This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315472 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/10/2024 11:31 am PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 5/10/2024 Time: 11:31 am use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3

use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code 12.[ F ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" 5. Date Received: for no utilization.

6. Contractor No.

No Medicare Utilization. Enter "Y" for yes or leave blank for no.

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

4. [ 1 ] Cost Report Status

Contractor

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 EAST BRUNSWICK (315472) 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	62, 739	-806	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	62, 739	-806	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 EAST BRUNSWICK In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315472 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:31 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 599 CRANSBURY ROAD 1.00 PO Box: 1.00 2.00 City: EAST BRUNSWICK State: NJ Zi p Code: 08816 2.00 3.00 County: MI DDLESEX CBSA Code: 35154 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 XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT EAST 315472 02/04/2002 N Р Ν 4.00 BRUNSWI CK 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 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) 01/01/2023 12/31/2023 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? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 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 N 19.01 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 20.00 Straight Line 544 412 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 23.00 544, 412 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 26.00 N (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) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 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 Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 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 mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 1.00 3.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 64.535 0 0

Heal th	Financial Systems	CARE ONE AT EAST B	RUNSWI CK	In Lie	u of Form CMS-2	2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315472		Worksheet S-2	
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023		
					5/10/2024 11:	31 am_
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative an	nd General cost	N	42. 00
	center? Enter Y or N. If yes, check box	x, and submit supporting	schedule listing cost	centers and		
	amounts.					
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Ch	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and address	of the home	HB0206	44. 00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of the	home office on the	lines	
	bel ow.	_				
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contrac	tor's Number: 1200	1	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00
47.00	City: FORT LEE	State: NJ	Zi p Cod	le: 0702	4	47. 00

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI K REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE Provider	F	Peri od: From 01/01/2023 To 12/31/2023		2
				10 12/31/2023	5/10/2024 11	
				Y/N	Date	
Į.	General Instruction: For all column 1 respon:	ses enter in column 1 "Y" fo	r Yes or "N" f	1.00 for No. For all	the date	
Į	responses the format will be (mm/dd/yyyy)					
	Completed by All Skilled Nursing Facilites  Provider Organization and Operation					-
.00	Has the provider changed ownership immediate	ly prior to the beginning of	the cost	N		1.0
	reporting period? If column 1 is "Y", enter	the date of the change in col	umn 2. (see			
	instructions)		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
	Has the provider terminated participation in column 1 is yes, enter in column 2 the date		N			2.0
	3, "V" for voluntary or "I" for involuntary.	or termination and in corumn				
00	Is the provider involved in business transac		Y			3. (
	contracts, with individuals or entities (e.g or medical supply companies) that are relate					
	officers, medical staff, management personne	I, or members of the board				
	of directors through ownership, control, or relationships? (see instructions)	family and other similar				
	Teratronships? (see Tristructrons)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports  Column 1: Were the financial statements prep	ared by a Cartified Dublic	Υ	A		4. (
00	Accountant? (Y/N) Column 2: If yes, enter "A	" for Audited, "C" for	'	A		4. (
	Compiled, or "R" for Reviewed. Submit comple	te copy or enter date				
	available in column 3. (see instructions) If Are the cost report total expenses and total	· · · · · · · · · · · · · · · · · · ·	N			5. (
	those on the filed financial statements? If		IN .			] 3. \
	reconciliation.			V 41	L	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				2. 00	
	Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2: Is the	provi der the	N	N	6. (
	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program	s? (Y/N) see instructions.		N		7.0
. 00	Were approvals and/or renewals obtained duri	ng the cost reporting period	for Nursing	N		8. 0
	School and/or Allied Health Program? (Y/N) s	ee instructions.			Y/N	
					1. 00	
-	<u>Bad Debts</u> Is the provider seeking reimbursement for ba	d dobte2 (V/N) soo instructio	ne		Υ	9. (
	If line 9 is "Y", did the provider's bad deb			reporting	N N	10. (
	period? If "Y", submit copy.					
	<pre>If line 9 is "Y", are patient deductibles an Bed Complement</pre>	d/or coinsurance waived? If "	Y", see instru	ictions.	N N	
	Have total beds available changed from prior	cost reporting period? If "Y	", see instruc	rtions		- 11.0
2. 00				ti ons.	N	11. 0
2. 00			Pai	rt A	Part B	
2. 00		Description 0				
<u> </u>	PS&R Data	Description	Y/N 1.00	Date 2.00	Part B Y/N 3.00	12. (
3. 00	Was the cost report prepared using the PS&R	Description	Pai Y/N	rt A Date	Part B Y/N	12. (
3. 00		Description	Y/N 1.00	Date 2.00	Part B Y/N 3.00	12. (
3. 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	Description	Y/N 1.00	Date 2.00	Part B Y/N 3.00	12. (
3. 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.)	Description	Y/N 1.00	Date 2.00	Part B Y/N 3.00	13.
3. 00 4. 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	Description	Y/N 1.00	Date 2.00	Part B Y/N 3.00	13.
3. 00 4. 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.) 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"	Description 0	Y/N 1.00	Date 2.00	Part B Y/N 3.00	13.
3. 00 4. 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.) 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	Description 0	Y/N 1.00	Date 2.00	Part B Y/N 3.00	13. (
3. 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.) 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"	Description 0	Y/N 1.00	Date 2.00	Part B Y/N 3.00	13. (
3. 00 4. 00 5. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments	Description 0	Y/N 1.00	Date 2.00	Part B Y/N 3.00	
3. 00 4. 00 5. 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.)  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.	Description 0	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	13. (
3. 00 4. 00 5. 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.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",	Description 0	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	13. (
3. 00 1. 00 5. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	Description 0	Pal Y/N 1.00 Y N	Date 2.00	Part B	13. (
3. 00 4. 00 5. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were	Description 0	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	13. (
3. 00 1. 00 5. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	Description 0	Pal Y/N 1.00 Y N	Date 2.00	Part B	13. (
3. 00 4. 00 5. 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.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	Description 0	Pal Y/N 1.00 Y  N  N	Date 2.00	Part B Y/N 3.00  Y  N  N	12. (
3. 00 4. 00 5. 00 7. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were	Description 0	Pal Y/N 1.00 Y N	Date 2.00	Part B	13. (
3. 00 4. 00 5. 00 7. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for Corrections of PS&R data for Other? Describe the other adjustments:	Description 0	Pal Y/N 1.00 Y  N  N	Date 2.00	Part B Y/N 3.00  Y  N  N	12. (
3. 00 4. 00 5. 00 6. 00 7. 00 8. 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.)  Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.  If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of 19 yes, see instructions.	Description 0	Pal Y/N 1.00 Y  N  N	Date 2.00	Part B Y/N 3.00  Y  N  N	12. 13. 14.

Heal th	Financial Systems CA	ARE ONE AT EAS	ST BRUNSWICK		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provi der		Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/10/2024 11:	pared:	
			1.	00	2. (	00	
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title/p		CHARLES		REED		19. 00
	held by the cost report preparer in columns 1, respectively.	2, and 3,					
20.00	Enter the employer/company name of the cost rep	oort E	EXECUCARE ASSO	CI ATES			20. 00
	preparer.						
21. 00	Enter the telephone number and email address of	1,	(609) 738-3200		CRWASSC@NETSCAF	PE. NET	21. 00
	report preparer in columns 1 and 2, respectivel	y.					

Health Financial Systems CARE ONE AT EACH SKILLED NURSING FACILITY HEALTH CARE CARE ONE AT EAST BRUNSWICK

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315472 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:31 am
		Part B		<b>.</b>	07 107 202 1 111 0 1 0
		Date			
		4. 00			
	PS&R Data				
13. 00	Was the cost report prepared using the PS&R	03/19/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and 4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14.00
11.00	for total and the provider's records for				11.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
	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.				
16. 00	1				16. 00
. 0. 00	adjustments made to PS&R data for				10.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17.00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
40.00	Describe the other adjustments:				10.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18. 00
	provider s records? IT if see Histractions.				
			3.00		
	Cost Report Preparer Contact Information				
19. 00	Enter the first name, last name and the title		VI CE-PRESI DENT		19. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
00.00	respecti vel y.				00.00
20.00	Enter the employer/company name of the cost r	eport			20. 00
21. 00	preparer. Enter the telephone number and email address	of the cost			21. 00
21.00	report preparer in columns 1 and 2, respective				21.00
	1. 1-1. 1 - 1-1-1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	, , .	I .	1	I I

Health Financial Systems CARE ONE AT EAST SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Provi der No.: 315472 Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/10/2024 11:31 am

Component   Number of Beds   Bard Days   Available   Title V   Title XIX   Title XIX						0 12/31/2023	5/10/2024 11: 3	
Novel   Any   Novel   Novel					I npa	atient Days/Vis	si ts	
1.00   SKILLED NURSING FACILITY   132   48,180   0   13,120   13,225   1.00		Component	Number of Beds		Title V	Title XVIII	Title XIX	
2.00   NURSING FACILITY			1.00		3.00	4. 00	5. 00	
1.00   Component   1.00   0   0   0   0   0   0   0   0   0		· ·	1					
MOME HEALTH AGENCY COST   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·		1				
District Cong Term Care		· ·	0	0				
A		1			0	0	0	
NOSPICE   0			0	U				
Total   Sum of lines 1-7   13.28   48, 180   0   13, 120   13, 235   8.00			0	0	0	0	0	
Component   Other   Total   Title V   Title XVIII   Title XIX			_	48 180	•			
1.00   SKILLED NURSING FACILITY   12,602   38,957   0   0   491   10,00   0   2,00   0   0   0   0   0   0   0   0   0		, , , , , , , , , , , , , , , , , , , ,						
1.00   SKILLED NURSING FACILITY   12,602   38,957   0   0   491   10,00   0   2,00   0   0   0   0   0   0   0   0   0								
1.00		Component						
2.00   NURSING FACILITY	1 00	SKILLED NUDSING FACILLITY						1 00
1.00   CF/IID   0   0   0   0   0   0   0   0   0				1			l	
A 00   HOME HEALTH ACENCY COST   0   0   0   0   0   0   0   0   0			0	0	0			
5.00			0	0				
SNF-Based CMHC			0	Ö				
Residence   Total (Sum of lines 1-7)   12,602   38,957   0   491   52   8.00   10   10   10   10   10   10   10	6.00							6.00
Discharges   Average Length of Stay   Other   Total   Title V   Title XVIII   Title XIX   Title XIX	7.00	HOSPI CE	0	0	0	0	0	7.00
Component   Other   Total   Title V   Title XVIII   Title XIX	8. 00	Total (Sum of lines 1-7)						8. 00
11.00			Di sch	arges	Aver	age Length of	Stay	
1.00		Component	Other					
2. 00								
3.00   ICF/IID			1	l			l .	
4. 00   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0			_	1				
5.00			0	0			0.00	
Component   Comp		1	0	0				
NO				0				
Note   Section   Section			0	0	0.00	0.00	0.00	
Average Length of Stay			448	991				
Total   Title V   Title XVIII   Title XIX   Other					Admi s	si ons		
16.00					1		2.1	
1.00   SKILLED NURSING FACILITY   39.31   0   519   20   437   1.00		Component						
2.00	1 00	SKILLED NURSING ENCLITY						1 00
3.00   ICF/IID   0.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1				l .	
A . 00			1	l .		0		
6.00 SNF-Based CMHC 7.00 HOSPICE 0.00 0 0 0 0 0 0 7.00 8.00 Total (Sum of lines 1-7) 39.31 0 519 20 437 8.00    Admissions   Full Time Equivalent		· ·						
Total   SKILLED NURSING FACILITY   Still Time   Still T	5.00	1	0. 00				0	5. 00
Result   Sum of lines 1-7   39.31   0   519   20   437   8.00	6.00	SNF-Based CMHC						6.00
Admissions   Full Time Equivalent   Total   Employees on Payrol   Workers   21.00   22.00   23.00		· ·	1	0				
Total   Employees on Payrol   Workers   21.00   22.00   23.00	8. 00	Total (Sum of lines 1-7)		Full Time		20	437	8. 00
Payrol   Workers     21.00   22.00   23.00								
21.00   22.00   23.00		Component	Total					
1. 00     SKILLED NURSING FACILITY     976     131. 23     0.00     1.00       2. 00     NURSING FACILITY     0     0.00     0.00     2.00       3. 00     I CF/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			21.00					
2.00     NURSING FACILITY     0     0.00     0.00       3.00     I CF/IID     0     0.00     0.00       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     0.00     6.00       7.00     HOSPI CE     0     0.00     0.00     7.00	1 00	SKILLED NURSING FACILLTY						1 00
3.00     I CF/I I D     0     0.00     0.00       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			1	l e				
4.00       HOME HEALTH AGENCY COST       0.00       0.00       4.00         5.00       Other Long Term Care       0.00       0.00       5.00         6.00       SNF-Based CMHC       0.00       0.00       6.00         7.00       HOSPI CE       0.00       0.00       0.00				ł				
6. 00 SNF-Based CMHC 0. 00 0. 00 6. 00 7. 00 HOSPI CE 0 0 0. 00 0. 00 7. 00				l e			j	
7. 00 HOSPICE 0 0. 00 0. 00 7. 00 7. 00			0	l e				
				l e				
8.00   Total (Sum of Lines 1-7)   976  131.23  0.00    8.00								
	8.00	Iotal (Sum of Lines 1-7)	976	131. 23	0.00			8. 00

