 Fo 12/31/2023		pared:
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from		Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES				1		
1.00	Total salaries (See Instructions)	8, 903, 870	0	8, 903, 870			1.00
2.00	Physician salaries-Part A	0	C		0.00		2.00
3.00	Physician salaries-Part B	0	C) (0.00		3.00
4.00	Home office personnel	0	0) (0.00		4.00
5.00	Sum of lines 2 through 4	0	0) (0.00		5.00
6.00	Revised wages (line 1 minus line 5)	8, 903, 870	0	8, 903, 870			6.00
7.00	Other Long Term Care	0	0		0.00		
8.00	HOME HEALTH AGENCY COST	0	0		0.00		
9.00	CMHC	0	0		0.00		
10.00	HOSPI CE	0	0		0.00		
11.00	Other excluded areas	0			0.00		
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0			0.00		
13.00	Total Adjusted Salaries (line 6 minus line 12)	8, 903, 870	C	8, 903, 870	270, 296. 00	32.94	13.00
	OTHER WAGES & RELATED COSTS		_				
14.00		6, 800	0	6, 800			
15.00	Contract Labor: Physician services-Part A	0	0		0.00		
16.00		0	0) (0.00	0.00	16.00
	WAGE-RELATED COSTS	1		1			
	Wage-related costs core (See Part IV)	1, 879, 539	0	1, 879, 539	9		17.00
18.00		0	0		C		18.00
19.00	Wage related costs (excluded units)	0	0		C		19.0
20.00		0	0		C		20.00
21.00		0	0		D		21.0
22.00	Total Adjusted Wage Related cost (see instructions)	1, 879, 539	0	1, 879, 539	9		22.00

Heal th	Financial Systems	CARE ONE AT	WELLI NGTON		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		norod.
					Fo 12/31/2023	Date/Time Pre 5/10/2024 11:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.		
					3		
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	(0.00	0.00	1.00
2.00	Administrative & General	725, 505	0	725, 50	5 16, 715. 00	43.40	2.00
3.00	Plant Operation, Maintenance & Repairs	102, 580	0	102, 580	5, 062. 00	20. 26	3.00
4.00	Laundry & Linen Service	58, 265	0	58, 26	5 3, 512. 00	16. 59	4.00
5.00	Housekeepi ng	386, 545	0	386, 54	5 20, 666. 00	18. 70	5.00
6.00	Dietary	634, 042	0	634, 042	2 27, 906. 00	22. 72	6.00
7.00	Nursing Administration	914, 389	0	914, 389	23, 786. 00	38.44	7.00
8.00	Central Services and Supply	2, 942	0	2, 942	2 78.00	37.72	8.00
9.00	Pharmacy	0	0	(0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	73, 318	0	73, 318	3 2, 188. 00	33. 51	10.00
11.00	Social Service	177, 913	0	177, 913	4, 600. 00	38.68	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	165, 101	0	165, 10 ⁻	1 7, 889. 00	20.93	13.00
14.00	Total (sum lines 1 thru 13)	3, 240, 600	0	3, 240, 600	112, 402. 00	28.83	14.00

	ancial Systems	CARE ONE AT WEL			u of Form CMS-2	
NF WAGE F	RELATED COSTS		Provider No.: 315152	Period: From 01/01/2023	Worksheet S-3 Part IV	
				To 12/31/2023		nared
					5/10/2024 11:	
					Amount	
					Reported	
DAD:					1.00	
	T IV - WAGE RELATED COSTS t A - Core List					-
	IREMENT COST					-
	K Employer Contributions				44, 086	1 1.
	Sheltered Annuity (TSA) Employer Cont	ribution			44,080	
	lified and Non-Qualified Pension Plan				0	
	or Year Pension Service Cost	cost			0	
	N ADMINISTRATIVE COSTS (Paid to Extern	al Organization)			0	4.
	K/TSA Plan Administration fees				0	5.
	al /Accounting/Management Fees-Pension	PLan			0	
	oloyee Managed Care Program Administrat				0	
	LTH AND INSURANCE COST					· · ·
	Ith Insurance (Purchased or Self Funde	d)			914, 818	8.
	escription Drug Plan				0	
	ital, Hearing and Vision Plan				0	
	e Insurance (If employee is owner or b	enefi ci arv)			1, 955	
	ident Insurance (If employee is owner				0	
	ability Insurance (If employee is owned				0	13.
	g-Term Care Insurance (If employee is				0	14.
	kers' Compensation Insurance				174, 314	15.
. 00 Ret	irement Health Care Cost (Only current	year, not the extrac	rdinary accrual require	ed by FASB 106.	0	16.
Non	cumulative portion)	5	5	5		
TAX						
	CA-Employers Portion Only				633, 526	17.
	licare Taxes - Employers Portion Only				0	
	employment Insurance				0	1
	ite or Federal Unemployment Taxes				106, 620	20.
OTH						
	ecutive Deferred Compensation				0	
	Care Cost and Allowances				0	
	tion Reimbursement	00)			4, 220	
1. UU IOt	al Wage Related cost (Sum of lines 1 -	23)			1, 879, 539	24.
					Amount	
					Reported 1.00	
Dar	t B - Other than Core Related Cost				1.00	
	IER WAGE RELATED COST				0	25.

SNF REPORTING OF DIRECT CARE EXPENDITURES Provider No.: 315152 Period: To 01/01/2023 Vorsheet S-3 Part V Date/Time Prepared: 5/10/2024 Vorsheet S-3 Part V Occupational Category Amount Reported Fringe Benefits Adjusted Salaries (col. 1 + col. 2) Paid Hours Salaries (col. 3 - 00 Vorsheet S-3 Part V Direct Salaries 1.00 2.00 3.00 4.00 5.00 Direct Salaries 1.00 2.00 3.00 4.00 5.00 Direct Salaries 1.694,419 390,296 2.084,915 41,759,00 49,93 2.00 2.00 Licensed Practical Nurses (LPNs) 1.694,419 390,296 2.084,915 41,759,00 49,93 2.00 3.00 Certified Nursing (sum of lines 1 through 3) 4.181,554 63,975 5.144,629 124,489,00 41,33 4.00 6.00 Physical Therapy Assistants 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <t< th=""><th>Heal th</th><th>Financial Systems</th><th>CARE ONE AT W</th><th>FLLINGTON</th><th></th><th>In Lie</th><th>eu of Form CMS-2</th><th>2540-10</th></t<>	Heal th	Financial Systems	CARE ONE AT W	FLLINGTON		In Lie	eu of Form CMS-2	2540-10
Reported Benefits Sal aries Col. Wage Col. 3 + col. Direct Salaries 1.00 2.00 3.00 4.00 5.00 Nursing Occupations 1.00 2.00 3.00 4.00 66.2 0.0 Registered Nurses (RNs) 918,475 211,539 1.130,014 17.046.00 66.29 1.00 2.00 Licensed Practical Nurses (LPNs) 1.694,619 390,296 2.084,915 41.759.00 49.93 2.00 3.00 Certified Nursing Assistant/Nursing 1.568,460 361,240 1,929,700 65,684.00 29.38 3.00 4.00 Total Nursing (sum of lines 1 through 3) 4,181,554 963,075 5,144,629 124,489.00 41.33 4.00 6.00 Physical Therapy Assistants 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00						Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/10/2024 11:	pared:
Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNS) 918,475 211,539 1,130,014 17,046.00 66.29 1.00 2.00 Licensed Practical Nurses (LPNS) 1,694,619 390,296 2.084,915 41,759.00 49.93 2.00 Assistants/Aides 1,664,619 361,240 1,929,700 65,684.00 29.38 3.00 Assistants/Aides 1,664,619 361,240 1,929,700 65,684.00 29.38 3.00 5.00 Physical Therapists 636,998 146,710 783,708 15,609.00 50.21 5.00 6.00 Physical Therapy Asistants 0 0 0.00 0.00 7.00 7.00 Registered Nurses 655,795 151,040 806,835 15,981.00 50.49 8.00 10.00 Cocupational Therapy Asistants 0 0 0.00 0.00 10.00 9.00 1.00 8.00 1.00 8.00 1.00 1.00 1.00 1.00 0 0.00		Occupational Category			Salaries (col	. Related to Salary in col.	Wage (col. 3 ÷	
Nursing Occupations 1.00 Registered Nurses (RNs) 918,475 211,539 1,130,014 17,046.00 66.29 1.00 2.00 Licensed Practical Nurses (LPNs) 1,694,619 390,296 2,084,915 41,759.00 49.93 2.00 3.00 Certified Nursing Assistant/Nursing 1,568,460 361,240 1,929,700 65,684.00 29.38 3.00 4.00 Total Nursing (sum of lines 1 through 3) 4,181,554 963,075 5,144,629 124,489.00 41.33 4.00 5.00 Physical Therapy Assistants 0 0 0.00 0.00 6.00 6.00 7.00 Physical Therapy Aides 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>			1.00	2.00	3.00	4.00	5.00	
1.00 Registered Nurses (RNs) 918.475 211,539 1.30,014 17,046.00 66.29 1.00 2.00 Licensed Practical Nurses (LPNs) 1,694,619 390,296 2,084,915 41,759.00 49.93 2.00 Assistants/Aides 1,564,460 361,240 1,929,700 65,684.00 29.38 3.00 Assistants/Aides 1,554 963,075 5,144,629 124.489,00 41.33 4.00 5.00 Physical Therapists 636,998 146,710 783,708 15,609.00 50.21 5.00 6.00 Occupational Therapy Assistants 0 0 0 0.00 0.00 6.00 9.00 Occupational Therapy Asistants 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		Direct Salaries						
2.00 Licensed Practical Nurses (LPNs) 1, 694, 619 390, 296 2, 084, 915 41, 759, 00 49, 93 2, 00 3.00 Certified Nursing Assistant/Nursing 1, 568, 460 361, 240 1, 929, 700 65, 684, 00 29, 38 3, 00 4.00 Total Nursing (sum of lines 1 through 3) 4, 181, 554 963, 075 5, 144, 629 124, 489, 00 41, 33 4, 00 5.00 Physical Theraps Assistants 636, 998 146, 710 783, 708 15, 609, 00 50.01 6, 00 7.00 Physical Therapy Assistants 655, 795 151, 040 806, 835 15, 981, 00 0.00 0.00 7.00 8.00 Occupational Therapy Aides 0 0 0 0.00 0.00 0.00 10.00 10.00 Bpeech Therapists 74, 209 17, 091 91, 300 1, 816, 00 50.28 1.00 10.00 Registreed Nurses (RNs) 0 0 0 0 0 0 0 0 0 0 0 0 0								
3.00 Certified Nursing Assistant/Nursing 1,568,460 361,240 1,929,700 65,684.00 29.38 3.00 Assistants/Aides 0 Total Nursing (sum of lines 1 through 3) 4,181,554 963,075 5,144,629 124,489.00 41.33 4.00 5.00 Physical Therapy Assistants 0 0 0.00 0.00 5.00 6.00 Physical Therapy Asistants 0 0 0.00 0.00 5.00 7.00 Physical Therapy Asistants 655,795 151,040 806,835 15,981.00 50.49 8.00 9.00 Occupational Therapy Asistants 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
Assistants/Ai des - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -								
5.00 Physical Therapists 636,998 146,710 783,708 15,609,00 50.21 5.00 6.00 Physical Therapy Asistants 0 0 0 0.00 0.00 6.00 7.00 Physical Therapy Asistants 0 0 0 0.00 0.00 6.00 8.00 Occupational Therapy Asistants 0 0 0 0.00 0.00 0.00 9.00 0.00 Occupational Therapy Asistants 0 0 0 0.00 0.00 9.00 0.00 Occupational Therapy Asistants 0 0 0 0.00 0.00 9.00 11.00 Speech Therapists 74,209 17,091 91,300 1,816.00 50.28 11.00 12.00 Respiratory Therapists 0 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0.00 10.00 13.00 14.00 Registered Nurses (RNs) 0	3.00		1, 568, 460	361, 240	1, 929, 70	0 65, 684. 00	29.38	3.00
6.00 Physical Therapy Assistants 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>								
7.00 Physical Therapy Aides 0 0 0 0.00 0.00 7.00 8.00 Occupational Therapists 655,795 151,040 806,835 15,981.00 50.49 8.00 9.00 Occupational Therapy Assistants 0 0 0.00 0.00 9.00 10.00 Occupational Therapy Aides 0 0 0.00 0.00 9.00 11.00 Speech Therapists 74,209 17,091 91,300 1,816.00 50.28 11.00 12.00 Respiratory Therapists 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0.00 13.00 14.00 Registered Nurses (RNS) 0 0 0.00 0.00 14.00 15.00 Certified Nursing Assistant/Nursing 0 0 0.00 0.00 15.00 16.00 Certified Nursing (sum of Lines 14 through 16) 0 0 0.00 0.00 16.00 <td< td=""><td></td><td></td><td>636, 998</td><td>146, 710</td><td>783, 70</td><td></td><td></td><td></td></td<>			636, 998	146, 710	783, 70			
8.00 Occupational Therapists 655,795 151,040 806,835 15,981.00 50.49 8.00 9.00 Occupational Therapy Assistants 0 0 0.00 0.00 0.00 9.00 10.00 Occupational Therapy Asistants 0 0 0 0.00 0.00 9.00 10.00 Speech Therapists 74,209 17,091 91,300 1,816.00 50.28 11.00 12.00 Respiratory Therapists 0 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0 0.00 0.00 12.00 14.00 Registered Nurses (RNS) 0 0 0.00 0.00 15.00 15.00 Licensed Practical Nurses (LPNS) 0 0 0.00 0.00 16.00 16.00 Physical Therapists 0 0 0.00 0.00 16.00 17.00 Total Nursing (sum of Lines 14 through 16) 0 0 0.00 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
9.00 Occupational Therapy Assistants 0 0 0 0 0.00 0.00 9.00 10.00 Occupational Therapy Aides 0 0 0 0.00 0.00 0.00 10.00 11.00 Speech Therapists 74,209 17,091 91,300 1,816.00 50.28 11.00 12.00 Respiratory Therapists 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0.00 0.00 13.00 Contract Labor Nursing Occupations 14.00 Registered Nurses (RNS) 0 0 0.00 0.00 14.00 15.00 Licensed Practical Nurses (LPNs) 0 0 0.00 0.00 15.00 16.00 Certified Nursing (sum of lines 14 through 16) 0 0 0.00 0.00 17.00 18.00 Physical Therapy Asistants 0 0 0.00 0.00 19.00 19.00		5 15	0	0				
10.00 Occupational Therapy Aides 0 0 0 0 0.00 0.00 10.00 11.00 Speech Therapists 74,209 17,091 91,300 1,816.00 50.28 11.00 12.00 Respiratory Therapists 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0.00 0.00 13.00 Contract Labor Nursing Occupations 14.00 Registered Nurses (RNS) 0 0 0.00 0.00 14.00 15.00 Licensed Practical Nurses (LPNS) 0 0 0.00 0.00 14.00 16.00 Certified Nursing (sum of lines 14 through 16) 0 0 0.00 0.00 18.00 19.00 Physical Therapy Asistants 0 0 0.00 0.00 19.00 20.00 Physical Therapy Asistants 0 0 0.00 0.00 20.00 19.00 Cocupational Therapy Asistants </td <td></td> <td></td> <td>655, 795</td> <td>151, 040</td> <td>806, 83</td> <td></td> <td></td> <td></td>			655, 795	151, 040	806, 83			
11.00 Speech Therapists 74,209 17,091 91,300 1,816.00 50.28 11.00 12.00 Respiratory Therapists 0 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0 0.00 0.00 12.00 13.00 Other Medical Staff 0 0 0 0.00 0.00 13.00 Nursing Occupations 14.00 Registered Nurses (RNs) 0 0 0.00 0.00 14.00 16.00 Certified Nursing Assistant/Nursing 0 0 0.00 0.00 14.00 17.00 Total Nursing (sum of Lines 14 through 16) 0 0 0.00 0.00 16.00 19.00 Physical Therapy Assistants 0 0 0.00 0.00 18.00 19.00 Physical Therapy Assistants 0 0 0.00 0.00 19.00 10.00 Ceupational Therapy Assistants 0 0 0.00 0.00 20.00 20.00 Physical Therapy Assistants			0	0				
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Assi stants/Ai des			0					
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18.00 Physi cal Therapi sts 0 0 0.00 18.00 19.00 Physi cal Therapy Assi stants 0 0 0.00 19.00 20.00 Physi cal Therapy Aides 0 0 0.00 0.00 19.00 20.00 Physi cal Therapy Aides 0 0 0.00 0.00 20.00 21.00 Occupati onal Therapi sts 0 0 0.00 0.00 21.00 22.00 Occupati onal Therapy Assi stants 0 0 0.00 0.00 22.00 23.00 Occupati onal Therapy Ai des 0 0 0.00 0.00 23.00 24.00 Speech Therapi sts 6, 800 6, 800 91.00 74.73 24.00 25.00 Respi ratory Therapi sts 0 0 0.00 0.00 25.00	17 00		0			0 0 00	0.00	17 00
19.00 Physical Therapy Assistants 0 0 0.00 19.00 20.00 Physical Therapy Aides 0 0 0.00 0.00 20.00 21.00 Occupati onal Therapists 0 0 0.00 0.00 20.00 22.00 Occupati onal Therapists 0 0 0.00 0.00 21.00 23.00 Occupati onal Therapy Aides 0 0 0.00 0.00 23.00 24.00 Speech Therapists 6,800 6,800 91.00 74.73 24.00 25.00 Respiratory Therapists 0 0 0.00 0.00 25.00			0					
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25.00 Respiratory Therapists 0 0 0.00 0.00 25.00			6, 800		6.80			
26.00 Other Medical Staff 0 0.00 0.00 26.00		Other Medical Staff	0					

