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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315464

Period: From 01/01/2023 To 12/31/2021 Date/Time Prepared: Date/Time Prepared:

			5/10/	/2024 11:33 am
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost rep	ort	Date: 5/10/2024	Time: 11:33 an
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report ent	er the number of times the provide	r resubmitted this cos	t report
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.		
Contractor	4.[1]Cost Report Status	6. Contractor No.		
use only	(1) As Submitted	7.[N] First Cost Report for this	Provider CCN	
		8.[N] Last Cost Report for this	Provider CCN	
		9. NPR Date:		
	(4) Reopened	10.[0]If line 4, column 1 is "4"	 : Enter number of time:	s reopened
	(5) Amended	11.Contractor Vendor Code	4	•
	5. Date Received:	12.[F] Medicare Utilization. Ente	 er "F" for full, "L" fo	rlow, or "N"
		for no utilization.		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT EVESHAM (315464) 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	-48, 728	-124	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	-48, 728	-124	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 EVESHAM In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315464 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:33 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 870 ROUTE 70 EAST PO Box: 1.00 2.00 City: MARLTON State: NJ Zi p Code: 08053 2.00 3.00 County: BURLINGTON CBSA Code: 15804 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT EVESHAM 315464 08/14/2000 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 663, 858 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 23 00 663, 858 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 38.00 Υ 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 66.936

Heal th	Financial Systems	CARE ONE AT EVE	SHAM	In Li	eu of Form CMS-:	2540-10
SKI LLE	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315464 Period:			Worksheet S-2		
COMPLE	X INDENTIFICATION DATA			From 01/01/2023		
				To 12/31/2023		
					5/10/2024 11:	33 am
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative	and General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing cos	t centers and		
	amounts.		_			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addres	s 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 th	e lines	
	bel ow.					
45.00	Name: HEALTHBRI GE	Contractor's Name: NOVITA	S SOLUTIONS Contr	actor's Number: 120	01	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46.00
47.00	City: FORT LEE	State: NJ	Zi p C	ode: 070	24	47. 00
46. 00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI	CARE ONE AT EVE		No.: 315464 P	In Li∈ eriod:	eu of Form CMS- Worksheet S-2	
	X REIMBURSEMENT QUESTIONNAIRE	IT HEALTH CARE	Provider	F	errod. rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	epared:
					Y/N	5/10/2024 11: Date	33 am
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilities	ses enter in column	1, "Y" fo	r Yes or "N" f	1.00 or No. For all	the date	
1.00	Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date 3, "V" for voluntary or "I" for involuntary.			N	2. 00	0.00	2. 00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider on I, or members of the	es, drug rits e board	Y			3.00
				Y/N 1.00	Type 2. 00	Date 3.00	
4.00	Financial Data and Reports		Dudal II a			1 0.00	4.00
4.00	Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" t te copy or enter da	for te	Y	A		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different	from	N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2:	Is the	provider the	N	N	6. 00
7. 00 8. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s	ng the cost reportin		for Nursing	N N		7. 00 8. 00
	School and/of Arried Hearth Frogram: (1719) S	ee mstructrons.				Y/N 1.00	
9. 00 10. 00	Bad Debts Is the provider seeking reimbursement for ballfline 9 is "Y", did the provider's bad deb				reporting	Y N	9. 00 10. 00
11. 00	period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an	d/or coi nsurance wai	ved? If "	Y", see instru	ctions.	N	11. 00
12. 00	Bed Complement Have total beds available changed from prior	cost reporting peri	od? If "Y			N	12. 00
		Description	n	Par Y/N	t A Date	Part B Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			Y	03/19/2024	Y	13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N		N	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			N		N	17. 00
18. 00	Was the cost report prepared only using the			N		N	18. 00

Heal th	Financial Systems CARE	ONE AT	EVESHAM		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALT	H CARE	Provi der N		Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2023 Fo 12/31/2023	Part II Date/Time Pre	nared·
					12, 01, 2020	5/10/2024 11:	33 am
			1.0	0	2. (00	
	Cost Report Preparer Contact Information						
19. 00	Enter the first name, last name and the title/position		HARLES		REED		19. 00
	held by the cost report preparer in columns 1, 2, and	d 3,					
	respecti vel y.						
20. 00	Enter the employer/company name of the cost report	E.	XECUCARE ASSOC	I ATES			20. 00
	preparer.						
21. 00	Enter the telephone number and email address of the	cost (609) 738-3200		CRWASSC@NETSCAF	PE. NET	21. 00
	report preparer in columns 1 and 2, respectively.						

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

CARE ONE AT EVESHAM

In Lieu of Form CMS-2540-10
From 01/01/2023
From 01/01/20

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To 12/31/2023		
		Part B Date 4.00				
	PS&R Data					
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	03/19/2024				13. 00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		VI CE-PRESI DENT			19. 00
20. 00	Enter the employer/company name of the cost r preparer.	report			:	20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective				:	21. 00

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

 Health Financial Systems
 CARE ONE AT

 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 Provi der No.: 315464 COMPLEX STATISTICAL DATA

				To	5 12/31/2023	Date/Time Prep 5/10/2024 11:3	
				I npa	atient Days/Vis		, , , , , , , , , , , , , , , , , , ,
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	144	52, 560	0	8, 266	14, 946	1. 00
2.00	NURSING FACILITY	0	0	0		0	2. 00
3.00	ICF/IID	0	0			0	3. 00
4.00	HOME HEALTH AGENCY COST		_	0	0	0	4. 00
5.00	Other Long Term Care	o o	0				5. 00
6.00	SNF-Based CMHC HOSPICE		0			0	6. 00
7. 00 8. 00	Total (Sum of lines 1-7)	144	52, 560	0	8, 266	0 14, 946	7. 00 8. 00
8.00	Total (Suil of Titles 1-7)	Inpatient D		U	Di scharges	14, 740	8.00
		Thipatrent b	ays/ VI SI ts		Di Schai ges		
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
		6.00	7. 00	8. 00	9. 00	10. 00	
1.00	SKILLED NURSING FACILITY	11, 942	35, 154	0	279	74	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	I CF/IID	0	0			0	3. 00 4. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0				4. 00 5. 00
6. 00	SNF-Based CMHC	o o	U				6. 00
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	11, 942	35, 154	ő	279	74	8. 00
	1	Di scha		Aver	age Length of	Stay	
		211	-			T1 11 V1V	
	Component	0ther 11.00	Total 12.00	Title V 13.00	Title XVIII 14.00	Ti tle XIX 15.00	
1. 00	SKILLED NURSING FACILITY	11.00	780		29. 63	201. 97	1. 00
2. 00	NURSING FACILITY	427	780	0.00	24.03	0.00	2. 00
3. 00	ICE/IID	Ö	0	0.00		0.00	3. 00
4. 00	HOME HEALTH AGENCY COST		_				4. 00
5.00	Other Long Term Care	o	0				5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	427	780	0.00	29. 63	201. 97	8. 00
		Average Length of Stay		Admi s	SIONS		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	·	16.00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	45. 07	0	309	48	444	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00	ICF/IID	0.00			0	0	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5.00	Other Long Term Care SNF-Based CMHC	0.00				0	5. 00
6. 00 7. 00	HOSPI CE	0.00	0	0	o	0	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	45. 07	0	309	48	444	8. 00
0.00	Total (Sam of Titles 17)	Admi ssi ons	Full Time		10		0.00
	C	T-+-1	Family and an	Managai al			
	Component	Total	Employees on Payroll	Nonpai d Workers			
		21. 00	22. 00	23. 00			
1. 00	SKILLED NURSING FACILITY	801	133. 04				1. 00
2.00	NURSING FACILITY	0	0.00	0.00			2. 00
3.00	ICF/IID	0	0. 00				3. 00
4.00	HOME HEALTH AGENCY COST		0. 00				4. 00
5.00	Other Long Term Care	0	0. 00				5. 00
6.00	SNF-Based CMHC		0.00				6. 00
7.00	HOSPICE	0	0.00	0.00			7. 00
8. 00	Total (Sum of lines 1-7)	801	133. 04	0.00			8. 00