Wage related costs (excluded units)

Total Adjusted Wage Related cost (see

Physician Part A - WRC

Physician Part B - WRC

instructions)

19.00

20.00

21.00

22.00

SNF WAGE INDEX INFORMATION Provi der No.: 315472 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/10/2024 11:31 am Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 Reported col . 4) Worksheet A-6  $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 9, 449, 346 9, 449, 346 272, 968. 00 34, 62 1.00 Physician salaries-Part A 0.00 2.00 0 0 0 0.00 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 0.00 4.00 4.00 Sum of lines 2 through 4 0 0.00 5.00 0 0.00 5.00 0 272, 968. 00 6.00 Revised wages (line 1 minus line 5) 9, 449, 346 9, 449, 346 34.62 6.00 7.00 Other Long Term Care 0 0 0.00 0.00 7.00 HOME HEALTH AGENCY COST 8.00 0 0 0.00 0.00 8.00 0.00 0 0 9.00 CMHC 0.00 9.00 0 10.00 HOSPI CE 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0.00 0.00 11.00 0 Subtotal Excluded salary (Sum of lines 7 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 9, 449, 346 C 9, 449, 346 272, 968. 00 34.62 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 59. 72 14.00 345, 757 345, 757 5, 790. 00 14.00 15.00 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 2, 091, 770 2, 091, 770 17.00 Wage-related costs other (See Part IV) 0 18.00

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2, 091, 770

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2, 091, 770

18.00

20.00

21.00

22.00

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315472

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/20

				'	0 12/31/2023	5/10/2024 11:	
		Amount	Reclass. of	Adjusted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
		·	Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	673, 310	0	673, 310	16, 394. 00	41. 07	2. 00
3.00	Plant Operation, Maintenance & Repairs	117, 136	0	117, 136	4, 169. 00	28. 10	3. 00
4.00	Laundry & Linen Service	63, 870	0	63, 870	3, 494. 00	18. 28	4. 00
5.00	Housekeepi ng	317, 324	0	317, 324	17, 154. 00	18. 50	5. 00
6.00	Di etary	601, 558	0	601, 558	26, 533. 00	22. 67	6. 00
7.00	Nursing Administration	840, 758	0	840, 758	17, 911. 00	46. 94	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	73, 458	0	73, 458	2, 161. 00	33. 99	10. 00
11.00	Soci al Servi ce	137, 456	0	137, 456	3, 929. 00	34. 98	11. 00
12.00	Nursing and Allied Health Ed. Act.						12. 00
13.00	Other General Service	207, 611	0	207, 611	9, 608. 00	21. 61	13.00
14.00	Total (sum lines 1 thru 13)	3, 032, 481	0	3, 032, 481	101, 353. 00	29. 92	14. 00

Health Financial Systems	CARE ONE AT EAST BRUNSWICK	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315472	Peri od: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:

PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST  1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 4.01K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Ung-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES	2024 11: 3 bunt brited 00  44, 203 0 0 0 0 117, 673 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
PART IV - WAGE RELATED COSTS  Part A - Core List  RETIREMENT COST  1.00	00 44, 203 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST  1.00 401K Employer Contributions 2.00 Tax Shel tered Annuity (TSA) Employer Contribution 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan 7.00 Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES FICA-Employers Portion Only	44, 203 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
Part A - Core List RETIREMENT COST  1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST  8.00 Health Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES FICA-Employers Portion Only	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
RETIREMENT COST  1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan 7.00 Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST  8.00 Health Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  FICA-Employers Portion Only	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1.00 401K Employer Contributions 2.00 Tax Shel tered Annui ty (TSA) Employer Contribution 3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES FICA-Employers Portion Only	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Tax Sheltered Annuity (TSA) Employer Contribution  Qualified and Non-Qualified Pension Plan Cost  Prior Year Pension Service Cost  PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  401K/TSA Plan Administration fees Legal /Accounting/Management Fees-Pension Plan  Employee Managed Care Program Administration Fees  HEALTH AND INSURANCE COST  Health Insurance (Purchased or Self Funded)  Prescription Drug Plan  Dental, Hearing and Vision Plan  Life Insurance (If employee is owner or beneficiary)  Accident Insurance (If employee is owner or beneficiary)  Disability Insurance (If employee is owner or beneficiary)  Long-Term Care Insurance (If employee is owner or beneficiary)  Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  FICA-Employers Portion Only	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3.00 Qualified and Non-Qualified Pension Plan Cost 4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan Find the polyce Managed Care Program Administration Fees HEALTH AND INSURANCE COST  8.00 Health Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only	0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
4.00 Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan Find over Managed Care Program Administration Fees HEALTH AND INSURANCE COST  8.00 Health Insurance (Purchased or Self Funded) 10.00 Dental, Hearing and Vision Plan Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only	0 0 0 0 0 117, 673 0	4. 00 5. 00 6. 00 7. 00 8. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  5.00 401K/TSA Plan Administration fees 6.00 Legal /Accounting/Management Fees-Pension Plan Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST  8.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only	0 0 0 0 117, 673 0	5. 00 6. 00 7. 00 8. 00
401K/TSA Plan Administration fees Legal /Accounting/Management Fees-Pension Plan Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded) 1,9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only	117, 673	6. 00 7. 00 8. 00
Legal / Accounting/Management Fees-Pension Plan Employee Managed Care Program Administration Fees  HEALTH AND INSURANCE COST  Heal th Insurance (Purchased or Self Funded) Prescription Drug Plan  10.00 Dental, Hearing and Vision Plan Life Insurance (If employee is owner or beneficiary) Accident Insurance (If employee is owner or beneficiary)  13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary)  Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	117, 673	6. 00 7. 00 8. 00
7.00 Employee Managed Care Program Administration Fees  HEALTH AND INSURANCE COST  8.00 Heal th Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	117, 673	7. 00
HEALTH AND INSURANCE COST  8.00 Health Insurance (Purchased or Self Funded) 1, 9.00 Prescription Drug Plan 10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only	117, 673	8. 00
Health Insurance (Purchased or Self Funded)  9.00 Prescription Drug Plan Dental, Hearing and Vision Plan Life Insurance (If employee is owner or beneficiary) Accident Insurance (If employee is owner or beneficiary) Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	0	
9.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 1	0	
10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	- 1	9. 00
11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	0	
12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only		10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only	2, 061	11. 00
14.00 15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 Long-Term Care Insurance (If employee is owner or beneficiary) Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES	0	12.00
15.00 Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	0	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only	o	14. 00
Non cumulative portion) TAXES  17. 00 FI CA-Employers Portion Only	133, 548	15. 00
Non cumulative portion) TAXES  17. 00 FI CA-Employers Portion Only	0	16. 00
17.00 FICA-Employers Portion Only		l
40.00 14.14	685, 677	17. 00
18.00 Medicare Taxes - Employers Portion Only	0	18. 00
19.00 Unemployment Insurance	0	19. 00
20.00 State or Federal Unemployment Taxes	104, 261	20.00
OTHER		
21.00 Executive Deferred Compensation	0	21.00
22.00 Day Care Cost and Allowances	0	22. 00
23.00 Tuition Reimbursement	4, 347	
24.00 Total Wage Related cost (Sum of lines 1 - 23)	091, 770	
	ount	
	orted	
	. 00	
Part B - Other than Core Related Cost		
25. 00 OTHER WAGE RELATED COST	0	25. 00

Occupational Category Amount Fringe Adjusted Paid Hours Average Reported Benefits Salaries (col. Related to Wage (c	. 3 ÷
Reported   Benefits   Salaries (col   Related to   Wage (c	
Reported   Benefit 5   pararies (cor.   Related to   mage (c	4)
1 + col. 2) Salary in col. col.	
3	
1.00 2.00 3.00 4.00 5.	)
Direct Salaries	
Nursing Occupations	
1.00 Registered Nurses (RNs) 1,460,645 338,414 1,799,059 28,457.00	63. 22 1. 00
2.00 Licensed Practical Nurses (LPNs) 1,620,932 375,551 1,996,483 42,688.00	46. 77 2. 00
3.00   Certified Nursing Assistant/Nursing   1,606,062   372,105   1,978,167   64,221.00	30. 80 3. 00
Assi stants/Ai des	
4.00 Total Nursing (sum of lines 1 through 3) 4,687,639 1,086,070 5,773,709 135,366.00	42. 65 4. 00
5.00 Physical Therapists 746, 967 173, 063 920, 030 17, 779.00	51. 75 5. 00
6.00 Physical Therapy Assistants 0 0 0 0.00	0.00 6.00
7.00 Physical Therapy Aides 0 0 0 0.00	0.00 7.00
8.00 Occupational Therapists 708,730 164,204 872,934 15,693.00	55. 63 8. 00
9.00 Occupational Therapy Assistants 0 0 0 0.00	0.00 9.00
10.00 Occupational Therapy Aides 0 0 0 0.00	0. 00 10. 00
11. 00   Speech Therapists   142, 959   33, 122   176, 081   2, 777. 00	63. 41 11. 00
12. 00   Respi ratory Therapi sts   0   0   0   0. 00	0.00 12.00
13.00 Other Medical Staff 0 0 0 0.00	0.00 13.00
Contract Labor	
Nursing Occupations	
14.00 Registered Nurses (RNs) 880 10.00	88. 00 14. 00
15.00 Licensed Practical Nurses (LPNs) 20,412 276.00 20,412	73. 96 15. 00
16.00   Certified Nursing Assistant/Nursing   295,570   295,570   4,926.00	60. 00 16. 00
Assi stants/Ai des	(0.70 47.00
17. 00 Total Nursing (sum of lines 14 through 16) 316, 862 316, 862 5, 212. 00	60. 79 17. 00
18. 00   Physical Therapists	0.00 18.00
19.00 Physical Therapy Assistants	0.00 19.00
20. 00   Physical Therapy Aides   0   0   0. 00	0.00 20.00
21.00 Occupational Therapists 0 0.00	0.00 21.00
22.00 Occupational Therapy Assistants	0.00 22.00
23.00 Occupational Therapy Aides 0 0.00	0.00 23.00
24. 00   Speech Therapists   0   0   0. 00	0.00 24.00
25. 00 Respiratory Therapists 28, 895 578. 00	49. 99 25. 00
26. 00 Other Medical Staff 0 0 0.00	0.00 26.00

Peri od: Worksheet S-7
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/10/2024 11:31 am

