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

OMB NO. 0938-0463 Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 315313	From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:30 am

			3/10	1/ 2024   11. 30 alli
PART I - COST I	REPORT STATUS	·		
Provi der	1. [ X ] Electronically prepared cost rep	oort	Date: 5/10/2024	Time: 11:30 am
use only	2. [ ] Manually prepared cost report			
	3. [ 0 ] If this is an amended report ent	er the number of times the provide	r resubmitted this cos	st report
	3.01 [ ] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.		
Contractor	4. [ 1 ] Cost Report Status	6. Contractor No.	<u> </u>	
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 time	es reopened
	(5) Amended	11. Contractor Vendor Code	4	'
	5. Date Received:	12.[ F ] Medicare Utilization. Enter for no utilization.	er "F" for full, "L" fo	or low, or "N"

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT CRESSKILL (315313) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1. 00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-17, 103	107	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	-17, 103	107	0	100.00

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

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

Health Financial Systems CARE ONE AT CRESSKILL In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315313 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:30 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 221 COUNTY ROAD PO Box: 1.00 2.00 City: CRESSKILL State: NJ Zi p Code: 07626 2.00 3.00 County: BERGEN CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT CRESSKILL 315313 05/14/1992 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 571, 251 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 571, 251 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 Υ 38, 00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 48 918

Heal th	Financial Systems	CARE ONE AT CRE	ESSKI LL		In Li	eu of Form CMS	-2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.:	315313	Peri od:	Worksheet S-	2
COMPLE	EX INDENTIFICATION DATA				From 01/01/202		
					To 12/31/202		
						5/10/2024 11	: 30 am
						Y/N	_
						1.00	
42.00						N	42. 00
	center? Enter Y or N. If yes, check bo	x, and submit supporting	schedule listir	ng cost c	enters and		
	amounts.						
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, C	hapter 10?			Y	43.00
43.00 Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10? 44.00 If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.				HB0206	44. 00		
	office on lines 45, 46 and 47.						
	1.00	2. 00			3. 00		
	If this facility is part of a chain or	ganization, enter the na	me and address	of the ho	ome office on t	he lines	
	bel ow.						
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVIT	AS SOLUTIONS	Contract	or's Number: 12	001	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:					46. 00
47. 00	City: FORT LEE	State: NJ		Zip Code	: 07	024	47. 00
				Zip Code	: 07	024	

Health Financial Systems CARE ONE AT CRESSKILL In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315313 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:30 am Date 1. 00 2.00 General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public Α Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. Ν 11.00 Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 03/19/2024 Υ 13.00 only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R Ν Ν 14 00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Heal th	Financial Systems	CARE ONE AT	CRES	SKI LL			In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY H	HEALTH CARE		Provi der	No.: 315313		ri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					To	om 01/01/2023	Date/Time Pre	pared.
							127 017 2020	5/10/2024 11:	30 am
				1. (	00		2. (	00	
	Cost Report Preparer Contact Information								
19.00	Enter the first name, last name and the title/po	osition (	CHARL	.ES		F	REED		19. 00
	held by the cost report preparer in columns 1, 2	2, and 3,							
	respecti vel y.								
20.00	Enter the employer/company name of the cost repo	ort	EXECU	CARE ASSO	CI ATES				20. 00
	preparer.								
21. 00	Enter the telephone number and email address of		(609)	738-3200		C	CRWASSC@NETSCAP	E. NET	21. 00
	report preparer in columns 1 and 2, respectively	<i>/</i> .							

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

CARE ONE AT CRESSKILL
Provider No.: 315313
Period: From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023		
		Part B Date			0, 10, 202 1 111	o diii
		4. 00				
40.00	PS&R Data	00/10/0001	1			
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/19/2024				13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
			3.00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		VI CE-PRESI DENT			19. 00
20. 00	Enter the employer/company name of the cost r preparer.	report				20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21. 00

In Lieu of Form CMS-2540-10 Health Financial Systems CARE ONE AT CRESSKILL Worksheet S-3

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315313 Peri od:

From 01/01/2023 COMPLEX STATISTICAL DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:30 am Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 1.00 3.00 5.00 4.00 2.00 1.00 SKILLED NURSING FACILITY 113 41, 245 0 11, 822 0 1.00 NURSING FACILITY 0 2.00 2.00 0 0 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4.00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 0 7.00 0 8.00 Total (Sum of lines 1-7) 113 41, 245 11,822 8.00 Inpatient Days/Visits Di scharges Title V Title XVIII Title XIX Component Other Total 6.00 7.00 8.00 9. 00 10.00 1.00 SKILLED NURSING FACILITY 13, 276 25, 098 0 429 0 1. 00 NURSING FACILITY 0 2.00 0 C 0 2.00 0 LCE/LLD 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 0 4.00 5.00 Other Long Term Care 0 5.00 6.00 SNF-Based CMHC 6.00 7.00 HOSPI CE 0 0 7.00 8.00 Total (Sum of lines 1-7) 13, 276 25, 098 429 8.00 Average Length of Stay Di scharges 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 0.00 1.00 324 753 NURSING FACILITY 0.00 2.00 0 0.00 2.00 C 3.00 ICF/IID 0 C 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 0.00 7.00 7.00 8.00 Total (Sum of lines 1-7) 324 753 0.00 27. 56 0.00 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16.00 17.00 18.00 19.00 20.00 1.00 SKILLED NURSING FACILITY 33. 33 462 292 1. 00 NURSING FACILITY 0.00 0 2.00 2.00 0 ICF/IID 0 3.00 3.00 0.00 0 4.00 HOME HEALTH AGENCY COST 4.00 5.00 Other Long Term Care 0.00 0 5.00 SNF-Based CMHC 6.00 6.00

8.00	Total (Sum of lines 1-7)	33. 33	0	462	0 292	8. 00
		Admi ssi ons	Full Time	Equi val ent		
	Component	Total	Employees on	Nonpai d		
			Payrol I	Workers		
		21. 00	22. 00	23. 00		
1.00	SKILLED NURSING FACILITY	754	112. 63	0.00		1. 00
2.00	NURSING FACILITY	0	0.00	0.00		2. 00
3.00	ICF/IID	0	0.00	0.00		3. 00
4.00	HOME HEALTH AGENCY COST		0.00	0.00		4. 00
5.00	Other Long Term Care	0	0.00	0.00		5. 00
6.00	SNF-Based CMHC		0.00	0.00		6. 00
7.00	HOSPI CE	0	0.00	0.00		7. 00
8.00	Total (Sum of lines 1-7)	754	112. 63	0.00		8. 00

0.00

0

0

0

7.00

7.00

HOSPI CE

				Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6		Salary in col.		
				<b>_</b>	3	ĺ	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	8, 113, 719	0	8, 113, 719	234, 278. 00	34. 63	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0. 00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	8, 113, 719	0	8, 113, 719	234, 278. 00	34. 63	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	3	8, 113, 719	0	8, 113, 719	234, 278. 00	34. 63	13.00
	12)						
	OTHER WAGES & RELATED COSTS		1	T			
14. 00	3	92, 986	0	92, 986			14. 00
15. 00		0	0	0	0.00		15. 00
16. 00		0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS		_				
17. 00	,	1, 504, 478	0	1, 504, 478			17. 00
18. 00	,	0	0	0			18. 00
19. 00	, ,	0	0	0			19. 00
20. 00		0	0	0			20.00
21. 00	9	0	0	0			21. 00
22. 00		1, 504, 478	0	1, 504, 478			22. 00
	instructions)		l	l			

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT CRESSKILL

 SKILL
 In Lieu of Form CMS-2540-10

 Provider No.: 315313
 Period: From 01/01/2023 Part III To 12/31/2023 Date/Time Prepared:

				1	0 12/31/2023		
		Amount	Dool ooo of	Adiusted	Doi d House	5/10/2024 11:	
		Amount	Reclass. of	1 2		Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	[ C	)  C	0.00	0.00	1. 00
2.00	Administrative & General	801, 911	C	801, 911	17, 995. 00	44. 56	2. 00
3.00	Plant Operation, Maintenance & Repairs	44, 947	C	44, 947	2, 119. 00	21. 21	3. 00
4.00	Laundry & Li nen Servi ce	98, 752	C	98, 752	5, 548. 00	17. 80	4. 00
5.00	Housekeepi ng	324, 587	l c	324, 587	15, 897. 00	20. 42	5. 00
6.00	Di etary	525, 446	l c	525, 446	23, 355. 00	22. 50	6. 00
7.00	Nursing Administration	926, 269	l c	926, 269	22, 842. 00	40. 55	7. 00
8.00	Central Services and Supply	30, 053	l c	30, 053	1, 466. 00	20. 50	8. 00
9.00	Pharmacy	0	l c	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	41, 971	l c	41, 971	2, 276. 00	18. 44	10.00
11.00	Soci al Servi ce	77, 978		77, 978	2, 088. 00	37. 35	11. 00
12.00	Nursing and Allied Health Ed. Act.				·		12. 00
13. 00	Other General Service	185, 878		185, 878	8, 212. 00	22, 63	13.00
14. 00	Total (sum lines 1 thru 13)	3, 057, 792		3, 057, 792	1		
00	1.024. (04 1.1.00 1 2 4 10)	5,007,772	1	0,007,772	, , , ,	1 00.01	00

Health Financial Systems	CARE ONE AT CRESSKILL	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315313	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 5/10/2024 11:	pared:
			Amount Reported	

	To 12/31/2023	Date/Time Prep 5/10/2024 11:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	43, 467	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
4.00	Prior Year Pension Service Cost	o	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7. 00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST	_	
8. 00	Heal th Insurance (Purchased or Self Funded)	638, 535	8. 00
9. 00	Prescription Drug Plan	0	9. 00
10. 00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 768	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	o o	13. 00
14. 00		0	14. 00
	Workers' Compensation Insurance	150, 446	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	130, 440	16. 00
10.00	Non cumulative portion)	o o	10.00
	TAXES		
17 00	FICA-Employers Portion Only	577, 022	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19.00
	State or Federal Unemployment Taxes	92, 323	
20.00	OTHER	72,020	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	o o	22. 00
	Tui ti on Rei mbursement	917	
	Total Wage Related cost (Sum of lines 1 - 23)	1, 504, 478	
24.00	Tratal mage herated soot (our of files 1 20)	Amount	24.00
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COST	0	25. 00
	•		

 SKILL
 In Lieu of Form CMS-2540-10

 Provider No.: 315313
 Period: From 01/01/2023
 Worksheet S-3 Part V Proposed of Time Proposed of Time

				To	12/31/2023	Date/Time Prep 5/10/2024 11:3	oared:
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	
	, , , , , , , , , , , , , , , , , , , ,	Reported		Salaries (col.		Wage (col. 3 ÷	
		·		1 + col. 2)	Salary in col.	col . 4)	
					3		
		1.00	2.00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 077, 578	215, 088				1.00
2.00	Licensed Practical Nurses (LPNs)	1, 280, 071	255, 506				2.00
3.00	Certified Nursing Assistant/Nursing	1, 380, 628	275, 577	1, 656, 205	55, 537. 00	29. 82	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 738, 277	746, 171	4, 484, 448			4. 00
5.00	Physical Therapists	540, 831	107, 951	648, 782	·		5.00
6.00	Physical Therapy Assistants	0	0	0	0. 00		6.00
7.00	Physical Therapy Aides	0	0	0	0. 00		7. 00
8.00	Occupational Therapists	606, 001	120, 960	726, 961	14, 058. 00		8.00
9.00	Occupational Therapy Assistants	0	0	0	0. 00		9.00
10.00	Occupational Therapy Aides	0	0	0	0.00		10.00
11. 00	Speech Therapists	77, 779	15, 525	93, 304	·		
12.00	Respi ratory Therapi sts	0	0	0	0. 00		12.00
13.00	Other Medical Staff	0	0	0	0.00	0. 00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	14, 908		14, 908			14.00
15. 00	Licensed Practical Nurses (LPNs)	32, 319		32, 319			15. 00
16. 00	Certified Nursing Assistant/Nursing	9, 776		9, 776	264. 00	37. 03	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	57, 003		57, 003			17. 00
18. 00	Physi cal Therapi sts	4, 778		4, 778			18. 00
19. 00	Physical Therapy Assistants	0		0	0. 00		
20. 00	Physical Therapy Aides	0		0	0. 00		20.00
21. 00	Occupational Therapists	0		0	0.00		21. 00
22. 00	Occupational Therapy Assistants	0		0	0. 00		22. 00
23. 00	Occupational Therapy Aides	0		. 0	0.00		23. 00
24. 00	Speech Therapists	4, 000		4, 000	53. 00		24. 00
25. 00	Respiratory Therapists	27, 205		27, 205	544. 00		
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