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der No.: 315152	Period: From 01/01/2023	Worksheet S	-7
		To 12/31/2023		
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5. 00 6. 00		RHX RHL		5.00
7.00		RMX		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
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		RLB		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		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30. 00 31. 00		HD1 HC2		30.00
32.00		HC1		32.00
33.00		HB2		33.00
34.00		HB1		34.00
35. 00 36. 00		LE2 LE1		35.00
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		LB2		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		CA2 CA1		52.00
53.00		SE3		53.00
54.00		SE2		54.00
55. 00 56. 00		SE1 SSC		55.00 56.00
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		60.00
62.00		LA1		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
70.00		PD1 PC2		70.00
72.00		PC1		72.00
73.00		PB2		73.00
74.00		PB1	1	74.00

Health Financial Systems CARE ONE AT	WELLI NGTON		In Lie	u of Form CM	/S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315152	Peri od:	Worksheet	S-7
			From 01/01/2023 To 12/31/2023		
			Group	Days	
			1.00	2.00	
76.00			PA1		76.00
99. 00			AAA		99.00
100. 00 TOTAL		-			100.00
		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 1 payments beginning 10/01/2003. Congress expected this incre expenses. For lines 101 through 106: Enter in column 1 the column 2 the percentage of total expenses for each category line 1, column 3. Indicate in column 3 "Y" for yes or "N" f with direct patient care and related expenses for each cate (See instructions)	ease to be used amount of the / to total SNF for no if the s	l for direct p expense for e revenue from pending refle	atient care and each category. Er Worksheet G-2, F ects increases as	related nterin Partl, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3))				101.00 102.00 103.00 104.00 105.00 106.00

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	CARE ONE AT WE EXPENSES			eri od:	u of Form CMS-2 Worksheet A	
				Fi Ti	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				[]		
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 913, 978			1, 913, 978	1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	62, 855 2, 050, 696	62, 855 2, 050, 696		61, 269 2, 050, 696	2.00 3.00
1.00	00400 ADMINI STRATI VE & GENERAL	725, 505	2, 755, 469	3, 480, 974	0	3, 480, 974	4.00
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	102, 580	667, 709	770, 289	-	770, 289	5.00
. 00	00600 LAUNDRY & LINEN SERVICE	58, 265	97, 796	156, 061	0	156, 061	6.00
. 00	00700 HOUSEKEEPI NG	386, 545	80, 125	466, 670	0	466, 670	7.00
. 00	00800 DI ETARY	634,042	380, 318	1, 014, 360	0	1,014,360	8.00
. 00	00900 NURSI NG ADMI NI STRATI ON	914, 389	284, 904	1, 199, 293		1, 199, 293	
0.00 1.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	2, 942	232, 892	235, 834		235, 412	
2.00	01200 MEDICAL RECORDS & LIBRARY	73, 318	26, 005 0	26, 005 73, 318		26, 005 73, 318	
3.00	01300 SOCIAL SERVICE	177, 913	0	177, 913	0	177, 913	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
5.00	01500 ACTI VI TES	165, 101	7, 714	172, 815	0	172, 815	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 SKILLED NURSING FACILITY	4, 181, 554	78, 411	4, 259, 965	0	4, 259, 965	30.00
1.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
2.00	03200 I CF/I I D	0	0	0	0	0	32.00
3.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	33.00
0.00	04000 RADI OLOGY	0	63, 317	63, 317	0	63, 317	40.00
1.00	04100 LABORATORY	0	62, 488		-	62, 488	
2.00	04200 I NTRAVENOUS THERAPY	0	150, 507	150, 507	0	150, 507	42.00
3.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
4.00	04400 PHYSI CAL THERAPY	751, 712	20, 309	772, 021	0	772, 021	44.00
5.00	04500 OCCUPATIONAL THERAPY	655, 795	0	655, 795	0	655, 795	
6.00 7.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	74, 209	6, 800 0	81, 009 0	0	81, 009 0	46.00 47.00
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	422	422	47.00
9.00	04900 DRUGS CHARGED TO PATIENTS	0	454, 631	454, 631	0	454, 631	49.00
0.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
1.00	05100 SUPPORT SURFACES	0	283	283	1, 586	1, 869	51.00
2.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
2.01	05201 OTHER ANCI LLARY SERVICES COST	0	0	0	0	0	52.01
2. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	52.02
0.00	06000 CLINIC	0	0	0	0	0	60. OC
	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
	06200 FQHC		-	_	-	-	62.00
3.00	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	r					
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	66, 288	66, 288		66, 288	
	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0	0	0	0	73.00 74.00
4.00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	/ 4.00
0. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80.00
1.00	08100 INTEREST EXPENSE		0	0	0	0	81.00
	08200 UTILIZATION REVIEW - SNF	0	0	0	0	0	82.00
3.00	08300 HOSPI CE	0	0	0	0	0	83.00
	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
4.01 9.00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	8, 903, 870	0 9, 463, 495	0 18, 367, 365	0	0 18, 367, 365	84.01 89.00
9.00	NONREI MBURSABLE COST CENTERS	0,903,070	7,403,473	10, 307, 303	0	10, 307, 303	07.00
0. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	9, 012	9, 012	0	9, 012	90.00
	09100 BARBER AND BEAUTY SHOP	0	4, 925	4, 925	0	4, 925	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
2.00			-			-	0.000
3.00	09300 NONPAID WORKERS	0	0	0	0	0	
3.00 4.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
3.00 4.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0 0 0 8, 903, 870	0 0 0 9, 477, 432	0 0 0 18, 381, 302	0	-	94.00 95.00

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	CARE ONE AT		No . 015150	In Lie Period:	u of Form CN Worksheet A	
RECLAS	STFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	PI OVI dei	No.: 315152	From 01/01/2023		
					To 12/31/2023	Date/Time F 5/10/2024 1	⁷ repared: 11:56 am
	Cost Center Description	Adjustments to	Net Expenses For Allocation				
		Wkst A-8)	(col. 5 +-				
			col. 6)	-			
	GENERAL SERVICE COST CENTERS	6.00	7.00				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	199, 078	2, 113, 056				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0		1			2.00
3.00	00300 EMPLOYEE BENEFITS	0	2,050,696	1			3.00
4.00 5.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	-744, 523	2, 736, 451 770, 289	1			4.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	156, 061	1			6.00
7.00	00700 HOUSEKEEPI NG	0	466, 670	1			7.00
8.00	00800 DI ETARY	-60					8.00
9.00 10.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	-2, 554					9.00
	01100 PHARMACY	-2,080	235, 412 23, 925	1			11.00
	01200 MEDICAL RECORDS & LIBRARY	0	73, 318	1			12.00
	01300 SOCIAL SERVICE	0	177, 913	1			13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1			14.00
15.00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0	172, 815				15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	- 39, 687	4, 220, 278	8			30.00
31.00	03100 NURSING FACILITY	0	C	1			31.00
	03200 CF/I D	0		1			32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C				33.00
40, 00	04000 RADI OLOGY	0	63, 317	/			40.00
41.00	04100 LABORATORY	0	62, 488	1			41.00
42.00	04200 I NTRAVENOUS THERAPY	-12, 041	138, 466				42.00
	04300 OXYGEN (INHALATION) THERAPY	0	C				43.00
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	772, 021 655, 795	1			44.00 45.00
	04600 SPEECH PATHOLOGY	0	81,009	1			46.00
	04700 ELECTROCARDI OLOGY	0	C	1			47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	422	1			48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	-36, 370	418, 261	1			49.00 50.00
	05100 SUPPORT SURFACES	0	1, 869				51.00
52.00	05200 COMPLEX MEDICAL EQUI PMENT	0	C	1			52.00
	05201 OTHER ANCI LLARY SERVICES COST	0		1			52.01
52.02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	C				52.02
60.00	06000 CLINIC	0	C				60.00
61.00	06100 RURAL HEALTH CLINIC	0	C	•			61.00
	06200 FQHC						62.00
63.00	06300 DIALYSIS	0	C				63.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	C				70.00
	07100 AMBULANCE	0					71.00
	07300 СМНС	0					73.00
74.00	07400 OTHER REIMBURSEMENT	0	C				74.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	C				80, 00
	08100 I NTEREST EXPENSE	0					81.00
	08200 UTILIZATION REVIEW - SNF	0	C				82.00
	08300 HOSPI CE	0	C				83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0					84.00 84.01
84. 01 89. 00	SUBTOTALS (sum of lines 1-84)	-638, 237	17, 729, 128				84.01
	NONREI MBURSABLE COST CENTERS			I			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	9, 012	1			90.00
	09100 BARBER AND BEAUTY SHOP	0	4, 925	1			91.00
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS			1			92.00 93.00
	09400 PATIENTS LAUNDRY	0		1			94.00
	09500 OTHER NONREI MBURSABLE COST	0	C				95.00
100.00	TOTAL	-638, 237	17, 743, 065				100.00