Amount Reclass of Adjusted Paid Hours Average Hour	y
Alliburit Recrass. or Augusteu raru nours Average nour	
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 II - DIRECT SALARIES	
SALARIES	
1.00 Total salaries (See Instructions) 9, 243, 126 0 9, 243, 126 276, 729.00 33.	
2.00 Physician salaries-Part A	
3.00 Physician salaries-Part B 0 0 0 0.00 0.0	•
4.00 Home office personnel 0 0 0 0.00 0.00	•
5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00	
6.00 Revised wages (line 1 minus line 5) 9,243,126 0 9,243,126 276,729.00 33.	
7.00 Other Long Term Care 0 0 0 0.00 0.00	
8.00 HOME HEALTH AGENCY COST 0 0 0.00 0.0	
9.00 CMHC 0 0 0 0.00 0.0	
10. 00 HOSPI CE 0 0 0 0. 00 0. 0	
11.00 Other excluded areas 0 0 0 0.00 0.00	11. 00
12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00	12.00
through 11)	
	13. 00
12)	_
OTHER WAGES & RELATED COSTS	_
14.00 Contract Labor: Patient Related & Mgmt 20,508 0 20,508 262.00 78.3	
	15. 00
16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00	16. 00
WAGE-RELATED COSTS	
17.00 Wage-related costs core (See Part IV)	17. 00
18.00 Wage-related costs other (See Part IV) 0 0 0	18. 00
19.00 Wage related costs (excluded units) 0 0 0	19. 00
20.00 Physician Part A - WRC 0 0 0	20. 00
21.00 Physician Part B - WRC 0 0 0	21. 00
22.00 Total Adjusted Wage Related cost (see 1,700,960 0 1,700,960	22. 00
instructions)	1

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT EVESHAM

Provi der No.: 315464

				Т	o 12/31/2023	Date/Time Prep 5/10/2024 11:	
		Amount	Reclass. of	Adj usted	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	0.00	0.00	1.00
2.00	Administrative & General	591, 455	(591, 455	13, 847. 00	42. 71	2.00
3.00	Plant Operation, Maintenance & Repairs	150, 124	(150, 124	6, 255. 00	24. 00	3. 00
4.00	Laundry & Li nen Servi ce	61, 738	(61, 738	3, 661. 00	16. 86	4. 00
5.00	Housekeepi ng	229, 144	(229, 144	13, 663. 00	16. 77	5. 00
6.00	Di etary	622, 801	(622, 801	26, 354. 00	23. 63	6. 00
7.00	Nursing Administration	577, 750	(577, 750	14, 775. 00	39. 10	7. 00
8.00	Central Services and Supply	32, 386	(32, 386	1, 235. 00	26. 22	8. 00
9.00	Pharmacy	0	(0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	56, 236	(56, 236	2, 176. 00	25. 84	10.00
11.00	Soci al Servi ce	150, 819	(150, 819	3, 905. 00	38. 62	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	173, 932	(173, 932	8, 466. 00	20. 54	13.00
14. 00	Total (sum lines 1 thru 13)	2, 646, 385	(2, 646, 385	94, 337. 00	28. 05	14. 00

Health Financial Systems	CARE ONE AT EVESHAM	In Lie	u of Form CMS-2	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315464	From 01/01/2023	Worksheet S-3 Part IV Date/Time Pre 5/10/2024 11:	pared:
			Amount	

PART IV - WAGE RELATED COSTS		10 12/31/2023	Date/lime Prep 5/10/2024 11:3	
PART IV - WAGE RELATED COSTS Part A - Core List			7'	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 43,473 1.00 2.00 3.00 401K Employer Contributions 62,00 3.00			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00	1.00	401K Employer Contributions	43, 473	1. 00
Prior Year Pension Service Cost 0 4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Admin istration Fees 0 5.00	3.00	Qualified and Non-Qualified Pension Plan Cost	0	3. 00
5.00 401K/TSA PI an Administration fees 0 5.00 6.00 Legal Accounting/Management Fees-Pension PI an 0 6.00 Employee Managed Care Program Administration Fees 0 7.00 8.00 Prescription Drug PI an 0 0 10.00 10	4.00	Prior Year Pension Service Cost	0	4. 00
Color Legal / Accounting / Management Fees - Pensi on Plan Color Employee Managed Care Program Administration Fees Color HeALTH AMD INSURANCE COST Color		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
To Employee Managed Care Program Administration Fees 10 7.00	5.00	401K/TSA Pl an Administration fees	0	5. 00
HEALTH AND INSURANCE COST S	6.00	Legal /Accounting/Management Fees-Pensi on Plan	0	6. 00
Real th Insurance (Purchased or Self Funded) 590,012 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental , Hearing and Vision Plan 0 10.00 10.00 Dental , Hearing and Vision Plan 0 10.00 10.00 Life Insurance (If employee is owner or beneficiary) 1,931 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Usability Insurance (If employee is owner or beneficiary) 0 13.00 Usability Insurance (If employee is owner or beneficiary) 0 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 264,744 15.00 Workers' Compensation Insurance 264,744 15.00 Non cumulative portion) TAXES 10.4 Employers Portion Only 0 16.00 Non cumulative portion) 17.00 ICA-Employers Portion Only 0 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 19.00 Unemployment Insurance 0 19.00 1	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9. 00 Prescription Drug Plan		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 1,931 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 264,744 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 FICA-Employers Portion Only 691,039 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 109,761 20.00 OTHER 20.00 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost 10.00 10.00 10.00 1	8.00	Health Insurance (Purchased or Self Funded)	590, 012	8. 00
11. 00	9.00	Prescription Drug Plan	0	9. 00
12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 264,744 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 TAXES	10.00	Dental, Hearing and Vision Plan	0	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 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 18.00 Modicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	1, 931	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
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 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 264, 744 26, 744 27. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes OTHER 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 30 Tuition Reimbursement 4. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion TAXES TAX	15.00	Workers' Compensation Insurance	264, 744	15. 00
TAXES 17.00 FI CA-Employers Portion Only 691,039 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 109,761 20.00 OTHER 20.00 Executive Deferred Compensation 0 21.00 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,700,960 24.00 Amount Reported 1.00 Part B - Other than Core Related Cost	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 FICA-Employers Portion Only 691,039 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 109, 761 21. 00 Executive Deferred Compensation 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 0 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1,700,960 24. 00 Part B - Other than Core Related Cost		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost 18.00 19.00 20.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.0				
19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 109,761 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of lines 1 - 23) 1,700,960 24.00 Amount Reported 1.00 Part B - Other than Core Related Cost	17. 00	FICA-Employers Portion Only	691, 039	17. 00
20.00 State or Federal Unemployment Taxes 109, 761 20.00	18.00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER 21.00 Executive Deferred Compensation 0 21.00	19.00	Unemployment Insurance	0	19. 00
21.00 Executive Deferred Compensation 0 21.00	20.00		109, 761	20. 00
22.00 Day Care Cost and Allowances 0 22.00		OTHER		
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,700,960 24.00 Amount Reported 1.00 Part B - Other than Core Related Cost	21.00	Executive Deferred Compensation	0	21. 00
24.00 Total Wage Related cost (Sum of lines 1 - 23) 1,700,960 24.00 Amount Reported 1.00 1.00	22.00	Day Care Cost and Allowances	0	22. 00
Amount Reported 1.00 Part B - Other than Core Related Cost	23.00	Tuition Reimbursement	0	23. 00
Part B - Other than Core Related Cost	24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 700, 960	24.00
Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost				
			1.00	
25. 00 OTHER WAGE RELATED COST 0 25. 00				
	25. 00	OTHER WAGE RELATED COST	0	25. 00