100		To 12/31/2023	Date/lime Prepared:   5/10/2024 11:30 am
1.00			Days
2.00	1.00		
2.00			
Section   Sect			
Section   Sect			
7.00 RML 8.00 RML 9.00 RML 9.00 RML 9.00 RML 9.00 RML 11.00 RML			
B. 00			
9.00   SIX			
11.00   Right   11.00   Right   11.00   Right   12.00   Right   12.00   Right   13.00   Right			
12.00   RUA   112.00   RUA   113.00   RUC   RU			
13.00   RVC   114.00   RVG   RVG   114.00   RVG   RVG   114.00   RVG   RVG   119.00   RVG			
14.00   RVB			
16.00   RHC   10.00   RHG   17.00   RHG   17.00   RHG   18.00   RHA			
17.00			
18 00			
19,00   RMB			
21.00   RIBA   22.00   RIBB   23.00   RIBB   23.0			
22.00   RIB   22.00   RIA   23.00   24.00   ES3   25.00   ES3   25.00   ES3   24.00   ES3   25.00   ES3   25.00   ES3   25.00   ES3   25.00   ES3   25.00   ES3			
23 00   RIA   23 00   ES3   24 00   ES3   24 00   ES5   25 00   ES5   26			
24.00   ESS   24.00   ESS   25.00   ESS   25			
25.00   ES2   25.00   27.00   ES1   26.00   27.00   HE2   27.00   HE2   27.00   HE2   27.00   HE2   27.00   HE3   28.00   HE3			
27. 00   HE2   27. 00   29. 00   HE1   28. 00   29. 00   HE1   28. 00   HD2   29. 00   HD2   29. 00   HD2   29. 00   HD3   30. 00   HD3   30. 00   HD3   31. 00   HC2   31. 00   HC3   32. 00   HC3   32. 00   HC3   33.	25. 00	ES2	25. 00
28.00 30.00 30.00 31.00 30.00 31.00 32.00 32.00 34.00 34.00 34.00 35.00 36.00			
29.00   HD2			
31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 38.00 39.00 LD2 37.00 39.00 LD2 39.00 LD2 39.00 LC1 49.00 LC2 49.00 41.00 LC2 49.00 41.00 LBB1 42.00 43.00 44.00 CE1 44.00 CE1 44.00 CE1 44.00 CE1 44.00 CC2 43.00 CC3 CC2 47.00 CC3 CC3 CC3 CC3 CC4 CC3 CC5 CC5 CC5 CC5 CC5 CC5 CC6 CC7 CC7 CC7 CC8 CC7 CC8 CC8 CC8 CC8 CC9 CC9 CC9 CC9 CC9 CC9			
32.00 34.00 34.00 35.00 36.00 36.00 36.00 36.00 37.00 38.00 38.00 39.00 LD1 38.00 39.00 LC2 39.00 40.00 LL1 101 38.00 40.00 LL2 41.00 LL2 41.00 42.00 42.00 43.00 44.00 44.00 44.00 44.00 45.00 46.00 46.00 47.00 48.00 49.00 55.00			
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 LE2 37. 00 39. 00 LD2 37. 00 39. 00 LC2 39. 00 LC2 39. 00 LC2 39. 00 LC2 39. 00 LC3 LC2 39. 00 LC4 LC3 40. 00 LC4 LC5 LC6 LC7			
34.00 35.00 36.00 36.00 37.00 38.00 38.00 38.00 38.00 39.00 30.00 40.00 40.00 40.00 40.00 41.00 42.00 42.00 43.00 44.00 44.00 45.00 46.00 46.00 47.00 48.00 48.00 49.00 48.00 49.00 48.00 49.00 48.00 48.00 49.00 51.00 52.00 53.00 53.00 55.00 56.00 57.00 58.00			
10			
37 00   38 00   1.02   37 00   38 00   1.01   38 00   1.02   39 00   1.02   39 00   1.02   39 00   1.02   39 00   1.02   39 00   1.00			
38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 51. 00 51. 00 51. 00 52. 00 53. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 56. 00 57. 00 58. 00 58. 00 59. 00 50. 00 60			
100			
100     100     110     120			
A2 00   A3 00   CE2			
43.00   CE2			
44. 00			
46. 00 47. 00 48. 00 CC2 47. 00 48. 00 CC2 47. 00 48. 00 CC1 48. 00 CC1 48. 00 CC2 47. 00 CC2 47. 00 CC2 48. 00 CC1 48. 00 CC1 48. 00 CC2 49. 00 CC2 50. 00 CC3 CC2 51. 00 CC4 51. 00 CC4 52. 00 CC4 52. 00 CC4 53. 00 SC3 SC3 SC3 SC3 SC3 SC4 SC5 SC5 SC6 SC0 SC5 SC7 SC8 SC8 SC7 SC8	44. 00		44. 00
47.00   CC2   47.00   48.00   CC1   48.00   CC1   48.00   CC1   48.00   CC1   48.00   CC2   49.00   CC2   49.00   CC2   51.00   CC3   CC3   SE3   SE3.00   CC4   SE2   SE3   SE3.00   SE3   SE3   SE3.00   SE2   SE4.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE1   SE5.00   SE3   SE3.00   SE			
48. 00   49. 00   50. 00   61. 00   62. 00   63. 00   65. 00   6			
49.00   CB2			
50. 00       CB1       50. 00         51. 00       CA2       51. 00         52. 00       CAT       52. 00         53. 00       SE3       53. 00         54. 00       SE2       54. 00         55. 00       SE1       55. 00         56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       PE2       67. 00         68. 00       PE1       68. 00         69. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB1       74. 00			
52. 00     CA1     52. 00       53. 00     SE3     53. 00       54. 00     SE2     54. 00       55. 00     SE1     55. 00       56. 00     SSC     56. 00       57. 00     SSB     57. 00       58. 00     SSA     58. 00       59. 00     IB2     59. 00       60. 00     IB1     60. 00       61. 00     IA2     61. 00       62. 00     IA1     62. 00       63. 00     BB2     63. 00       64. 00     BB1     64. 00       65. 00     BA2     65. 00       66. 00     BA1     66. 00       67. 00     PE2     67. 00       68. 00     PP1     68. 00       69. 00     PD2     69. 00       70. 00     PC2     71. 00       72. 00     PR2     73. 00       74. 00     PP1     74. 00	50. 00	CB1	50.00
53. 00       SE3       53. 00         54. 00       SE1       55. 00         55. 00       SE1       55. 00         56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       PE2       67. 00         68. 00       PE1       68. 00         69. 00       PD1       70. 00         70. 00       PC2       71. 00         72. 00       PC3       73. 00         74. 00       PB1       74. 00			
54.00     SE2     54.00       55.00     SE1     55.00       56.00     SSC     56.00       57.00     SSB     57.00       58.00     SSA     58.00       59.00     IB2     59.00       60.00     IB1     60.00       61.00     IA2     61.00       62.00     IA1     62.00       63.00     BB2     63.00       64.00     BB1     64.00       65.00     BA1     66.00       67.00     BA1     66.00       67.00     PE2     67.00       68.00     PE1     68.00       69.00     PD1     70.00       71.00     PC2     71.00       72.00     PC2     71.00       73.00     PB2     73.00       74.00     PB1     74.00			
56. 00       SSC       56. 00         57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       IB2       59. 00         60. 00       IB1       60. 00         61. 00       IA2       61. 00         62. 00       IA1       62. 00         63. 00       BB2       63. 00         64. 00       BB1       64. 00         65. 00       BA2       65. 00         66. 00       BA1       66. 00         67. 00       PE2       67. 00         68. 00       PP2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PB2       73. 00         74. 00       PB1       74. 00	54. 00	SE2	54.00
57. 00       SSB       57. 00         58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       64. 00       65. 00         64. 00       65. 00       66. 00         66. 00       67. 00       66. 00         67. 00       68. 00       69. 00         70. 00       PD1       68. 00         69. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PC1       72. 00         73. 00       PB1       74. 00			
58. 00       SSA       58. 00         59. 00       1B2       59. 00         60. 00       1B1       60. 00         61. 00       1A2       61. 00         62. 00       1A1       62. 00         63. 00       64. 00       65. 00         64. 00       65. 00       66. 00         66. 00       67. 00       68. 0         68. 00       PE1       68. 00         69. 00       PD2       69. 00         70. 00       PD1       70. 00         71. 00       PC2       71. 00         72. 00       PR2       73. 00         74. 00       PB1       74. 00			
59. 00         60. 00         61. 00         62. 00         63. 00         64. 00         64. 00         65. 00         66. 00         67. 00         68. 00         69. 00         70. 00         70. 00         71. 00         72. 00         73. 00         74. 00			
61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  61. 00 61. 00 62. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 6			59. 00
62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BA1 62. 00 BB2 63. 00 64. 00 BB1 64. 00 BB4 65. 00 BB4 66. 00 PE2 67. 00 PE1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB2 PC3. 00 PB3 PB1 74. 00			
63. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BB2 BB1 64. 00 BA1 66. 00 BA1 66. 00 PE1 68. 00 PP1 70. 00 PP1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PB1 72. 00 PB1 74. 00	61.00		61.00
64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BB1 64. 00 BA2 65. 00 BA1 66. 00 PE2 67. 00 PE1 68. 00 PD2 70. 00 PD1 70. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00			
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00  BA2 BA1 66. 00 PE2 67. 00 PE1 68. 00 PP1 70. 00 PD2 71. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB2 73. 00 PB1 74. 00	64. 00	BB1	64. 00
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PE2 67. 00 PB1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 PC1 72. 00 PB2 73. 00 PB2 74. 00			65. 00
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 Ref (68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 PC1 72. 00 PC3 PC1 PC2 PC1 72. 00 PC3 PC1 PC2 PC1 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC4 PC5 PC7			
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PD2 PB1 F0. 00 F0.			
70. 00 71. 00 72. 00 73. 00 74. 00 PB2 PB1 70. 00 71. 00 PC2 71. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00		PD2	69.00
72. 00 73. 00 74. 00 PB1 72. 00 PB1 74. 00	70. 00	PD1	70.00
73. 00 74. 00 PB1 73. 00 74. 00		PC2	
74.00 PB1 74.00			
75. 00 PA2 75. 00	74. 00	PB1	74. 00
	75. 00	PA2	75. 00

Health Financial Systems	CARE ONE AT CRES	SKI LL		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315313	Peri od:	Worksheet S-	7
				From 01/01/2023 To 12/31/2023	Date/Time Pr 5/10/2024 11	epared: : 30 am_
				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 Vo payments beginning 10/01/2003. Congress expect expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fowith direct patient care and related expenses (See instructions)	cted this increase of column 1 the amount each category to cor yes or "N" for no	to be used nt of the total SNF o if the s	for direct   expense for or revenue from pending reflo	oatient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
101. 00 Staffi ng						101. 00
102.00 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105. 00 OTHER (SPECIFY)						105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, lir	ne 1, column 3)					106.00

Heal th	Financial Systems	CARE ONE AT C	RESSKI LL		In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet A  Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	5/10/2024 11:   Reclassified   Trial Balance   (col. 3 +-   col. 4)	30 am
		1.00	2.00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS    00100 CAP REL COSTS - BLDGS & FIXTURES		2 ((2 470	2 (/2 47		2 //2 /70	1 00
1. 00 2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES		2, 663, 478 256, 845			2, 663, 478 256, 845	1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 619, 522			1, 619, 522	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	801, 911	2, 610, 141			3, 412, 052	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	44, 947	375, 598			420, 545	5. 00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	98, 752	59, 582			158, 334	6. 00 7. 00
7. 00 8. 00	00800 DI ETARY	324, 587 525, 446	48, 278 301, 802			372, 865 827, 248	ł
9. 00	00900 NURSING ADMINISTRATION	926, 269	95, 952			1, 022, 221	ł
10.00	01000 CENTRAL SERVICES & SUPPLY	30, 053	220, 053			250, 106	
11. 00	01100 PHARMACY	0	7, 503			7, 503	
	01200 MEDI CAL RECORDS & LI BRARY	41, 971	0	41, 97		41, 971	
13. 00 14. 00	O1300   SOCIAL SERVICE   O1400   NURSING AND ALLIED HEALTH EDUCATION	77, 978	0	77, 97	8 0	77, 978 0	13. 00 14. 00
	01500 ACTI VI TES	185, 878	21, 007		-	_	ı
	INPATIENT ROUTINE SERVICE COST CENTERS		•				
30. 00	03000 SKILLED NURSING FACILITY	3, 738, 277	147, 912	3, 886, 18		3, 886, 189	•
31.00	03100 NURSING FACILITY	0	0		0 0	0	31. 00 32. 00
	03300 OTHER LONG TERM CARE	0	0	•	0 0	-	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			<u>oj</u>		00.00
40. 00	04000 RADI OLOGY	0	57, 022				1
41. 00	04100 LABORATORY	0	101, 583			101, 583	
42. 00 43. 00	04200   INTRAVENOUS THERAPY   04300   OXYGEN (INHALATION) THERAPY	0	209, 304	209, 30	4 0	209, 304 0	
44. 00	04400 PHYSI CAL THERAPY	633, 870	21, 216	655, 08	6 0	655, 086	1
45.00	04500 OCCUPATIONAL THERAPY	606, 001	0	606, 00		606, 001	1
	04600 SPEECH PATHOLOGY	77, 779	4, 000			81, 779	1
47. 00 48. 00	04700  ELECTROCARDI OLOGY   04800  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	
49. 00	04900 DRUGS CHARGED TO PATTENTS	0	578, 194	578, 19	4 0	578, 194	
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	1
51. 00	05100 SUPPORT SURFACES	0	0		0 0	0	
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52. 00 52. 01
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST   05202 MEDICAL SERVICES	0	0		0 0	-	ı
02.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		l .	<u> </u>		02.02
60.00	06000 CLI NI C	0	0		0 0		
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	
	06200 FOHC 06300 DI ALYSI S	0	0		0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			0  0	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70. 00
	07100 AMBULANCE	0	51, 673	51, 67			71.00
73.00	O7300   CMHC   O7400   OTHER REIMBURSEMENT	0	0		0 0	0	
74.00	SPECIAL PURPOSE COST CENTERS	ı o	0		0	0	74.00
80.00			0		0 0	0	80.00
81. 00	08100 I NTEREST EXPENSE		0		0 0	0	
82. 00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	
83. 00 84. 00	08300   HOSPI CE   08400   OTHER SPECI AL PURPOSE COST	0	0		0 0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	o	0		0 0	Ö	ı
89. 00	SUBTOTALS (sum of lines 1-84)	8, 113, 719	9, 450, 665	17, 564, 38	4 0	17, 564, 384	89. 00
00 00	NONREIMBURSABLE COST CENTERS  O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		15 700	15 70	0 0	15 700	00 00
90. 00 91. 00	1 1 1		15, 788 5, 229				90. 00 91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0		o o	0	92. 00
	09300 NONPALD WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0		0	0	
95. 00 100. 00	l l	8, 113, 719	9, 471, 682	17, 585, 40	0 1	0 17, 585, 401	
	1 - 1	27 7 107 7 17	., ., ., 302	1, 555, 16	,	1 11,000,101	