Health Financial Systems	CARE ONE AT WELLI	NGTON		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			Increases			
	Cost Center	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 PATIENTS	ARGED TO	48.0	0 0	422	1.00
(1) C - RECLASS SUPPORT SURFACES						1
2.00	SUPPORT SURFACES		51. (0 0	1, 586	2.00
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	2, 008	100.00
	of columns 4 and 5					
	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 WELL	NGTON		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 56 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	0 0	422	1.00
(1) C - RECLASS SUPPORT SURFACES						
2.00	CAP REL COSTS - MOV	ABLE	2.0	0 0	1, 586	2.00
	EQUI PMENT					
TOTALS						
100.00				0	2, 008	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.

Systems	CARE ONE AT				u of Form CMS-2	2540-10
OF CAPITAL COSTS CENTERS		Provi der	No.: 315152	Period: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 56 am
			Acqui si ti ons	S		
cription	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
	1.00	2.00	3.00	4.00	5.00	
OF CHANGES IN CAPITAL ASSET BAL	ANCES		1			
	0	0		0 0	0	1.00
ovements	0	0		0 0	0	2.00
and Fixtures	0	0		0 0	0	3.00
Improvements	0	0		0 0	0	4.00
ipment	0	0		0 0	0	5.00
quipment	0	0		0 0	0	6.00
(sum of lines 1-6)	0	0		0 0	0	7.00
ng Items	0	0		0 0	0	8.00
ne 7 minus line 8)	0	0		0 0	0	9.00
cription	Endi ng Bal ance					
		Depreciated				
	6,00	Assets 7.00				
OF CHANGES IN CAPITAL ASSET BAL		7.00				
I CHANGES THE CALLTAE ASSET DAE		0				1.00
ovements	0	0				2.00
and Fixtures	0	0				3.00
Improvements	0	0				4.00
i pment	0	0				5.00
quipment	0	0				6.00
(sum of lines 1-6)	0	0				7.00
ng Items	0	0				8.00
ne 7 minus line 8)	0	0				9.00
quip (sum ng l	ment oflines 1-6) tems	ment 0 oflines 1-6) 0 tems 0	ment 0 0 of lines 1-6) 0 0 tems 0 0	ment 0 0 of lines 1-6) 0 0 tems 0 0	ment 0 0 of lines 1-6) 0 0 tems 0 0	ment 0 0 of lines 1-6) 0 0 tems 0 0

	Financial Systems MENTS TO EXPENSES	CARE ONE AT WI		No.: 315152	Period:	u of Form CMS-2 Worksheet A-8	
12021	MENTS TO EXPENSES		Provider	NO.: 315152	From 01/01/2023	worksneet A-8	
					To 12/31/2023		
				Expense C	lassification on	<u>5/10/2024 11:</u> Worksheet A	
					ch the Amount is		
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Ádjustment					
		1.00	2.00		3.00	4.00	
00	Investment income on restricted funds (chapter 2)	В	-4,308	CAP REL COST FIXTURES	S - BLDGS &	1.00	1
00	Trade, quantity, and time discounts (chapter		C			0.00	2
	8)						
00	Refunds and rebates of expenses (chapter 8)		C			0.00	
00	Rental of provider space by suppliers		C			0.00	4.
00	(chapter 8) Telephone services (pay stations excluded)		C			0.00	5
	(chapter 21)		U			0.00	
00	Television and radio service (chapter 21)		0			0.00	
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based physician adjustment	A-8-2	C				8
00	Home office cost (chapter 21)		C			0.00	9
00	Sale of scrap, waste, etc. (chapter 23)		C)		0.00	10
00	Nonallowable costs related to certain		C)		0.00	11
. 00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	265, 995				12
. 00	related organizations (chapter 10)	A-0-1	200, 990				12
. 00	Laundry and Linen service		C			0.00	13
. 00	Revenue - Employee meals		C			0.00	14
. 00	Cost of meals - Guests	В		DI ETARY		8.00	
00	Sale of medical supplies to other than patients		C			0.00	16
. 00	Sale of drugs to other than patients		C			0.00	17
00	Sale of medical records and abstracts		0			0.00	
00	Vending machines		C			0.00	
. 00	Income from imposition of interest, finance		C			0.00	20
. 00	or penalty charges (chapter 21) Interest expense on Medicare overpayments		C			0.00	21
. 00	and borrowings to repay Medicare		0			0.00	2
	overpayments						
. 00	Utilization reviewphysicians' compensation		C	UTI LI ZATI ON	REVIEW - SNF	82.00	22
. 00	(chapter 21) Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	22
. 00	beprecration-burrarings and frixtures		0	FIXTURES	5 - DED05 &	1.00	23
. 00	Depreciationmovable equipment		C	CAP REL COST	S – MOVABLE	2.00	24
				EQUI PMENT			
	RESIDENT REPLACEMENT I TEMS	A		ADMI NI STRATI ADMI NI STRATI		4.00	
01	MARKETING EXPENSE MARKETING CORP EXPENSE	A		ADMI NI STRATI		4.00 4.00	
03	MARKETING - MEALS	A		ADMI NI STRATI		4.00	
04	SPONSORSHI PS	A		ADMI NI STRATI		4.00	
05	OTHER DONATIONS	A		ADMI NI STRATI		4.00	
06	BAD DEBT EXPENSE	A		ADMI NI STRATI		4.00	
. 07 . 08	BAD DEBT EXPENSE - MEDICARE OTHER MEDICAL SERVICES EXPENSE	A A		ADMI NI STRATI SKI LLED NURS		4.00 30.00	
. 08	RESIDENT PERSONAL ITEMS	B		ADMI NI STRATI		4.00	
. 10	OTHER REVENUE	B		ADMI NI STRATI		4.00	
. 11	OTHER INCOME	В		ADMI NI STRATI		4.00	25
~ ~~	Total (sum of lines 1 through 99) (Transfer		-638, 237	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 MENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	CARE ONE AT W ATIONS AND HOME		No.: 315152	Peri od:	of Form CMS- Worksheet A-8	
FFICE	E COSTS					Parts I-II	
						Date/Time Pre 5/10/2024 11:	
		Line No.	Cost (Center	Expense		
		1.00		00	3.0		1
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	OR	
	CLAIMED HOME OFFICE COSTS:	1.000					
. 00			CAP REL COSTS	- BLDGS &	RENT - RELATED I	PARTY	1.00
. 00			ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES		2.00
. 00			NURSING ADMINI		PHARMACY CONSUL	TANT	3.00
. 00		10.000	CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPE	NSE	4.00
. 00		11.00F	PHARMACY		DRUGS-NON-PRESCI	RI PTI ON,	5.00
					NON-LEGEND		
. 00			PHARMACY		PHARMACY SUPPLI	ES	6.00
7.00 8.00			NTRAVENOUS TH		I V EXPENSE DRUGS-PRESCRI PT		7.00
. 00		49.00L	KUUS CHARGED	IU FAILLIIS	DRUGS OTH	ION, LEGEND	0.00
. 00		49. OOE	DRUGS CHARGED	TO PATI ENTS	DRUGS-PRESCRI PT	ION, LEGEND	9.00
					DRUGS MAN		
0. 01		49. OOE	ORUGS CHARGED	TO PATI ENTS	DRUGS-PRESCRI PT	I ON, MEDI CARE	9.0
		0.00			A		
9. 02 9. 03		0. 00 0. 00					9.02
0.00	TOTALS (sum of lines 1-9). Transfer column	0.00					10.00
0.00	6, line 100 to Worksheet A-8, column 3, line						10.00
	12.						
		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 REQUIR				ED ORGANI ZATI ONS	OR	
	CLAIMED HOME OFFICE COSTS:			i			
. 00		1, 882, 560	1, 679, 174				1.00
		976, 687	861, 033				2.00
		00 075	04 000				3.0
. 00		29, 375	31, 929				
. 00		56, 955	56, 955		0		
. 00 . 00 . 00		56, 955 22, 659	56, 955 24, 629	-1, 97	0 70		5.0
. 00 . 00 . 00 . 00		56, 955	56, 955	-1, 97 -11	0 70 10		5. 0 6. 0
. 00 . 00 . 00 . 00 . 00		56, 955 22, 659 1, 266	56, 955 24, 629 1, 376	-1, 97 -11 -12, 04	0 70 10 11		5.0 6.0 7.0
2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 7. 00 8. 00 9. 00		56, 955 22, 659 1, 266 138, 466 37, 070 177, 795	56, 955 24, 629 1, 376 150, 507	-1, 97 -11 -12, 04 -3, 22 -15, 46	0 70 10 11 23 50		5.00 6.00 7.00 8.00 9.00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00		56, 955 22, 659 1, 266 138, 466 37, 070 177, 795 203, 396	56, 955 24, 629 1, 376 150, 507 40, 293 193, 255 221, 083	-1,97 -11 -12,04 -3,22 -15,46 -17,68	0 70 10 11 23 30 87		5. 00 6. 00 7. 00 8. 00 9. 00 9. 00
 . 00 . 01 . 02 		56, 955 22, 659 1, 266 138, 466 37, 070 177, 795	56, 955 24, 629 1, 376 150, 507 40, 293 193, 255	-1,97 -11 -12,04 -3,22 -15,46 -17,68	0 70 10 11 23 50		5.00 6.00 7.00 8.00 9.00 9.00
3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 9. 01 9. 02 9. 03	TOTALS (our of lines 1.0) Transfer estimat	56, 955 22, 659 1, 266 138, 466 37, 070 177, 795 203, 396 0 0	56, 955 24, 629 1, 376 150, 507 40, 293 193, 255 221, 083 0 0	-1,97 -11 -12,04 -3,22 -15,46 -17,68	0 70 10 11 23 50 37 0 0		4.00 5.00 6.00 7.00 8.00 9.00 9.00 9.02 9.02
 . 00 . 01 . 02 	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	56, 955 22, 659 1, 266 138, 466 37, 070 177, 795 203, 396	56, 955 24, 629 1, 376 150, 507 40, 293 193, 255 221, 083	-1,97 -11 -12,04 -3,22 -15,46 -17,68	0 70 10 11 23 50 37 0 0		5.00 6.00 7.00 8.00 9.00 9.01

Health Financial Systems	CARE ONE AT W	ELLI NGTON	In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Provi der No. : 315152	From 01/01/2023	Worksheet A-8 Parts I-II Date/Time Prep 5/10/2024 11:	bared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00	A	DANI EL STRAUS	41.00	1.00
2.00	A	MOSHAEL STRAUS	5.00	2.00
3.00	A	DES 2009 GST TRUST	9.00	3.00
4.00	А	BETHLA STRAUS	2.00	4.00
5.00	А	JOEL JAFFE FAMILY TRUST	0.00	5.00
6.00	А	DES HOLDING CO. INC. & DES	43.00	6.00
		2009 FAM		
7.00	А	DANI EL STRAUS	41.00	7.00
8.00	А	DANI EL STRAUS	41.00	8.00
9.00	А	DES HOLDING CO. INC.	22.00	9.00
10.00	F	PARTNERS PHARMACY SERVICES	0.00	10.00
		LLC		
100.00 G. Other (financial or non-financi	al)		0.00	100.00
speci fy:				

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

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

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

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

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

Director, officer, administrator, or key person of related organization or relative of such person has financial 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		301 UNION STREET LLC	41.00	REALTY	1.00
2.00		301 UNION STREET LLC	5.00	REALTY	2.00
3.00		301 UNION STREET LLC	9.00	REALTY	3.00
4.00		301 UNION STREET LLC	2.00	REALTY	4.00
5.00		301 UNION STREET LLC	0.00	REALTY	5.00
6.00		301 UNION STREET LLC	43.00	REALTY	6.00
7.00		HEALTHBRIDGE MANAGEMENT LLC	100.00	MANAGEMENT	7.00
8.00		TOTALCARE LLC	99.00	WOUND CARE	8.00
9.00		TOTALCARE LLC	1.00	WOUND CARE	9.00
10.00		PARTNERS PHARMACY LLC	100.00	PHARMACY	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.