Amount Reported Reported Reported Reported Reported Reported Reported Related to to alary in col. Salaries (col. 1 + col. 2) Salaries (col. 1 + col. 2) Salaries (col. 4) Nage (col. 3 + col. 4) Nage (col. 4)					Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:3	oared:
Reported Benefits Salaries (col. Related to Salary in col. Wage (col. 3 +		Occupational Category	Amount	Fri nge	Adjusted	Paid Hours		JO UIII
Direct Salaries		occupational category						
Direct Salaries Nursing Occupations Segistered Nurses (RNs) Segistered Nurses (LPNs) Segistered Nurses (RNs) Segistered Nurses (LPNs) Segistered Nu								
Di rect Sal ari es Nursing Occupations S95, 394 111, 788 707, 182 12, 392, 00 57, 07 1, 00 2, 00 Li censed Practical Nurses (LPNs) 1, 749, 970 328, 564 2, 078, 534 47, 519, 00 43, 74 2, 00 2, 00 Certi fied Nursing Assistant/Nursing 1, 713, 030 321, 628 2, 034, 658 69, 140, 00 29, 43 3, 00 Assistants/Aid des Assistants/Aid des 1, 033, 875 194, 114 1, 227, 989 23, 784, 00 51, 63 5, 00 Physical Therapists 0 0 0 0, 00					,	3	,	
Nursing Occupations			1.00	2.00	3.00	4. 00	5. 00	
1.00 Registered Nurses (RNs) 595,394 111,788 707,182 12,392.00 57.07 1.00		Direct Salaries						
2.00 Li censed Practical Nurses (LPNs) 1,749,970 328,564 2,078,534 47,519.00 43.74 2.00		Nursing Occupations						
3.00 Certified Nursing Assistant/Nursing 1,713,030 321,628 2,034,658 69,140.00 29,43 3.00 Assistants/Aides 1,031,030 321,628 2,034,658 69,140.00 29,43 3.00 Assistants/Aides 1,033,875 194,114 1,227,989 23,784.00 51,63 5.00 6.00 Physical Therapy Assistants 0 0 0 0 0 0 0 0.00 0.00 6.00 0.00	1.00	Registered Nurses (RNs)	595, 394	111, 788	707, 182	12, 392. 00	57. 07	1.00
Assistants/Aides 4.00 Total Nursing (sum of lines 1 through 3) 4, 058, 394 761, 980 4, 820, 374 129, 051.00 37.35 4.00 6.00 Physical Therapists 1, 033, 875 194, 114 1, 227, 989 23, 784.00 51. 63 5.00 6.00 Physical Therapy Assistants 0 0 0 0 0.00 0.00 6.00 7.00 Physical Therapy Aides 0 0 0 0 0.00 0.00 0.00 7.00 8.00 Occupational Therapy Assistants 0 0 0 0 0 0.00 0.00 7.00 8.00 Occupational Therapy Assistants 0 0 0 0 0 0 0.00 0.00 9.00 10.00 Occupational Therapy Assistants 0 0 0 0 0 0 0.00 0.00 9.00 10.00 Occupational Therapy Assistants 0 0 0 0 0 0 0.00 0.00 9.00 11.00 Speech Therapists 278, 784 52, 343 331, 127 6, 480.00 51.10 11.00 12.00 Respiratory Therapists 73, 687 13, 835 87,522 1, 852.00 47. 26 12.00 13.00 Other Medical Staff 0 0 0 0 0.00 0.00 13.00 14.00 Registered Nurses (RNs) 6, 679 6, 679 74.00 90.26 14.00 15.00 Licensed Practical Nurses (LPNs) 0 0 0.00 0.00 50.60 16.00 16.00 Certified Nursing Assistant/Nursing 506 506 10.00 50.60 16.00 17.00 Total Nursing (sum of lines 14 through 16) 7, 185 7, 185 84.00 85.54 17.00 18.00 Physical Therapists 0 0 0.00 0.00 0.00 19.00 20.00 Physical Therapy Asistants 0 0 0.00 0.00 0.00 19.00 20.00 Physical Therapy Asistants	2.00	Licensed Practical Nurses (LPNs)	1, 749, 970	328, 564	2, 078, 534	47, 519. 00	43. 74	2.00
4.00 Total Nursing (sum of lines 1 through 3) 4,058,394 761,980 4,820,374 129,051.00 37.35 4.00 5.00 Physical Therapists 1,033,875 194,114 1,227,989 23,784.00 51.63 5.00 6.00 Physical Therapy Assistants 0 0 0 0.00	3.00	Certified Nursing Assistant/Nursing	1, 713, 030	321, 628	2, 034, 658	69, 140. 00	29. 43	3.00
5.00 Physical Therapists 1,033,875 194,114 1,227,989 23,784.00 51.63 5.00 6.00 Physical Therapy Assistants 0 0 0 0.00 0.00 0.00 6.00 7.00 Physical Therapy Asistants 0 0 0 0.00 0.00 0.00 7.00 8.00 Occupational Therapy Assistants 997,762 187,334 1,185,096 21,225.00 55.83 8.00 9.00 Occupational Therapy Assistants 0 0 0 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
6.00 Physical Therapy Assistants 0 0 0 0 0 0.00 0.00 6.00 7.00 8.00 Physical Therapy Aides 0 0 0 0 0 0.00 0.00 7.00 8.00 Occupational Therapists 997,762 187,334 1,185,096 21,225.00 55.83 8.00 Occupational Therapy Assistants 0 0 0 0 0.00 0.00 0.00 9.00 9.00 0.00 0.00 0.00 9.00 0.00 0.00 0.00 9.00 0.00 0.00 0.00 9.00 0.00 0.00 0.00 0.00 9.00 0.00						i i		
7. 00 Physical Therapy Aides 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1, 033, 875	194, 114	1, 227, 989	i i		