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

 
 Heal th Financial
 Systems
 CARE ON

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315313 | Peri od: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To 12/31/2023 Date/Time Pre 5/10/2024 11:	
	Cost Center Description	Adjustments to	Net Expenses	5/10/2024 11.	30 alli
	·		For Allocation		
		Wkst A-8)	(col. 5 +- col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-3, 025		·	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	C	256, 845	l .	2.00
3.00	00300 EMPLOYEE BENEFITS	1 075 0/0	1, 619, 522		3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	-1, 075, 868			4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE				6. 00
7. 00	00700 HOUSEKEEPI NG	C	372, 865		7. 00
8.00	00800 DI ETARY	-50			8. 00
9.00	00900 NURSING ADMINISTRATION	-2, 210			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0,00	250, 106		10.00
11. 00 12. 00	01100   PHARMACY   01200   MEDI CAL RECORDS & LI BRARY	-600			11. 00 12. 00
	01300 SOCIAL SERVICE				13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION				14. 00
15.00	01500 ACTI VI TES	C	206, 885		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	-37, 677			30.00
31. 00 32. 00	03100 NURSING FACILITY 03200   CF/IID	C		l .	31. 00 32. 00
	03300 OTHER LONG TERM CARE			l .	33. 00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	C			40. 00
	04100 LABORATORY	C	,		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	-16, 744	1		42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY		0 655, 086		43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		606, 001		45. 00
	04600 SPEECH PATHOLOGY		81, 779		46. 00
47.00	04700 ELECTROCARDI OLOGY	C	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	1		48. 00
	04900 DRUGS CHARGED TO PATIENTS	-46, 255	1		49. 00
	O5000   DENTAL CARE - TITLE XIX ONLY   O5100   SUPPORT SURFACES		1		50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		1		52.00
	05201 OTHER ANCILLARY SERVICES COST	C	o		52. 01
52. 02	05202 MEDI CAL SERVI CES	C	0		52. 02
	OUTPATIENT SERVICE COST CENTERS	Τ	J		
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	C	1	l control of the cont	60. 00 61. 00
62. 00	06200 FQHC		,		62. 00
63. 00	06300 DI ALYSI S	C	0		63. 00
	OTHER REIMBURSABLE COST CENTERS				
70. 00	07000 HOME HEALTH AGENCY COST	C		l .	70.00
	07100 AMBULANCE	C		l .	71.00
	07300  CMHC   07400  OTHER REI MBURSEMENT	C			73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS		,		74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	C	0		80. 00
	1 1	C	0		81. 00
	08200 UTILIZATION REVIEW - SNF	C	0		82. 00
83. 00 84. 00	08300   HOSPI CE   08400   OTHER SPECI AL PURPOSE COST I		0		83. 00 84. 00
84. 00	08401 OTHER SPECIAL PURPOSE COST I				84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 182, 429	_		89. 00
	NONREI MBURSABLE COST CENTERS				
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	15, 788		90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		5, 229	•	91. 00 92. 00
	09300 NONPALD WORKERS				93.00
	09400 PATIENTS LAUNDRY		o o		94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	C	0		95. 00
100.00	TOTAL	-1, 182, 429	16, 402, 972		100. 00

Health Financial Systems	CARE ONE AT CRESS	SKI LL		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			Increases			
	Cost Center	^	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	0	100.00
	of columns 4 and 5	must				
	equal sum of column	s 8 and				
	9)					

<sup>(1)</sup> A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. (2) Transfer to Worksheet A, col. 5, line as appropriate.

Health Financial Systems	CARE ONE AT CRESS	SKI LL		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315313		Worksheet A-6	)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/10/2024 11:	30 am
			Decreases			
	Cost Center	-	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
TOTALS						
100. 00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT CRESSKILL In Lieu of Form CMS-2540-10 Provi der No.: 315313

				''	J 12/31/2023	5/10/2024 11:	
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1, 540, 000		0	0	0	1. 00
2.00	Land Improvements	88, 809	34, 164		34, 164	0	2. 00
3.00	Buildings and Fixtures	14, 208, 483	4, 958	0	4, 958	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	563, 414	79, 928	0	79, 928	0	5. 00
6.00	Movable Equipment	2, 923, 519		0	2, 533	0	6. 00
7.00	Subtotal (sum of lines 1-6)	19, 324, 225	121, 583	0	121, 583	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	19, 324, 225		0	121, 583	0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1, 540, 000	0				1. 00
2.00	Land Improvements	122, 973	0				2. 00
3.00	Buildings and Fixtures	14, 213, 441	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	643, 342	0				5. 00
6.00	Movable Equipment	2, 926, 052	0				6. 00
7.00	Subtotal (sum of lines 1-6)	19, 445, 808	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	19, 445, 808	0				9. 00

Provi der No.: 315313

Peri od: Worksheet A-8

From 01/01/2023 | Worksheet A-8 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	5/10/2024 11:	
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
						1
						1
					1	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adj ustment	0.00			
1.00		1.00	2.00	3.00	4.00	1 00
1. 00	Investment income on restricted funds	В	-3, 025	CAP REL COSTS - BLDGS &	1.00	1. 00
2.00	(chapter 2)			FI XTURES	0.00	2 00
2.00	Trade, quantity, and time discounts (chapter		0	1	0.00	2. 00
3.00	8)   Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers				0.00	4.00
4.00	(chapter 8)				0.00	4.00
5. 00	Tel ephone services (pay stations excluded)		O		0.00	5. 00
5.00	(chapter 21)				0.00	3.00
6. 00	Television and radio service (chapter 21)		O		0.00	6. 00
7. 00	Parking lot (chapter 21)		Ö		0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	Ö			8.00
	physician adjustment		_			
9.00	Home office cost (chapter 21)		O		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		O		0.00	10.00
11. 00	Nonallowable costs related to certain		O		0.00	11. 00
	Capital expenditures (chapter 24)					ł
12.00	Adjustment resulting from transactions with	A-8-1	-278, 989			12. 00
	related organizations (chapter 10)					ł
13.00	Laundry and linen service		0		0.00	13. 00
14.00	Revenue - Employee meals		0		0.00	14. 00
15. 00	Cost of meals - Guests	В	-50	DI ETARY	8.00	•
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					1
17. 00	Sale of drugs to other than patients		0	O Company	0.00	1
18. 00	Sale of medical records and abstracts		0	O TOTAL CONTRACTOR OF THE PROPERTY OF THE PROP	0.00	•
19. 00	Vending machines		0	)	0.00	•
20. 00	Income from imposition of interest, finance		0	O The state of the	0.00	20. 00
	or penalty charges (chapter 21)	-				
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
22.00	overpayments		0	UTILIZATION DEVLEW SNE	92.00	22.00
22. 00	Utilization reviewphysicians' compensation (chapter 21)			OUTILIZATION REVIEW - SNF	82.00	22. 00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	bepreciationburidings and fratures			FIXTURES	1.00	23.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
00	Tage Tage To the second of the			EQUI PMENT	2.00	00
25. 00	FACILITY MARKETING	Α	-6. 490	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETI NG EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	•
25. 02	MARKETING CORP EXPENSE	A	· ·	ADMINISTRATIVE & GENERAL	4.00	•
25. 03	MARKETING - MEALS	A		ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	SHOWS & CONFERENCES	A	-141	ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	CHARI TABLE CONTRIBUTIONS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 06	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 07	BAD DEBT EXPENSE	Α	-670, 708	ADMINISTRATIVE & GENERAL	4.00	25. 07
25. 08	BAD DEBT EXPENSE - MEDICARE	A	-64, 471	ADMINISTRATIVE & GENERAL	4.00	25. 08
25. 09	PATIENT MEDICAL FEES	A	-1, 500	SKILLED NURSING FACILITY	30.00	25. 09
25. 10	OTHER MEDICAL SERVICES EXPENSE	A	-36, 177	SKILLED NURSING FACILITY	30.00	25. 10
25. 11	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	4.00	
25. 12	OTHER I NCOME	В	-8, 982	ADMINISTRATIVE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-1, 182, 429			100. 00
	to Worksheet A, col. 6, line 100)					l

to Worksheet A, col. 6, line 100)

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

Health Financial Systems CARE ONE AT CONTROL OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME CARE ONE AT CRESSKILL In Lieu of Form CMS-2540-10

Provider No.: 315313 | Period: | Worksheet A-8-1 | From 01/01/2023 | Parts I-II | To 12/21/2023 | Parts I-II | Prepar OFFICE COSTS

OTTTOL				Ť	o 12/31/2023 Date/Time Pi 5/10/2024 1	repared: :30 am
		Line No.	Cost (	Center	Expense Items	
		1. 00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00	CENTIMES THAME OF THE GOOTS!	4. 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	1.00
2.00		9. 00	NURSING ADMINI	STRATI ON	PHARMACY CONSULTANT	2.00
3.00			CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPENSE	3. 00
4. 00		11. 00	PHARMACY		DRUGS-NON-PRESCRI PTI ON, NON-LEGEND	4. 00
5.00		11.00	PHARMACY		PHARMACY SUPPLIES	5. 00
6. 00			INTRAVENOUS TH	ERAPY	I V EXPENSE	6.00
7. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	7. 00
8.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND	8. 00
9. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS MAN DRUGS-PRESCRIPTION, MEDICAR	9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.				A	10. 00
	12.	Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col. 5)		
			5			
		4. 00	5. 00	6. 00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS OR	
1.00		659, 629		-213, 180		1. 00
2.00		25, 417				2. 00
3.00		47, 021	47, 021	•	1	3. 00
4.00		6, 618				4. 00
5.00		285				5. 00
6.00		192, 560				6. 00
7.00		15, 271	16, 599			7. 00 8. 00
8. 00 9. 00		165, 307 351, 361	179, 681 381, 914			9.00
10.00	TOTALS (sum of lines 1-9). Transfer column	1, 463, 469				10.00
10.00	6, line 100 to Worksheet A-8, column 3, line 12.	1, 400, 409	1, 742, 430	-270, 707		10.00

5/10/2024 11:30 am Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1. 00	A	CARE ONE	100.00	1.00
2.00	A	CARE ONE	100.00	2. 00
3.00	A	CARE ONE	100.00	3.00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8.00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financia	1)		0.00	100.00
speci fy:	[			

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

		Rel ated Organi	zation(s) and/	or Home Office
		Name	Percentage of	Type of Business
Ownership   4.00   5.00   6.00		4. 00	· · · · · · · · · · · · · · · · · · ·	6. 00

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

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

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

1.00		HEALTHBRIDGE MANAGEMENT	100.00	HOME OFFICE	1. 00
2.00		PARTNERS PHARMACY	64. 87	AFFI LI ATE	2. 00
3.00		TOTAL CARE	100.00	AFFI LI ATE	3. 00
4.00			0.00		4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	speci fy:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