	024 11:31 am
Group Dat	
1.00 2.0	
1. 00 RUX	1.00
2. 00 RUL	2.00
3. 00   RVX   RVL	3.00
5. 00 RHX	4. 00 5. 00
6. 00 RHL	6.00
7. 00 RMX	7. 00
8.00	8.00
9. 00 RLX	9. 00
10. 00 RUC	10.00
11. 00 RUB	11. 00
12. 00 RUA	12. 00
13. 00 RVC	13. 00
14. 00 RVB	14. 00
15. 00 RVA	15. 00
16. 00 RHC	16. 00
17. 00 RHB	17. 00
18. 00 RHA	18. 00
19. 00 RMC	19. 00
20. 00 RMB RMA	20. 00 21. 00
22. 00 RLB	22.00
23. 00 RLA	23. 00
24. 00 ES3	24. 00
25. 00 ES2	25. 00
26. 00 ES1	26. 00
27. 00 HE2	27. 00
28. 00 HE1	28. 00
29. 00 HD2	29. 00
30. 00 HD1	30. 00
31. 00 HC2	31. 00
32. 00 HC1	32. 00
33. 00 HB2	33.00
34. 00 HB1	34.00
35. 00   LE2   LE1	35. 00 36. 00
36. 00   LE1   LD2	37.00
38. 00 LD1	38. 00
39. 00 LC2	39. 00
40. 00 LC1	40. 00
41. 00 LB2	41.00
42. 00 LB1	42. 00
43. 00 CE2	43. 00
44. 00   CE1	44. 00
45. 00 CD2	45. 00
46. 00 CD1	46. 00
47. 00 CC2	47. 00
48. 00 CC1	48. 00
49. 00   CB2   CB1	49. 00 50. 00
51. 00 CA2	51.00
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 I B2	59. 00
60. 00 I B1	60.00
61. 00 IA2	61.00
62. 00   I A1   BB2	62. 00 63. 00
63. 00 BB2 BB1	64. 00
65. 00 BA2	65. 00
66. 00 BA1	66.00
67. 00 PE2	67. 00
68. 00 PE1	68. 00
69. 00 PD2	69. 00
70. 00 PD1	70. 00
71. 00 PC2	71. 00
72. 00 PC1	72. 00
73. 00 PB2	73. 00
74. 00 PB1	74. 00
75. 00 PA2	75. 00

Health Financial Systems	CARE ONE AT EAST BRUNSWICK		In Lie	u of Form CMS-	2540-10	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-7	'	
			From 01/01/2023 To 12/31/2023			
			Group	Days		
			1. 00	2. 00		
76. 00			PA1		76. 00	
99. 00			AAA		99. 00	
100. 00 TOTAL		_			100.00	
		Expenses	Percentage	Y/N		
		1.00	2. 00	3. 00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101.00 Staffing					101. 00 102. 00	
102.00 Recruitment 103.00 Retention of employees					102.00	
104.00 Training					104. 00	
9						
105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, I	ine 1, column 3)				105. 00 106. 00	

Heal th	Financial Systems	CARE ONE AT EAST	BRUNSWI CK		In Lie	u of Form CMS-	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023		
	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)	31 am
	I	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES		1, 611, 763	1, 611, 76	2 0	1, 611, 763	1.00
2. 00 3. 00 4. 00 5. 00 6. 00	00200 CAP REL COSTS - BEDGG & TIXTORES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0 673, 310 117, 136 63, 870	263, 741 2, 189, 301 3, 155, 911 530, 604 80, 887	263, 74 2, 189, 30 3, 829, 22 647, 74	1 -30, 504 1 0 1 0 0 0	233, 237 2, 189, 301 3, 829, 221 647, 740 144, 757	2. 00 3. 00 4. 00 5. 00
7. 00 8. 00 9. 00 10. 00 11. 00	00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	317, 324 601, 558 840, 758 0	40, 287 373, 197 138, 248 228, 590 47, 592	357, 61 974, 75 979, 00 228, 59	1 0 5 0 6 0 -18, 967	357, 611 974, 755 979, 006 209, 623 47, 592	7. 00 8. 00 9. 00 10. 00
12. 00 13. 00 14. 00 15. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES INPATIENT ROUTINE SERVICE COST CENTERS	73, 458 137, 456 0 207, 611	263 0 0 7, 905	137, 45	6 0 0	73, 721 137, 456 0 215, 516	13. 00 14. 00
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 I CF/II D 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	4, 687, 639 0 0 0	466, 381 0 0 0		0 0 0 0 0 0 0 0	5, 154, 020 0 0 0	31. 00 32. 00
40. 00 41. 00 42. 00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0 0	64, 774 84, 146 200, 903	84, 14 200, 90	6 3 0	64, 774 84, 146 200, 903	41. 00 42. 00
43. 00 44. 00 45. 00 46. 00 47. 00	04300 OXYGEN (I NHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0 877, 537 708, 730 142, 959	30, 518 0 0 0		0 0	0 908, 055 708, 730 142, 959 0	44. 00 45. 00 46. 00
48. 00 49. 00 50. 00 51. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 0 0	776, 269 0 0 0	776, 26	0 18, 967 9 0 0 0 0 0 30, 504	18, 967 776, 269 0 30, 504	48. 00 49. 00 50. 00 51. 00
52. 00 52. 01 52. 02	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0 0	0		0 0 0	0 0 0	52. 01
		0 0	0		0 0 0	0	
73. 00		0 0 0 0	0 27, 753 0 0		0 0 3 0 0 0 0 0		
80. 00 81. 00 82. 00 83. 00 84. 00 84. 01 89. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0 0 0 0 0 9,449,346	0 0 0 0 0 0 10, 319, 033	19, 768, 37	0 0 0 0 0 0 0 0 0 0 0 0 0 0 9 0	0 0 0 0 0 0 19, 768, 379	82. 00 83. 00 84. 00 84. 01
92. 00 93. 00 94. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0 0 0 0 0 0 0 0 0 9, 449, 346	8, 836 3, 976 0 0 0 0 10, 331, 845	3, 97	6 0 0 0 0 0 0 0 0 0	0 0 0 0	91. 00 92. 00 93. 00 94. 00 95. 00

 
 Heal th Financial
 Systems
 CARE ONE A

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315472 | Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To 12/31/2023 Date/Time Pro 5/10/2024 11:	
	Cost Center Description	Adjustments to	Net Expenses	5/10/2024 11.	31 alli
	·		For Allocation		
		Wkst A-8)	(col. 5 +-		
		6. 00	col. 6) 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-2, 922	1, 608, 841		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	233, 237	'	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	2, 189, 301	l e e e e e e e e e e e e e e e e e e e	3. 00
4.00	00400 ADMI NI STRATI VE & GENERAL	-1, 127, 833			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	1,	1	5. 00
6. 00 7. 00	00600  LAUNDRY & LINEN SERVICE  00700  HOUSEKEEPING		144, 757 357, 611	•	6. 00 7. 00
8. 00	00800 DI ETARY		974, 755	1	8. 00
9.00	00900 NURSING ADMINISTRATION	-3, 340		1	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	209, 623		10.00
11. 00	01100 PHARMACY	-3, 807		l e e e e e e e e e e e e e e e e e e e	11. 00
	01200 MEDI CAL RECORDS & LI BRARY	0	1		12.00
	O1300   SOCIAL SERVICE   O1400   NURSING AND ALLIED HEALTH EDUCATION	0	1	l e e e e e e e e e e e e e e e e e e e	13. 00 14. 00
	01500 ACTIVITES		-	l .	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		210,010	'	10.00
30.00	03000 SKILLED NURSING FACILITY	-36, 328	5, 117, 692		30.00
31.00	03100 NURSING FACILITY	0	0		31. 00
32.00	03200   CF/IID	0		l .	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	) 0		33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY		64 774		40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY				40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	-16, 072	1,		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	1		43.00
44.00	04400 PHYSI CAL THERAPY	0	908, 055		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	708, 730	·	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	142, 959		46. 00
47. 00	04700  ELECTROCARDI OLOGY   04800  MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1	1	47. 00 48. 00
	04900 DRUGS CHARGED TO PATIENTS	-62, 101			49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	02, 101	l .		50.00
	05100 SUPPORT SURFACES	0	30, 504		51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0		i e	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	)	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC		0		60.00
61. 00	06100 RURAL HEALTH CLINIC		1		61. 00
62. 00	06200 FQHC				62. 00
63.00	06300 DI ALYSI S	0	0		63. 00
	OTHER REIMBURSABLE COST CENTERS				
70.00	07000 HOME HEALTH AGENCY COST	0		l .	70.00
	07100 AMBULANCE	0			71.00
	O7300  CMHC   O7400  OTHER REI MBURSEMENT	0			73.00
7 1. 00	SPECIAL PURPOSE COST CENTERS		, <u>_</u>		7 1. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80.00
	08100 I NTEREST EXPENSE	0	0		81. 00
	08200 UTILIZATION REVIEW - SNF	0	0		82. 00
	08300 HOSPI CE	0	0		83. 00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II				84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-1, 252, 403	1		89. 00
57.00	NONREI MBURSABLE COST CENTERS	., 202, 400	., .5,515,776		1 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	8, 836		90.00
	09100 BARBER AND BEAUTY SHOP	0	3, 976		91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		92.00
	09300 NONPAI D WORKERS	0	0		93. 00
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST		0		94. 00 95. 00
100.00	1	-1, 252, 403	18, 528, 788		100.00
. 50. 50	1 - 1	., 232, 100	1	1	1

Health Financial Systems	CARE ONE AT EAST BR	UNSWI CK		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 31 am_
	Increases					
	Cost Center	•	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
(1) A - RECLASS MED SUPP CHARGED						
1.00	MEDICAL SUPPLIES CHAPATIENTS	ARGED TO	48. 00	0	18, 967	1. 00
(1) C - RECLASS SUPPORT SURFACES						
2.00	SUPPORT SURFACES		51. 00	0	30, 504	2.00
TOTALS						
100. 00	Total Reclassificati	ons (Sum		0	49, 471	100.00
	of columns 4 and 5 r	must				
	equal sum of columns 9)	s 8 and				

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

Health Financial Systems	CARE ONE AT EAST BR	UNSWI CK		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 31 am
	Decreases					
	Cost Center	ſ	Li ne #	Sal ary	Non Salary	
	6. 00		7.00	8. 00	9. 00	
(1) A - RECLASS MED SUPP CHARGED						
1. 00	CENTRAL SERVICES &	SUPPLY	10. 0	00	18, 967	1.00
(1) C - RECLASS SUPPORT SURFACES						
2. 00	CAP REL COSTS - MOV	ABLE	2. 0	00	30, 504	2. 00
	EQUI PMENT					
TOTALS						
100. 00				0	49, 471	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 EAST BRUNSWICK In Lieu of Form CMS-2540-10

Provider No.: 315472 | Period: | Worksheet A-7 | From 01/01/2023 | To 12/31/2023 | Date/Time Preparent

					To 12/31/2023	Date/Time Prep 5/10/2024 11:	
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	1	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1, 108, 427	0		0	0	1. 00
2.00	Land Improvements	0	4, 958		0 4, 958		2. 00
3.00	Buildings and Fixtures	8, 164, 632	32, 941		0 32, 941	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equi pment	526, 463	0		0	0	5. 00
6.00	Movable Equipment	3, 716, 562	17, 535		0 17, 535		6. 00
7.00	Subtotal (sum of lines 1-6)	13, 516, 084	55, 434		0 55, 434	0	7. 00
8.00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	13, 516, 084	55, 434		0 55, 434	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1, 108, 427	0				1. 00
2.00	Land Improvements	4, 958	0				2. 00
3.00	Buildings and Fixtures	8, 197, 573	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	526, 463	0				5.00
6.00	Movable Equipment	3, 734, 097	0				6. 00
7.00	Subtotal (sum of lines 1-6)	13, 571, 518	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	13, 571, 518	0				9. 00

Provi der No.: 315472 Peri od: Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 31 am Worksheet A-8