8.00 Occupational Therapists 997,762 187,334 1,185,096 21,225.00 55.83 8.00 9.00 Occupational Therapy Assistants 0 0 0 0 0 0 0.00 9.00 10.00 Occupational Therapy Aides 0 0 0 0 0 0.00 0.00 10.00 11.00 Speech Therapists 278,784 52,343 331,127 6,480.00 51.10 11.00 Respiratory Therapists 73,687 13,835 87,522 1,852.00 47.26 12.00 13.00 Occupational Therapy Aides 0 0 0 0 0 0 0.00 0.00 13.00 Occupational Therapists 73,687 13,835 87,522 1,852.00 47.26 12.00 Occupational Therapists 73,687 13,835 87,522 1,852.00 13.00 Occupations Occupati	6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
9.00 Occupational Therapy Assistants O O O O O O O O O	7.00	Physi cal Therapy Ai des	0	0	0	0.00	0.00	7.00
10.00 Occupational Therapy Aides O O O O O O O O O	8.00	Occupational Therapists	997, 762	187, 334	1, 185, 096	21, 225. 00	55. 83	8.00
11.00 Speech Therapists 278, 784 52, 343 331, 127 6, 480.00 51.10 11.00 12.00 Respiratory Therapists 73, 687 13, 835 87, 522 1, 852.00 47.26 12.00 13.00 Other Medical Staff 0 0 0 0 0.00 13.00 Contract Labor Nursing Occupations	9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
12.00 Respiratory Therapists 73,687 13,835 87,522 1,852.00 47.26 12.00 0 10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
13.00 Other Medical Staff	11.00	Speech Therapists	278, 784	52, 343	331, 127	6, 480. 00	51. 10	11.00
Contract Labor Nursi ng Occupations Sequence Se	12.00	Respi ratory Therapi sts	73, 687	13, 835	87, 522	1, 852. 00	47. 26	12.00
Nursi ng Occupations 14.00 Registered Nurses (RNs) 6,679 6,679 74.00 90.26 14.00 15.00 Li censed Practical Nurses (LPNs) 0 0 0.00 0.00 15.00 16.00 Certified Nursi ng Assistant/Nursi ng Assistant/Nursi ng Assistants/Ai des 506 506 10.00 50.60 16.00 17.00 Total Nursi ng (sum of lines 14 through 16) 7,185 7,185 84.00 85.54 17.00 18.00 Physical Therapists 0 0 0.00 0.00 18.00 19.00 Physical Therapy Assistants 0 0 0.00 0.00 19.00 20.00 Physical Therapy Aides 0 0 0.00 0.00 20.00 20.00 Physical Therapy Aides 0 0 0.00 0.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.0	13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
14.00 Registered Nurses (RNs) 6,679 6,679 74.00 90.26 14.00 15.00 Licensed Practical Nurses (LPNs) 0 0.00 0.00 15.00 16.00 Certified Nursing Assistant/Nursing Assistant/Nursing Assistants/Aides 506 506 10.00 50.60 16.00 17.00 Total Nursing (sum of lines 14 through 16) 7,185 7,185 84.00 85.54 17.00 18.00 Physical Therapists 0 0.00 0.00 0.00 18.00 19.00 Physical Therapy Assistants 0 0.00 0.00 0.00 19.00 20.00 Physical Therapy Aides 0 0.00 0.00 0.00 20.00		Contract Labor						
15.00 Li censed Practi cal Nurses (LPNs) 0 0.00 0.00 15.00 16.00 Certi fi ed Nursi ng Assi stant/Nursi ng Assi stant/Nursi ng Assi stants/Ai des 7,185 7,185 84.00 85.54 17.00 17.00 Physi cal Therapy Assi stants 0 0 0.00 0.00 18.00 19.00 Physi cal Therapy Assi stants 0 0 0.00 0.00 19.00 20.00 Physi cal Therapy Ai des 0 0 0.00 0.00 0.00 20.00								
16. 00	14.00		6, 679		6, 679			
Assistants/Ai des 17. 00 Total Nursing (sum of lines 14 through 16) 18. 00 Physical Therapists 19. 00 Physical Therapy Assistants 20. 00 Physical Therapy Ai des Assistants/Ai des 7, 185 7, 185 84. 00 0. 00 0. 00 0. 00 19. 00 0. 00 19. 00 0. 00	15. 00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
17. 00 Total Nursing (sum of lines 14 through 16) 7, 185 7, 185 84. 00 85. 54 17. 00 18. 00 Physical Therapists 0 0.00 0.00 18. 00 19. 00 Physical Therapy Assistants 0 0.00 0.00 0.00 19. 00 20. 00 Physical Therapy Aides 0 0.00 0.00 0.00 20. 00	16.00		506		506	10.00	50. 60	16.00
18.00 Physical Therapists 0 0.00 0.00 18.00 19.00 Physical Therapy Assistants 0 0.00 0.00 19.00 20.00 Physical Therapy Aides 0 0.00 0.00 0.00 20.00								
19.00 Physical Therapy Assistants 0 0.00 0.00 19.00 20.00 Physical Therapy Aides 0 0.00 0.00 0.00 20.00			7, 185		7, 185			
20. 00 Physi cal Therapy Ai des 0 0 0. 00 0. 00 20. 00		'	0		0		1	
	19. 00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
21.00 $\left \begin{array}{cccccccccccccccccccccccccccccccccccc$	20.00		0		0			
	21. 00	Occupational Therapists	0		0	0.00		21.00
22.00 Occupational Therapy Assistants 0 0 0.00 22.00	22. 00		0		0			
23.00 Occupational Therapy Aides 0 0 0.00 23.00			0		0			
24.00 Speech Therapists 13,323 13,323 178.00 74.85 24.00			13, 323		13, 323			
25. 00 Respiratory Therapists 0 0 0. 00 25. 00			0		0			
26. 00 Other Medical Staff 0 0 0. 00 0. 00 26. 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 11:33 am