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

SKILL In Lieu of Form CMS-2540-10
Provider No.: 315313 Period: Worksheet B
From 01/01/2023 Part I
12/21/2023 Part (Time Propaged) Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					To	12/31/2023	Date/Time Pre 5/10/2024 11:	pared:
				CAPI TAL REL	_ATED COSTS		57 107 2024 11.	30 aiii
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
			for Cost Allocation	FI XTURES	EQUI PMENT	BENEFI TS		
			(from Wkst A					
			col. 7)	1. 00	2. 00	3. 00	3A	
1 00		AL SERVICE COST CENTERS	2 440 452	2 440 453				1 00
1. 00 2. 00		CAP REL COSTS - BLDGS & FLXTURES CAP REL COSTS - MOVABLE EQUIPMENT	2, 660, 453 256, 845	2, 660, 453	256, 845			1. 00 2. 00
3.00	1	EMPLOYEE BENEFITS	1, 619, 522	0	0	1, 619, 522	2 (70 202	3.00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	2, 336, 184 420, 545	166, 847 156, 793	16, 108 15, 137	160, 064 8, 972	2, 679, 203 601, 447	4. 00 5. 00
6.00	00600	LAUNDRY & LINEN SERVICE	158, 334	88, 858	8, 579	19, 711	275, 482	6. 00
7. 00 8. 00	1	HOUSEKEEPI NG DI ETARY	372, 865 827, 198	54, 687 230, 638	5, 280 22, 266	64, 789 104, 881	497, 621 1, 184, 983	7. 00 8. 00
9.00	00900	NURSING ADMINISTRATION	1, 020, 011	30, 571	2, 951	184, 886	1, 238, 419	9. 00
10. 00 11. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	250, 106 6, 903	0	0	5, 999 0	256, 105 6, 903	10. 00 11. 00
12. 00	01200	MEDICAL RECORDS & LIBRARY	41, 971	0	0	8, 378	50, 349	12. 00
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	77, 978	6, 793 0	656 0	15, 565	100, 992 0	13. 00 14. 00
15. 00	01500	ACTI VI TES	206, 885	0		37, 102	243, 987	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	3, 848, 512	1, 767, 999	170, 684	746, 168	6, 533, 363	30. 00
31. 00		NURSING FACILITY	0	0	0	0	0, 333, 303	31. 00
32. 00 33. 00			0	0	0	0	0	32. 00 33. 00
33.00		LARY SERVICE COST CENTERS	0	0	O O	<u></u>	0	33.00
40. 00 41. 00		RADI OLOGY LABORATORY	57, 022 101, 583	6, 793 0		0	64, 471 101, 583	40. 00 41. 00
42. 00		INTRAVENOUS THERAPY	192, 560	0	0	o	192, 560	42. 00
43.00		OXYGEN (INHALATION) THERAPY	0	10 2/1	0	124 522	0	43.00
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	655, 086 606, 001	19, 361 44, 157	1, 869 4, 263	126, 522 120, 960	802, 838 775, 381	44. 00 45. 00
46.00		SPEECH PATHOLOGY	81, 779	11, 889	1, 148	15, 525	110, 341	46. 00
47. 00 48. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 54, 687		ol Ol	0 59, 967	47. 00 48. 00
49. 00	04900	DRUGS CHARGED TO PATIENTS	531, 939	6, 793	656	o	539, 388	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0	0	ol Ol	0	50. 00 51. 00
52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	o	0	52. 00
52. 01 52. 02		OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		0	0	52. 01 52. 02
	OUTPA	TIENT SERVICE COST CENTERS		-	-	-1		
60. 00 61. 00		CLINIC RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62.00	06200	FQHC	]		_			62. 00
63. 00		DIALYSIS REIMBURSABLE COST CENTERS	0	0	0	0	0	63. 00
70. 00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 73. 00	07100	AMBULANCE CMHC	51, 673 0	0	-	0	51, 673 0	71. 00 73. 00
74. 00	07400	OTHER REIMBURSEMENT	0	0	0	o	0	74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00		INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0	0	o	0	82. 00 83. 00
84.00	08400	OTHER SPECIAL PURPOSE COST I	0	0	0	Ō	0	84. 00
84. 01 89. 00	08401	OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0 16, 381, 955	0 2, 646, 866	0 255, 533	0 1, 619, 522	0 16, 367, 056	84. 01 89. 00
		MBURSABLE COST CENTERS						
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	15, 788 5, 229	0 13, 587	0 1, 312	0	15, 788 20, 128	90. 00 91. 00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	92. 00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0	0	0	0 0	0	93. 00 94. 00
95.00	1	OTHER NONREIMBURSABLE COST	0	o O	ő	ŏ	0	95. 00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00		TOTAL	16, 402, 972	2, 660, 453	256, 845	1, 619, 522	16, 402, 972	

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315313

				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	00 4111
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	2, 679, 203					3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	117, 417	718, 864				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	53, 781	27, 335				6. 00
7.00	00700 HOUSEKEEPI NG	97, 148	16, 823	0	611, 592		7. 00
8.00	00800 DI ETARY	231, 337	70, 950	1	64, 313	1, 551, 583	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	241, 769	9, 404	0	8, 525	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	49, 998 1, 348	0	0	0	0 0	10. 00 11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	9, 829	0	0	0	0	12.00
13. 00	01300 SOCIAL SERVICE	19, 716	2, 090	o o	1, 894	ő	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	47, 632	0	0	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 075 4/5	F.40.000	057.500	400.007	4 554 500	1 00 00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 275, 465	543, 882	356, 598	493, 006	1, 551, 583 0	30. 00 31. 00
32.00	03200   CF/IID		0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	o o	0	Ö	33. 00
	ANCILLARY SERVICE COST CENTERS	-					
40.00	04000 RADI OLOGY	12, 586	2, 090	0	1, 894	0	40. 00
41. 00	04100 LABORATORY	19, 831	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	37, 592	0	0	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 156, 733	5, 956		5, 399	0	43. 00 44. 00
45. 00	04500 OCCUPATIONAL THERAPY	151, 373	13, 584		12, 313	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	21, 541	3, 657		3, 315	Ö	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 707	16, 823		15, 250	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	105, 301	2, 090	i .	1, 894	0	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		0		0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	o	0	o	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	· -	0	-	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61. 00 62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u>,                                     </u>			00.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	07100 AMBULANCE	10, 088	0	0	0		71. 00
73.00	07300 CMHC	0	0	0	0	0	1
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	) 0	U	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	2 (72 102	714 (04	0	(07,003	1 551 503	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2, 672, 192	714, 684	356, 598	607, 803	1, 551, 583	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	3, 082	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	3, 929	4, 180	o o	3, 789	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments		0		0	0	95. 00 98. 00
99. 00	Negative Cost Centers		0		0	0	99.00
100.00	1 9	2, 679, 203	718, 864	356, 598	611, 592		
		,		'	'		

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315313 Peri od: From 01/01/2023 Part I

Date/Time Prepared: 12/31/2023 5/10/2024 11:30 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 1, 498, 117 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 306, 103 10.00 01100 PHARMACY 8, 251 11.00 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 60, 178 12.00 13.00 01300 SOCIAL SERVICE 0 124, 692 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 C 0 0 15.00 01500 ACTI VI TES C 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 1, 498, 117 306, 103 8, 251 60, 178 124, 692 30.00 03100 NURSING FACILITY 31 00 C Ω 31.00 32.00 03200 | CF/IID 0 C 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 Ω 0 0 Λ 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0 0 0 0 0 0 0 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 04400 PHYSI CAL THERAPY 0 44.00 0 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0 45.00 46.00 04600 SPEECH PATHOLOGY 00000 0 0 46.00 0 04700 ELECTROCARDI OLOGY 0 47.00 0 47 00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY O 50 00 0 05100 SUPPORT SURFACES 0 51.00 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 52.00 52.00 0 ol 52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 52 02 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0 0 60.00 60.00 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 o 0 61.00 06200 FOHC 62.00 62 00 06300 DI ALYSI S 0 0 63.00 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 C 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 H0SPLCE 83.00 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 84.01 SUBTOTALS (sum of lines 1-84) 306<u>, 103</u> 60, 178 124, 692 1, 498, 117 8, 251 89.00 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 C 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00

0

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1, 498, 117

C

C

306, 103

0

8, 251

0

60, 178

95.00

98 00

0 99.00

124, 692 100. 00

09500 OTHER NONREIMBURSABLE COST

Cross Foot Adjustments

Negative Cost Centers

95.00

98.00

99.00

100.00

 
 SKILL
 In Lieu of Form CMS-2540-10

 Provider No.: 315313
 Period: From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:
 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					1	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
				OTHER GENERAL			37 107 2024 11.	30 diii
		Coat Contar Decement on	NUDCING AND	SERVI CE	Cubtatal	Doot Stondown	Total	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
			EDUCATI ON			,		
	CENED	AL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00		CAP REL COSTS - BLDGS & FLXTURES						1. 00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00		EMPLOYEE BENEFITS						3.00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	1	LAUNDRY & LINEN SERVICE						6. 00
7.00		HOUSEKEEPI NG						7. 00
8. 00 9. 00		DI ETARY NURSI NG ADMINI STRATI ON						8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100	PHARMACY						11. 00
12.00	1	MEDICAL RECORDS & LIBRARY						12.00
13. 00 14. 00	1	SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0					13. 00 14. 00
15. 00	1	ACTI VI TES	0	291, 619				15. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	1	SKILLED NURSING FACILITY NURSING FACILITY	0	291, 619 0			13, 042, 857 0	30. 00 31. 00
32. 00		ICF/IID			•		0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0			0	33. 00
40.00		LARY SERVICE COST CENTERS	1 0		81, 041		01 041	40.00
40. 00 41. 00	1	RADI OLOGY LABORATORY		0			81, 041 121, 414	40. 00 41. 00
42.00	1	INTRAVENOUS THERAPY	0	0			230, 152	
43.00	1	OXYGEN (INHALATION) THERAPY	0	0	`	1	0	
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0			970, 926 952, 651	44. 00 45. 00
46. 00		SPEECH PATHOLOGY	0	Ö		1	138, 854	46. 00
47. 00		ELECTROCARDI OLOGY	0	0	`	1	0	47. 00
48. 00 49. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	103, 747 648, 673		103, 747 648, 673	48. 00 49. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	Ö	Ö	040, 075		040, 073	50.00
51.00		SUPPORT SURFACES	0	0	(	o	0	51. 00
52. 00 52. 01		COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST	0	0	,	0	0	52. 00 52. 01
52. 01	1	MEDICAL SERVICES		0		-	0	52. 01
		TIENT SERVICE COST CENTERS	-	-				
60.00		CLINIC	0	-			0	60.00
61. 00 62. 00	06200	RURAL HEALTH CLINIC	0	0	(	0	0	61. 00 62. 00
63.00		DI ALYSI S	0	О	(	o	0	
		REIMBURSABLE COST CENTERS	1	_	1	-		
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0	0	61, 761		0 61, 761	
73. 00	07300	CMHC	0	Ö		_	01, 701	
74. 00		OTHER REIMBURSEMENT	0	0	(	0	0	74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES	1	I	I			80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF						82. 00
83.00		HOSPI CE	0	0	(	0	0	
84. 00 84. 01		OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II					0	84. 00 84. 01
89. 00		SUBTOTALS (sum of lines 1-84)	0	291, 619	16, 352, 076	0	16, 352, 076	
00.00		MBURSABLE COST CENTERS	1		10.076		40.070	00.00
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0			18, 870 32, 026	
92. 00		PHYSICIANS PRIVATE OFFICES	0	Ö	02, 020	o o	0	92. 00
93.00		NONPALD WORKERS	0	0	(	0	0	93.00
94. 00 95. 00		PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST	0	0			0	94. 00 95. 00
98.00	0 7 3 0 0	Cross Foot Adjustments				ol ol	0	98.00
99. 00		Negative Cost Centers	0	0	(	o	0	99. 00
100.00	)	TOTAL	0	291, 619	16, 402, 972	2  0	16, 402, 972	100. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315313

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
			CAPI TAL REL	ATED COSTS		5/10/2024 11.	30 alli
	Cost Contan Dogoni ati on	Di mantlu	DI DCC 0	MOVADI E	Cubtatal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal					
		Related Costs	1.00	2.00	2.4	2.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	3. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	0	0	
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	166, 847 156, 793	16, 108 15, 137	182, 955 171, 930	0	1
6. 00	00600 LAUNDRY & LINEN SERVICE	o	88, 858	8, 579	97, 437	0	
7.00	00700 HOUSEKEEPI NG	0	54, 687	5, 280	59, 967	0	
8.00	00800 DI ETARY	0	230, 638	22, 266	252, 904	0	
9. 00 10. 00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	30, 571	2, 951 0	33, 522	0	
11. 00	01100 PHARMACY	o	o	Ö	ő	0	
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	o	0	o	0	1
13. 00 14. 00	01300 SOCIAL SERVICE	0	6, 793	656	7, 449	0	
15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	0	0	0	0	
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS	31		<u> </u>	٥		1
30. 00	03000 SKILLED NURSING FACILITY	0	1, 767, 999	170, 684	1, 938, 683	0	
31.00	03100 NURSING FACILITY 03200   CF/IID	0	0	0	0	0	
32. 00 33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u></u>	<u> </u>	<u> </u>		00.00
40.00	04000 RADI OLOGY	0	6, 793	656	7, 449	0	1
41.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	1
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	
44. 00	04400 PHYSI CAL THERAPY	Ö	19, 361	1, 869	21, 230	0	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	44, 157	4, 263	48, 420	0	1
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	11, 889	1, 148 0	13, 037	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	54, 687	5, 280	59, 967	0	
49. 00	04900 DRUGS CHARGED TO PATIENTS	Ö	6, 793	656	7, 449	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	
51. 00 52. 00	05100   SUPPORT SURFACES   05200   COMPLEX   MEDI CAL   EQUI   PMENT	0	0	0	0	0	
52. 00	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	1
52. 02	05202 MEDI CAL SERVI CES	Ö	Ö	0	Ö	0	
	OUTPATIENT SERVICE COST CENTERS						
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	1
62. 00	06200 FQHC	J J	U	U	U	U	62.00
63.00	06300 DI ALYSI S	0	0	0	0	0	
70.00	OTHER REIMBURSABLE COST CENTERS	1	a	al	ما		
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	0	0	
73. 00	07300 CMHC	o	o	Ö	ő	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS	Т	T		I		00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	0	o	0	O	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)		2, 646, 866	255, 533	2, 902, 399	0	
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	2, 040, 000	233, 333	2, 702, 377		07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	
91. 00	09100 BARBER AND BEAUTY SHOP	0	13, 587	1, 312	14, 899	0	1
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	
94. 00	09400 PATIENTS LAUNDRY		ol	ol	ol	0	
95.00	09500 OTHER NONREIMBURSABLE COST	0	ō	O	o	0	95. 00
98.00	Cross Foot Adjustments		_	_	0	=	98.00
99. 00 100. 00	Negative Cost Centers TOTAL	o	0 2, 660, 453	0 256, 845	0 2, 917, 298	0	99. 00 100. 00
100.00	, I TOTAL	١	2, 000, 403	230, 043	2, 711, 270	O	1.00.00