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

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

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

Heal th	Financial Systems	CARE ONE AT N	VELLI NGTON		In Lie	u of Form CMS-2	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2023	Worksheet B Part I	
				Т	0 12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		for Cost Allocation	FI XTURES	EQUI PMENT	BENEFI TS		
		(from Wkst A					
		col. 7) 0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	2, 113, 056 61, 269	2, 113, 056	61, 269			1.00 2.00
3.00	00300 EMPLOYEE BENEFITS	2, 050, 696	0	01, 209			3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	2, 736, 451	166, 392	4, 825		3, 074, 763	4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	770, 289 156, 061	63, 744 45, 465	1, 848 1, 318		859, 507 216, 263	5.00 6.00
7.00	00700 HOUSEKEEPING	466, 670	9, 843	285		565, 825	7.00
8.00	00800 DI ETARY	1, 014, 300	141, 960	4, 116		1, 306, 405	8.00
9.00 10.00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	1, 196, 739 235, 412	15, 819 8, 788	459 255		1, 423, 615 245, 133	9.00 10.00
11.00	01100 PHARMACY	233, 412	9, 374	233		33, 571	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	73, 318	19, 217	557		109, 978	12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	177, 913 0	212, 091 0	6, 150 0		437, 130 0	13.00 14.00
15.00	01500 ACTI VI TES	172, 815	0	0		210, 840	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 0 4 4 707		0(0.07)		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	4, 220, 278 0	1, 246, 707 0	36, 149 0		6, 466, 210 0	30.00 31.00
32.00	03200 I CF/I I D	0	0	0		0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS	63, 317	0	0	0	63, 317	40.00
41.00	04100 LABORATORY	62, 488	0	0		62, 488	41.00
42.00	04200 I NTRAVENOUS THERAPY	138, 466	0	0	-	138, 466	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 772, 021	0 112, 021	0 3, 248	-	0 1, 060, 421	43.00 44.00
45.00	04500 OCCUPATI ONAL THERAPY	655, 795	39, 020	1, 131		846, 985	45.00
46.00	04600 SPEECH PATHOLOGY	81,009	2, 929	85		101, 114	46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 422	0	0	0	0 422	47.00 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	418, 261	0	0	0	418, 261	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 52.00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	1, 869 0	0	0	0	1, 869 0	51.00 52.00
52.01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52.01
52.02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52.02
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 63.00	06200 FQHC 06300 DI ALYSI S	0	0	o	0	0	62.00 63.00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	0	0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0		0	70.00
71.00 73.00	07100 AMBULANCE 07300 CMHC	66, 288	0	0		66, 288 0	71.00 73.00
74.00	07400 OTHER REIMBURSEMENT	0	0	0	-	0	74.00
	SPECIAL PURPOSE COST CENTERS	· · · ·					
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84.00 84.01
89.00	SUBTOTALS (sum of lines 1-84)	17, 729, 128	2, 093, 370	60, 698	2, 050, 696		89.00
	NONREI MBURSABLE COST CENTERS			_	_		
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	9, 012 4, 925	0 19, 686	0 571		9, 012 25, 182	90.00 91.00
92.00	09200 PHYSI CLANS PRI VATE OFFICES	4,723	0	0	0	23, 102	92.00
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0		0	0	94.00 95.00
98.00	Cross Foot Adjustments	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	99.00
100.00) TOTAL	17, 743, 065	2, 113, 056	61, 269	2, 050, 696	17, 743, 065	100.00

Heal th	Financial Systems	CARE ONE AT \	VELLI NGTON		In Lie	u of Form CMS-	2540-10
	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part I Date/Time Pre 5/10/2024 11:	pared: 56 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	т т		1			
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0.074.740					1.00 2.00 3.00
4.00 5.00 6.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	3, 074, 763 180, 170 45, 333	1, 039, 677 25, 104				4.00 5.00 6.00
7.00	00700 HOUSEKEEPI NG	118, 608	5, 435		689, 868		7.00
8.00	00800 DI ETARY	273, 849	78, 385		53, 586	1, 712, 225	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	298, 418	8, 735		5, 971	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	51, 385 7, 037	4, 853 5, 176		3, 317 3, 538	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	23, 054	10, 611		7, 254	0	12.00
	01300 SOCIAL SERVICE	91,631	117, 108		80, 058	0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	
15.00	01500 ACTI VI TES	44, 196	0	0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	1, 355, 440	688, 383		470, 593	1, 712, 225	30.00
31.00	03100 NURSING FACILITY	0	0		0	0	31.00
32.00 33.00	03200 I CF/IID 03300 OTHER LONG TERM CARE	0	0		0	0	
33.00	ANCI LLARY SERVICE COST CENTERS	0	0	<u>/</u> 0	0	0	33.00
40.00	04000 RADI OLOGY	13, 273	0	0	0	0	40.00
41.00	04100 LABORATORY	13, 099	0	0	0	0	
42.00	04200 I NTRAVENOUS THERAPY	29, 025	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	-	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	222, 285	61, 854		42, 285	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	177, 545	21, 545		14, 729	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	21, 196 0	1, 618 0		1, 106 0	0	46.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	88	0		0	0	
	04900 DRUGS CHARGED TO PATIENTS	87,676	0	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	392	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52.01	05201 OTHER ANCI LLARY SERVICES COST	0	0		0	0	52.01
52.02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	52.02
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		-	0	
62.00	06200 FQHC		-	-	-	-	62.00
63.00	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	-	0	0	
71.00	07100 AMBULANCE	13, 895	0	-	0	0	
	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0		0	0	•
74.00	SPECIAL PURPOSE COST CENTERS	0	0	γ0	0	0	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	
84.01	08401 OTHER SPECIAL PURPOSE COST II	2 047 505	1 000 007		0	1 712 225	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	3, 067, 595	1, 028, 807	286, 700	682, 437	1, 712, 225	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1, 889	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	5, 279	10, 870		7, 431	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98.00 99.00
99.00 100.00		3, 074, 763	1, 039, 677	286, 700	0 689, 868	0 1, 712, 225	
. 50. 00		1 3, 5, 1, 100	.,,,	1 200,700	007,000	., , , , , , , , , , , , , , , , , , ,	1.00.00

Environment From 10/07/2023 Part J Loss Program Environment NURSI NK DN IN STRATO DEVICe 10 PloAseACY RECORDS 4 LICENT DOI: 10.00 DO	Health Financial Systems	CARE ONE AT				u of Form CMS-	2540-10
ADMINI STRATION SERVICES & SUPPLY RECORDS & LIBRAY I 10 0010100 11.00 11.00 12.00 13.00 10 001000 ARR LOSTS - MOVALE SUPPLY LOSD & FIXTURES 10.00 11.00 12.00 13.00 10 0000 ARR LOSTS - MOVALE EQUIPRET LOSD & FIXTURE & CENERL LOSD & FIXTURE & FIXTURE & CENERL LOSD & FIXTURE	COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		From 01/01/2023	Date/Time Pre	pared: 56 am
BUREAL SERVICE COST CENTERS 10 00 00100 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL COST - SUMMARI F BULPHINT 2 00 00200 CAP REL CAP STARTION 1.736,739 00 00200 CAP REL COST - SUMMARI F BULPHINT 0 00 00200 CAP REL CAP STARTION 1.736,739 00 00200 CAP REL SERVICE 0 00 00200 CAP REL SERVICE COST CENTERS 0 00 00200 CAP REL COST CENTERS 0 00 00	Cost Center Description		SERVICES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
100 000000000000000000000000000000000000		9.00	10.00	11.00	12.00	13.00	
0.0 0.000 0.0000 PARTINE & SERVICE 9 0.0 0.0000 PARTINE & SERVICE 9 9 0.0 0.0000 PARTINE & SERVICE 9 9 0.0 0.0000 PARTINE & SERVICE 9 9 0.0 0.0000 PARTINE SERVICE 9 9 0.0 0.0000 PARTINE SERVICE 9 9 0.0 0.0000 PARTINE SERVICE 9 9 9 0.0 0.0000 PARTINE SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			1 1 00
100 DOROO ADDI MI STRATI VE & GENERAL 4.0 00 DOSCO PLAT OPERATION, MINTS. & A EPAIRS 5.0 00 DOSCO PLATANO PRATION, MINTS. & A EPAIRS 5.0 00 DOSCO PLATANO PRATION, MINTS & A TION 1.730, 739 00 DOSCO PLATANO PRATION, MINTS NATION 1.730, 739 000 DOSCO PLATANO, SERVICE S. SUPPY 0 0 49, 322 11.00 DIAGNESKE PLANO, SERVICE COST CENTRES 0 0 0 0 000 DOSCIAL SERVICE COST CENTRES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						1.00 2.00 3.00
0:00 000000 LUNREY & LUNEN SERVICE 6.00 000000 1.1 6.00 000000 1.1 0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.	4. 00 00400 ADMINI STRATI VE & GENERAL						4.00
0.00 000000 DETARY 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.0000000000000000 0.00000000000000000000000000000000000	6.00 00600 LAUNDRY & LINEN SERVICE						6.00
0.000 00000 NURSING ADMINISTRATION 1.736,739 0 0.0 0.1000 01000 CENTRAL SERVICES SUPPLY 0 0.0 0.0 0.1000 01000 CENTRAL SERVICES SUPPLY 0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0							8.00
11.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td>1, 736, 739</td> <td></td> <td></td> <td></td> <td></td> <td>9.00</td>		1, 736, 739					9.00
12.00 10200 MEDICAL RECORDS & LIBRARY 0 0 150.0 150.0 725.927 13.0 14.00 11000 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 01000 CENTRAL SERVICES & SUPPLY	0	304, 688	3			10.00
13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 <th< td=""><td></td><td>0</td><td>0</td><td>49, 32</td><td></td><td></td><td>11.00</td></th<>		0	0	49, 32			11.00
14.00 Olicolo MURSING AND ALLIED HEALTH EDUCATION O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O		0	0			725 027	12.00
15.00 0 0 0 0 0 0 0 15.00 INNATI RE SERVICE COST CENTERS		0			-		
INPATI ENT ROUTI NE SERVICE COST CENTERS Image: Center Service Cost Centers 00 03000 NURSI NG FACILITY 1,736,739 304,668 49,322 150,897 725,927 30,0 10.00 0300 NURSI NG FACILITY 1,736,739 304,668 49,322 150,897 725,927 30,0 10.00 04000 RAD 0LOGY 0 0 0 0 0 0 0 30,0 10.00 04000 RAD 0LOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		-	-	
00.00 03000 SKILLED NURSI NG FACILITY 1,736,739 304,688 49,322 150.897 725,927 30.0 20.00 33200 ICF/I ID 0 0 0 0 33.0 21.00 33200 ICF/I ID 0 0 0 0 0 33.0 21.00 33200 ICF/I ID 0 0 0 0 0 33.0 21.00 03200 ICF/I ID 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				4	<u> </u>	0	10.00
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33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 <th< td=""><td></td><td>-</td><td></td><td></td><td></td><td>-</td><td></td></th<>		-				-	
MACL LARY SERVICE COST CENTERS O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O <th< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td><td>1</td></th<>		-					1
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11.00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td>0</td> <td>0</td> <td>ป</td> <td>0 0</td> <td>0</td> <td>40.00</td>		0	0	ป	0 0	0	40.00
12:00 04200 INTRAVENUIS THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0<		1					
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15:00 04500 04500 04500 04500 05700 45.00 16:00 04600 SPECH PATHONGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td></td><td>1</td></t<>		0	C		0 0		1
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17 00 0 0700 ELECTROCARDIOLOGY 0 0 0 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>45.00</td></t<>		0	0		0 0	0	45.00
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50.00 05000 Dextral_CARE - 11 TLE_XIX_ONLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0 0		
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OUTPATIENT SERVICE COST CENTERS Image: Cost Centers 50.00 06000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td>52.01 05201 OTHER ANCILLARY SERVICES COST</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>52.01</td>	52.01 05201 OTHER ANCILLARY SERVICES COST	0	C		0 0	0	52.01
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74.00 OT400 OTHER REI MBURSEMENT O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O </td <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td>1</td>		0	C				1
SPECIAL PURPOSE COST CENTERS 30.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.0 31.00 08100 INTEREST EXPENSE 81.0 32.00 08200 UTI LIZATION REVIEW - SNF 82.0 32.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 83.0 34.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.0 34.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 84.0 39.00 SUBTOTALS (sum of lines 1-84) 1,736,739 304,688 49,322 150,897 725,927 89.0 NORREI MBURSABLE COST CENTERS 0 0 0 0 0 90.0 91.0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00 92.00 92.00 93.00 93.00 93.00 93.00 92.00 93.00 93.00 92.00 93.00 93.00 93.00 <td></td> <td>0</td> <td>0</td> <td>D</td> <td></td> <td></td> <td>1</td>		0	0	D			1
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81.00 08100 INTEREST EXPENSE 81.00 81.00 81.00 81.00 32.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 33.00 08300 HOSPICE 0 0 83.00 34.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 34.01 08401 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 39.00 SUBTOTALS (sum of lines 1-84) 1,736,739 304,688 49,322 150,897 725,927 89.00 NONREL IMBURSABLE COST CENTERS 0 0 0 0 0 90.00 91.00 94.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00 0 0 0 92.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00							00 00
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NONRE I MBURSABLE COST CENTERS 00.00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 01.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 91.00 02.00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.00 09300 NONPAID WORKERS 0 0 0 0 93.00 0 94.00 0 0 0 0 94.00 941.00 0 0 0 0 94.00 9400 PATI ENTS LAUNDRY 0 0 0 0 94.00 95.00 0 0 0 0 94.00 95.00 0 0 0 0 94.00 95.00 0 0 0 0 0 94.00 95.00 0 0 0 0 0 98.0 98.0 98.0 98.0 98.0 98.0 98.0 99.0 99.0 0		0	C		0 0		1
OPO.00 GIFT, FLOWER, COFFEE SHOPS & CANTEEN O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O		1, 736, 739	304, 688	49, 32	2 150, 897	725, 927	89.00
OP1.00 O9100 BARBER AND BEAUTY SHOP 0 0 0 0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 93.0 93.0 93.0 93.0 93.0 93.0 94.0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.					0		00.00
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	98.00 Cross Foot Adjustments	0	C				98.00
100.00 101AL 1,736,739 304,688 49,322 150,897 725,927 100.0	5	0	C		0 0		
	100. 00 TOTAL	1, 736, 739	304, 688	3 49,32	150, 897	725, 927	100.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CARE ONE AT			Period:	u of Form CMS- Worksheet B	2540-10
					rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/10/2024 11:	epared:
			OTHER GENERAL SERVI CE			371072024 11.	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION 14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	TT		1			1
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPING						7.00
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0	255, 036	1			15.00
30.00	03000 SKILLED NURSING FACILITY	0	255, 036	14, 202, 160	0 0	14, 202, 160	30.00
31.00	03100 NURSING FACILITY	0	C			0	1
32.00	03200 CF/I D	0	C			0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	() 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	76, 590) 0	76, 590	40.00
40.00 41.00	04100 LABORATORY	0	0			75, 587	
42.00	04200 I NTRAVENOUS THERAPY	0	C			167, 491	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0			0	1
44.00	04400 PHYSI CAL THERAPY	0	0	1, 386, 845	5 O	1, 386, 845	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0	.,		1, 060, 804	
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	125, 034		125, 034 0	1
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	510		510	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	505, 937		505, 937	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	2, 261		2, 261	
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0			0	
52.01	05201 OTHER ANCI LLARY SERVICES COST 05202 MEDI CAL SERVICES	0	0			0	
52.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	, 0	0	52.02
60.00	06000 CLI NI C	0	C	(0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	C	0	0 0	0	
	06200 FQHC		0			0	62.00
o3.UU	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	C	(0 0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0 0	0	70.00
	07100 AMBULANCE	0	C			80, 183	
	07300 CMHC	0	C			0	
74.00	07400 OTHER REI MBURSEMENT	0	0	(0 0	0	74.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			80.00
	08100 INTEREST EXPENSE						80.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	C	0	0 0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	(0	0	•
84.01	08401 OTHER SPECIAL PURPOSE COST II	0			0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	255, 036	17, 683, 402	2 0	17, 683, 402	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	10, 901	0	10, 901	90.00
	09100 BARBER AND BEAUTY SHOP	0	C	48, 762		48, 762	
	09200 PHYSICIANS PRIVATE OFFICES	0	C	0		0	
93.00	09300 NONPALD WORKERS	0	0	(0	0	
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0			0	
95.00 98.00	Cross Foot Adjustments	0				0	
99.00	Negative Cost Centers	0	C C		0	0	99.00
100.00		0	255, 036	17, 743, 065	5 O	17, 743, 065	100.00