					5/10/2024 11:	31 am
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1.00	2.00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-2, 922	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		C		0.00	2.00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		C		0.00	3. 00
4.00	Rental of provider space by suppliers		l c		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		C		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		C		0.00	6.00
7.00	Parking Lot (chapter 21)		l c		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	l			8. 00
	physici an adjustment					
9.00	Home office cost (chapter 21)		l		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		l c		0.00	10.00
11. 00	Nonallowable costs related to certain	•	l c		0.00	
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-262, 227	,		12.00
	related organizations (chapter 10)		,			
13.00	Laundry and Linen service	•	l c		0.00	13. 00
14.00	Revenue - Employee meals		l c		1	14. 00
15. 00	Cost of meals - Guests		l c		0.00	
16. 00	Sale of medical supplies to other than		Č	l .	1	16. 00
	patients				0.00	10.00
17.00	Sale of drugs to other than patients		l c		0.00	17. 00
18. 00	Sale of medical records and abstracts		ĺ			18. 00
19. 00	Vending machines		ĺ	l .	0.00	
20. 00	Income from imposition of interest, finance		ĺ	l .	0.00	
20.00	or penalty charges (chapter 21)				0.00	20.00
21. 00	Interest expense on Medicare overpayments		d		0.00	21. 00
21.00	and borrowings to repay Medicare				0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation			UTILIZATION REVIEW - SNF	82 00	22. 00
22.00	(chapter 21)				02.00	22.00
23. 00	Depreciationbuildings and fixtures		l c	CAP REL COSTS - BLDGS &	1.00	23. 00
	p			FIXTURES		
24. 00	Depreciationmovable equipment		(	CAP REL COSTS - MOVABLE	2.00	24. 00
2 00	Bopt det att ett metabt e equi pinette			EQUI PMENT	2.00	2 00
25. 00	RESIDENT REPLACEMENT ITEMS	Α	-11 355	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETI NG EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	MARKETI NG CORP EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	MARKETING CONT EXTENSE	Ä		BADMINISTRATIVE & GENERAL	4.00	
25. 04	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 06	BAD DEBT EXPENSE - MEDICARE	A		PADMINISTRATIVE & GENERAL	4.00	
25. 07	BAD DEBT EXPENSE - WEDICARE  BAD DEBT EXPENSE - OTHER	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07 25. 08	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	
25. 08	OTHER REVENUE	B B	l		4.00	
	4	l B		ADMINISTRATIVE & GENERAL	1	
25. 10	4	l R	ł	ADMINISTRATIVE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-1, 252, 403			100. 00
(1) D-	LO WOLKSHEEL A, COL. 6, TIME 100) scription - all chapter references in this co	lump portoi = +-	CMC Dub 15 1	 	1	l

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

CARE ONE AT EAST BRUNSWICK

Health Financial Systems CARE ONE AT EAST STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

OFFICE (	00313					Date/Time Pre 5/10/2024 11:	
		Line No.	Cost (	Center	Expense	Items	
		1. 00	2.		3. 0		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		4. 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES		1. 00
2. 00			NURSING ADMINI		PHARMACY CONSUL		2. 00
3. 00			CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPE		3. 00
4. 00		11. 00	PHARMACY		DRUGS-NON-PRESC NON-LEGEND	RI PTI ON,	4. 00
5. 00			PHARMACY		PHARMACY SUPPLI	ES	5. 00
6. 00			INTRAVENOUS TH		IV EXPENSE		6. 00
7. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PT DRUGS OTH	ION, LEGEND	7. 00
8. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PT DRUGS MAN	ION, LEGEND	8. 00
9. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PT	ION, MEDICARE	9. 00
6	TOTALS (sum of lines 1-9). Transfer column 5, line 100 to Worksheet A-8, column 3, line 12.						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 REQUIR CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		782, 051	958, 958		7		1. 00
2. 00		38, 408					2. 00
3. 00		78, 125			1		3. 00
4.00		42, 461	46, 153				4. 00
5.00		1, 324					5.00
6. 00 7. 00		184, 831	200, 903				6. 00 7. 00
8. 00		60, 871 262, 917	66, 164 285, 779				8.00
9. 00		390, 380					9. 00
10. 00 T	TOTALS (sum of lines 1-9). Transfer column 5, line 100 to Worksheet A-8, column 3, line 12.	1, 841, 368					10. 00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provi der No.: 315472 | Peri od: From 01/01/2023 To 12/31/2023

Worksheet A-8-1 Parts I-II Date/Time Prepared:

| Symbol (1) | Name | Percentage of Ownership | 1.00 | 2.00 | 3.00 |

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

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

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

1.00	A	DANI EL STRAUS	41.00	1.00
2.00	A	DANI EL STRAUS	41.00	2. 00
3.00	A	DES HOLDING CO. INC.	22. 00	3.00
4.00	F	PARTNERS PHARMACY SERVICES	0.00	4.00
		LLC		
5. 00			0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of Ownership	Type of Business	
	4. 00	5. 00	6. 00	
DADT II INTERDELATIONOULD TO BELATER ORGANIE	ZATLONICO AND COD HOME OFFICE			4

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.

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

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

RUNSWICK In Lieu of Form CMS-2540-10
Provider No.: 315472 Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			To	12/31/2023	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/10/2024 11:	31 alli
		DI 200 4	1101/151 5	5451 0V55		
Cost Center Description	Net Expenses for Cost	BLDGS & FLXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TTATORES	EQUIT MENT	DEINETTTS		
	(from Wkst A					
	col . 7)	1 00	2.00	2.00	2.4	
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	3A	
1. 00 O0100 CAP REL COSTS - BLDGS & FIXTURES	1, 608, 841	1, 608, 841				1. 00
2.00   00200   CAP REL COSTS - MOVABLE EQUIPMENT	233, 237		233, 237			2. 00
3. 00 00300 EMPLOYEE BENEFITS	2, 189, 301	0	0	2, 189, 301	2 150 250	3. 00
4.00   OO400   ADMINISTRATIVE & GENERAL 5.00   OO500   PLANT OPERATION, MAINT. & REPAIRS	2, 701, 388 647, 740	263, 650 60, 529	38, 222 8, 775	155, 998 27, 139	3, 159, 258 744, 183	4. 00 5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE	144, 757	79, 641	11, 546	14, 798	250, 742	6. 00
7. 00   00700   HOUSEKEEPI NG	357, 611	10, 303	1, 494	73, 520	442, 928	7. 00
8. 00   00800   DI ETARY	974, 755	127, 034	18, 416	139, 374	1, 259, 579	8. 00
9. 00 00900 NURSING ADMINISTRATION 10. 00 01000 CENTRAL SERVICES & SUPPLY	975, 666 209, 623	11, 745	1, 703 0	194, 794	1, 183, 908 209, 623	9. 00 10. 00
11. 00 01100 PHARMACY	43, 785	o	o	o	43, 785	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	73, 721	10, 045	1, 456	17, 019	102, 241	12.00
13. 00 01300 SOCI AL SERVI CE	137, 456	3, 658	530	31, 847	173, 491	13.00
14.00   01400   NURSING AND ALLIED HEALTH EDUCATION 15.00   01500   ACTIVITES	215, 516	0	0	48, 101	0 263, 617	14. 00 15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	213, 310	<u> </u>	- υ <sub>լ</sub>	40, 101	203, 017	13.00
30.00 03000 SKILLED NURSING FACILITY	5, 117, 692	955, 384	138, 503	1, 086, 070	7, 297, 649	30.00
31. 00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00   03200   I CF/I I D 33.00   03300   OTHER LONG TERM CARE	0	0	0	0	0	32. 00 33. 00
ANCI LLARY SERVICE COST CENTERS	9		<u> </u>	<u> </u>	0	33. 00
40. 00 04000 RADI OLOGY	64, 774	0	0	0	64, 774	40.00
41. 00   04100   LABORATORY 42. 00   04200   I NTRAVENOUS THERAPY	84, 146 184, 831	0	0	0	84, 146 184, 831	41. 00 42. 00
43. 00   04300   0XYGEN (I NHALATION) THERAPY	104, 631	o	0	o	104, 831	43. 00
44. 00 O4400 PHYSI CAL THERAPY	908, 055	16, 948	2, 457	203, 315	1, 130, 775	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	708, 730	8, 757	1, 270	164, 204	882, 961	45.00
46. 00   04600   SPEECH PATHOLOGY 47. 00   04700   ELECTROCARDI OLOGY	142, 959	8, 757 0	1, 270 0	33, 122	186, 108 0	46. 00 47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 967	23, 542	3, 413	o	45, <b>9</b> 22	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	714, 168	20, 606	2, 987	0	737, 761	49. 00
50. 00   05000   DENTAL CARE - TITLE XIX ONLY 51. 00   05100   SUPPORT SURFACES	30, 504	0	0	0	0 30, 504	50. 00 51. 00
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	30, 304	o	0	o	30, 304	52. 00
52.01 05201 OTHER ANCILLARY SERVICES COST	0	o	0	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	l ol	ol	0	ol	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC	o	Ö	Ö	Ö	Ö	61. 00
62. 00 06200 FQHC						62. 00
63. 00 O6300 DI ALYSI S OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	63. 00
70. 00 07000 HOME HEALTH AGENCY COST	0	ol	0	0	0	70. 00
71. 00   07100   AMBULANCE	27, 753	o	0	0	27, 753	71. 00
73. 00   07300   CMHC	0	0	0	0	0	73.00
74. 00 07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	U <sub>I</sub>	U	<u> </u>	0	74. 00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00 08100 INTEREST EXPENSE						81. 00
82. 00   08200   UTI LI ZATI ON REVI EW - SNF			0	0	0	82.00
83. 00   08300   HOSPI CE 84. 00   08400   OTHER SPECI AL PURPOSE COST	0	0	0	0	0	83. 00 84. 00
84. 01 08401 OTHER SPECIAL PURPOSE COST II		Ö	0	o	0	84. 01
89.00 SUBTOTALS (sum of lines 1-84)	18, 515, 976	1, 600, 599	232, 042	2, 189, 301	18, 506, 539	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	8, 836	٥	0	ام	8, 836	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	3, 976	8, 242	1, 195	0	13, 413	91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	O	0	0	0	92.00
93. 00   09300   NONPALD WORKERS	0	0	0	0	0	93.00
94. 00   09400   PATI ENTS LAUNDRY 95. 00   09500   OTHER NONREI MBURSABLE COST		O O	0	0	0	94. 00 95. 00
98.00 Cross Foot Adjustments	o	o	0	ō	0	98. 00
99.00 Negative Cost Centers	10 530 700	1 (00 041	0	0	10 520 700	99.00
100. 00   T0TAL	18, 528, 788	1, 608, 841	233, 237	2, 189, 301	18, 528, 788	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315472 | Period:

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

5/10/2024 11:31 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAIRS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 3, 159, 258 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 152, 969 897, 152 5.00 00600 LAUNDRY & LINEN SERVICE 51.541 55, 618 357, 901 6.00 6.00 7.00 00700 HOUSEKEEPI NG 91,045 7, 195 C 541, 168 7.00 88, 715 57, 542 8.00 00800 DI ETARY 258, 910 0 1,664,746 8.00 9.00 00900 NURSING ADMINISTRATION 243, 356 0 5, 320 9.00 8, 202 43, 089 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 C Ω 11.00 01100 PHARMACY 9,000 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 21,016 7,015 4.550 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 2.554 0 35, 662 1.657 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 01500 ACTI VI TES 54, 187 0 15.00 15.00 NPATIENT ROUTINE SERVICE COST CENTERS 357, 901 1, 664, 746 30.00 03000 SKILLED NURSING FACILLTY 1 500 060 667, 198 432, 757 30.00 31.00 03100 NURSING FACILITY C Λ 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 13, 314 0 0 0 0 40.00 41.00 04100 LABORATORY 17, 296 0 0 41.00 0 37, 993 42 00 04200 I NTRAVENOUS THERAPY 0 0 42 00 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY C 0 0 43.00 04400 PHYSI CAL THERAPY 232, 434 11, 836 7,677 44.00 44.00 0 04500 OCCUPATIONAL THERAPY 45.00 181, 495 6, 116 0 3, 967 45.00 0 04600 SPEECH PATHOLOGY 46 00 38, 255 3.967 46 00 6, 116 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 439 48.00 48.00 16, 441 10,664 151, 649 49.00 04900 DRUGS CHARGED TO PATIENTS 14, 390 9.334 0 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50.00 C 0 0 51.00 05100 SUPPORT SURFACES 6, 270 C 0 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 52.00 52.01 05201 OTHER ANCILLARY SERVICES COST 0 Λ 0 ol 0 52.01 05202 MEDICAL SERVICES 52.02 0 0 0 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 60 00 06000 CLI NI C 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 61.00 0 0 0 0 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 0 0 0 0 70.00 71.00 07100 AMBULANCE 5.705 C 0 0 0 71.00 73.00 07300 CMHC 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 C 84.00 08401 OTHER SPECIAL PURPOSE COST II 84.01 84.01 1, 664, 746 89.00 SUBTOTALS (sum of lines 1-84) 3, 154, 685 891, 396 357. 901 537, 435 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 1,816 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 91.00 2.757 5.756 3.733 0 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 92.00  $\Gamma$ 93.00 09300 NONPALD WORKERS 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST 95 00 0 O 0 95 00 Ω 0 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 99.00 0 0 0 100.00 TOTAL 3, 159, 258 897, 152 357, 901 541, 168 1, 664, 746 100. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315472 | Period: Worksheet B From 01/01/2023 | Part I To 12/31/2023 | Date/Time Prepared:

0 99.00

213, 364 100. 00

5/10/2024 11:31 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, 440, 786 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 252, 712 10.00 01100 PHARMACY 11.00 0 52, 785 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 134, 822 12.00 13.00 01300 SOCIAL SERVICE 0 0 213, 364 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 0 14.00 C 0 0 15.00 01500 ACTI VI TES 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 1, 440, 786 252, 712 52, 785 134, 822 213, 364 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 04000 RADI OLOGY 40.00 0 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 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 0 47 00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 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 Ω 52.02 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0 0 60.00 60.00 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 o 0 61.00 06200 FOHC 62 00 62 00 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 C 84.01 SUBTOTALS (sum of lines 1-84) 1, 440, 786 213, 364 252, 712 52, 785 134, 822 89.00 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 C 0 09100 BARBER AND BEAUTY SHOP 0 0 91.00 0 0 91.00 0 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 95.00 C 0 Cross Foot Adjustments 98.00 0 98 00

1, 440, 786

252, 712

52, 785

134, 822

Negative Cost Centers

99.00

100.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315472

				-	Γο 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL			37 107 2024 11.	31 alli
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TES	Subtotal	Post Stepdown	Total	
		ALLIED HEALTH EDUCATION			Adjustments		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS		T				
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12. 00
13. 00 14. 00	01300 SOCIAL SERVICE						13. 00 14. 00
15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	l .				15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		317,004	TI.			13.00
30.00	03000 SKILLED NURSING FACILITY	0	317, 804	14, 332, 584	4 0	14, 332, 584	30. 00
31. 00	03100 NURSING FACILITY	0	-		0	0	31.00
32. 00 33. 00	03200   CF/IID 03300 OTHER LONG TERM CARE	0				0	32.00
33.00	ANCI LLARY SERVICE COST CENTERS			<u>/</u>	<u>)</u>	0	33.00
40.00	04000 RADI OLOGY	0	С	78, 088	3 0	78, 088	40. 00
41. 00	04100 LABORATORY	0	-	101, 442	1	101, 442	
42. 00	04200 I NTRAVENOUS THERAPY	0	0	222, 82		222, 824	
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY			1, 382, 722	0	0 1, 382, 722	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY			1, 074, 539	1	1, 074, 539	
46. 00	04600 SPEECH PATHOLOGY	0	o	234, 446		234, 446	
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	82, 460	1	82, 466	
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY			913, 134	1 0	913, 134 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	Ö	36, 77	4 0	36, 774	1
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	O		0 0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0		1	0	0	52. 01
52. 02	05202 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0		) (	0	0	52. 02
60. 00	06000 CLINIC	0			o	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	o		o	0	61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	)  (	0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0			ol	0	70.00
	07100 AMBULANCE	0	Ö	33, 458			71.00
73. 00	07300 CMHC	0	-		0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	)  (	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100   INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0		0	0	1
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II		0			0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)			18, 492, 47	7 0	18, 492, 477	89. 00
07.00	NONREI MBURSABLE COST CENTERS		017,001	10, 172, 17	, <sub> </sub>	10, 172, 177	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		10, 652		10, 652	
91.00	09100 BARBER AND BEAUTY SHOP	0	0	25, 659	9 0	25, 659	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS					0	
94. 00	09400 PATIENTS LAUNDRY			$\delta$		0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST		0		o o	0	95. 00
98. 00	Cross Foot Adjustments	0	0		0	0	
99. 00 100. 00	Negative Cost Centers   TOTAL	0	0 317, 804	)   18, 528, 788		0 18, 528, 788	99.00
100.00	) ITOTAL		317, 604	rj 10, 520, 700	S <sub>1</sub> 0	10, 520, 700	1100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315472

					10	12/31/2023	Date/IIme Pre 5/10/2024 11:	
				CAPI TAL REL	ATED COSTS		07 107 2021 11.	OT GIII
		0 1 0 1 5 11	D	DI DOC. A	MOVARIE		ENDLOVEE	
		Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
			Capi tal	TTATORES	EQ011 MEIVI		DENETTIO	
			Related Costs					
	CENED	AL CEDIM CE COCE CENTEDO	0	1. 00	2.00	2A	3. 00	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00		CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	1	EMPLOYEE BENEFITS	0	0		0	0	3. 00
4.00		ADMINISTRATIVE & GENERAL	0	263, 650		301, 872	0	4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	0	60, 529 79, 641	8, 775 11, 546	69, 304 91, 187	0	5. 00 6. 00
7. 00	1	HOUSEKEEPI NG	0	10, 303		11, 797	0	7. 00
8.00	1	DIETARY	0	127, 034		145, 450	0	8. 00
9.00		NURSING ADMINISTRATION	0	11, 745	1, 703	13, 448	0	9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	10, 045	1, 456	11, 501	0	11. 00 12. 00
13. 00	1	SOCIAL SERVICE		3, 658		4, 188	0	13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0	1	0	0	14. 00
15. 00		ACTI VI TES	0	0	0	0	0	15. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS		OFF 204	120 502	1 002 007	0	20.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	0	955, 384 0		1, 093, 887 0	0	30. 00 31. 00
32. 00		ICF/IID	0	0	1	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33. 00
		LARY SERVICE COST CENTERS						
40.00		RADI OLOGY LABORATORY	0	0		0	0	
41. 00 42. 00		LABURATURY   INTRAVENOUS THERAPY	0	0	0	0	0	41. 00 42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	l	0	0	43. 00
44.00		PHYSI CAL THERAPY	0	16, 948	2, 457	19, 405	0	44. 00
45. 00		OCCUPATIONAL THERAPY	0	8, 757		10, 027	0	45. 00
46. 00 47. 00	1	SPEECH PATHOLOGY	0	8, 757 0		10, 027	0	46. 00 47. 00
48. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23, 542		26, 955	0	48.00
49. 00		DRUGS CHARGED TO PATIENTS	o o	20, 606		23, 593	0	49. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51.00	1	SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00 52. 01		COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 00 52. 01
52. 01		MEDICAL SERVICES	0	0		0	0	52. 01
02.02		TIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		02.02
60. 00		CLINIC	0	0		0	0	60. 00
61.00		RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200	DI ALYSI S	0	0	0	0	0	62. 00 63. 00
00.00		REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		00.00
		HOME HEALTH AGENCY COST	0	0	0	0		70. 00
71.00	1	AMBULANCE	0	0	0	0	0	
73. 00 74. 00	07300	OTHER REIMBURSEMENT	0	0		0	0	73. 00 74. 00
7 1. 00		AL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		71.00
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00		INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE	0	0	0	0	0	82. 00 83. 00
84. 00		OTHER SPECIAL PURPOSE COST I	0	0	l	0	0	84. 00
84. 01		OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	NOVE	SUBTOTALS (sum of lines 1-84)	0	1, 600, 599	232, 042	1, 832, 641	0	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		ما	0	90. 00
91. 00	1	BARBER AND BEAUTY SHOP	0	8, 242	1, 195	9, 437	0	•
92. 00	1	PHYSICIANS PRIVATE OFFICES		0	0	0	0	ı
93. 00		NONPALD WORKERS	0	0	0	o	0	93. 00
94. 00		PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00 98. 00	04200	OTHER NONREIMBURSABLE COST Cross Foot Adjustments		O		0	0	95. 00 98. 00
99. 00		Negative Cost Centers		0	О	o	0	•
100.00	)	TOTAL	o	1, 608, 841	233, 237	1, 842, 078		100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315472

	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	J alli
		4.00	REPAI RS 5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	301, 872 14, 616 4, 925 8, 700 24, 739 23, 253 4, 117 860	83, 920 5, 203 673 8, 298 767 0	101, 315 0 0 0 0 0 0	21, 170 2, 251 208 0 0	180, 738 0 0 0	9. 00 10. 00 11. 00
12. 00 13. 00	01200   MEDICAL RECORDS & LIBRARY   01300   SOCIAL SERVICE	2, 008 3, 408	656 239		178 65	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	3, 400	237		05	0	14. 00
15. 00	01500 ACTI VI TES	5, 178	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	9,9	-	_	-1		
30.00	03000 SKILLED NURSING FACILITY	143, 333	62, 411	101, 315	16, 930	180, 738	30. 00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200   CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1		_			
40.00	04000 RADI OLOGY	1, 272	0		0	0	40.00
41. 00 42. 00	04100   LABORATORY   04200   I NTRAVENOUS   THERAPY	1, 653 3, 630	0	0	0	0	41. 00 42. 00
42.00	04300 OXYGEN (INHALATION) THERAPY	3, 630	0		0	0	43. 00
	04400 PHYSI CAL THERAPY	22, 210	1, 107		300	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	17, 342	572	1	155	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	3, 655	572		155	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	o	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	902	1, 538	0	417	0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	14, 490	1, 346	0	365	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
	05100 SUPPORT SURFACES	599	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUI PMENT	0	0	0	0	0	52.00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST   05202 MEDICAL SERVICES	0	0			0	52. 01 52. 02
32. 02	OUTPATIENT SERVICE COST CENTERS	J U	0	<u> </u>	l ol	0	32.02
60.00	06000 CLINIC	0	0	0	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	o	0		o	0	61. 00
62.00	06200 FQHC						62. 00
63.00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	545	0	0	0	0	71.00
	07300  CMHC   07400  OTHER REI MBURSEMENT	0	0			0	
74.00	SPECIAL PURPOSE COST CENTERS	J U		1 0	U U	0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100   NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	0	0	0	o	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	_	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	301, 435	83, 382	101, 315	21, 024	180, 738	89. 00
00.00	NONREI MBURSABLE COST CENTERS	4					00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	174	0		· ·	0	
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	263	538 0	1	146	0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS		0	_		0	93.00
94. 00	09400 PATIENTS LAUNDRY		0		ا	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0			0	95.00
98. 00	Cross Foot Adjustments			0	o	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	
100.00	TOTAL	301, 872	83, 920	101, 315	21, 170	180, 738	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315472

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	<u> </u>
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY	44.00	LI BRARY	10.00	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	37, 676					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	4, 117				10.00
11.00	01100 PHARMACY	0	0	860	14 242		11. 00 12. 00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0	0	0	14, 343	7, 900	12.00
14. 00	1 1		0	0	0	7, 400	14. 00
15. 00	· ·		0	0	0	0	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	<u>~</u> _		10.00
30.00		37, 676	4, 117	860	14, 343	7, 900	30.00
31. 00	03100 NURSING FACILITY	o	0	0	0	0	31. 00
32.00		o	0	0	0	0	32. 00
33. 00		0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	1	0	0	0	0	0	40.00
41. 00	1	0	0	0	0	0	41.00
42. 00 43. 00	i i	0	0	0	0	0	42. 00 43. 00
44. 00			0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		0	0	0	0	45. 00
46. 00	1	Ö	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	o	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	49. 00
50. 00	1	0	0	0	0	0	50. 00
51. 00		0	0	0	0	0	51. 00
52. 00	1 1	0	0	0	0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	l ol	0	U U	U	0	52. 02
60. 00		l ol	0	O	0	0	60.00
61. 00	· ·	l ő	0	0	0	0	61. 00
62. 00	1 1		_				62. 00
63.00	06300 DI ALYSI S	o	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	1	0	0	0	0	0	70. 00
71. 00	1	0	0	0	0	0	71.00
73. 00		0	0	0	0	0	73. 00 74. 00
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	l ol	0	l o	U	0	74.00
80. 00							80. 00
81. 00	1 1						81. 00
82. 00	i i						82. 00
83. 00	08300 HOSPI CE	O	0	0	0	0	83. 00
84. 00		O	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00		37, 676	4, 117	860	14, 343	7, 900	89. 00
00.00	NONREI MBURSABLE COST CENTERS					-	00.00
90.00		0	0	0	0	0	90.00
91. 00 92. 00	1 1	0	0	0	0	0	91. 00 92. 00
93. 00	1 1		0		0	0	93.00
94. 00	1 1		0		n	0	94. 00
95. 00			0		ő	0	95. 00
98. 00			0	0			98. 00
99. 00	1 1 0	0	0	0	O	0	99. 00
100.0	D TOTAL	37, 676	4, 117	860	14, 343	7, 900	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.: 315472