Provi der No.: 315313

				T	0 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	oo aiii
		& GENERAL	OPERATION,	LINEN SERVICE			
			MAINT. & REPAIRS				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	100.055					3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	182, 955 8, 018	179, 948				4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	3, 672	6, 843	i .			6. 00
7.00	00700 HOUSEKEEPI NG	6, 634	4, 211	1	70, 812		7. 00
8.00	00800 DI ETARY	15, 797	17, 760	1	7, 446	293, 907	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	16, 509	2, 354	0	987	0	9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	3, 414 92	0	0	0	0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	671	0	0	0	0	12.00
13. 00	01300 SOCIAL SERVICE	1, 346	523	ő	219	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	3, 253	0	0	0	0	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	07 101	12/ 140	107.050	F7 000	202 007	20.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	87, 101	136, 148	107, 952 0	57, 082	293, 907 0	30. 00 31. 00
32. 00	03200   CF/11D		0	_	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	o	0	Ö	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	859	523	1	219	0	40. 00
41. 00	04100 LABORATORY	1, 354	0	0	0	0	41.00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	2, 567	0	0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	10, 703	1, 491	0	625	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	10, 337	3, 400	ő	1, 426	0	45. 00
46.00	04600 SPEECH PATHOLOGY	1, 471	915	0	384	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	_	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	799	4, 211	1	1, 766	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	7, 191	523 0	1	219	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	o	0	ő	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	o	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
40.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	T ol	0	0	0	0	40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC		0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC	١	0		O	O	62. 00
63.00	06300 DI ALYSI S	o	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00		0	0	0	0	0	70.00
	07100   AMBULANCE   07300   CMHC	689	0	0	0	0	71. 00 73. 00
74.00	07400 OTHER REIMBURSEMENT		0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS	-1	-		-1		
80.00							80. 00
81. 00	1						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II		0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	182, 477	178, 902	107, 952	70, 373	293, 907	89. 00
	NONREI MBURSABLE COST CENTERS				,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	210	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	268	1, 046	0	439	0	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY		0	0	n	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST		0	Ö	ő	0	95. 00
98. 00	Cross Foot Adjustments			0	О	0	98. 00
99.00		0	0	0	0	0	99.00
100.00	D TOTAL	182, 955	179, 948	107, 952	70, 812	293, 907	100.00

Provi der No.: 315313

				' '	12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINI STRATION	SUPPLY		LI BRARY		
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00
8.00	00900 NURSI NG ADMI NI STRATI ON	E2 272					8.00
9. 00 10. 00	01000 CENTRAL SERVICES & SUPPLY	53, 372	3, 414				9. 00 10. 00
11. 00	01100 PHARMACY		3, 414	92			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		0	0	671		12. 00
13. 00	01300 SOCI AL SERVI CE		0	0	0,1	9, 537	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		ol	0	0	0	14. 00
15. 00	01500 ACTI VI TES	o	o	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 SKILLED NURSING FACILITY	53, 372	3, 414	92	671	9, 537	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200   CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI 0L0GY	0	0	0	0	_	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	0	U	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY	0	U	0	0	0	47. 00 48. 00
49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS		0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY		0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES		0	0	0	0	51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		Ö	0	0	ő	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	o	o	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	o	o	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-,	-	-		
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
63.00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS		_1		_		
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0	0	0	0	71.00
	07400 OTHER REIMBURSEMENT	0	U	0	0	0 0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	l ol	U <sub>I</sub>	U	U	U	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	o	o	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	o	o	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	O	О	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	53, 372	3, 414	92	671	9, 537	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	_	91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95.00	09500 OTHER NONREI MBURSABLE COST		O	0	O	0	95.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00		53, 372	3, 414		671		100.00
100.00	/ ITOTAL	33,372	3, 414	72	0/1	7, 557	1.00.00

 
 SKILL
 In Lieu of Form CMS-2540-10

 Provider No.: 315313
 Period: From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:
 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

						To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared:
				OTHER GENERAL			37 107 2024 11.	50 alli
		0 1 0 1 5 11	NUIDCI NO AND	SERVI CE		D 1 C1 D	<b>.</b>	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
			EDUCATI ON			/iaj as imerite		
	OFNED	AL CERVI OF COCT OFFITERS	14.00	15. 00	16. 00	17. 00	18. 00	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS - BLDGS & FIXTURES	1		I			1. 00
2. 00		CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00		EMPLOYEE BENEFITS						3. 00
4.00	1	ADMINISTRATIVE & GENERAL						4.00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00		HOUSEKEEPI NG						7. 00
8.00		DI ETARY						8. 00
9.00		NURSI NG ADMINI STRATI ON						9.00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY						10. 00 11. 00
12. 00	1	MEDICAL RECORDS & LIBRARY						12. 00
13. 00		SOCIAL SERVICE						13. 00
14. 00 15. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	2 252				14.00
15.00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	0	3, 253				15. 00
30. 00		SKILLED NURSING FACILITY	0	3, 253	2, 691, 21	2 0	2, 691, 212	30. 00
31. 00		NURSING FACILITY	0	0	1	0 0	0	
32.00		ICF/IID	0	0	1	0 0	0	•
33. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	] 0	0	l	0 0	0	33. 00
40. 00		RADI OLOGY	0	0	9, 05	0 0	9, 050	40. 00
41.00	1	LABORATORY	0	0			1, 354	41. 00
42.00		INTRAVENOUS THERAPY	0	0			2, 567	1
43. 00 44. 00	1	OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0			0 9 0	0 34, 049	
45. 00	1	OCCUPATI ONAL THERAPY	0	Ö	1		63, 583	1
46. 00		SPEECH PATHOLOGY	0	0		7 0	15, 807	46. 00
47. 00		ELECTROCARDI OLOGY	0	0		0 0	0	47. 00
48. 00 49. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS			66, 74 15, 38		66, 743 15, 382	1
50. 00	1	DENTAL CARE - TITLE XIX ONLY	0	Ö	12,22	0 0	0	50.00
51.00		SUPPORT SURFACES	0	0		0 0	0	
52. 00 52. 01		COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST	0	0		0 0	0	52. 00 52. 01
52. 01	1	MEDICAL SERVICES			1	0 0	0	52. 01
	OUTPA <sup>*</sup>	TIENT SERVICE COST CENTERS		-				
60.00		CLINIC	0	-	1	0 0	0	60.00
61. 00 62. 00	06200	RURAL HEALTH CLINIC	0	0		0 0	0	61. 00 62. 00
63. 00	1	DIALYSIS	0	0		o	0	1
	OTHER	REIMBURSABLE COST CENTERS						
70.00		HOME HEALTH AGENCY COST	0	0	1	0 0	0	
71. 00 73. 00	07100	AMBULANCE CMHC	0		68	0 0	689 0	1
		OTHER REIMBURSEMENT	Ö	Ö	1	0 0	0	
		AL PURPOSE COST CENTERS	ı	I	ı			
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82.00		UTILIZATION REVIEW - SNF						82.00
83. 00		HOSPI CE	0	0		0 0	0	•
84.00		OTHER SPECIAL PURPOSE COST I	0	0		0 0	0	
84. 01 89. 00	08401	OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0	0 3, 253	2, 900, 43	0 0	0 2, 900, 436	
07.00	NONRE	IMBURSABLE COST CENTERS		3, 233	2, 700, 43	0  0	2, 700, 430	0 7. 00
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1		210	1
91.00		BARBER AND BEAUTY SHOP	0	0	16, 65	2 0	16, 652	
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0	0			0	
94. 00		PATIENTS LAUNDRY	0	0		ŏ o	0	
95.00		OTHER NONREIMBURSABLE COST	0	0		0 0	0	
98. 00		Cross Foot Adjustments	0	0		0 0	0	
99. 00 100. 00		Negative Cost Centers TOTAL	0	3, 253	2, 917, 29	8 0	0 2, 917, 298	99. 00 100. 00
	1			, 5,200	_, _,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, Y	_,, 270	,

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315313

				'	0 12/31/2023	Date/lime Pre 5/10/2024 11:	
		CAPITAL REI	ATED COSTS				
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3. 00	4A	4. 00	
	ENERAL SERVICE COST CENTERS	1 00 1/0		I		I	
2.00 0	10100 CAP REL COSTS - BLDGS & FIXTURES 10200 CAP REL COSTS - MOVABLE EQUIPMENT 10300 EMPLOYEE BENEFITS	39, 162	39, 162 0				1.00 2.00 3.00
	10400 ADMINISTRATIVE & GENERAL 10500 PLANT OPERATION, MAINT. & REPAIRS	2, 456 2, 308				13, 723, 769 601, 447	4. 00 5. 00
7.00 0	10600 LAUNDRY & LINEN SERVICE 10700 HOUSEKEEPING	1, 308 805	805	324, 587	0	497, 621	6. 00 7. 00
9.00 0	10800 DI ETARY 10900 NURSI NG ADMI NI STRATI ON	3, 395 450	450	926, 269	0	1, 238, 419	1
11.00 0	11000 CENTRAL SERVICES & SUPPLY 11100 PHARMACY 11200 MEDICAL RECORDS & LIBRARY	0	0	30, 053 ( 41, 971	0	256, 105 6, 903 50, 349	11. 00
13. 00 0	1300 SOCIAL SERVICE 1400 NURSING AND ALLIED HEALTH EDUCATION	100	100	77, 978	0	100, 992	
15. 00 0	01500 ACTIVITES NPATIENT ROUTINE SERVICE COST CENTERS	0	0				15. 00
30.00 0	33000 SKILLED NURSING FACILITY 33100 NURSING FACILITY	26, 025	26, 025	3, 738, 277			30. 00 31. 00
32. 00 0	13100 NORSING FACILITY 13200 ICF/IID 13300 OTHER LONG TERM CARE	0	0		0	0	32. 00 33. 00
А	HOULLARY SERVICE COST CENTERS  4000 RADI OLOGY	100					
4	14100 LABORATORY 14200 I NTRAVENOUS THERAPY	0	0			,	
44. 00 0	14300 OXYGEN (INHALATION) THERAPY 14400 PHYSICAL THERAPY	0 285	l		0	0 802, 838	
46. 00 0	14500 OCCUPATI ONAL THERAPY 14600 SPEECH PATHOLOGY	650 175	175	77, 779	0	775, 381 110, 341	45. 00 46. 00
48. 00 0	14700 ELECTROCARDIOLOGY 14800 MEDICAL SUPPLIES CHARGED TO PATIENTS	805 100	l	(	0	59, 967	47. 00 48. 00
50.00 0	14900 DRUGS CHARGED TO PATIENTS 15000 DENTAL CARE - TITLE XIX ONLY 15100 SUPPORT SURFACES	100	100		0	539, 388 0 0	49. 00 50. 00 51. 00
52. 00 0	15200 COMPLEX MEDICAL EQUIPMENT 15201 OTHER ANCILLARY SERVICES COST	0	0		0	0	52. 00 52. 01
52. 02 0	15202 MEDICAL SERVICES UTPATIENT SERVICE COST CENTERS	0	0			-	52. 02
60.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0				60. 00 61. 00
63.00 0	16200 FQHC 16300 DI ALYSI S	0	0	(	0	0	62. 00 63. 00
	THER REIMBURSABLE COST CENTERS 17000 HOME HEALTH AGENCY COST	0	0	(	0	0	70. 00
	17100 AMBULANCE 17300 CMHC	0 0	0	(		51, 673 0	1
S	17400 OTHER REIMBURSEMENT PECIAL PURPOSE COST CENTERS	0	0	(	0	0	
81. 00 0	18000 MALPRACTICE PREMIUMS & PAID LOSSES 18100 INTEREST EXPENSE						80.00
83. 00 0	18200 UTILIZATION REVIEW - SNF 18300 HOSPICE	0	0	(	0	0	82. 00 83. 00
	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	38, 962	0 0 38, 962	8, 113, 719	0 0 -2, 679, 203	0 0 13, 687, 853	84. 00 84. 01 89. 00
N	ONREI MBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	36, 702					
91.00 0	19100 BARBER AND BEAUTY SHOP 19200 PHYSICIANS PRIVATE OFFICES	200			0		
94. 00 0	19300 NONPALD WORKERS 19400 PATLENTS LAUNDRY	0	0	(	-	0	93. 00 94. 00
98. 00	07500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	(	0	0	95. 00 98. 00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 660, 453	256, 845	1, 619, 522	2	2, 679, 203	99. 00 102. 00
103. 00 104. 00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	67. 934554	6. 558526	0. 199603	3	0. 195224 182, 955	