	Financial Systems TION OF CAPITAL RELATED COSTS	CARE ONE AT W			Peri od:	u of Form CMS- Worksheet B	2340-10
					From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 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	
	GENERAL SERVICE COST CENTERS	T T					
1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00 9.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY		0 166, 392 63, 744 45, 465 9, 843 141, 960 15, 819 8, 788	4, 82 1, 84 1, 31 28 4, 11 45 25	8 65, 592 8 46, 783 5 10, 128 6 146, 076 9 16, 278		4.00 5.00 6.00 7.00 8.00 9.00
11.00 12.00 13.00 14.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	000000000000000000000000000000000000000	9, 374 19, 217 212, 091 0	27. 55 6, 15	2 9, 646 7 19, 774 0 218, 241 0 0		11.00 12.00 13.00 14.00
5.00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	1	0 0	C	15.00
31.00 32.00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY 03200 I CF/I I D 03300 OTHER LONG TERM CARE	0 0 0 0	1, 246, 707 0 0 0		9 1, 282, 856 0 0 0 0 0 0 0 0		31.00 32.00
	ANCI LLARY SERVI CE COST CENTERS						10.00
1.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	000000000000000000000000000000000000000	0 0 0				41.00 42.00
14.00 15.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0 112, 021 39, 020 2, 929	3, 24 1, 13 8	1 40, 151		44.00 45.00
17.00 18.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	2, 727			C	47.00 48.00
50.00 51.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0000				50.00 51.00
	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES UTDATLENT SERVICE COST CENTERS	0	0 0		0 0 0 0 0 0	0 0 0	52.01
	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0 0 0	C	
	06200 F0HC 06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	0		0 0	C	62.00 63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	C	70.00
73.00	07100 AMBULANCE 07300 CMHC 07400 OTHER REIMBURSEMENT	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	73.00
	SPECIAL PURPOSE COST CENTERS	1					
31.00 32.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						80.00 81.00 82.00
34.00 34.01	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I 08401 OTHER SPECI AL PURPOSE COST I I	0 0 0	0 0 0			0 0 0	84. 00 84. 01
39.00 90.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	2, 093, 370	60, 69	8 2, 154, 068 0 0	C	
91.00 92.00 93.00 94.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0 0 0 0	19, 686 0 0 0	57	1 20, 257 0 0 0 0 0 0 0 0	0 0 0 0	91.00 92.00 93.00 94.00
95.00 98.00 99.00 100.00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers TOTAL	0	0 0 2, 113, 056	61, 26	0 0 0 0 0 9 2, 174, 325	C	98.00

Heal th	Financial Systems	CARE ONE AT \	NELLI NGTON		In Lie	u of Form CMS-:	2540-10
	ATION OF CAPITAL RELATED COSTS				eriod: rom 01/01/2023	Worksheet B Part II	
				Ť			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	
		4.00	5.00	6.00	7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS	1 1		1			1 4 4 4
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINI STRATI VE & GENERAL	171, 217					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	10, 033	75, 625				5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	2, 524 6, 605	1, 826 395		17, 128		6.00 7.00
7.00 8.00	00800 DI ETARY	15, 250	5, 702		1, 330	168, 358	1
9.00	00900 NURSI NG ADMI NI STRATI ON	16, 618	635		148	0	1
10.00	01000 CENTRAL SERVICES & SUPPLY	2, 861	353		82	0	
11.00		392	377		88	0	
12.00 13.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	1, 284 5, 103	772 8, 518		180 1, 988	0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0, 510		0	0	1
15.00	01500 ACTI VI TES	2, 461	C	0	0	0	15.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			51.100	44.495	4 (0, 0 5 0	
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	75, 475 0	50, 072 0		11, 685 0	168, 358 0	1
31.00	03200 I CF/I I D	0	0		0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	
	ANCILLARY SERVICE COST CENTERS			1			
40.00		739	0			0	
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	729 1, 616	0		0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	-	0	0	1
44.00	04400 PHYSI CAL THERAPY	12, 378	4, 499	0	1, 050	0	1
45.00	04500 OCCUPATI ONAL THERAPY	9, 887	1, 567		366	0	
46.00		1, 180	118		27	0	
47.00 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	4, 882	C	0	0	0	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	0	0	0	
51.00	05100 SUPPORT SURFACES	22	0	0	0	0	
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0	C C		0	0	
52.01	05201 OTHER ANOTELART SERVICES COST	0	0		0	0	1
	OUTPATIENT SERVICE COST CENTERS		-				
60.00		0	C				
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	C	0	0	0	61.00 62.00
	06300 DI ALYSI S	0	C	0	0	0	1
00.00	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	C	-	0	0	
71.00 73.00	07100 AMBULANCE	774	0		0	0	1
	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0		0	0	1
7 1. 00	SPECIAL PURPOSE COST CENTERS			- <u> </u>		0	/ 1. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00							81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF		0		0	0	82.00
83.00 84.00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	
84.01	08401 OTHER SPECIAL PURPOSE COST II	0	C	0	0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	170, 818	74, 834	51, 133	16, 944	168, 358	89.00
00.00	NONREI MBURSABLE COST CENTERS	40-	~				00.00
90.00 91.00		105 294	0 791		0 184	0	
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	294	191		184	0	1
93.00		0	0	0	0	0	1
94.00	09400 PATIENTS LAUNDRY	0	C	0	0	0	
95.00	09500 OTHER NONREI MBURSABLE COST	0	0	0	0	0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0	0		0	0	
100.00		171, 217	75, 625	51, 133	17, 128		
							•

	Financial Systems	CARE ONE AT N	VELLI NGTON		In Lie	u of Form CMS-	2540-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/10/2024 11:	
	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	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	33, 679 0	12, 339				8.00 9.00 10.00
11.00 12.00	01100 PHARMACY	0	0	10, 50			11.00
12.00 13.00 14.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0 22,010 0 0 0 0	233, 850 0	1
15.00	01500 ACTI VI TES	0	0		0 0	0	15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	33, 679	12, 339	10, 50	3 22,010	233, 850	30.00
31.00	03100 NURSING FACILITY	0	12, 337		0 0	233, 830	
32.00 33.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0			0	1
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	1	5 0	0	33.00
40.00	04000 RADI OLOGY	0	C		0 0	0	1
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0			0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	
44.00	04400 PHYSI CAL THERAPY	0	0		0 0	0	
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0			0	
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0			0	
51.00	05100 SUPPORT SURFACES	0	C		0 0	0	
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0			0	
52. 01 52. 02	05201 OTHER ANCI LLARY SERVICES COST 05202 MEDI CAL SERVICES	0	0			0	
	OUTPATIENT SERVICE COST CENTERS			1			
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0			0	
62.00	06200 FQHC	0	0		5 0	0	62.00
63.00	06300 DI ALYSI S	0	0		0 0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	C		0 0	0	70.00
71.00	07100 AMBULANCE	0	C	1	0 0	0	1
73.00		0	0			0	1
74.00	07400 OTHER REI MBURSEMENT SPECI AL PURPOSE COST CENTERS	0		1	J U	0	74.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 82.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF						81.00 82.00
82.00	08300 HOSPICE	0	C		o o	0	1
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0		0 0	0	84.00
84.01 89.00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0	12 220		0 0	0 233, 850	1
07.00	NONREIMBURSABLE COST CENTERS	33, 679	12, 339	10, 50	3 22,010	233, 850	_ 07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0			0	
92.00 93.00	09300 NONPAID WORKERS	0	0			0	1
94.00	09400 PATIENTS LAUNDRY	0	C		0 0	0	
95.00 98.00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0		0	0	95.00 98.00
98.00 99.00	Negative Cost Centers	0	C		0 0	0	1
100.00	DITOTAL	33, 679	12, 339	10, 50	3 22, 010	233, 850	100.00