	2024 11:33 am_
	ays
	00
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 RML	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
51. 00 CA2 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 IB1	60.00
61. 00 I A2	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 EVESHA	ΑM		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Pr	rovi der	No.: 315464	Peri od:	Worksheet S-7	7
				From 01/01/2023 To 12/31/2023		
					5/10/2024 11:	33 am
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1.00	2. 00	3. 00	
A notice published in the Federal Register 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 Recrui tment						102. 00
103.00 Retention of employees						103. 00
104. 00 Trai ni ng						104. 00
105.00 OTHER (SPECIFY)	4 1 0)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne i, column 3)	I				106. 00

	Financial Systems	CARE ONE AT E			In Lie	u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre	pared:
						5/10/2024 11:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Reclassified	
				+ col . 2)	ons Increase/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col . 4)	
					A-6)	33,	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	T		T	-T -		
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 502, 266 175, 226			1, 502, 266	1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 735, 433			175, 226 1, 735, 433	1
4. 00	00400 ADMI NI STRATI VE & GENERAL	591, 455	2, 341, 064			2, 932, 519	
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	150, 124	458, 604			608, 728	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	61, 738	66, 197	127, 935	5 0	127, 935	6. 00
7.00	00700 HOUSEKEEPI NG	229, 144	37, 053			266, 197	7. 00
8.00	00800 DI ETARY	622, 801	386, 746			1, 009, 547	8. 00
9.00	00900 NURSING ADMINISTRATION	577, 750	109, 209			686, 959	
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	32, 386	172, 021 32, 198			204, 407 32, 198	
12. 00	01200 MEDICAL RECORDS & LIBRARY	56, 236	32, 170	56, 236		56, 236	
13. 00	01300 SOCIAL SERVICE	150, 819	0	150, 819		150, 819	
14.00		0	0		0	0	14. 00
15. 00	01500 ACTI VI TES	173, 932	14, 168	188, 100	0	188, 100	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1 470 00	.1	4 470 004	
30.00	03000 SKILLED NURSING FACILITY	4, 132, 081	46, 250	4, 178, 33	0	4, 178, 331	•
32.00	03100 NURSING FACILITY 03200 CF/IID		0			0	
33. 00	03300 OTHER LONG TERM CARE		0			0	•
00.00	ANCI LLARY SERVI CE COST CENTERS	9			<u> </u>	<u> </u>	00.00
40.00	04000 RADI OLOGY	0	92, 144	92, 144	1 0	92, 144	40. 00
41.00	04100 LABORATORY	0	53, 916			53, 916	•
42. 00	04200 I NTRAVENOUS THERAPY	0	184, 128			184, 128	1
	04300 OXYGEN (INHALATION) THERAPY	1 100 114	24.754		-	1 222 070	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	1, 188, 114 997, 762	34, 756	1, 222, 870 997, 762		1, 222, 870 997, 762	1
46. 00	04600 SPEECH PATHOLOGY	278, 784	13, 323			292, 107	
47. 00	04700 ELECTROCARDI OLOGY	0	0		o o	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	565, 283	565, 283	0	565, 283	
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	
51.00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	
52. 00	05201 OTHER ANCILLARY SERVICES COST		0			0	•
52. 02	05202 MEDI CAL SERVI CES		0		o o	-	
	OUTPATIENT SERVICE COST CENTERS	-1	-		-		
60.00	06000 CLI NI C	0	0	(0	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0	(0	0	
	06200 FQHC						62.00
63.00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	U	0) 0	0	63. 00
70 00	07000 HOME HEALTH AGENCY COST		0		0	0	70.00
71. 00	1 1	o	43, 391	43, 39	0		71.00
73.00	07300 CMHC	0	0	. (0	0	1
74.00	07400 OTHER REIMBURSEMENT	0	0	(0	0	74. 00
	SPECIAL PURPOSE COST CENTERS			1			
80.00	1		0	(0	0	
	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF		0			0 0	
83. 00	08300 HOSPI CE		0			0	ı
84. 00	1 1	o	0		0	0	ı
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	(0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	9, 243, 126	8, 063, 376	17, 306, 502	2 0	17, 306, 502	89. 00
00.00	NONREI MBURSABLE COST CENTERS		/ //0			/ //0	00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		6, 668 8, 697			6, 668 8 697	90. 00 91. 00
	09200 PHYSI CLANS PRI VATE OFFI CES		3, 047 N	0, 09		0, 097	
	09300 NONPAID WORKERS	l ő	0	(o o	0	
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	•
	09500 OTHER NONREIMBURSABLE COST	0	0	(0	0	
100.00	TOTAL	9, 243, 126	8, 078, 741	17, 321, 867	7 0	17, 321, 867	100. 00

 Heal th Financial
 Systems
 CARE 0

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der No.: 315464

				To 12/31/2023	Date/Time Prepared: 5/10/2024 11:33 am
	Cost Center Description	Adjustments to	Net Expenses		57 107 2024 11. 33 aiii
	·		For Allocation		
		Wkst A-8)	(col. 5 +- col. 6)		
		6.00	7.00	-	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-3, 245		1	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	C	175, 226	1	2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	-388, 903	1, 735, 433 2, 543, 616	1	3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-388, 403		1	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	-11, 976	1	1	6. 00
7. 00	00700 HOUSEKEEPI NG	C		1	7. 00
8.00	00800 DI ETARY	-142	1, 009, 405		8. 00
9.00	00900 NURSING ADMINISTRATION	-1, 989	1	1	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0.57	,	1	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	-2, 576	1	•	11. 00
13. 00	01300 SOCIAL SERVICE		1	1	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		1	1	14. 00
15. 00	01500 ACTI VI TES	C	188, 100		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	-31, 276		1	30. 00
31. 00	03100 NURSING FACILITY	C		l .	31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	C	1	1	32. 00 33. 00
33.00	ANCILLARY SERVICE COST CENTERS		,, 0	,	33.00
40. 00	04000 RADI OLOGY		92, 144		40. 00
41. 00	04100 LABORATORY	C			41. 00
42.00	04200 I NTRAVENOUS THERAPY	-14, 730	169, 398		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	C		1	43. 00
44. 00	04400 PHYSI CAL THERAPY	C	1,,	1	44.00
45. 00	04500 OCCUPATIONAL THERAPY		997, 762	1	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY		292, 107	1	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		-		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	-45, 222	520, 061		49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0		50.00
51.00	05100 SUPPORT SURFACES	C	1	0	51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	C	1	1	52.00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES	C		1	52. 01 52. 02
32. 02	OUTPATIENT SERVICE COST CENTERS		<u> </u>	/	52.02
60. 00	06000 CLINIC	C	0		60.00
61.00	06100 RURAL HEALTH CLINIC	C	0		61. 00
62.00	06200 FQHC				62. 00
63. 00	06300 DI ALYSI S	C	0		63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	C	0	1	70.00
	07100 AMBULANCE			1	71.00
	07300 CMHC			1	73.00
		C		•	74. 00
	SPECIAL PURPOSE COST CENTERS				
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	C	-		80. 00
81. 00	08100 I NTEREST EXPENSE	C			81.00
82. 00 83. 00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	C			82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I				84.00
84. 01	08401 OTHER SPECIAL PURPOSE COST II		o o		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-500, 059	16, 806, 443		89. 00
	NONREI MBURSABLE COST CENTERS				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C			90.00
91.00	09100 BARBER AND BEAUTY SHOP	C	8, 697		91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS				92. 00 93. 00
	09400 PATIENTS LAUNDRY				94.00
95. 00	1		o o		95. 00
100.00	TOTAL	-500, 059	16, 821, 808	3	100. 00

Health Financial Systems	CARE ONE AT EVESHAM			In Lieu of Form CMS-2		
RECLASSI FI CATI ONS	Provi der No.: 315464			Peri od:	Worksheet A-6	,
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Increases					
	Cost Center	ſ	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificat	ions (Sum		0	0	100.00
	of columns 4 and 5 must					
	equal sum of column	s 8 and				
	9)					

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 EVE	SHAM		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315464	Peri od:	Worksheet A-6)
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	epared:
					5/10/2024 11:	33 am_
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
TOTALS						
100.00				0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT EVESHAM In Lieu of Form CMS-2540-10 Provider No.: 315464 | Period: | Worksheet A-7 | From 01/01/2023 | To 12/31/2023 | Date/Time Preparation

					To 12/31/2023	Date/Time Prep 5/10/2024 11:	pared: 33 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		_		_1	I _	
1.00	Land	1, 399, 702	0		0	0	1. 00
2.00	Land Improvements	1, 022, 886	90, 233		0 90, 233	0	2. 00
3.00	Buildings and Fixtures	10, 620, 367	0		0	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equi pment	456, 209	7, 126		0 7, 126	0	5. 00
6.00	Movable Equipment	3, 011, 786	70		0 70	0	6. 00
7.00	Subtotal (sum of lines 1-6)	16, 510, 950	97, 429		0 97, 429	0	7. 00
8.00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	16, 510, 950	97, 429		0 97, 429	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, 399, 702	0				1. 00
2.00	Land Improvements	1, 113, 119	0				2. 00
3.00	Buildings and Fixtures	10, 620, 367	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	463, 335	0				5. 00
6.00	Movable Equipment	3, 011, 856	0				6. 00
7.00	Subtotal (sum of lines 1-6)	16, 608, 379	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	16, 608, 379	0				9. 00

From 01/01/2023 | Nate/Time Prepared:

				To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				Expense Classification or		JJ alli
				To/From Which the Amount is		
					•	
	5 (4)	(0) 5 1 5			T	
	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	1.00 B		CAP REL COSTS - BLDGS &	1.00	1. 00
1.00	(chapter 2)	, D	5, 245	FI XTURES	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4.00	Rental of provider space by suppliers		0		0.00	4. 00
F 00	(chapter 8)				0.00	F 00
5. 00	Tel ephone services (pay stations excluded)		0)	0.00	5. 00
6. 00	(chapter 21) Television and radio service (chapter 21)		0		0.00	6. 00
7. 00	Parking lot (chapter 21)		0		0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	0		0.00	8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0	P	0.00	11. 00
10.00	Capital expenditures (chapter 24)	1 0 1	1 1/0			10.00
12. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	1, 169	,		12. 00
13. 00	Laundry and Linen service	В	_11 976	LAUNDRY & LINEN SERVICE	6.00	13. 00
14. 00	Revenue - Employee meals		11, 770)	0.00	14. 00
15. 00	Cost of meals - Guests	В	-142	DI ETARY	8.00	15. 00
16.00	Sale of medical supplies to other than		0		0.00	16. 00
	pati ents					
17. 00	Sale of drugs to other than patients		0	P	0.00	17. 00
18.00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vending machines		0		0.00	19.00
20. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0)	0.00	20. 00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
21.00	and borrowings to repay Medicare		O		0.00	21.00
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
24.00	Daniel di la constitución de la		0	FI XTURES	2.00	24.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE EQUIPMENT	2.00	24. 00
25. 00	RESIDENT REPLACEMENT ITEMS	Α	-650	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETI NG EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 02	MARKETING CORP EXPENSE	A	· ·	ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	MARKETING - MEALS	Α		ADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	SHOWS & CONFERENCES	Α	-280	ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	BAD DEBT EXPENSE	A	-317, 646	ADMINISTRATIVE & GENERAL	4.00	25. 05
25. 06	BAD DEBT EXPENSE - MEDICARE	Α		ADMINISTRATIVE & GENERAL	4.00	25. 06
25. 07	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	25. 07
25. 08	OTHER REVENUE	В	-5, 453	ADMINISTRATIVE & GENERAL	4.00	25. 08
25. 09	Other adjustment (specify)		500.050		0.00	25. 09
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-500, 059			100. 00
(4) D	to worksheet A, Cor. 6, Title 100)	 	CMC Duk 1E 1	1	1	l

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

CARE ONE AT EVESHAM Provi der No.: 315464

Heal th Financial Systems CARE ONE AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

OFFICE	COSTS					Date/Time Pre 5/10/2024 11:	
		Li ne No.	Cost (Center	Expense		
		1. 00	2.		3.0		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1. 00	CLAIMED HOME OFFICE COSTS.	4 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES		1.00
2. 00			NURSING ADMINI		PHARMACY CONSUL		2.00
3.00			CENTRAL SERVIC		WOUND CARE EXPE		3. 00
4.00			PHARMACY		DRUGS-NON-PRESC		4. 00
					NON-LEGEND	•	
5.00		11. 00	PHARMACY		PHARMACY SUPPLI	ES	5. 00
6.00		42. 00	INTRAVENOUS TH	ERAPY	IV EXPENSE		6. 00
7.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PT	ION, LEGEND	7. 00
					DRUGS OTH		
8.00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PT	ION, LEGEND	8. 00
0.00		40.00	DDUIGG GUADGED	TO DATI FUTO	DRUGS MAN	LON MEDICADE	
9. 00		49. 00	DRUGS CHARGED	10 PATTENTS	DRUGS-PRESCRI PT	ION, MEDICARE	9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column				A		10. 00
10.00	6, line 100 to Worksheet A-8, column 3, line						10.00
	12.						
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minus			
		Cost	Wkst. A, col.	col. 5)			
			5				
	DART I GOOTO INCURRED AND AR MOTHER DECIME	4. 00	5.00	6.00	000000000000000000000000000000000000000	0.0	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
1. 00	CLAIMED HOME OFFICE COSTS:	935, 988	870, 302	65, 686			1.00
2. 00		22, 870					2.00
3.00		44, 641	44, 641				3.00
4. 00		28, 930					4.00
5. 00		692					5. 00
6.00		169, 398					6.00
7. 00		66, 288		1			7. 00
8.00		235, 026	255, 463	-20, 437	,		8. 00
9.00		218, 747	237, 768	-19, 021			9. 00
10.00	TOTALS (sum of lines 1-9). Transfer column	1, 722, 580	1, 721, 411	1, 169			10.00
	6, line 100 to Worksheet A-8, column 3, line						
	12.						

OFFICE COSTS

Parts I-II Date/Time Prepared:

12/31/2023

5/10/2024 11:33 am Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1.00	Α	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.

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.

SHAM In Lieu of Form CMS-2540-10
Provider No.: 315464 | 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 5/10/2024 11:	
				CAPI TAL REL	ATED COSTS		5/10/2024 11.	ss alli
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		Sect Control Boost (pt. on	for Cost	FIXTURES	EQUI PMENT	BENEFI TS	ouz tota.	
			Allocation (from Wkst A					
			col . 7)					
	CENED	AL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	3A	
1.00		CAP REL COSTS - BLDGS & FIXTURES	1, 499, 021	1, 499, 021				1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT	175, 226	0	175, 226	1 705 400		2.00
3. 00 4. 00		EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	1, 735, 433 2, 543, 616	0 162, 158	-	1, 735, 433 111, 048	2, 835, 777	3. 00 4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	608, 728	48, 047	5, 616	28, 186	690, 577	5. 00
6. 00 7. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	115, 959 266, 197	10, 682 11, 154	1, 249 1, 304	11, 592 43, 023	139, 482 321, 678	6. 00 7. 00
8. 00	1	DIETARY	1, 009, 405	149, 546		116, 933	1, 293, 365	8. 00
9.00		NURSING ADMINISTRATION	684, 970	125, 265		108, 475	933, 353	9. 00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY	204, 407 29, 622	0	0	6, 081 0	210, 488 29, 622	10. 00 11. 00
12. 00		MEDICAL RECORDS & LIBRARY	56, 236	0	Ö	10, 559	66, 795	
13.00		SOCIAL SERVICE	150, 819	0	0	28, 317	179, 136	13.00
14. 00 15. 00		NURSING AND ALLIED HEALTH EDUCATION ACTIVITES	188, 100	0	0	0 32, 656	0 220, 756	14. 00 15. 00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	4, 147, 055	909, 974 0	106, 370 0	775, 813 0	5, 939, 212 0	30. 00 31. 00
32. 00		ICF/IID		0	-	ő	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	92, 144	0	O	ol	92, 144	40. 00
41.00	04100	LABORATORY	53, 916	0	Ō	ō	53, 916	41. 00
42. 00 43. 00	1	INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	169, 398	0	0	0	169, 398 0	42. 00 43. 00
44. 00		PHYSICAL THERAPY	1, 222, 870	60, 059		223, 073	1, 513, 022	44. 00
45. 00	1	OCCUPATIONAL THERAPY	997, 762	2, 059		187, 334	1, 187, 396	
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	292, 107	3, 861 0	451 0	52, 343 0	348, 762 0	46. 00 47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	O	7, 722	903	Ö	8, 625	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	520, 061	8, 494	993	0	529, 548	49. 00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES		0	0	ol Ol	0	50. 00 51. 00
52. 00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	o	0	52. 00
52. 01 52. 02		OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		0	0	52. 01 52. 02
02. 02	OUTPA	TIENT SERVICE COST CENTERS				<u> </u>	0	02. 02
60.00		CLINIC	0	0		0	0	60.00
61. 00 62. 00	06200	RURAL HEALTH CLINIC		U	U	ď	U	61. 00 62. 00
63.00	06300	DIALYSIS	0	0	0	0	0	63. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71. 00	1	AMBULANCE	43, 391	0	Ö	ő	43, 391	
73.00	07300	CMHC OTHER REIMBURSEMENT	0	0		0	0	73. 00 74. 00
74. 00		AL PURPOSE COST CENTERS	<u> </u>	U	0	U _I	U	74.00
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	1	INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00	1	HOSPI CE	o	0	О	o	0	83. 00
84.00		OTHER SPECIAL PURPOSE COST I	0	0	0	o	0	84. 00
84. 01 89. 00	08401	OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	16, 806, 443	1, 499, 021	175, 226	1, 735, 433	0 16, 806, 443	84. 01 89. 00
		IMBURSABLE COST CENTERS						
90. 00 91. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	6, 668 8, 697	0	0	0	6, 668 8, 697	90. 00 91. 00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	o o	ő	0	92. 00
93.00	1	NONPALD WORKERS	0	0	0	O	0	93. 00 94. 00
94. 00 95. 00	1	PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST		0		ol Ol	0	94. 00 95. 00
98. 00		Cross Foot Adjustments	0	0	O	0	0	98.00
99. 00 100. 00		Negative Cost Centers TOTAL	0 16, 821, 808	0 1, 499, 021	0 175, 226	0 1, 735, 433	0 16, 821, 808	99. 00 100. 00
	1	1 -		., .,,, 321	, 220	., , 55, .50	. 2, 32 . , 300	