Health Financial Systems	CARE ONE AT	CRESSKI LL		In Lieu of Form CMS-2540-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der No.: 315313		Peri od:	Worksheet B-1		
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/10/2024 11:		
	CAPITAL REL	LATED COSTS					
Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
	1. 00	2. 00	3. 00	4A	4. 00		
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000	D	0. 013331	105. 00	

Provi der No.: 315313

				1	0 12/31/2023	Date/lime Pre 5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(PATIENT DAYS)			(PATIENT DAYS)	
		(SQUARE FEET)				(	
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	I	T	ı	I	ı	4 00
1. 00 2. 00	OO100   CAP REL COSTS - BLDGS & FIXTURES   OO200   CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINI STRATI VE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	34, 398					5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 308					6. 00
7.00	00700 HOUSEKEEPI NG	805		32, 285			7. 00
8.00	00800 DI ETARY	3, 395	0	3, 395	75, 294		8. 00
9. 00	00900 NURSING ADMINISTRATION	450		450	0	25, 098	1
10.00	01000 CENTRAL SERVI CES & SUPPLY	0	1	0	0	0	
11. 00	01100 PHARMACY	0	0	0	0	0	1
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	100	0	100	0	0	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	100	0	100	0	0	
	01500 ACTIVITES			0	0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 SKILLED NURSING FACILITY	26, 025	25, 098	26, 025	75, 294	25, 098	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200   CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS	1	1		_		
40. 00	04000 RADI OLOGY	100		100	0	0	
41. 00	04100 LABORATORY	0	1	0	0	1	
42. 00 43. 00	04200   NTRAVENOUS THERAPY 04300   OXYGEN (INHALATION) THERAPY	0	1	0	0	0	
44. 00	04400 PHYSI CAL THERAPY	285	_	285	0	0	
45. 00	04500 OCCUPATI ONAL THERAPY	650	l .	650		Ö	
46. 00	04600 SPEECH PATHOLOGY	175		175		Ö	
47.00	04700 ELECTROCARDI OLOGY	0		0	0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	805	0	805	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	100	0	100	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0		0	0	0	
52. 01	05201 OTHER ANCI LLARY SERVI CES COST	0		0	_	0	
52. 02	05202 MEDICAL SERVICES   OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52. 02
60. 00	06000 CLINIC	1 0	0	0		0	60.00
	06100 RURAL HEALTH CLINIC		0	0	0	Ö	
62. 00	06200 FQHC			Ī	_		62. 00
	06300 DI ALYSI S	0	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0		0			
	07100 AMBULANCE	0				1	
	07300 CMHC	0		0	0	0	1
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100   NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	0	О	0	0	0	1
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84.00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0		0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	34, 198	25, 098	32, 085	75, 294	25, 098	89. 00
	NONREI MBURSABLE COST CENTERS				I		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	0	0	
91. 00	09100 BARBER AND BEAUTY SHOP	200		200	0	0	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	_		0	0	
93.00	09400 PATIENTS LAUNDRY		0	0	0	0	
94. 00 95. 00	09500 OTHER NONREIMBURSABLE COST					0	
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99.00
102.00		718, 864	356, 598	611, 592	1, 551, 583	1, 498, 117	
	Part I)						
103.00	Unit cost multiplier (Wkst. B, Part I)	20. 898424					
		170 040	107, 952	70, 812	293, 907	I 53 372	104.00
104.00		179, 948	107, 732	, 0, 0, 2	270, 707	00,072	1.000
	Part II)						
104. 00 105. 00	Part II)	5. 231351			3. 903458		

Provi der No.: 315313

CENTRAL   SERVICE OF CENTRES   SOLAL SERVICE   NURSING AND   SERVICE   NURSING AND   SERVICE   NURSING AND   SERVICE   SERVICE OF CENTRES   SOLAL SERVICE   SERVICE OF CENTRES   SOLAL SERVICE   SERVICE OF CENTRES   SOLAL SERVICE   SERV					'	0 12/31/2023	Date/lime Pre   5/10/2024 11:	
CREATER SERVICE COST CENTERS   10.00   11.00   12.00   13.00   14.00   12.00   13.00   14.00   12.00   13.00   14.00   12.00   13.00   14.00   12.00   13.00   14.00   12.00   13.00   13.00   13.00   14.00   13.00		Cost Center Description	SERVICES & SUPPLY		RECORDS & LI BRARY		NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED	
CREATER SERVICE COST CENTERS   1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			10.00	11.00	12.00	13.00		
2.00   DISCRICTOR MELLOSIS - MOVABLE FOUR PARMEN   3.00								
3.00 000000   IMPROVED REPRETIENCE AGENT AS GENERAL SERVICE SE								1. 00
4.00 000400 ADMINISTRATIVE & CEMERAL								
5.00   OBOSOD   LANT OPERATI ON, MAINT. & REPAIRS								
0.000   0.0000   LUMINOFY & LINEN SERVICE								
7.00   00700   HOUSEKEEPING		· ·						
8.00 000000 INTERNAL ORDINAL STRATION		l i						
9.00   00000   MIRSINER ADMINISTRATION   9.00   10.00								
10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   11.0		l i						
11.00   01100   PIMAMANCY   0   25,008     11.00   12.00   1			25 098		•			
12.00   01.200 MEDICAL RECORDS & LIBRAY   0   0   25.098   12.00   13.00   1			0	25. 098				11. 00
14.00   01400   NURSING ABD ALLIED HEALTH EDICATION   0   0   0   0   0   0   0   0   0			0	0	1			12. 00
15.00   0.1500   ACT IVITES	13.00	01300 SOCIAL SERVICE	0	0	0	25, 098		13. 00
IMPATIENT ROUTINE SERVICE COST CENTERS   25,098   25,098   25,098   25,098   0 30.00   31.00	14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
30.00   0.3000   SKILLED MURSING FACILITY   25,098   25,098   25,098   25,098   0.30 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.31 0   0.30 0   0.51 0   0.32 0   0.	15.00		0	0	0	0	0	15. 00
31 0.0   03100   NURSI NO FACILITY					1			
32.00   0.300   CEYLI D   0   0   0   0   0   0   32.00				25, 098	25, 098	25, 098		
33.00   03300   OTHER LONG TERM CARE			_	0	0	0		
ARCILLARY SERVICE COST CENTERS    1.00				0		0		
40.00   04000   RADIOLOGY	33.00		U	U	<u> </u>	U	U	33.00
1.00   0.100   LABORATIONY	40 00		0	0	0	0	0	40 00
42.00   04200   NTEANEMOUS THERAPY   0   0   0   0   0   42.00			1	0	Ö	o		41. 00
44.00   04400   PHYSICAL THERAPY   0   0   0   0   0   44.00			0	0	o	0	0	42.00
45.00 0 4500 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 45.00 47.00 0 4700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 47.00 47.00 0 4700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 47.00 47.00 0 4800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 47.00 49.00 0 4900 DRUIG CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 49.00 51.00 0 5000 DRUIL CARE THITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 0 51.00 51.00 0 5000 DRUIL CARE THITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 51.00 51.00 0 5000 DRUIL CARE THITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 51.00 51.00 0 5000 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 0 0 0 0 0 0 51.00 52.01 0 5000 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 0 0 0 0 0 0 52.01 52.01 0 5200 DRUIL CARE SUPPLIES CHARGES SOST 0 0 0 0 0 0 0 0 0 0 0 52.01 52.01 0 5200 DRUIL CARE SUPPLIES CHARGES SOST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
46.00   04600   SPEECH PATHOLOGY   0   0   0   0   0   0   0   46.00   48.00   04800 MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   48.00   04800 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   50.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO PATIENTS   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO DRUGS   0   0   0   0   0   60.00   05000 DRUGS CHARGED TO CHARGE TO C	44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   47.00   49.00   04900   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   49.00   04900   DRUIGA CARE TO THE TAIL TO THE TEXT   0   0   0   0   0   0   0   51.00   05000   DENTIAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05000   DENTIAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05000   DENTIAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05000   DENTIAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   52.01   05000   COMPLEX MEDICAL EQUI PMENT   0   0   0   0   0   0   0   52.01   05201   OTHER - ANCILLARY SERVICES COST   0   0   0   0   0   0   0   52.01   05201   OTHER - ANCILLARY SERVICES COST   0   0   0   0   0   0   52.01   05202   MEDICAL SERVICES   0   0   0   0   0   0   0   52.01   05202   MEDICAL SERVICES   0   0   0   0   0   0   0   51.00   05200   CLINIC   0   0   0   0   0   0   0   52.01   05201   OTHER - ANCILLARY SERVICES COST CENTERS   0   0   0   0   0   0   0   51.00   0500   CLINIC   0   0   0   0   0   0   0   0   0   51.00   05200   CLINIC   0   0   0   0   0   0   0   0   0			0	0	0	0		45. 00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0	0	0		46.00
49.00   04900   DRUISC CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0			0	0		0		
50.00   05000   05000   05000   05000   0500   0			0	0	0	0		
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   51.00		l i	0	0		0		
52.00   OS200   COMPLEX MEDICAL EQUIPMENT   O   O   O   O   O   O   O   O   O			0	0		0		1
52.01   05201   OTHER ANCILLARY SERVICES COST   0   0   0   0   0   0   52.01			0	0	0	0		52. 00
DUTPATIENT SERVICE COST CENTERS			0	0	o	0	0	52. 01
60.00	52.02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
61.00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   62.00   62.00   62.00   63.00   06200   FOHC   0   0   0   0   0   0   0   0   63.00   06300   DIALYSIS   0   0   0   0   0   0   0   0   63.00   07.00   07.00   07.00   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0								
62.00					0	0		
63.00			O	0	0	0	0	1
OTHER RELIBIURSABLE COST CENTERS				0		0	_	
70,00   07000   IMBULANCE	03.00		0	0	<u> </u>	U U	0	03.00
71. 00	70. 00		0	0	0	0	0	70.00
74. 00			0	0	o	0	0	
SPECIAL PURPOSE COST CENTERS   SO. 00			0	0	0	0	0	73. 00
80.00	74.00		0	0	0	0	0	74.00
81.00   81.00   81.00   INTEREST EXPENSE     81.00   82.00   UTI LI ZATI ON REVIEW - SNF   82.00   82.00   UTI LI ZATI ON REVIEW - SNF   82.00   82.00   08200   UTI LI ZATI ON REVIEW - SNF   82.00   82.00   08400   OTHER SPECI AL PURPOSE COST     0 0 0 0 0 0 0 0 0 0 84.00   84.00   84.01   08401   OTHER SPECI AL PURPOSE COST     0 0 0 0 0 0 0 0 0 0 84.00   84.00					1	i i		
82.00   08200   UTILIZATION REVIEW - SNF								
83. 00								
84. 00			0	0	_	٨	n	
84. 01			0	0	0	0		
SUBTOTALS (sum of lines 1-84)   25,098   25,098   25,098   25,098   0 89.00			0	0	Ö	o		84. 01
NONREI   MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0			25, 098	25, 098	25, 098	25, 098		89. 00
91.00		NONREI MBURSABLE COST CENTERS						
92. 00	90.00		0	0	0	0	0	90.00
93.00			0	0	0	0		91.00
94.00			0	0	0	0		
95. 00			0	0		0		
98.00 99.00 102.00 103.00 104.00 105.00 105.00 105.00 106.00 107.00 108.00 109.			0	0		0		
99. 00 102. 00 102. 00 103. 00 104. 00 105. 00 105. 00 106. 00 107. 00 108. 00 109. 00								
102.00   Cost to be allocated (per Wkst. B, Part I)   103.00   Unit cost multiplier (Wkst. B, Part I)   12.196310   Cost to be allocated (per Wkst. B, Part II)   12.196310   Cost to be allocated (per Wkst. B, Part III)   105.00   Unit cost multiplier (Wkst. B, Part III)   Unit cost multiplier (Wkst. B, Part IIII)   Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		, ,						99.00
103.00     Unit cost multiplier (Wkst. B, Part I)     12.196310     0.328751     2.397721     4.968205     0.000000 103.00       104.00     Cost to be allocated (per Wkst. B, Part II)     3,414     92     671     9,537     0 104.00       105.00     Unit cost multiplier (Wkst. B, Part II)     0.136027     0.003666     0.026735     0.379990     0.000000 105.00			306, 103	8, 251	60, 178	124, 692	0	
104.00   Cost to be allocated (per Wkst. B, Part II)   105.00   Unit cost multiplier (Wkst. B, Part   0.136027   0.003666   0.026735   0.379990   0.000000   105.00			]			.,		
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.136027 0.003666 0.026735 0.379990 0.000000 105.00			1		1			
105.00 Unit cost multiplier (Wkst. B, Part 0.136027 0.003666 0.026735 0.379990 0.000000 105.00	104.00		3, 414	92	671	9, 537	0	104.00
	105 00		0 134037	0.003444	0.004735	0.370000	0 000000	105 00
	105.00		0. 136027	0. 003666	0.026/35	0.3/9990	0.00000	105.00
		1 1117	1	l	I .	<u> </u>	ı	1