					To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared:
			OTHER GENERAL			37 107 2024 11.	J I dill
	Cost Contar Decemintion	NUDCING AND	SERVI CE	Cubtatal	Doot Stan Down	Total	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		EDUCATI ON			,		
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY						10. 00 11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	F 470				14. 00
15. 00	O1500  ACTIVITES   INPATIENT ROUTINE SERVICE COST CENTERS	0	5, 178	<u> </u>			15. 00
30. 00	03000 SKILLED NURSING FACILITY	0	5, 178	1, 668, 68	3 0	1, 668, 688	30.00
31. 00	03100 NURSING FACILITY	0	0	1	0	0	31. 00
32.00	03200   CF/    D	0	0	•	0	l .	1
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	)	0	0	33.00
40. 00	04000 RADI OLOGY	0	0	1, 27	2 0	1, 272	40. 00
41.00	04100 LABORATORY	0	0	1			1
42.00	04200 I NTRAVENOUS THERAPY	0	0	3, 630		-,	1
43. 00 44. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	43, 02		0 43, 022	
45. 00	04500 OCCUPATIONAL THERAPY			28, 09		28, 096	1
46. 00	04600 SPEECH PATHOLOGY	0	0	14, 40		1	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	•	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	29, 81: 39, 79		29, 812 39, 794	1
50. 00	05000 DENTAL CARE - TITLE XIX ONLY			) 37, 77		0	1
51.00	05100 SUPPORT SURFACES	0	0	59	9 0	599	
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	1	0	0	
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST   05202 MEDICAL SERVICES	0	0		0 0	•	
32. 02	OUTPATIENT SERVICE COST CENTERS	0		<u>' </u>	<u>J</u>	0	32.02
60.00	06000 CLI NI C	0	0		0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	
62. 00 63. 00	06200 FQHC 06300 DI ALYSI S		0	,	0	0	62.00
03.00	OTHER REI MBURSABLE COST CENTERS			/	<u>)</u>	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0		
71. 00		0	0	54!			
73. 00 74. 00	07300 CMHC 07400 OTHER REIMBURSEMENT	0	0	l	0 0	<b>l</b>	
74.00	SPECIAL PURPOSE COST CENTERS	0		/	<u>)</u>	0	74.00
80.00							80.00
81. 00							81. 00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF			,			82. 00
84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	0				0	1
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	Ö		0	·	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	5, 178	1, 831, 520	0	1, 831, 520	89. 00
90. 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0	Ιο	17-	4 O	174	90. 00
90.00		0		10, 38		l	1
92. 00	I I	0	0	1	o o	0	1
93. 00	09300 NONPALD WORKERS	0	0	1	0	0	
94. 00 95. 00		0	0	1	0	0	
98.00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0					1
99. 00	Negative Cost Centers	0	0		o o		1
100.00	DOTAL	0	5, 178	1, 842, 07	s o	1, 842, 078	100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315472

					Т	o 12/31/2023	Date/Time Prep 5/10/2024 11:	
			CAPI TAL REI	LATED COSTS				
		Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
			1.00	2.00	SALARI ES) 3. 00	4A	4. 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	3.00	44	4.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES	31, 231					1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS		31, 231				2.00
3. 00 4. 00	1	ADMINISTRATIVE & GENERAL	0 5, 118	_			15, 369, 530	3. 00 4. 00
5. 00		PLANT OPERATION, MAINT. & REPAIRS	1, 175				744, 183	5. 00
6.00		LAUNDRY & LINEN SERVICE	1, 546				250, 742	6. 00
7. 00 8. 00	1	HOUSEKEEPI NG DI ETARY	200 2, 466				442, 928 1, 259, 579	7. 00 8. 00
9. 00		NURSING ADMINISTRATION	228				1, 183, 908	9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	0		0	209, 623	
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0 195	0 195		0	43, 785	
13. 00		SOCIAL SERVICE	71	71	73, 458 137, 456		102, 241 173, 491	12. 00 13. 00
14. 00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	О	C	0	0	14. 00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	0	0	207, 611	0	263, 617	15. 00
30. 00		SKILLED NURSING FACILITY	18, 546	18, 546	4, 687, 639	0	7, 297, 649	30. 00
31.00	1	NURSING FACILITY	0	0	C	0	0	31. 00
32. 00 33. 00		CF/IID   OTHER LONG TERM CARE	0	0		0	0	32. 00 33. 00
33.00		LARY SERVICE COST CENTERS	0	0		0		33.00
40. 00		RADI OLOGY	0	0			64, 774	40. 00
41. 00 42. 00	1	LABORATORY INTRAVENOUS THERAPY	0	0		0	84, 146 184, 831	41. 00 42. 00
42.00	1	OXYGEN (INHALATION) THERAPY		0	i d	0	184, 831	42.00
44. 00	04400	PHYSI CAL THERAPY	329			0	1, 130, 775	
45. 00		OCCUPATIONAL THERAPY	170				882, 961	
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	170				186, 108	46. 00 47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	457			Ö	45, 922	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	400		C	0	737, 761	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0		0	30, 504	50. 00 51. 00
52. 00		COMPLEX MEDICAL EQUIPMENT	0	Ö	C	Ö	0	52. 00
52. 01		OTHER ANCILLARY SERVICES COST	0	0			0	52. 01
52. 02		MEDICAL SERVICES TIENT SERVICE COST CENTERS	0	0	C	<u> </u>		52. 02
60.00		CLI NI C	0	_				60. 00
61. 00 62. 00	06100 06200	RURAL HEALTH CLINIC	0	0	C	0	0	61. 00 62. 00
63. 00		DIALYSIS	0	О	C	О	0	63. 00
70.00		REIMBURSABLE COST CENTERS						
		HOME HEALTH AGENCY COST AMBULANCE	0	0	l ~	0	27, 753	70. 00 71. 00
73.00	07300	СМНС	0	Ö		-	0	
74. 00		OTHER REIMBURSEMENT	0	0	C	0	0	74. 00
80. 00		AL PURPOSE COST CENTERS  MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	08100	INTEREST EXPENSE						81. 00
82.00	1	UTILIZATION REVIEW - SNF			_		0	82.00
83. 00 84. 00		HOSPICE OTHER SPECIAL PURPOSE COST I		0		0		83. 00 84. 00
84. 01		OTHER SPECIAL PURPOSE COST II	0	0	C	0	0	84. 01
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)  IMBURSABLE COST CENTERS	31, 071	31, 071	9, 449, 346	-3, 159, 258	15, 347, 281	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	8, 836	90. 00
91. 00	1	BARBER AND BEAUTY SHOP	160	160	C	0	13, 413	
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0	0	0	0	0	92. 00 93. 00
94. 00	1	PATIENTS LAUNDRY	0	Ö	Ö	Ö	Ö	94. 00
95. 00	09500	OTHER NONREIMBURSABLE COST	0	0	C	0	0	95.00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00		Cost to be allocated (per Wkst. B,	1, 608, 841	233, 237	2, 189, 301		3, 159, 258	
103.00		Part I) Unit cost multiplier (Wkst. B, Part I)	51. 514233	7. 468125	0. 231688		0. 205553	103 00
103.00		Cost to be allocated (per Wkst. B,	31. 314233	7. 400125	0. 231000		301, 872	
		Part II)	l	I			l l	

Health Financial Systems	CARE ONE AT EA	ST BRUNSWICK		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
				10 12/31/2023	5/10/2024 11:	31 am_
	CAPITAL REI	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	FMPLOYFF	Reconciliation	ADMI NI STDATI VE	
cost center bescription	FIXTURES	EQUI PMENT	BENEFITS	Reconciliation	& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
	,	,	SALARI ES)		,	
	1.00	2. 00	3. 00	4A	4. 00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000	D	0. 019641	105. 00
11)						l

Provi der No.: 315472

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: Worksheet B-1

						5/10/2024 11:	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION, MAINT. &	(PATIENT DAYS)	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		REPAIRS	(PATTENT DAYS)			(PATIENT DAYS)	
		(SQUARE FEET)				(17417EW1 BATO)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS					1	
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						3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	24, 938					5.00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 546					6.00
7. 00	00700 HOUSEKEEPI NG	200		23, 192			7. 00
8. 00	00800 DI ETARY	2, 466	1	2, 466			8. 00
9.00	00900 NURSING ADMINISTRATION	228	l .	228		38, 957	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	C	0	0	0	0	10.00
11. 00	01100 PHARMACY	C	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	195	1	195	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	71	1	71	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	1	0	0	0	14.00
15. 00	01500 ACTIVITES	C	) 0	0	0	0	15. 00
20.00	O3000 SKILLED NURSING FACILITY	18, 546	38, 957	10 5/4	114 071	38, 957	30.00
30. 00 31. 00	03100 NURSING FACILITY	10, 340	30, 937	18, 546	116, 871	30, 937	31.00
32. 00	03200   CF/11D			0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE				0	0	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS		,				00.00
40.00	04000 RADI OLOGY	C	0	0	0	0	40.00
41.00	04100 LABORATORY	C	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	C	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	1	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	329		329		0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	170	l l	170		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	170	1	170	0	0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	457		0 457	0	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	400	l control of the cont	400	0	0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	400	1	400	0	0	50.00
51. 00	05100 SUPPORT SURFACES		ol o		0	o o	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		o o	Ö	0	ō	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C	o	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	C	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS	,					
60. 00	06000 CLI NI C	C	1	0		0	
61. 00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63. 00	OCTUED DELMBURGABLE COST CENTERS		) <u> </u>		0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST			0	0	0	70. 00
	07100 AMBULANCE				_		
	07300 CMHC		ol o		0	ő	
74.00	07400 OTHER REIMBURSEMENT	C	o	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS						]
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE	1					81.00
82.00	08200 UTILIZATION REVIEW - SNF	_		_	_	_	82.00
83.00	08300 HOSPI CE		0	0	0	0	83.00
84.00	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II				0	0	84.00
84. 01 89. 00	SUBTOTALS (sum of lines 1-84)	24, 778	38, 957	23, 032	116, 871	38, 957	84. 01 89. 00
07.00	NONREI MBURSABLE COST CENTERS	24,770	y 30, <del>7</del> 37	23, 032	110, 071	30, 737	1 07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		) 0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	160	l control of the cont		_		91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		o	0	Ō	0	92.00
93.00	09300 NONPALD WORKERS		0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	C	) 0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	C	) 0	0	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers	007 455				4 ==:	99.00
102.00	1	897, 152	357, 901	541, 168	1, 664, 746	1, 440, 786	102.00
103.00	Part I)   Unit cost multiplier (Wkst. B, Part I)	35. 975299	9. 187078	23. 334253	14. 244304	36. 984008	103 00
103.00		83, 920	l .	1			103.00
104.00	Part II)	03, 720	, 101, 313	21, 1/0	100, 730	37,070	104.00
105.00	1 1 '	3. 365146	2. 600688	0. 912815	1. 546474	0. 967118	105.00
-							