	Financial Systems TION OF CAPITAL RELATED COSTS	CARE ONE AT N		1	Period: From 01/01/2023	u of Form CMS-: Worksheet B Part II	
				-	Го 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 56 am
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	1		1			
	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						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	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0.444				14.00
15.00	01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 461	l			15.00
31. 00 32. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0	2, 461 0 0 0		1 0 0 0 0 0 0 0 0 0	1, 954, 421 0 0 0	32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	ol	0	739		720	40.00
41. 00 42. 00 43. 00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY				0 0 5 0 0 0 5 0 5 0 1 0	739 729 1, 616 0 133, 196 51, 971 4, 339	41.00 42.00 43.00 44.00 45.00
50.00 51.00 52.00 52.01	04700 ELECTROCARDI OLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST			4, 88 (22	0 0 2 0 0 0 0 0	0 5 4, 882 0 22 0 0 0	48.00 49.00 50.00 51.00 52.00 52.01
52. UZ	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	C	<u>ı</u> (0 0	0	52.02
61. 00 62. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC 06300 DIALYSIS 0THER REIMBURSABLE COST CENTERS	000000000000000000000000000000000000000	C C C			0	•
71.00 73.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC 07400 OTHER REIMBURSEMENT	0 0 0	0 0 0	774		0 774 0 0	71.00 73.00
80.00 81.00 82.00 83.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	000000000000000000000000000000000000000	0 0 0 2, 461			0 0 2, 152, 694	80.00 81.00 82.00 83.00 84.00 84.01
91.00 92.00 93.00 94.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREI MBURSABLE COST Cross Foot Adjustments Negative Cost Centers TOTAL		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102 21, 520 (((((((((((((((((((5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	105 21, 526 0 0 0 0 0 0 2, 174, 325	91.00 92.00 93.00 94.00 95.00 98.00 99.00

UST AL	Financial Systems LLOCATION - STATISTICAL BASIS		WELLI NGTON Provi der		Period: From 01/01/2023	eu of Form CMS-2 Worksheet B-1	
					o 12/31/2023	Date/Time Pre 5/10/2024 11:	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDGS & FI XTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
		1.00	2.00	SALARIES) 3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	T		1			
. 00 . 00 . 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	36, 066 0 2, 840 1, 088	36, 066 0 2, 840 1, 088	8, 903, 870 725, 505	-3, 074, 763	14, 668, 302 859, 507	1.0 2.0 3.0 4.0 5.0
. 00 . 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	776 168 2, 423 270	776 168 2, 423 270	386, 545 634, 042	5 O 2 O	216, 263 565, 825 1, 306, 405 1, 423, 615	7.0 8.0
1.00 2.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	150 160 328 3, 620	150 160 328 3, 620	73, 318	0 3 0	245, 133 33, 571 109, 978 437, 130	11. 0 12. 0
5.00	01400 01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0 0 21, 279	000	(165, 101	0 0	0 210, 840	14.0 15.0
1.00 2.00 3.00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	21, 279 0 0		0 0 0 0	6, 466, 210 0 0	31. 0 32. 0
0. 00	ANCI LLARY SERVICE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0			63, 317 62, 488 138, 466	41.0
3.00 4.00 5.00	04300 0XYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0 1, 912 666	0 1, 912 666	655, 795	5 O	1, 060, 421 846, 985	43.0 44.0
7.00 8.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS	50 0 0 0	50 0 0 0	74, 209 () ()		101, 114 0 422 418, 261	47.0 48.0
1. 00 2. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	000000000000000000000000000000000000000	0 0 0			0 1, 869 0 0	52.0
2. 02	05202 MEDI CAL SERVI CES	0	0	c c	0	0	
0. 00 1. 00	OUTPATI ENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	0	0				
	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	0	(C	0 0	0	63. C
0. 00 1. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0 0 0		0 0	0 66, 288 0	71.0
80. 00	07400 OTHER REI MBURSEMENT SPECIAL PURPOSE COST CENTERS 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	0) o	0	74.0 80.0
2.00 3.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST I	0	0			0	
4. 01 9. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0 35, 730	0 35, 730	8, 903, 870	0 -3, 074, 763	0 14, 634, 108	84.0
1.00 2.00 3.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 00400 BATLENTS LAUNDRY	0 336 0 0	0 336 0 0			9, 012 25, 182 0 0	91.0 92.0 93.0
95.00 98.00 99.00	09400 PATIENTS LAUNDRY 09500 OTHER NONRELMBURSABLE COST Cross Foot Adjustments Negative Cost Centers	0	0			000000000000000000000000000000000000000	95. C 98. C 99. C
02.00 03.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	2, 113, 056 58. 588588				3, 074, 763 0. 209620	

Health Financial Systems	CARE ONE AT	WELLI NGTON		In Lie	eu of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023	Worksheet B-1	
				To 12/31/2023		
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDGS & FLXTURES	MOVABLE FOULPMENT	EMPLOYEE BENEFITS	Reconci I i ati on	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. 011673	105.00

ST AI	LLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2023		
				T	0 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG		NURSI NG	
		OPERATION, MAINT. &	LINEN SERVICE (PATIENT DAYS)	· · · · · · · · · · · · · · · · · · ·	(MEALS SERVED)		
		REPAI RS				(PATIENT DAYS)	
		(SQUARE FEET)					
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
	00100 CAP REL COSTS - BLDGS & FIXTURES						1 1.
	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.
	00300 EMPLOYEE BENEFITS						3.
	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	32, 138					4.
	00600 LAUNDRY & LINEN SERVICE	776					6.
	00700 HOUSEKEEPI NG	168					7.
	00800 DI ETARY	2, 423		2, 423			8.
	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	270		270 150		34, 210 0	
	01100 PHARMACY	160		160		0	
	01200 MEDI CAL RECORDS & LI BRARY	328		328		0	
	01300 SOCIAL SERVICE	3, 620		3, 620		0	
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES			0		0	
	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	0	0	0	1 15.
	03000 SKILLED NURSING FACILITY	21, 279	34, 210	21, 279	102, 630	34, 210	30.
	03100 NURSING FACILITY	C			-		
	03200 I CF/I I D 03300 OTHER LONG TERM CARE						
	ANCI LLARY SERVICE COST CENTERS		<u> </u>	0	0	0	53.
	04000 RADI OLOGY	0	0 0	0	0	0	40.
	04100 LABORATORY	C	-	0	-	-	
	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY		-	0	0	0	
	04400 PHYSI CAL THERAPY	1, 912		1, 912	-		
	04500 OCCUPATI ONAL THERAPY	666		666		0	
	04600 SPEECH PATHOLOGY	50		50		0	
	04700 ELECTROCARDI OLOGY		-	0	0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS				0		
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	Ő	0	0	
	05100 SUPPORT SURFACES	C	0	0	0	0	
	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST			0	0	0	
	05202 MEDICAL SERVICES		-	0	-	-	
	OUTPATIENT SERVICE COST CENTERS	-	-	-			
	06000 CLI NI C	C				0	
	06100 RURAL HEALTH CLINIC 06200 FOHC	C	0	0	0	0	
	06300 DI ALYSI S		0	0	0	o	62. 63.
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	C					
	07100 AMBULANCE	0	-				
	07300 CMHC 07400 OTHER REIMBURSEMENT			0	-	-	
	SPECIAL PURPOSE COST CENTERS	~		,		~	1
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.
	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.
	08200 HOSPICE		0	0	0	0	82.
	08400 OTHER SPECIAL PURPOSE COST I		0	0	0	0	
	08401 OTHER SPECIAL PURPOSE COST II	C	0	0	0	0	
00	SUBTOTALS (sum of lines 1-84)	31, 802	2 34, 210	30, 858	102, 630	34, 210	89
	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C) 0	0	0	0	90
	09100 BARBER AND BEAUTY SHOP	336	-	-	-	0	
00	09200 PHYSICIANS PRIVATE OFFICES	C		0	0	0	92
	09300 NONPALD WORKERS		0	0	0	0	
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST			0	0	0	
00	Cross Foot Adjustments		, U		0		95
00	Negative Cost Centers						99
2. 00	Cost to be allocated (per Wkst. B,	1, 039, 677	286, 700	689, 868	1, 712, 225	1, 736, 739	102
3. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	32. 350395	8. 380590	22. 115407	16. 683475	50. 766998	103
3.00 4.00	Cost to be allocated (per Wkst. B,	75, 625					
	Part II)	, 0, 020	.,				
	Unit cost multiplier (Wkst. B, Part	2. 353133	1. 494680	0. 549080	1.640437	0. 984478	1

ST A	Financial Systems LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NURSING AND	50 2
		SERVICES & SUPPLY	(PATIENT DAYS)	RECORDS & LI BRARY	(DATIENT DAVE)	ALLIED HEALTH EDUCATION	
		(PATIENT DAYS)		(PATIENT DAYS)	(PATIENT DAYS)	(ASSI GNED	
						TIME)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1	1	1	1		1
	00200 CAP REL COSTS - BEDGS & FIXTURES						1
	00300 EMPLOYEE BENEFITS						3
	00400 ADMINISTRATIVE & GENERAL						4
	00500 PLANT OPERATION, MAINT. & REPAIRS						5
	00600 LAUNDRY & LINEN SERVICE						6
	00700 HOUSEKEEPI NG 00800 DI ETARY						7
	00900 NURSI NG ADMI NI STRATI ON						9
	01000 CENTRAL SERVICES & SUPPLY	34, 210					10
	01100 PHARMACY	0	34, 210				11
	01200 MEDI CAL RECORDS & LI BRARY	(0	01/210			12
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION					0	13
-	01500 ACTIVITES		-		-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		,		<u>, </u>		
	03000 SKILLED NURSING FACILITY	34, 210	34, 210	34, 210	34, 210	0	30
	03100 NURSING FACILITY	0	-		-	0	31
	03200 ICF/IID 03300 OTHER LONG TERM CARE		-			0	32
	ANCILLARY SERVICE COST CENTERS	(<u>y</u> (0	33
	04000 RADI OLOGY	(0	0	40
00	04100 LABORATORY	0		c c	0 0	0	41
	04200 I NTRAVENOUS THERAPY	(C	Ű	0	42
	04300 OXYGEN (INHALATION) THERAPY				0	0	43
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY					0	44
	04600 SPEECH PATHOLOGY					0	46
00	04700 ELECTROCARDI OLOGY	0		C	0 0	0	47
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 0	C	0 0	0	48
	04900 DRUGS CHARGED TO PATIENTS	0		0	0	0	49
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES					0	50 51
	05200 COMPLEX MEDICAL EQUI PMENT					0	52
	05201 OTHER ANCILLARY SERVICES COST	0		C	0 0	0	52
	05202 MEDI CAL SERVI CES	(0 0	0	0 0	0	52
	OUTPATIENT SERVICE COST CENTERS					0	1
	06100 RURAL HEALTH CLINIC					0	60
	06200 FQHC				, O	0	62
	06300 DI ALYSI S	(0 0	0	0 0	0	
	OTHER REIMBURSABLE COST CENTERS			1			
	07000 HOME HEALTH AGENCY COST	0				0	70
	07100 AMBULANCE 07300 CMHC		°		-	0	7
	07400 OTHER REIMBURSEMENT		-		-	0	74
	SPECIAL PURPOSE COST CENTERS		-	-			
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80
	08100 INTEREST EXPENSE						81
	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE					0	82
	08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST I					0	84
	08401 OTHER SPECIAL PURPOSE COST II	0			Ó	0	84
00	SUBTOTALS (sum of lines 1-84)	34, 210	34, 210	34, 210	34, 210	0	89
	NONREI MBURSABLE COST CENTERS		T		1		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	-			0	90
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES					0	91 92
	09300 NONPALD WORKERS	((0	93
	09400 PATIENTS LAUNDRY	0		C	0 0	0	94
	09500 OTHER NONREI MBURSABLE COST	0) c	0 0	0	95
00	Cross Foot Adjustments						98
00	Negative Cost Centers	204 400	40.000	150.005			99
2.00	Cost to be allocated (per Wkst. B, Part I)	304, 688	49, 322	150, 897	725, 927	0	102
3. 00		8. 906402	1. 441742	4. 410903	21. 219731	0.000000	103
4.00		12, 339					104
	Part II)						
5.00	-	0. 360684	0. 307015	0. 643379	6. 835721	0.000000	