SHAM In Lieu of Form CMS-2540-10
Provider No.: 315464 | Period: | Worksheet B From 01/01/2023 | Part I To 12/31/2023 | Date/Time Prepared:

					o 12/31/2023		
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/10/2024 11: DI ETARY	33 alli
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	4 00	7.00	9 00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 835, 777					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	140, 020	830, 597	•			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	28, 281	6, 884				6. 00
7.00	00700 HOUSEKEEPI NG	65, 223	7, 188			1 (00 400	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	262, 240 189, 245	96, 377 80, 729	•	46, 516 38, 963	1, 698, 498 0	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	42, 678	00, 72 9		30, 703	0	10.00
11. 00	01100 PHARMACY	6,006	0		ol ol	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	13, 543	0	o c	o	0	12.00
13.00	01300 SOCIAL SERVICE	36, 321	0) c	o	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	44, 760	0) C	0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 004 004	FO(440	474 (47	200 044	4 (00 400	00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 204, 221	586, 448	174, 647	283, 044	1, 698, 498 0	30. 00 31. 00
31.00	03200 CF/IID	0	0			0	31.00
33. 00	03300 OTHER LONG TERM CARE	0	0		1	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		,	1 o		00.00
40.00	04000 RADI OLOGY	18, 683	0) C	0	0	40. 00
41.00	04100 LABORATORY	10, 932	0) c	o	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	34, 347	0	0	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	306, 777	38, 706	1	18, 681	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	240, 754	1, 327	1	640	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	70, 714	2, 488		1, 201	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 749	4, 976		2, 402	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	107, 370	5, 474	•		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	o c	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0) c	o	0	51. 00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0) C	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	O	0) C	ol	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0		-	0	61. 00
62. 00	06200 FQHC		· ·			ŭ	62. 00
63.00	06300 DI ALYSI S	0	0	0	o	0	63. 00
	OTHER REIMBURSABLE COST CENTERS			,			
70.00	07000 HOME HEALTH AGENCY COST	0	0		-	0	70.00
71. 00		8, 798	0		0	0	71.00
74. 00	07300 CMHC 07400 OTHER REI MBURSEMENT	0	0			0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u></u>	<u> </u>		74.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID 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	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2, 832, 662	830, 597	174, 647	394, 089	1, 698, 498	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1, 352	0) C	n n	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	1, 763	0		-	0	91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		-	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0) C	o	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	o o	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0		0	0	95. 00
98. 00 99. 00	Cross Foot Adjustments	0	0			0	98. 00 99. 00
99. 00 100. 00	Negative Cost Centers TOTAL	2, 835, 777	830, 597	174, 647	394, 089		
100.00	, include	2,000,777	030, 371	1 174,047	374,009	1, 070, 470	1.00.00

				10	5 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	<u> </u>
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	1, 242, 290					8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	253, 166				10. 00
11. 00	01100 PHARMACY	0	0	35, 628			11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	80, 338	l e	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION		0	0	0	215, 457	13. 00 14. 00
15. 00	01500 ACTIVITES		0	0	0		15. 00
13. 00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			13.00
30.00	03000 SKILLED NURSING FACILITY	1, 242, 290	253, 166	35, 628	80, 338	215, 457	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
40.00	ANCI LLARY SERVI CE COST CENTERS		٥				40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0	0	0	0	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY		0	0	0		42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		Ö	Ö	0	Ö	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY		0	0	0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		0	0	0	0	51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	l o	0	Ö	0	Ö	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	0	0	0 1 0	60. 00 61. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	U	U	U	U	62.00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			00.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
	07300 CMHC	0	0	0	0	0	73. 00
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS] 0	0	0	0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID 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	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	050.4(0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	1, 242, 290	253, 166	35, 628	80, 338	215, 457	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	n	O	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		0	Ö	0	Ö	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	o	o	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	O	0	0	0	93. 00
94.00	09400 PATI ENTS LAUNDRY	0	0	0	0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	^	0	98. 00 99. 00
100.00	1 1 9	1, 242, 290	253, 166	35, 628	80, 338		
	i i i	. = :=, =, 9]		, -20	, 500		

| 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.: 315464

						To 12/31/2023	Date/Time Pre 5/10/2024 11:	
				OTHER GENERAL			37 107 2024 11.	JJ dili
		Coat Contar Decement on	NUDCLNC AND	SERVI CE	Cubtatal	Doot Standown	Total	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
			EDUCATI ON			,		
	CENED	AL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	_	CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	1	EMPLOYEE BENEFITS						3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS			•			4. 00 5. 00
6. 00	1	LAUNDRY & LINEN SERVICE						6. 00
7.00		HOUSEKEEPI NG						7.00
8. 00 9. 00		DI ETARY NURSI NG ADMINI STRATI ON						8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY			•			10.00
11.00		PHARMACY						11.00
12. 00 13. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE						12. 00 13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTI VI TES	0	265, 516				15. 00
30. 00		SKILLED NURSING FACILITY	0	265, 516	11, 978, 46	5 0	11, 978, 465	30. 00
31. 00		NURSING FACILITY	0	203, 310	1	0	0	1
32.00		ICF/IID	0	0	1	0 0	0	1
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0		0	0	33.00
40. 00		RADI OLOGY	0	С	110, 82	7 0	110, 827	40. 00
41. 00	1	LABORATORY	0	0			64, 848	1
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0	,	5 0	203, 745 0	1
44. 00	1	PHYSI CAL THERAPY	0			-	1, 877, 186	
45.00		OCCUPATIONAL THERAPY	0	O	1, 430, 11	7 0	1, 430, 117	45. 00
46.00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	423, 16	5 0	423, 165 0	46. 00 47. 00
47. 00 48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS			17, 75	2 0	17, 752	1
49.00	04900	DRUGS CHARGED TO PATIENTS	0	O	645, 03		645, 034	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0	0	
51. 00 52. 00		SUPPORT SURFACES COMPLEX MEDICAL EQUIPMENT				0	0	
52. 01		OTHER ANCILLARY SERVICES COST	0	o		0	0	1
52. 02		MEDI CAL SERVI CES	0	0		0	0	52. 02
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	0		0 (0	60.00
61. 00		RURAL HEALTH CLINIC	0	o	1	0	0	
62.00	06200							62.00
63. 00		DI ALYSI S REI MBURSABLE COST CENTERS	0	0		0	0	63.00
70.00	07000	HOME HEALTH AGENCY COST	0	0		0 0	0	
71.00		AMBULANCE	0	0	52, 18		52, 189	
73. 00 74. 00	07300	OTHER REIMBURSEMENT	0	0	1	0	0	
7 11 00		AL PURPOSE COST CENTERS				J		7 00
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00	1	HOSPI CE	0	o		0 0	0	
84.00		OTHER SPECIAL PURPOSE COST I	0	0		0	0	
84. 01 89. 00	08401	OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0	265, 516	16, 803, 32	0 8 0	0 16, 803, 328	
07.00	NONRE	IMBURSABLE COST CENTERS		200,010	10,000,02	5	10, 000, 020	07.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			8, 020	1
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0	0	10, 46	0	10, 460 0	1
93. 00		NONPALD WORKERS	0				0	1
94.00		PATIENTS LAUNDRY	0	0		0	0	
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0			0	0	
99. 00		Negative Cost Centers	0				0	99. 00
100.00)	TOTAL	0	265, 516	16, 821, 80	8 0	16, 821, 808	100. 00