Provi der No.: 315472

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	O I Gill
		SERVICES &	(PATIENT DAYS)		/- · - · - · · · · · · · · · · · · · · ·	ALLI ED HEALTH	
		SUPPLY		LI BRARY	(PATIENT DAYS)	EDUCATI ON	
		(PATIENT DAYS)		(PATIENT DAYS)		(ASSI GNED TIME)	
		10.00	11. 00	12. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS	1					
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 ADMI NI STRATI VE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8. 00 9. 00	00800   DI ETARY   00900   NURSI NG   ADMI NI STRATI ON						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	38, 957	,				10.00
11. 00	01100 PHARMACY	30, 737	38, 957	,			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY		00, 707	38, 957			12.00
13. 00	01300 SOCIAL SERVICE	0	o	0			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	) c	0	0	14. 00
15.00	01500 ACTI VI TES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	38, 957	38, 957	38, 957	38, 957	0	30.00
31. 00	03100 NURSING FACILITY	0	1	0	0	0	31. 00
32. 00	03200   CF/IID	0		1	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	) <u> </u>	0	0	33.00
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0		) C	O	0	40.00
41. 00	04100 LABORATORY					0	41.00
42. 00	04200 I NTRAVENOUS THERAPY				1	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY				0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY				0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	o	o c	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	) c	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	) c	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0			0	0	52. 01
52. 02	05202   MEDI CAL SERVI CES   OUTPATI ENT SERVI CE COST CENTERS	0	)	) <u> </u>	0	0	52. 02
60. 00	06000 CLINIC	0	1		O	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		1		0	0	61.00
62. 00	06200 FQHC					Ŭ	62.00
63. 00	06300 DI ALYSI S	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
	07100 AMBULANCE	0	0	0	0	0	71. 00
	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	) <u> </u>	) <u> </u>	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS		I	1			00 00
80. 00 81. 00	08000   MALPRACTICE PREMIUMS & PAID LOSSES   08100   INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 H0SPI CE	0			0	0	83.00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0			O	Ö	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	o	o c	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	38, 957	38, 957	38, 957	38, 957	0	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0		O C	0	0	92.00
93.00	09300 NONPAL D WORKERS				0	0	93.00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST					0	94. 00 95. 00
98. 00 98. 00	Cross Foot Adjustments		1	7			98.00
99.00	Negative Cost Centers						99.00
102.00		252, 712	52, 785	134, 822	213, 364	n	102.00
	Part I)	232,712	]		2.3,301		
103.00	1 1 '	6. 486947	1. 354955	3. 460790	5. 476910	0. 000000	103. 00
104.00	Cost to be allocated (per Wkst. B,	4, 117	860	14, 343	7, 900	0	104. 00
	Part II)						
105.00		0. 105681	0. 022076	0. 368175	0. 202788	0. 000000	105. 00
	)		1	1			I

CARE ONE AT EAST BRUNSWICK In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 31 am Provi der No.: 315472

				1.5	5/10/2024 11: 31 am
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TES		
			(PATIENT DAYS)		
	GENER	AL SERVICE COST CENTERS	15. 00		
1. 00		CAP REL COSTS - BLDGS & FLXTURES			1.00
2. 00	1	CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00		EMPLOYEE BENEFITS			3.00
4.00	00400	ADMINISTRATIVE & GENERAL			4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00		LAUNDRY & LINEN SERVICE			6. 00
7.00		HOUSEKEEPI NG			7. 00
8.00	1	DI ETARY			8.00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY			9.00
11. 00		PHARMACY			11.00
12. 00	1	MEDICAL RECORDS & LIBRARY			12.00
13. 00	1	SOCIAL SERVICE			13. 00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00		ACTI VI TES	38, 957		15. 00
		IENT ROUTINE SERVICE COST CENTERS			
30.00	1	SKILLED NURSING FACILITY	38, 957		30.00
31.00		NURSING FACILITY ICF/IID	0		31. 00 32. 00
32. 00 33. 00		OTHER LONG TERM CARE	0		32.00
33.00		LARY SERVICE COST CENTERS	<u> </u>		33.00
40. 00		RADI OLOGY	0		40.00
41. 00	1	LABORATORY	0		41.00
42.00	1	INTRAVENOUS THERAPY	0		42. 00
43.00	04300	OXYGEN (INHALATION) THERAPY	0		43.00
44.00	1	PHYSI CAL THERAPY	0		44.00
45. 00		OCCUPATI ONAL THERAPY	0		45. 00
46. 00	1	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			49.00
50. 00	1	DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	1	SUPPORT SURFACES	0		51.00
52. 00	1	COMPLEX MEDICAL EQUIPMENT	0		52. 00
52. 01	05201	OTHER ANCILLARY SERVICES COST	0		52. 01
52. 02		MEDICAL SERVICES	0		52. 02
(0.00		TIENT SERVICE COST CENTERS			(0.00
60. 00 61. 00	1	CLINIC RURAL HEALTH CLINIC	0		60.00
62. 00	06200				62.00
63. 00	1	DI ALYSI S	0		63.00
		REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0		70.00
	1	AMBULANCE	0		71. 00
	07300		0		73. 00
74. 00		OTHER REIMBURSEMENT	0		74. 00
90 00		AL PURPOSE COST CENTERS			80.00
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	o		83. 00
84.00		OTHER SPECIAL PURPOSE COST I	0		84. 00
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0		84. 01
89. 00		SUBTOTALS (sum of lines 1-84)	38, 957		89. 00
00.00		I MBURSABLE COST CENTERS			22
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0		91. 00 92. 00
93.00		NONPAID WORKERS			93.00
94. 00		PATIENTS LAUNDRY	0		94.00
95. 00		OTHER NONREIMBURSABLE COST	l o		95. 00
98. 00		Cross Foot Adjustments			98. 00
99. 00		Negative Cost Centers			99. 00
102.00	)	Cost to be allocated (per Wkst. B,	317, 804		102. 00
100.00		Part I)	0.457045		100 00
103.00	1	Unit cost multiplier (Wkst. B, Part I)	8. 157815		103.00
104.00	<u>'</u>	Cost to be allocated (per Wkst. B, Part II)	5, 178		104. 00
105.00		Unit cost multiplier (Wkst. B, Part	0. 132916		105. 00
		II			

Health Financial Systems CARE ONE AT EAST BE		CARE ONE AT EAST BRUNSWICK	In Lieu of Form CMS-2540-10
	RATIO OF COST TO CHARGES FOR	ANCLILIARY AND OUTPATIENT COST CENTERS Provider No · 315472	Period: Worksheet C

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:31 am Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 18 col. 2 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 78, 088 161, 935 0. 482218 40.00 04100 LABORATORY 101, 442 210, 365 0. 482219 41.00 41.00 222, 824 0. 443645 42.00 04200 I NTRAVENOUS THERAPY 502, 258 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 382, 722 2, 974, 626 0.464839 44.00 04500 OCCUPATIONAL THERAPY 45.00 1, 074, 539 3, 116, 642 0.344775 45.00 04600 SPEECH PATHOLOGY 0.350600 46.00 234, 446 668, 700 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 82, 466 47, 417 1.739165 48.00 04900 DRUGS CHARGED TO PATIENTS 1, 940, 672 0. 470525 49.00 49.00 913, 134 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 50.00 51.00 05100 SUPPORT SURFACES 36, 774 76, 259 0.482225 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 0 52.01 05202 MEDICAL SERVICES 0.000000 52.02 0 52.02 OUTPATIENT SERVICE COST CENTERS 0. 000000 60.00 06000 CLI NI C 0 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

33, 458

4, 159, 893

69, 382

9, 768, 256

0. 482229 71. 00

100. 00

71. 00 07100 AMBULANCE

Total

100.00

Health Financial Systems	CARE ONE AT EA	AST BRUNSWICK			eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	epared: 31 am
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pi	rogram Charges	s Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	0. 482218			0 18, 944		
41. 00   04100   LABORATORY	0. 482219			0 23, 485	0	
42. 00   04200   I NTRAVENOUS THERAPY	0. 443645			0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	l .		0	0	1 .0.00
44. 00   04400   PHYSI CAL THERAPY	0. 464839			0 679, 290	l .	44.00
45. 00   04500   OCCUPATI ONAL THERAPY	0. 344775			0 550, 751	l .	
46. 00 04600 SPEECH PATHOLOGY	0. 350600			0 127, 920	0	1
47. 00   04700   ELECTROCARDI OLOGY	0. 000000	l .		0	· · · · · · · · · · · · · · · · · · ·	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 739165			0 82, 466		
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 470525			0 141, 640	0	1
50. 00   05000   DENTAL CARE - TITLE XIX ONLY	0. 000000	l .		0		50.00
51. 00   05100   SUPPORT SURFACES	0. 482225			0 36, 774	0	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000			0	0	
52. 01   05201 OTHER ANCILLARY SERVICES COST	0. 000000			0	0	
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52. 02
OUTPATIENT SERVICE COST CENTERS						
60. 00   06000   CLI NI C	0. 000000	0		0	0	.   00. 00
61. 00   06100   RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC						62.00
63. 00   06300   DI ALYSI S	0. 000000			0	_	
71. 00   07100   AMBULANCE (2)	0. 482229	l .		0	0	
100.00   Total (Sum of Lines 40 - 71)		3, 936, 314		0 1, 661, 270	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 on	l y.					

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

Heal th	Financial Systems	CARE ONE AT EA	ST BRUNSWICK		In Lie	eu of Form CMS-2	2540-10
	TIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315472	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Pre 5/10/2024 11:	pared:
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST						
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	0. 470525	1.00
2.00	Program vaccine charges (From your reco				,	2, 593	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transfe	er this amoun	t to Worksheet	1, 220	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
			Allied Health		Cost (From	& Allied	
		•	(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
				Costs - Part		Through (Col.	
				(Col . 2 / Col		3 x Col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS			3.00	4.00	3.00	
	ANCI LLARY SERVI CE COST CENTERS	TOK NOKSTNO &	ALLIED HEALTH				
40. 00	04000 RADI OLOGY	78, 088	0	0.0000	00 18, 944	0	40.00
41. 00	04100 LABORATORY	101, 442		0. 00000			41. 00
	04200 I NTRAVENOUS THERAPY	222, 824		0. 00000		٥	
43. 00	04300 OXYGEN (INHALATION) THERAPY	222,024		0. 00000		٥	
44. 00	04400 PHYSI CAL THERAPY	1, 382, 722		0. 00000			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	1, 074, 539		0. 00000		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	234, 446		0. 00000			46. 00
	04700 ELECTROCARDI OLOGY	0	0	0.00000		Ö	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	82, 466	0	0.00000			
49. 00	04900 DRUGS CHARGED TO PATIENTS	913, 134		0.00000			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000		0	50.00
51. 00	05100 SUPPORT SURFACES	36, 774	l	0. 00000		0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0.00000		1	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	1 0	0. 00000		Ö	
	05202 MEDI CAL SERVI CES	0	l	0.00000		Ö	
100.00		4, 126, 435	Ö		1, 661, 270	0	100.00

eal th	Financial Systems CARE ONE AT EAST B	RUNSWI CK	In Lie	u of Form CMS-2	2540-1	
OMPUTATION OF INPATIENT ROUTINE COSTS Provider No.: 315472 Period: W						
From 01/01/2023   Parts I - I   To 12/31/2023   Date/Time						
			127 017 2020	5/10/2024 11:		
		Title XVIII	Skilled Nursing	PPS		
			Facility		1	
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00		
	NPATI ENT DAYS					
	Inpatient days including private room days			38, 957	1.0	
	Private room days			0	2. 0	
00	Inpatient days including private room days applicable to the Pr			13, 120		
	Medically necessary private room days applicable to the Program			14 222 504	4.0	
	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			14, 332, 584	5.0	
	General inpatient routine service charges			20, 013, 523	6.0	
	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 716145		
	Enter private room charges from your records	,		0	8.0	
. 00						
	2)					
	The state of the s					
1. 00	00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)					
2. 00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12.0	
	Average per diem private room cost differential (Line 7 times I			0.00		
4. 00	Private room cost differential adjustment (Line 2 times line 13	)		0	14.0	
	General inpatient routine service cost net of private room cost	differential (Line 5	minus line 14)	14, 332, 584	15.0	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS			0.7.04		
	Adjusted general inpatient service cost per diem (Line 15 divi Program routine service cost (Line 3 times line 16)	ded by line 1)		367. 91 4, 826, 979		
	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		4, 620, 979	1	
	Total program general inpatient routine service cost (Line 17			4, 826, 979		
0. 00	Capital related cost allocated to inpatient routine service cos		t II column 18,	1, 668, 688		
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)					
	Per diem capital related costs (Line 20 divided by line 1)			42. 83		
1	Program capital related cost (Line 3 times line 21)			561, 930		
3. 00 1. 00	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From prov	i dom mocomdo)		4, 265, 049 0	23. C	
5.00	Aggregate charges to beneficialities for excess costs (From prov Total program routine service costs for comparison to the cost	limitation (line 23 mi	nus Line 24)	4, 265, 049		
	Enter the per diem limitation (1)	Trim tatron (Line 25 iii	ilus IIIIe 24)	4, 203, 047	26.0	
	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27.0	
	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)				28. 0	
) Lir	es 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX	•		
				1. 00		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	38, 957	1.00
2.00	Program inpatient days (see instructions)	13, 120	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. 336782	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 EAST   ATLON OF INPATIENT ROUTINE COSTS	Provi der No.: 315472	In Lie Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	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			38, 957	1.				
00	Private room days			0	2				
0	Inpatient days including private room days applicable to the P			13, 235					
00	Medically necessary private room days applicable to the Progra Total general inpatient routine service cost	m		14 222 504	5				
IU	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			14, 332, 584	) 3				
0	General inpatient routine service charges			20, 013, 523	6				
0	General inpatient routine service cost/charge ratio (Line 5 d	ivided by line 6)		0. 716145					
0	Enter private room charges from your records								
0	Average private room per diem charge (Private room charges line 8 divided by private room days, line								
	2)			0. 00					
00									
00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)  0.								
00	Average per diem private room charge differential (Line 9 minu	,		0. 00					
00	Average per diem private room cost differential (Line 7 times			0. 00					
00	Private room cost differential adjustment (Line 2 times line 1			0					
00		t differential (Line 5	minus line 14)	14, 332, 584	15				
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS  Adjusted general inpatient service cost per diem (Line 15 div	ided by Line 1)		367. 91	16				
00	Program routine service cost (Line 3 times line 16)	rued by Title 1)		4, 869, 289					
00	Medically necessary private room cost applicable to program (	line 4 times line 13)		4, 007, 207	18				
00	Total program general inpatient routine service cost (Line 17	,		4, 869, 289					
00	Capital related cost allocated to inpatient routine service co	. ,	t II column 18.	1, 668, 688					
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)		·						
00	Per diem capital related costs (Line 20 divided by line 1)			42. 83	21				
00	Program capital related cost (Line 3 times line 21)			566, 855					
00	Inpatient routine service cost (Line 19 minus line 22)			4, 302, 434					
00	Aggregate charges to beneficiaries for excess costs (From pro			0					
00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	4, 302, 434					
00	Enter the per diem limitation (1)		0() (1)	0. 00					
00	Inpatient routine service cost limitation (Line 3 times the pe			0	27				
00	(Transfer to Worksheet E, Part II, line 4) (See instructions)	e resser of line 25 or	iine 2/)	0 Reimbursable inpatient routine service costs (Line 22 plus) the lesser of line 25 or line 27) 4,869,289 28					