COSTA	Financial Systems LLOCATION - STATISTICAL BASIS		LINGTON Provider No.: 315152	Period: From 01/01/2023	u of Form CMS-2540-10 Worksheet B-1
				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:56 am
	Cost Center Description	OTHER GENERAL SERVI CE ACTI VI TES (PATI ENT DAYS) 15.00			
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
1.00 2.00	00200 CAP REL COSTS - BEDGS & FIXTORES				1.00
3.00	00300 EMPLOYEE BENEFITS				3.00
4.00	00400 ADMINISTRATIVE & GENERAL				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING				6.00 7.00
8.00	00800 DI ETARY				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON				9.00
10.00	01000 CENTRAL SERVICES & SUPPLY				10.00
	01100 PHARMACY				11.00
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE				12.00 13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION				14.00
	01500 ACTI VI TES	34, 210			15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 SKI LLED NURSI NG FACI LI TY	34, 210			30.00
	03100 NURSING FACILITY 03200 ICF/IID	0			31.00 32.00
	03300 OTHER LONG TERM CARE	0			33.00
00.00	ANCI LLARY SERVICE COST CENTERS				
	04000 RADI OLOGY	0			40.00
	04100 LABORATORY	0			41.00
	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0			42.00 43.00
	04400 PHYSI CAL THERAPY	0			43.00
	04500 OCCUPATI ONAL THERAPY	0			45.00
	04600 SPEECH PATHOLOGY	0			46.00
	04700 ELECTROCARDI OLOGY	0			47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			48.00 49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
51.00	05100 SUPPORT SURFACES	0			51.00
	05200 COMPLEX MEDICAL EQUI PMENT	0			52.00
	05201 OTHER ANCI LLARY SERVICES COST 05202 MEDI CAL SERVICES	0			52. 01 52. 02
52.02	OUTPATIENT SERVICE COST CENTERS	0			
	06000 CLI NI C	0			60.00
	06100 RURAL HEALTH CLINIC	0			61.00
	06200 FQHC 06300 DI ALYSI S	0			62.00 63.00
03.00	OTHER REIMBURSABLE COST CENTERS	0			03.00
	07000 HOME HEALTH AGENCY COST	0			70.00
	07100 AMBULANCE	0			71.00
	07300 CMHC 07400 OTHER REIMBURSEMENT	0			73.00 74.00
/ 1. 00	SPECIAL PURPOSE COST CENTERS				
	08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
	08100 INTEREST EXPENSE				81.00
	08200 UTI LI ZATI ON REVI EW – SNF 08300 HOSPI CE	0			82.00 83.00
	08400 OTHER SPECIAL PURPOSE COST I	0			84.00
	08401 OTHER SPECIAL PURPOSE COST II	0			84. 01
89.00	SUBTOTALS (sum of lines 1-84)	34, 210			89.00
	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.00
	09000 BARBER AND BEAUTY SHOP	0			90.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0			92.00
	09300 NONPAID WORKERS	0			93.00
	09400 PATIENTS LAUNDRY	0			94.00 95.00
95.00 98.00	09500 OTHER NONREI MBURSABLE COST Cross Foot Adjustments				95.00
99.00 99.00	Negative Cost Centers				99.00
102.00	Cost to be allocated (per Wkst. B,	255, 036			102.00
100.00	Part I)	7 455040			100.00
103.00 104.00		7. 455013 2, 461			103.00 104.00
104.00	Part II)	2,401			104.00
	Unit cost multiplier (Wkst. B, Part	0.071938			105.00

Health Financial Systems	CARE ONE AT WELLI	NGTON		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT	COST CENTERS	Provi der	No.: 315152	Period:	Worksheet C	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod
				10 12/31/2023	5/10/2024 11:	
Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
			Wkst. B, Pt I	,	divided by	
			col. 18)		col. 2	
			1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS						
40. 00 04000 RADI OLOGY			76, 59			
41.00 04100 LABORATORY			75, 58			
42.00 04200 I NTRAVENOUS THERAPY			167, 49	-		
43. 00 04300 OXYGEN (INHALATION) THERAPY			1	0 0		
44.00 04400 PHYSI CAL THERAPY			1, 386, 84			
45. 00 04500 OCCUPATI ONAL THERAPY			1, 060, 80			
46. 00 04600 SPEECH PATHOLOGY			125, 03	4 398, 754		
47.00 04700 ELECTROCARDI OLOGY				0 0	0.000000	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			51			•
49.00 04900 DRUGS CHARGED TO PATIENTS			505, 93	1, 136, 577		•
50. 00 05000 DENTAL CARE - TITLE XIX ONLY			2.20	0 0	0.00000	
51.00 05100 SUPPORT SURFACES 52.00 05200 COMPLEX MEDICAL EQUIPMENT			2, 26	3, 964	0. 570383 0. 000000	
52.00 05200 COMPLEX MEDICAL EQUIPMENT 52.01 05201 OTHER ANCI LLARY SERVICES COST				0 0	0. 000000	•
52. 02 05202 MEDICAL SERVICES				0 0	0. 000000	•
OUTPATIENT SERVICE COST CENTERS				0 0	0.00000	52.02
60. 00 06000 CLINIC				0 0	0, 000000	60.00
61.00 06100 RURAL HEALTH CLINIC				0	0.000000	61.00
62. 00 06200 FQHC						62.00
63. 00 06300 DI ALYSI S				0 0	0. 000000	
71. 00 07100 AMBULANCE			80, 18	165, 720		•
100.00 Total			3, 481, 24			100.00
			1	1	I	

Health Financial Systems	CARE ONE AT	WELLI NGTON			In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315152		ri od:	Worksheet D	
				Fro	om 01/01/2023 12/31/2023	Part I Date/Time Pre	narod
				10	12/31/2023	5/10/2024 11:	56 am
		Title	XVIII (1)	Ski	illed Nursing	PPS	
					Facility		
		Health Care Pi	rogram Charge	es	Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Pa	art A (col. 1	Part B (col. 1	
	to Charges				x col. 2)	x col. 3)	
	(Fr. Wkst. C						
	Column 3)						
	1.00	2.00	3.00		4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	IENT COST						-
ANCI LLARY SERVI CE COST CENTERS	0 400050	04 007	[0	45 440		1 40 00
40. 00 04000 RADI OLOGY	0. 483850			0	15, 148	0	
41.00 04100 LABORATORY	0. 483850			0	15, 570	0	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0. 445138	18, 941		0	8, 431	0	42.00
43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 44. 00 04400 PHYSI CAL THERAPY	0. 000000 0. 485806	1, 507, 870		0	722 522	0	43.00 44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 363477			0	732, 532	0	44.00
46. 00 04600 SPEECH PATHOLOGY	0. 363477	1, 516, 710 196, 380		0	551, 289 61, 577	0	45.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	190, 380		0	01, 577	0	48.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 482955	1, 056		0	510	0	47.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 482 955	148, 467		0	66, 089	0	48.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	140, 407		0	00,007	0	50.00
51. 00 05100 SUPPORT SURFACES	0. 570383	3, 964		0	2, 261	0	51.00
52. 00 05200 COMPLEX MEDICAL EQUI PMENT	0. 000000	3, 704		0	2, 201	0	52.00
52. 01 05201 OTHER ANCI LLARY SERVICES COST	0. 000000	0		0	0	0	52.00
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS	0.000000			0	0	Ŭ	02.02
60. 00 06000 CLINIC	0.000000	0		0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC					-		61.00
62.00 06200 FQHC							62.00
63. 00 06300 DI ALYSI S	0. 000000	0		0	о	0	63.00
71.00 07100 AMBULANCE (2)	0. 483846			0		0	71.00
100.00 Total (Sum of Lines 40 - 71)		3, 456, 875		0	1, 453, 407	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	у.						
	-						

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

Health Financial Systems	CARE ONE AT W	/ELLI NGTON		In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315152	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
		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 cc 2.00 Program vaccine charges (From your recc 3.00 Program costs (Line 1 x line 2) (Title E. Part I, line 18) E. Part I, line 18	ords, or the PS&	R)			0. 445141 0 0	1.00 2.00 3.00
Cost Center Description	Total Cost (From Wkst. B, A Part I, Col. 18	(From Wkst. B, Part I, Col. 14)	Allied Healt	al I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS ANCILLARY SERVICE COST CENTERS	FOR NURSING & A	ALLIED HEALTH				
40.00 04000 RADI OLOGY 41.00 04100 LABORATORY 42.00 04200 I NTRAVENOUS THERAPY 43.00 04300 OXYGEN (1 NHALATI ON) THERAPY 44.00 04400 PHYSI CAL THERAPY 45.00 04500 OCCUPATI ONAL THERAPY 46.00 04600 SPEECH PATHOLOGY 47.00 04700 ELECTROCARDI OLOGY 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 49.00 04900 DRUGS CHARGED TO PATI ENTS	76, 590 75, 587 167, 491 0 1, 386, 845 1, 060, 804 125, 034 0 510 505, 937	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000	00 15, 570 00 8, 431 00 0 00 732, 532 00 551, 289 00 61, 577 00 0 00 510	0 0 0 0 0 0 0 0 0 0 0 0 0 0	41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00
50:00 05000 DENTAL CARE - TITLE XIX ONLY 51:00 05000 DENTAL CARE - TITLE XIX ONLY 51:00 05100 SUPPORT SURFACES 52:00 05200 COMPLEX MEDICAL EQUIPMENT 52:01 05201 OTHER ANCILLARY SERVICES COST 52:02 05202 MEDICAL SERVICES 100:00 Total (Sum of Lines 40 - 52)	0 2, 261 0 0 0 0 3, 401, 059	0 0 0 0 0 0 0 0	0. 00000 0. 00000 0. 00000 0. 00000 0. 00000	00 0 00 2,261 00 0 00 0	0 0 0 0 0	50.00 51.00 52.00 52.01

1.00Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)0.002.00Average per diem private room charge differential (Line 9 minus line 11) average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)0.004.00Private room cost differential adjustment (Line 2 times line 13) PROGRAM INPATIENT ROUTINE SERVICE COSTS0.006.00Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) 8.00415.15 3,874,1800.00Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) 1.003,874,180 5.011.00Per diem capital related costs (Line 19 minus line 21) 3.005.7.13 5.33,137 5.33,137 5.003.00Inpatient routine service cost for comparison to the cost limitation (Line 23 minus line 24) 6.003,341,043 6.006.00Total program routine service cost for comparison to the cost limitation line 26) (1)3,341,043	UMPUT	ATION OF INPATIENT ROUTINE COSTS		Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	epare
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.00Program capital related cost (Line 3 times line 21)533,137.00Inpatient routine service cost (Line 19 minus line 22)3,341,043.00Aggregate charges to beneficiaries for excess costs (From provider records)0.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3,341,043.00Enter the per diem limitation (1)3,341,043.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		line 30 for SNF; line 31 for NF, or line 32 for I	CF/IID)			
.00Inpatient routine service cost (Line 19 minus line 22)3, 341, 043.00Aggregate charges to beneficiaries for excess costs (From provider records)0.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3, 341, 043.00Enter the per diem limitation (1)3, 341, 043.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	. 00	Per diem capital related costs (Line 20 divided	by line 1)		57.13	21
.00Aggregate charges to beneficiaries for excess costs (From provider records)0.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3, 341, 043.00Enter the per diem limitation (1).00.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1).00	. 00	Program capital related cost (Line 3 times line	21)		533, 137	22
.00Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)3, 341, 043.00Enter the per diem limitation (1).00.00Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	. 00	Inpatient routine service cost (Line 19 minus li	ne 22)		3, 341, 043	23
.00 Enter the per diem limitation (1) .00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	. 00	Aggregate charges to beneficiaries for excess cos	sts (From provider records)		0	24
.00 Enter the per diem limitation (1) .00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)	. 00	Total program routine service costs for compariso	on to the cost limitation (Line 23 mir	nus line 24)	3, 341, 043	25
	. 00	Enter the per diem limitation (1)				26
	. 00	Inpatient routine service cost limitation (Line 3	3 times the per diem limitation line 2	26) (1)		27
						28

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	34, 210	1.00
2.00	Program inpatient days (see instructions)	9, 332	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. 272786	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Т

Heal th	Financial Systems	CARE ONE AT WELLINGTON	In Lie	u of Form CMS-2	2540-10
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315152	Peri od:	Worksheet D-1	
			From 01/01/2023		
			To 12/31/2023		
				5/10/2024 11:	56 am
		Title XIX	Skilled Nursing		
			Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COST	ſS			
	INPATIENT DAYS				
1.00	Inpatient days including private room days			34, 210	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days a	applicable to the Program		9, 963	3.00
4.00	Medically necessary private room days applic	cable to the Program		0	4.00
F 00	Total general inpatient routine convice cost	- -		11 202 1/0	