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315313

				To 12/31/2023   Date/Time Pre	
			OTHER GENERAL		
		Cost Center Description	SERVI CE ACTI VI TES		
		Cost Center Description	(PATIENT DAYS)		
			15. 00		
1 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES			1 00
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES  CAP REL COSTS - MOVABLE EQUIPMENT			1. 00 2. 00
3.00	1	EMPLOYEE BENEFITS			3. 00
4.00		ADMINISTRATIVE & GENERAL			4. 00
5. 00 6. 00	4	PLANT OPERATION, MAINT. & REPAIRS   LAUNDRY & LINEN SERVICE			5. 00 6. 00
7. 00		HOUSEKEEPING			7. 00
8.00		DI ETARY			8. 00
9.00	1	NURSING ADMINISTRATION			9. 00
10. 00 11. 00	1	CENTRAL SERVICES & SUPPLY   PHARMACY			10.00
12. 00	1	MEDICAL RECORDS & LIBRARY			12.00
13.00	1	SOCIAL SERVICE			13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	25 000		14.00
15. 00		ACTIVITES   ENT ROUTINE SERVICE COST CENTERS	25, 098		15. 00
30.00		SKILLED NURSING FACILITY	25, 098		30.00
31. 00		NURSING FACILITY	0		31. 00
32. 00 33. 00		ICF/IID	0 0		32. 00 33. 00
33.00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	<u> </u>		33.00
40.00		RADI OLOGY	0		40. 00
41. 00	1	LABORATORY	0		41.00
42. 00 43. 00	1	INTRAVENOUS THERAPY  OXYGEN (INHALATION) THERAPY	0		42. 00 43. 00
44. 00	1	PHYSI CAL THERAPY	0		44. 00
45.00	04500	OCCUPATI ONAL THERAPY	O		45. 00
46.00		SPEECH PATHOLOGY	0		46. 00
47. 00 48. 00	1	ELECTROCARDIOLOGY   MEDICAL SUPPLIES CHARGED TO PATIENTS	0		47. 00 48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	o		49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0		50.00
51.00	4	SUPPORT SURFACES	0		51.00
52. 00 52. 01	1	COMPLEX MEDICAL EQUIPMENT   OTHER ANCILLARY SERVICES COST	0		52. 00 52. 01
52. 02	1	MEDI CAL SERVI CES	O		52. 02
		TIENT SERVICE COST CENTERS			
60. 00 61. 00	1	CLINIC  RURAL HEALTH CLINIC	0		60. 00 61. 00
62. 00	06200				62. 00
63.00		DIALYSIS	0		63. 00
70.00		REIMBURSABLE COST CENTERS	l ol		70.00
70. 00 71. 00		HOME HEALTH AGENCY COST   AMBULANCE	0		70.00 71.00
	07300		0		73. 00
74. 00		OTHER REIMBURSEMENT	0		74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81. 00		INTEREST EXPENSE			81. 00
82. 00		UTILIZATION REVIEW - SNF			82. 00
83. 00		HOSPICE OTHER SPECIAL PURPOSE COST I	0		83.00
84. 00 84. 01	4	OTHER SPECIAL PURPOSE COST I	0		84. 00 84. 01
89. 00	00.0.	SUBTOTALS (sum of lines 1-84)	25, 098		89. 00
	-	I MBURSABLE COST CENTERS	1		
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN  BARBER AND BEAUTY SHOP	0		90. 00 91. 00
92. 00		PHYSICIANS PRIVATE OFFICES	0		92.00
93.00	09300	NONPALD WORKERS	O		93. 00
94.00		PATIENTS LAUNDRY	0		94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments			95. 00 98. 00
99. 00	1	Negative Cost Centers			99.00
102.00	D	Cost to be allocated (per Wkst. B,	291, 619		102. 00
103.00		Part      Unit cost multiplier (Wkst. B, Part   )	11. 619213		103. 00
103.00	1	Cost to be allocated (per Wkst. B,	3, 253		103.00
		Part II)			
105.00	ו	Unit cost multiplier (Wkst. B, Part	0. 129612		105. 00
	ļ	11)	1		I

Health Financial Systems	CARE ONE AT CRESSKILL	In	Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR ANCILLA	RY AND OUTPATIENT COST CENTERS Provi	ider No.: 315313 Period:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:30 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 81, 041 142, 555 0. 568489 40.00 04100 LABORATORY 121, 414 253, 957 0.478089 41.00 41.00 523, 260 42.00 04200 I NTRAVENOUS THERAPY 230, 152 0. 439843 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 970, 926 2, 122, 318 0. 457484 44.00 04500 OCCUPATIONAL THERAPY 2, 928, 899 45.00 952, 651 0. 325259 45.00 04600 SPEECH PATHOLOGY 409, 563 0.339030 46.00 138, 854 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 103, 747 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 0. 448758 49.00 49.00 648, 673 1, 445, 485 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0 0.000000 0 52.01 05202 MEDICAL SERVICES 0 0.000000 52.02 52.02 OUTPATIENT SERVICE COST CENTERS 0 0. 000000 60.00 06000 CLI NI C 0 60.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62. 00 06200 FQHC 62.00 63. 00 06300 DI ALYSI S 0.000000 63.00 71. 00 07100 AMBULANCE 129, 182 61, 761 0. 478093 71.00

3, 309, 219

7, 955, 219

100. 00

100.00

Total

Health Financial Systems	CARE ONE AT	CRESSKI LL		In Li€	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	epared: 30 am
		Title	XVIII (1)	Skilled Nursing	PPS	
		Lucal Ale Corre		Facility	Program Cost	1
		Health Care P				
	Ratio of Cost	Part A	Part B		Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Col umn 3)	0.00				
DART I ON OUR ATLANT OF ANOLUL ARV AND OUTDAT	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					-
ANCILLARY SERVICE COST CENTERS	0.5/0400	05.007	ı	00.450		40.00
40. 00   04000   RADI OLOGY	0. 568489			0 20, 458		
41. 00   04100   LABORATORY	0. 478089			0 36, 475	l .	
42. 00   04200   I NTRAVENOUS THERAPY	0. 439843	l .		0	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0.000000			0 (00 01)	0	
44. 00   04400   PHYSI CAL THERAPY 45. 00   04500   OCCUPATI ONAL THERAPY	0. 457484 0. 325259			0 608, 016		1
46. 00   04600   SPEECH PATHOLOGY	0. 325259			0 553, 350 0 76, 886		1
47. 00   04700   ELECTROCARDI OLOGY	0. 000000			70,000		
48. 00   04800   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000			0	0	
49. 00   04900 DRUGS CHARGED TO PATIENTS	0. 448758			0 118, 547		
50. 00   05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			110, 547		50.00
51. 00   05100  SUPPORT SURFACES	0. 000000	l .		0	0	
52. 00   05200   COMPLEX   MEDI CAL   EQUI PMENT	0. 000000			0	0	
52. 01   05200   OTHER ANCILLARY SERVICES COST	0. 000000			0	0	
52. 02   05202   MEDI CAL   SERVI CES   COST	0. 000000			0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	<u> </u>	1	0	0	32.02
60. 00 06000 CLINIC	0. 000000			0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.00000					61.00
62. 00   06200   FQHC						62.00
63. 00 06300 DI ALYSI S	0. 000000	0		0	0	
71. 00   07100   AMBULANCE (2)	0. 478093			o	l o	
100.00 Total (Sum of lines 40 - 71)		3, 633, 531		0 1, 413, 732		100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	V		1	, , , , , , , , , ,		
(., . 5. 2. 2. 6 V and ATA 450 COT 411115 1, 2, 4114 4 OTT	J.					

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

	Financial Systems	CARE ONE AT	CRESSKI LL		In Lie	u of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315313	Period: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/10/2024 11:	pared: 30 am
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		<u> </u>				
						1. 00	
	PART II - APPORTIONMENT OF VACCINE COST		/F !!! ! !			0.440750	
1.00	Drugs charged to patients - ratio of co			t C, column 3	line 49)	0. 448758	1.00
2.00	Program vaccine charges (From your reco					438 197	2.00
3. 00	Program costs (Line 1 x line 2) (Title E, Part I, line 18)	XVIII, PPS pro	viders, transfe	er this amoun	t to worksneet	197	3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
			Allied Health	Nursing &	Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,			Heal th Costs	
		18	Part I, Col.	Costs to Tota	I I, Col. 4)	for Pass	
			,	Costs - Part		Through (Col.	
				(Col. 2 / Col		3 x Col. 4)	
		1.00	2.00	1)	4.00	F 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	1.00		3. 00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	FUR NURSTING &	ALLIED HEALIH				l I
40.00	04000 RADI OLOGY	81, 041	0	0.00000	20, 458	0	40.00
	04100 LABORATORY	121, 414		0. 00000		0	
42. 00	04200 I NTRAVENOUS THERAPY	230, 152		0. 00000		0	
43. 00	04300 OXYGEN (INHALATION) THERAPY	0		0.00000		0	
44.00	04400 PHYSI CAL THERAPY	970, 926	0	0.00000		0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	952, 651	0	0. 00000	553, 350	0	45.00
46.00	04600 SPEECH PATHOLOGY	138, 854	0	0.00000	76, 886	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 747	0	0. 00000	0 0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	648, 673	0	0. 00000		0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	50.00
	05100 SUPPORT SURFACES	0	0	0. 00000		0	
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0. 00000		0	
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0.00000		0	
52. 02	05202 MEDI CAL SERVI CES	0	0	0.00000	0	0	52. 02
100.00	Total (Sum of lines 40 - 52)	3, 247, 458	0		1, 413, 732		100.00

ealth Fina	ncial Systems	CARE ONE AT CRE	SSKILL	In Lie	u of Form CMS-2	2540-1
OMPUTATI OI	N OF INPATIENT ROUTINE COSTS		Provi der No.: 315313	Peri od: From 01/01/2023 To 12/31/2023		pared:
			Title XVIII	Skilled Nursing Facility		
					1. 00	
PART	I CALCULATION OF INPATIENT ROUTIN	E COSTS			1.00	
I NPA	TIENT DAYS					İ
	tient days including private room	days			25, 098	
	rate room days				0	2.0
	tient days including private room				11, 822	3.0
	cally necessary private room days Il general inpatient routine servic		m		0 13, 042, 857	4.0 5.0
	ATE ROOM DIFFERENTIAL ADJUSTMENT	e cost			13, 042, 637	] 5.0
	eral inpatient routine service char	aes			14, 377, 693	6.0
	eral inpatient routine service cost		ivided by line 6)		0. 907159	
	r private room charges from your r		,		0	8. (
	age private room per diem charge (	Private room charges lin	e 8 divided by private	room days, line	0.00	9. (
1 /						10.
	.00 Enter semi-private room charges from your records .00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by					10. 11.
	-private room days)	rge (Seiii - private rooiii	charges fille 10, divide	d by	0. 00	11.0
	rage per diem private room charge o	ifferential (Line 9 minu	s line 11)		0.00	12. (
	age per diem private room cost dif				0.00	13. (
1	ate room cost differential adjustm	•	•		0	14. (
	eral inpatient routine service cost		t differential (Line 5	minus line 14)	13, 042, 857	15. (
	RAM INPATIENT ROUTINE SERVICE COST sted general inpatient service cos		ided by Line 1)		519. 68	16. (
	ram routine service cost (Line 3		rueu by Title T)		6, 143, 657	
	cally necessary private room cost		line 4 times line 13)		0, 110, 007	18. (
	l program general inpatient routir	11 1 3 1	,		6, 143, 657	19. (
	tal related cost allocated to inpa		sts (From Wkst. B, Par	t II column 18,	2, 691, 212	20. (
1	30 for SNF; line 31 for NF, or li					
1	diem capital related costs (Line	,			107. 23	
	ram capital related cost (Line 3 tient routine service cost (Line				1, 267, 673 4, 875, 984	
	regate charges to beneficiaries for		vider records)		4, 873, 784	24.
	Il program routine service costs fo			nus line 24)	4, 875, 984	25.
4	er the per diem limitation (1)	,				26.
	tient routine service cost limitat					27. (
	bursable inpatient routine service		e lesser of line 25 or	line 27)		28. (
	nsfer to Worksheet E, Part II, lir 26 and 27 are not applicable for ti					l