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	38, 957	1.00
2.00	Program inpatient days (see instructions)	13, 235	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. 339734	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 EAST BE	RUNSWI CK	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	R TITLE XVIII	Provi der No.: 315472	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:31 am
		Title XVIII	Skilled Nursing	PPS

		II tie xviii	Facility	PP5	
			Tacifity		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		11.00	
1.00	Inpatient PPS amount (See Instructions)			9, 848, 873	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,		9, 848, 873	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			1, 325, 800	5. 00
6.00	Allowable bad debts (From your records)			412, 933	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		167, 537	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			268, 406	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)			8, 791, 479	11. 00
12.00	Interim payments (See instructions)			8, 538, 384	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			14, 527	
14. 75	Sequestration for non-claims based amounts (see instructions)			5, 368	
14. 99	Sequestration amount (see instructions)			170, 461 62, 739	•
15. 00					
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)				18.00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			1, 220	
20.00	Medicare Part B ancillary charges (See instructions)			2, 593	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			1, 220	
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)	ctions)		0	
24. 01 24. 02	Allowable Bad debts for dual eligible beneficiaries (see instru Adjusted reimbursable bad debts (see instructions)	Ctrons)		0	24. 01 24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			1, 220	
26. 00	Interim payments (See instructions)			2, 002	
27. 00	Tentative adjustment			2,002	
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			24	
29. 00	Balance due provider/program (see instructions)			-806	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2		30.00
55. 50	1. Totalia amainta (Manari amabi a cost i aport i talla) i il decordano	5 omo 1 ab. 13 2,	0000.011 110.2	٥١	30.00

WORSHEET E-1

WORSHEET E-1

FOOT def No.: 313472

FOR TOT.

FOR 01/01/2023

To 12/31/2023

Date/Time Prepared: 5/10/2024 11: 31 am

Title XVIII Skilled Nursing PPS

		11 11	e XVIII S	Killed Nursing	PPS	
		Innation	t Part A	Facility	t B	
		<u>'</u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		8, 338, 085		2, 002	1.00
2.00	Interim payments payable on individual bills, either		210, 154		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, lenter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/09/2023	9, 855		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0	3. 53 3. 54
3. 54	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-9, 855			3. 54
3. 99	- 3.98)		-9, 855		ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 538, 384		2, 002	4. 00
1. 00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		0,000,001		2,002	1. 00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATIVE TO PROGRAM		0			5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
0. 77	- 5. 98)		Ĭ		Ĭ	0. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		62, 739		0	6. 01
6. 02	PROVI DER TO PROGRAM		0		806	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 601, 123		1, 196	7. 00
			Contract	tor Name	Contractor	
					Number	
0.00	Name of Contractor		1.	00	2. 00	0.00
	Name of Contractor					8. 00

<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 EBALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column onl y)

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

oni y)				1270172020	5/10/2024 11:	31 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	Assets					
	CURRENT ASSETS	5, 070	1			
1.00	Cash on hand and in banks	56, 979			0	
2.00	Temporary investments Notes receivable					
4. 00	Accounts receivable	2, 740, 383				
5. 00	Other recei vabl es	0		o o	Ö	
6.00	Less: allowances for uncollectible notes and accounts	-527, 568	C	0	0	6. 00
	recei vabl e					
7.00	Inventory	0		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	29, 987	•	0	0	
10.00	Due from other funds	51, 104		, i		
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 350, 885	1	-		
	FIXED ASSETS			-		1
12.00	Land	1, 108, 427	C	0	0	12.00
13.00	Land improvements	4, 958	C	0	0	13.00
14. 00	Less: Accumulated depreciation	-661	C	-	- 1	1
15.00	Buildings	8, 197, 573		0	0	
16.00	Less Accumulated depreciation Leasehold improvements	-5, 891, 483		0	0	
17. 00 18. 00	Less: Accumulated Amortization			-	0	
19. 00	Fi xed equipment	526, 463		-	0	
20. 00	Less: Accumulated depreciation	-429, 947				
21. 00	Automobiles and trucks	63, 200		o o	o	
22. 00	Less: Accumulated depreciation	-63, 200	C	0	0	22. 00
23. 00	Maj or movable equipment	3, 670, 897	C	0	0	23. 00
24. 00	Less: Accumulated depreciation	-3, 254, 799	C	0	0	1
25. 00	Minor equipment - Depreciable	0	(	0	0	
26. 00	Mi nor equipment nondepreciable	722 170		-	0	1
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	722, 178 4, 653, 606		-	0	
20.00	OTHER ASSETS	4, 033, 000		<u> </u>		20.00
29. 00	Investments	0	C	0	0	29.00
30.00	Deposits on Leases	0	C	0	0	30.00
31. 00	Due from owners/officers	0	C	0	0	
32. 00	Other assets	1, 480, 867	1	, i	0	1
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 480, 867		-	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	8, 485, 358		) U	0	34.00
	CURRENT LIABILITIES					1
35.00	Accounts payable	1, 525, 364	(	0	0	35.00
36.00	Salaries, wages, and fees payable	270, 240	C	0	0	36.00
37. 00	Payroll taxes payable	201	C	0	0	
38. 00	Notes & Loans payable (Short term)	0	(	0	0	
39. 00	Deferred income	0	(	0	0	
40. 00 41. 00	Accel erated payments Due to other funds	23, 989	(		0	40.00
42. 00	Other current liabilities	4, 016, 762		-		1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 836, 556				
	LONG TERM LIABILITIES	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			_	1
44.00	Mortgage payable	12, 789, 825	C	0	0	44.00
45.00	Notes payable	0	C	0	-	
46.00	Unsecured Loans	0	C	0	0	
47. 00	Loans from owners:	0	C	0	0	
48. 00	Other long term liabilities	-24, 913, 684	1	0	0	
49. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	12 122 050	0	-	0	1
50. 00 51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-12, 123, 859 -6, 287, 303		-		
31.00	CAPITAL ACCOUNTS	-0, 207, 303		0		31.00
52. 00	General fund balance	14, 772, 661				52.00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
	Donor created - endowment fund balance - unrestricted			0		55. 00
55.00			I .	0	1	56. 00
56.00	Governing body created - endowment fund balance					
56. 00 57. 00	Plant fund balance - invested in plant				0	
56.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
56. 00 57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	14 772 661			0	58. 00
56. 00 57. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	14, 772, 661 8, 485, 358		0 0		58. 00 59. 00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315472

| Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					10 12/31/2023	5/10/2024 11:	
		Genera	I Fund	Special F	Purpose Fund	Endowment Fund	or am
				·			
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 15, 378, 804	3. 00	4. 00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-606, 130				2. 00
3.00	Total (sum of line 1 and line 2)		14, 772, 674		0		3. 00
4. 00	Additions (credit adjustments)		, , , 2, 0, .				4. 00
5. 00	(	0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 5 - 9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)		14, 772, 674		0		11. 00
12.00	Deductions (debit adjustments)						12.00
13. 00	ROUNDI NG	13			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16.00		0			0	0	16.00
17. 00	Total deductions (sum of lines 12 17)	0	10		0	0	17. 00 18. 00
18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance		13 14, 772, 661		0		18.00
19.00	sheet (Line 11 - line 18)		14, 772, 001		0		19.00
	Janeet (Erne 11 Trie 10)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3. 00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00			0				5. 00
6.00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 5 - 9)	0	U		0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	Deductions (debit adjustments)						12. 00
13. 00	ROUNDI NG		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 13 - 17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (Line 11 - line 18)						

Health Financial Systems	CARE ONE AT EAST BRUNSW	VI CK		In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPEN	ISES Prov	vider N	lo.: 315472	From 01/01/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/10/2024 11:	pared:
Cost Center Description			Inpati ent	Outpati ent	Total	
			1 00	2.00	3 00	

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Peri od: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/10/2024 11:	pared: 31 am
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		20, 013, 52	23	20, 013, 523	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		20, 013, 52	23	20, 013, 523	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		9, 768, 25	66 0	9, 768, 256	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
	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3	to	29, 781, 77	79 0	29, 781, 779	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description		'			
	·			1. 00	2.00	
-	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				19, 781, 191	1. 00
2.00	Add (Specify)			0		2.00
3.00				0		3. 00
4.00				0		4.00
5. 00				0		5. 00
6. 00				0		6. 00
7. 00				0		7. 00
8. 00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9. 00	Deduct (Specify)			0	_	9. 00
10.00				0		10.00
11. 00				0		11. 00
12. 00				0		12.00
13. 00				l ő		13. 00
	Total Deductions (Sum of Lines 9 - 13)				0	14. 00
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				19, 781, 191	
	1.112. 1p1.11g Expenses (cam of fines ) and of militae (fine fi)			Į į	.,,,,,,,,,,	

Heal th	Financial Systems	CARE ONE AT EAST BE	RUNSWI CK	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSE		ES	Provi der No.: 315472	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Prep	
					5/10/2024 11:3	31 am_
					1. 00	
1. 00	1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			29, 781, 779	1. 00	
2.00 Less: contractual allowances and discounts on patients accounts					10, 617, 037	2.00
3.00 Net patient revenues (Line 1 minus line 2)					19, 164, 742	3.00

	To 12/31/2023	Date/Time Prep 5/10/2024 11:3	
		37 107 2024 11.	J I dill
		1.00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	29, 781, 779	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	10, 617, 037	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	19, 164, 742	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	19, 781, 191	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-616, 449	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2, 922	7. 00
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase di scounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12. 00	Parking lot receipts	0	12.00
13. 00	Revenue from laundry and linen service	0	13.00
14. 00	Revenue from meals sold to employees and guests	0	14.00
15. 00	Revenue from rental of living quarters	0	15.00
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21. 00		0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23. 00	Governmental appropriations	0	23. 00
24. 00	BARBER AND BEAUTY	1, 361	24. 00
24. 01	OTHER REV	5, 183	24. 01
24. 02	OTHER INCOME	853	24. 02
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)	10, 319	25. 00
26. 00	Total (Line 5 plus line 25)	-606, 130	
27. 00	Other expenses (specify)	0	27. 00
28. 00		0	28. 00
29. 00		0	29. 00
	Total other expenses (Sum of lines 27 - 29)	0	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	-606, 130	31.00