4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	14, 202, 160	5.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	15, 802, 512	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0. 898728	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	0.00	9.00
	2)		
	Enter semi-private room charges from your records		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)		
	Average per diem private room charge differential (Line 9 minus line 11)		12.00
	Average per diem private room cost differential (Line 7 times line 12)		13.00
	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, 202, 160	15.00
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	415.15	
	Program routine service cost (Line 3 times line 16)	4, 136, 139	
	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
	Total program general inpatient routine service cost (Line 17 plus line 18)	4, 136, 139	
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18,	1, 954, 421	20.00
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		
	Per diem capital related costs (Line 20 divided by line 1)		21.00
	Program capital related cost (Line 3 times line 21)	569, 186	
	Inpatient routine service cost (Line 19 minus line 22)	3, 566, 953	
	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	3, 566, 953	
	Enter the per diem limitation (1)		26.00
	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)	4, 136, 139	28.00
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		
(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	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	34, 210	1.00
2.00	Program inpatient days (see instructions)	9, 963	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. 291231	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

CALCU	Financial Systems CARE ONE AT ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	WELLINGTON Provider No. : 215152	Peri od:	u of Form CMS-2	2040 10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIIT	Provi der No.: 315152	From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prep 5/10/2024 11:5	
		Title XVIII	Skilled Nursing	PPS	<u></u>
			Facility		
		MDUDCEMENT		1.00	
1.00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REII Inpatient PPS amount (See Instructions)	MBURSEMENT		8, 412, 868	1.00
2.00	Nursing and Allied Health Education Activities (pass throu	ab navments)		0, 412, 000	2.00
3.00	Subtotal (Sum of Lines 1 and 2)	gri payments)		8, 412, 868	3.00
4.00	Primary payor amounts			0, 412, 000	4.00
5.00	Coi nsurance			1, 119, 556	5.00
6.00	Allowable bad debts (From your records)			414, 687	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See i	nstructions)		227, 867	7. OC
8.00	Adjusted reimbursable bad debts. (See instructions)	,		269, 547	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			7, 562, 859	11.00
12.00	Interim payments (See instructions)			7, 477, 499	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestration			0	14.50
14.55	Demonstration payment adjustment amount after sequestratio			1, 210	
14.75	Sequestration for non-claims based amounts (see instructio	ns)		5, 391	14.75
14.99	Sequestration amount (see instructions)			145, 866	
15.00	Balance due provider/program (see Instructions)	damaa with CNC Dub 15 2 a	$a a \pm i a = 115 a$	-67, 107	15.00
16.00	Protested amounts (Nonallowable cost report items in accor PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LES			0	16.00
17.00	Ancillary services Part B	SSER OF COST OR CHARGES - T	ITEL AVITT UNLT	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19.00	Total reasonable costs (Sum of Lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22.00	Primary payor amounts			0	22.00
23.00	Coinsurance and deductibles			0	23.00
24.00	Allowable bad debts (From your records)			0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see i	nstructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)			0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.00
26.00	Interim payments (See instructions)			0	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify	op.		0	28.00
28.50 28.55	Demonstration payment adjustment amount before sequestration payment adjustment amount after sequestration			0	28.50 28.55
28.55	Sequestration payment adjustment amount after sequestration [Sequestration amount (see instructions)	11		0	28.55
28.99	Balance due provider/program (see instructions)			0	20.99
				0	_ <u>~</u> /. 00

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315152	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Date/Time Prep 5/10/2024 11:5	pared: 56 am
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	<u></u>
		Inpatier	nt Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero		7, 146, 2 362, 1		0 0	1.00 2.00
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					3.00
01	ADJUSTMENTS TO PROVIDER		1	0	0	3.0
02	Absostments to thoriber			0	o	3.02
03				0	0	3.03
04				0	0	3.04
05				0	0	3.0
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM	06/06/2023	30, 8	81	0	3.5
51				0	0	3.5
52				0	0	3.5
53				0	0	3.5
54				0	0	3.5
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-30, 8	181	0	3.9
~~	- 3.98)			~~	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		7,477,4	.99	0	4.0
	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)					5.0
	Program to Provider					
. 01	TENTATI VE TO PROVI DER			0	0	5.0
. 02				0	0	5.0
. 03				0	0	5.0
	Provider to Program					
. 50	TENTATI VE TO PROGRAM			0	0	5.5
. 51				0	0	5.5
. 52				0	0	5.5
. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5.9
. 00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	PROGRAM TO PROVIDER			0	0	6.0
. 01	PROVIDER TO PROVIDER		67, 1	07	0	6.0
. 02 . 00	Total Medicare program liability (see instructions)		7, 410, 3		0	7.0
. 00	Total mean care program traditity (see thistractions)			actor Name	Contractor	7.0
			Contra		Number	
				1.00	2.00	
	Name of Contractor					8.0

 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.

	SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet G Date/Time Pre 5/10/2024 11:	epareo 56 ar
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
	Assets CURRENT ASSETS					-
	Cash on hand and in banks	506, 321		0 0	0	1.
	Temporary investments	0		0 0	0	
1 00	Notes receivable	0		0 0	0	3.
	Accounts receivable	2, 290, 274		0 0	0	
	Other receivables	0		0 0	0	
	Less: allowances for uncollectible notes and accounts	-605, 925		0 0	0	6.
	recei vabl e I nventory	0		0	0	7.
	Prepaid expenses	26, 544		0 0	0	
	Other current assets	78, 812		0 0	0	
00 [Due from other funds	0		0 0	0	10.
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 296, 026		0 0	0	11.
	I XED ASSETS	T	1	-		
	Land	0		0 0	0	
	Land improvements	0		0 0 0 0	0	
	Less: Accumulated depreciation Buildings			0 0	0	
	Less Accumulated depreciation			0 0	0	
	Leasehold improvements			0 0	0	
	Less: Accumulated Amortization	0		0 0	0	
	Fixed equipment	0		0 0	0	
00 1	Less: Accumulated depreciation	0		0 0	0	20
	Automobiles and trucks	0		0 0	0	21
	Less: Accumulated depreciation	0		0 0	0	
	Major movable equipment	0		0 0	0	
	Less: Accumulated depreciation	0		0 0	0	
	Winor equipment – Depreciable Winor equipment nondepreciable	0		0 0 0 0	0	
	Other fixed assets	1, 325		0 0	0	
	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	1, 325		0 0	0	
	DTHER ASSETS	.,	1	-, -,		1
00 1	Investments	0		0 0	0	29
	Deposits on leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets	1,009,150		0 0 0 0	0	
	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)	1, 009, 150 3, 306, 501		0 0 0 0	0	
	iabilities and Fund Balances	3, 300, 301	1	<u> </u>	0	1 34
	CURRENT LIABILITIES					1
	Accounts payable	1, 356, 536		0 0	0	35
	Salaries, wages, and fees payable	176, 729		0 0	0	36
00 F	Payroll taxes payable	-2, 841		0 0	0	
	Notes & loans payable (Short term)	0		0 0	0	
	Deferred income	0		0 0	0	
	Accelerated payments	(5.027		0	0	40
	Due to other funds Other current liabilities	65, 927 2, 158, 011		0 0 0 0	0 0	
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3, 754, 362		0 0	0	
_	LONG TERM LIABILITIES	3,734,302	1	0 0	0	43
	Mortgage payable	0		0 0	0	44
	Notes payable	0		0 0	0	
	Unsecured Loans	0		0 0	0	
	Loans from owners:	0		0 0	0	
	Other long term liabilities	-37, 302, 084		0 0	0	
	OTHER (SPECIFY)	0			0	
	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	-37, 302, 084		0 0 0 0	0	
	CAPITAL ACCOUNTS	-33, 547, 722	1		0	4 21
	General fund balance	36, 854, 223				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
00 0	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	24 054 222			~	1 = 0
	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	36, 854, 223 3, 306, 501			0	
	THAT THADLET AND FUND BALANCES INUM OF LIDES 51 200	1 3. 300. 501	1	0 0	()	1 00

Heal th	Financial Systems	CARE ONE AT WELLINGTON					In Lieu of Form CMS-2540-10				
STATEMENT OF CHANGES IN FUND BALANCES			Provi der No.: 315152		Period: From 01/01/2023 To 12/31/2023		Worksheet G-1 Date/Time Prepared: 5/10/2024 11:56 am				
		General	Fund		Speci al	Pur	rpose Fund	Endowment Fu			
		1.00	2.0	0	2 00		4.00	E 00	_		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ROUNDING Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	1.00 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-9 36, 8	0 11, 421 57, 201 54, 220 3 54, 223	3.00		4.00 0 0 0 0	5.00		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	
18.00 19.00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)		36, 8	0 54, 223			0 0			18. 00 19. 00	
		Endowment Fund		Pl ant	Fund						
		6.00	7.0	0	8.00						
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) ROUNDING	0		0 0 0 0		0				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 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	000000000000000000000000000000000000000		0 0 0 0		0 0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	

Heal th	Financial Systems	CARE ONE AT WELLI	NGTON			In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	5	Provi der	No.: 315152	Peri Froi To	iod: m 01/01/2023 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/10/2024 11:	
	Cost Center Description			I npati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I - PATIENT REVENUES							
	General Inpatient Routine Care Services			15 000 5	10		45 000 540	
1.00	SKILLED NURSING FACILITY			15, 802, 5	12		15, 802, 512	1.00
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE			15 000 5	0		0	4.00
5.00	Total general inpatient care services (Sum of	lines I - 4)		15, 802, 5	12		15, 802, 512	5.00
(00	All Other Care Services			0 170 0	70	0	0 170 070	(00
6.00	ANCI LLARY SERVI CES CLI NI C			8, 170, 0	/8	0	8, 170, 078	6.00
7.00 8.00	HOME HEALTH AGENCY COST					0	0	7.00 8.00
8.00 9.00	AMBULANCE					0	-	8.00 9.00
						0	0	
	RURAL HEALTH CLINIC FOHC					0	0	10. 00 10. 10
	CMHC					0	0	10.10
	HOSPICE				0	0	0	12.00
	OTHER (SPECIFY)				0	0	0	12.00
	Total Patient Revenues (Sum of lines 5 - 13)	(Transfor column 2	t 0	23, 972, 5	00	0	23, 972, 590	
14.00	Worksheet G-3, Line 1)	(Transfer column 3	10	23, 972, 5	90	0	23, 972, 590	14.00
	Cost Center Description							
						1.00	2.00	
	PART II - OPERATING EXPENSES							
1.00	Operating Expenses (Per Worksheet A, Col. 3,	Line 100)					18, 381, 302	1.00
2.00	Add (Specify)					0		2.00
3.00						0		3.00
4.00						0		4.00
5.00						0		5.00
6.00						0		6.00
7.00						0		7.00
8.00	Total Additions (Sum of lines 2 - 7)						0	8.00
9.00	Deduct (Specify)					0		9.00
10.00						0		10.00
11.00						0		11.00
12.00						0		12.00
13.00						0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)						0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and	8, minus line 14)					18, 381, 302	15.00

Hoal th	alth Financial Systems CARE ONE AT WELLINGTON In Lieu					2540-10
	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315152 Period:			Worksheet G-3		
STATEN	ENT OF FATTENT REVENUES AND OF ERATING EXTENSES		11001001 10 313132	From 01/01/2023	worksneet 0-5	
				To 12/31/2023		
					5/10/2024 11:	56 am
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part				23, 972, 590	1.00
2.00	Less: contractual allowances and discounts on	patients accounts			6, 576, 736	2.00
3.00	Net patient revenues (Line 1 minus line 2)				17, 395, 854	3.00
4.00	Less: total operating expenses (From Worksheet		ne 15)		18, 381, 302	4.00
5.00	Net income from service to patients (Line 3 mi	nus 4)			-985, 448	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				4, 308	7.00
8.00	Revenues from communications (Telephone and I	nternet service)			0	
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and guest	S			60	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical supp		n patients		0	16.00
17.00	Revenue from sale of drugs to other than patie				0	17.00
18.00	Revenue from sale of medical records and abstr				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, et	,			0	19.00
20.00	Revenue from gifts, flower, coffee shops, cant	teen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of skilled nursing space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	BARBER AND BEAUTY				7, 133	
24.01	RESIDENT PERSONAL ITEMS				274	
24.02	OTHER REVENUES				3, 728	
24.03	OTHER INCOME				12, 744	24.03
24.50	COVI D-19 PHE Funding				0	24.50
25.00	Total other income (Sum of lines 6 - 24)				28, 247	
26.00	Total (Line 5 plus line 25)				-957, 201	26.00
27.00	Other expenses (specify)				0	27.00
28.00					0	28.00
29.00					0	29.00
	Total other expenses (Sum of lines 27 - 29)				0	30.00
31.00	Net income (or loss) for the period (Line 26 m	ninus line 30)			-957, 201	31.00