		1.00	1
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	25, 098	1. 00
2.00	Program inpatient days (see instructions)	11, 822	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. 471034	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems CARE ONE AT CARE	Provi der No.: 315313	Peri od: From 01/01/2023 To 12/31/2023		pare
		Title XIX	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			25, 098	1.
00	Private room days			0	2.
00	Inpatient days including private room days applicable to the			0	3
00	Medically necessary private room days applicable to the Prog	ram		0	4
0	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			13, 042, 857	5
0	General inpatient routine service charges			14, 377, 693	6
0	General inpatient routine service charges  General inpatient routine service cost/charge ratio (Line 5)	divided by line 6)		0. 907159	
	Enter private room charges from your records	divided by Time 0)		0. 707 137	8
Enter private room charges from your records  Average private room per diem charge (Private room charges line 8 divided by private room days, line				0.00	9
00	2)			0	10
00	3				
00	semi-private room per drem charge (semi-private room  semi-private room days)	iii charges irne 10, divide	ed by	0.00	' '
00	Average per diem private room charge differential (Line 9 mi	nus line 11)		0.00	12
00	Average per diem private room cost differential (Line 7 time	s line 12)		0.00	13
00	Private room cost differential adjustment (Line 2 times line	,		0	14
00	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	ost differential (Line 5	minus line 14)	13, 042, 857	15
00	Adjusted general inpatient service cost per diem (Line 15 d	ivided by line 1)		519. 68	16
00	Program routine service cost (Line 3 times line 16)	,		0	17
00	Medically necessary private room cost applicable to program			0	18
00	Total program general inpatient routine service cost (Line			0	19
00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	2, 691, 212	20
00	Per diem capital related costs (Line 20 divided by line 1)			107. 23	21
00	Program capital related cost (Line 3 times line 21)			0	22
00	Inpatient routine service cost (Line 19 minus line 22)			0	
00	Aggregate charges to beneficiaries for excess costs (From p	,		0	24
00	Total program routine service costs for comparison to the co	st limitation (Line 23 mi	nus line 24)	0	25
00	Enter the per diem limitation (1)		0() (4)	0.00	
00	Inpatient routine service cost limitation (Line 3 times the			0	27
00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E. Part II, line 4) (See instructions		iine 21)	0	28

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	25, 098	1.00
2.00	Program inpatient days (see instructions)	0	2. 00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3. 00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.000000	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	CARE ONE AT CRES	SSKILL	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR TITLE XVIII	Provi der No.: 315313	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:30 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	EMEIV1		10, 517, 185	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	1
3.00	Subtotal (Sum of lines 1 and 2)	3		10, 517, 185	1
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			1, 262, 200	5. 00
6.00	Allowable bad debts (From your records)			158, 392	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			102, 955	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)			9, 357, 940	11. 00
12.00	Interim payments (See instructions)			9, 172, 196	12. 00
13.00	Tentati ve adjustment			0	13. 00
14.00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			15, 688	
14. 75	Sequestration for non-claims based amounts (see instructions)			2, 059	•
14. 99	Sequestration amount (see instructions)			185, 100	
15. 00	Balance due provider/program (see Instructions)			-17, 103	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			197	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			197	•
20.00	Medicare Part B ancillary charges (See instructions)			438	1
21. 00	Cost of covered services (Lesser of line 19 or line 20)			197	
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)	ations)		0	
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	Ctions)		0	1
24. 02 25. 00	Adjusted reimbursable bad debts (see instructions)			197	
26. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) Interim payments (See instructions)			86	•
27. 00	Tentati ve adjustment			0	•
28. 00	Other Adjustments (See instructions) Specify			0	
28. 50	Demonstration payment adjustment amount before sequestration			0	•
28. 55	Demonstration payment adjustment amount before sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			4	28. 99
29. 00	Balance due provider/program (see instructions)			107	•
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	0	
30. 00	1. States amounts (nonarronable cost report realis) in accordance	5 5mo 1 db. 10 2,	110.2	٥١	1 30.00

From 01/01/2023
To 12/31/2023

To 12/31/2023 Date/Time Prepared: 5/10/2024 11:30 am

Title XVIII Skilled Nursing PPS

Fooility:

		11 (1	e AVIII	Facility	PPS	
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		9, 054, 197		86	1. 00
2.00	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,		124, 459		0	2. 00
3.00	enter zero 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
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER		0			3. 02
3. 02			0			3. 02
3. 04			0			3. 04
3. 05			0			3. 05
3. 03	Provider to Program					3. 00
3.50	ADJUSTMENTS TO PROGRAM	06/09/2023	6, 460		0	3. 50
3. 51	7.65 CO TIMELATO TO TAXONO MI	00, 07, 2020	0, 100		l ol	3. 51
3. 52			0		0	3. 52
3. 53			0		l ol	3. 53
3. 54			0		l ol	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-6, 460		o o	3. 99
4 00	- 3. 98)		0.470.407			4 00
4.00	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)		9, 172, 196		86	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	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. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		l ol	5. 02
5. 03			0		l ol	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
	PROGRAM TO PROVI DER		0		107	6. 01
6. 01			1		0	6. 02
6. 01 6. 02	PROVI DER TO PROGRAM		17, 103		( )	
	PROVIDER TO PROGRAM Total Medicare program liability (see instructions)		17, 103 9, 155, 093		193	7. 00
6.02	i i				193 Contractor	
6. 02	i i		9, 155, 093	tor Name	193	

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

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

Provi der No.: 315313 | Peri od: From 01/01/202

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 30 am

oni y)		Conoral Fund	Cnoci fi o F	adaumant Fund	5/10/2024 11:	30 am
		General Fund	Purpose Fund	ndowment Fund	Plant Fund	
	Assets	1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	120, 707	0	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	3, 027, 822	0	0	0	
5. 00	Other receivables	3,027,622	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	-650, 073	l	o	0	
	recei vabl e					
7. 00	Inventory	0	0	0	0	
8. 00	Prepaid expenses	6, 065	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	17, 604	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	2, 522, 125	0	0	0	
11.00	FIXED ASSETS	2, 322, 123	9	<u> </u>		1
12. 00	Land	1, 540, 000	0	0	0	12.0
13. 00	Land improvements	122, 973	О	0	0	13.0
14. 00	Less: Accumulated depreciation	-35, 581	0	0	0	
15.00	Buildings	14, 213, 441	0	0	0	
16. 00 17. 00	Less Accumulated depreciation Leasehold improvements	-9, 374, 330	0	O O	0	
18. 00	Less: Accumulated Amortization	0	0	0	0	
19. 00	Fi xed equipment	643, 342	Ö	o	0	
20. 00	Less: Accumulated depreciation	-930, 037	O	0	0	
21. 00	Automobiles and trucks	0	О	0	0	21.0
22. 00	Less: Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	2, 926, 052	0	0	0	
24. 00	Less: Accumulated depreciation	-2, 210, 347	0	0	0	1
25. 00 26. 00	Minor equipment - Depreciable Minor equipment nondepreciable	0	0	0	0	
27. 00	Other fixed assets	224, 000	0	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	7, 119, 513	Ö	o	0	
	OTHER ASSETS					
29. 00	Investments	0	0	0	0	1
30. 00	Deposits on Leases	0	0	0	0	
31.00	Due from owners/officers	(20.50)	0	0	0	
32. 00 33. 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	629, 586 629, 586	0	0	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	10, 271, 224	Ö	0	0	
	Liabilities and Fund Balances	•				
	CURRENT LIABILITIES	_				
35. 00	Accounts payable	1, 195, 155	0	0	0	
36.00	Salaries, wages, and fees payable	114, 763	0	0	0	
37. 00 38. 00	Payroll taxes payable Notes & Loans payable (Short term)	-37, 978	0	0	0	
39. 00	Deferred income	0		0	0	
40. 00	Accel erated payments	0		J	· ·	40. 0
41. 00	Due to other funds	17, 604	0	0	0	41.0
42. 00	Other current liabilities	33, 427, 176		0	0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	34, 716, 720	0	0	0	43.0
44.00	LONG TERM LIABILITIES			ما	0	144 0
44. 00 45. 00	Mortgage payable Notes payable		0	0	0	
46. 00	Unsecured Loans		0	0	0	
47. 00	Loans from owners:	0	l ö	o	0	
48. 00	Other long term liabilities	-52, 942, 480	o	0	0	
49. 00	OTHER (SPECIFY)	0	О	0	0	
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-52, 942, 480	0	0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-18, 225, 760	0	0	0	51.0
52. 00	CAPITAL ACCOUNTS  General fund balance	28, 496, 984				52.0
53. 00	Specific purpose fund	20, 470, 704	0			53. 0
54. 00	Donor created - endowment fund balance - restricted			o		54. 0
55. 00	Donor created - endowment fund balance - unrestricted			0		55. C
56. 00	Governing body created - endowment fund balance			0		56.0
57. 00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58.0
	mont agament and avnor-!		i e			1
58. 00	replacement, and expansion	20 404 004		^	^	E0 0
58. 00 59. 00 60. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	28, 496, 984 10, 271, 224		0	0	

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

STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315313 | Peri od: From 01/01/2023

Worksheet G-1

12/31/2023 Date/Time Prepared: 5/10/2024 11:30 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 28, 855, 355 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -142, 884 2.00 3.00 Total (sum of line 1 and line 2) 28, 712, 471 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0000 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 28, 712, 471 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 215, 487 0 13.00 14.00 0 0 0 14.00 0 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 215, 487 18.00 Fund balance at end of period per balance 19.00 28, 496, 984 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 0 0 Subtotal (line 3 plus line 10) 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 14.00 0 14.00 15.00 0 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 0 0 19.00 Fund balance at end of period per balance 19.00 sheet (Line 11 - line 18)

	Financial Systems	CARE ONE AT CRES				u of Form CMS-2	
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		SES	Provi der		Peri od: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description			Inpati ent	Outpati ent	Total	30 alli
	oust defiter beschiptron			1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES			1.00	2.00	0.00	
	General Inpatient Routine Care Services						1
1. 00	SKILLED NURSING FACILITY			14, 377, 69	93	14, 377, 693	1.00
2. 00	NURSING FACILITY				O	0	1
3. 00	ICF/IID				0	0	3.00
4. 00	OTHER LONG TERM CARE				0	0	4. 00
5.00	Total general inpatient care services (Sum	of lines 1 - 4)		14, 377, 69	93	14, 377, 693	5. 00
	All Other Care Services						1
6. 00	ANCI LLARY SERVI CES			7, 955, 21	9 0	7, 955, 219	6.00
7.00	CLINIC				0	0	7.00
8. 00	HOME HEALTH AGENCY COST				0	0	8.00
9.00	AMBULANCE				0	0	9. 00
10. 00	RURAL HEALTH CLINIC				0	0	10.00
10. 10	FQHC				0	0	10. 10
11. 00	CMHC				0	0	11. 00
12.00	HOSPI CE				0 0	0	12.00
13.00	OTHER (SPECIFY)				0 0	0	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13	3) (Transfer column 3	to	22, 332, 91	2 0	22, 332, 912	14.00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES						
1. 00	Operating Expenses (Per Worksheet A, Col. 3	3, Line 100)				17, 585, 401	1.00
2.00	Add (Specify)				0		2. 00
3. 00					0		3. 00
4. 00					0		4. 00
5.00					0		5. 00
6. 00					0		6. 00
7.00					0		7. 00
0 00	Total Additions (Sum of Lines 2 7)						0 00

8.00

9. 00 10. 00 11. 00

12. 00 13. 00 14. 00

0

17, 585, 401 15. 00

8.00

9.00

10. 00 11. 00

12.00

Total Additions (Sum of lines 2 - 7)

15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

13.00 14.00 Total Deductions (Sum of lines 9 - 13)

Deduct (Specify)

Heal th	Financial Systems CARE	ONE AT CRESSKILL	In Lie	u of Form CMS-2	2540-10	
	STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES   Provider No.: 315313   Period:				Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:		
				1. 00		
1.00	Total patient revenues (From Wkst. G-2, Part I, col	3 line 14)		22, 332, 912	1. 00	
2.00	Less: contractual allowances and discounts on patients accounts				2. 00	
3. 00	Net patient revenues (Line 1 minus line 2)				3. 00	
4. 00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)					
5.00	Net income from service to patients (Line 3 minus 4)		17, 585, 401 -223, 570			
	Other income:			·		
6.00	Contributions, donations, bequests, etc	0	6. 00			
7.00	Income from investments	3, 025	7. 00			
8.00	Revenues from communications (Telephone and Interne	0	8. 00			
9.00	Revenue from television and radio service	0	9. 00			
10.00	Purchase di scounts				10.00	
11.00	Rebates and refunds of expenses				11. 00	
12.00	Parking lot receipts				12. 00	
13.00	Revenue from Laundry and Linen service			0	13. 00	
14.00	Revenue from meals sold to employees and guests				14. 00	
15.00	Revenue from rental of living quarters				15. 00	
	Revenue from sale of medical and surgical supplies to other than patients				16. 00	
	Revenue from sale of drugs to other than patients	0				
	Revenue from sale of medical records and abstracts	0	10.00			
	Tuition (fees, sale of textbooks, uniforms, etc.)	0				
	Revenue from gifts, flower, coffee shops, canteen			0		
	Rental of vending machines			0	21. 00	
	Rental of skilled nursing space			0	22. 00	
22 00	Covernmental appropriations			0	22 00	

0

6, 449

274

0 24.50

0 27.00

0 29. 00

0 30.00

-142, 884 31. 00

61, 906

8, 982

80, 686

-142, 884

23.00

24. 01

24.02

24.03

25.00

26.00

28.00

Governmental appropriations

Other expenses (specify)

24.50 COVID-19 PHE Funding 25.00 Total other income (Sum of lines 6 - 24) 26.00 Total (Line 5 plus line 25)

30.00 Total other expenses (Sum of lines 27 - 29)

31.00 Net income (or loss) for the period (Line 26 minus line 30)

24. 00 BARBER AND BEAUTY

24. 01 OTHER REVENUES 24. 02 NJ PROVI DER TAX

24. 03 OTHER INCOME

23.00

27. 00

28.00

29.00