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315464

					То	12/31/2023	Date/Time Pre 5/10/2024 11:	
				CAPI TAL REL	ATED COSTS		37 107 2024 11.	JJ alli
		Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
			Assigned New Capital	FI XTURES	EQUI PMENT		BENEFITS	
			Related Costs					
			0	1. 00	2.00	2A	3. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	0	0	0	0	0	2. 00 3. 00
4. 00		ADMINISTRATIVE & GENERAL	0	162, 158	T .	181, 113	0	4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	0	48, 047	5, 616	53, 663	0	5. 00
6.00		LAUNDRY & LINEN SERVICE	0	10, 682	· ·	11, 931	0	6. 00
7. 00	1	HOUSEKEEPI NG	0	11, 154		12, 458	0	7. 00
8. 00 9. 00		DI ETARY NURSI NG ADMI NI STRATI ON	0	149, 546		167, 027 139, 908	0	8. 00 9. 00
10.00	1	CENTRAL SERVICES & SUPPLY	0	125, 265 0	14, 643	139, 908	0	10.00
11. 00		PHARMACY	0	0	Ö	o	0	11. 00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	О	0	12. 00
13.00		SOCIAL SERVICE	0	0	0	0	0	13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	l ol	0	0	0	0	15. 00
30. 00		SKILLED NURSING FACILITY	0	909, 974	106, 370	1, 016, 344	0	30.00
31. 00	1	NURSING FACILITY	0	0	0	0	0	31. 00
32.00		ICF/IID	0	0	0	О	0	32. 00
33.00		OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40.00		LARY SERVICE COST CENTERS		O		ol	0	1 40 00
40. 00 41. 00		RADI OLOGY LABORATORY		0	0	0	0	40. 00 41. 00
42. 00		INTRAVENOUS THERAPY		Ö	Ö	Ö	0	42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	0	Ö	0	43. 00
44.00		PHYSI CAL THERAPY	0	60, 059	7, 020	67, 079	0	44. 00
45. 00	1	OCCUPATIONAL THERAPY	0	2, 059		2, 300	0	45. 00
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	3, 861 0	451 0	4, 312 0	0	46. 00 47. 00
47.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 722	903	8, 625	0	48.00
49. 00		DRUGS CHARGED TO PATIENTS		8, 494	993	9, 487	0	49. 00
50.00		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	1	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52.00
52. 01 52. 02	1	OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0	0	0	0	52. 01 52. 02
32. 02		TIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		32.02
60.00		CLINIC	0	0	0	0	0	60.00
61. 00		RURAL HEALTH CLINIC	0	0	0	О	0	61. 00
62. 00	06200		_	_	_	_	_	62. 00
63. 00		DI ALYSI S	0	0	0	0	0	63. 00
70 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71. 00		AMBULANCE	0	0	ŭ l	o	0	
73.00	07300	СМНС	0	0	0	О	0	
74. 00		OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
00.00		AL PURPOSE COST CENTERS						00.00
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE	1					80. 00 81. 00
82. 00	1	UTILIZATION REVIEW - SNF						82. 00
83. 00	1	HOSPI CE	0	0	0	o	0	1
84. 00		OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	1
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) IMBURSABLE COST CENTERS	0	1, 499, 021	175, 226	1, 674, 247	0	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	O	0	90.00
91. 00		BARBER AND BEAUTY SHOP	0	0	O	Ö	0	
92. 00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	92. 00
93. 00	1	NONPALD WORKERS	0	0	0	0	0	
94. 00		PATIENTS LAUNDRY	0	0	0	0	0	
95. 00 98. 00	04200	OTHER NONREIMBURSABLE COST Cross Foot Adjustments		O		0	0	95. 00 98. 00
99. 00		Negative Cost Centers	1	0	o	ol	0	•
100.00)	TOTAL	o	1, 499, 021	175, 226	1, 674, 247		100. 00

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315464

					o 12/31/2023		
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/10/2024 11: DI ETARY	33 am
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	4.00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	181, 113					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	8, 943	62, 606				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 806	519	1	I I		6. 00
7. 00	00700 HOUSEKEEPI NG	4, 166	542	1	,		7. 00
8.00	00800 DI ETARY	16, 749	7, 264	1	-,	193, 066	8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	12, 087 2, 726	6, 085		1, 697	0	9. 00 10. 00
11. 00	01100 PHARMACY	384	0			0	11.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	865	0		o o	0	12. 00
13.00	01300 SOCIAL SERVICE	2, 320	O		o	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0) c	o	0	14. 00
15. 00	01500 ACTI VI TES	2, 859	0) C	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	76, 905	44, 203			193, 066	30.00
31.00	03100 NURSI NG FACI LI TY 03200 CF/IID	0	0		ا ۱	0	31.00
32. 00 33. 00	03300 OTHER LONG TERM CARE	0 0	0			0	32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	ı o		1	ų	0	33.00
40. 00	04000 RADI OLOGY	1, 193	0		ol	0	40. 00
41. 00	04100 LABORATORY	698	0		-	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	2, 194	O) c	o	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0) c	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	19, 594	2, 917		814	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	15, 377	100	•	28	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	4, 516	188	1	52	0	46.00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 112	0 375	1	105	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS	6, 858	413	1		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0, 030	413		0	0	50.00
51. 00	05100 SUPPORT SURFACES	o	0		o	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	O) c	o	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0) c	0	0	52. 01
52. 02		0	0) <u> </u>	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS				.l		
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0		-	0	60. 00 61. 00
62. 00	06200 FOHC	U U	U		, o	Ü	62.00
63. 00	06300 DI ALYSI S	0	0		0	0	63.00
	OTHER REIMBURSABLE COST CENTERS	-1	-		-1		
70.00	07000 HOME HEALTH AGENCY COST	0	C) C	0	0	70. 00
	07100 AMBULANCE	562	0) C	0	0	71. 00
	07300 CMHC	0	0	0	0	0	73. 00
74. 00		0	0) <u> </u>	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 H0SPI CE	0	0		o	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0) c	o	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0) c	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	180, 914	62, 606	14, 256	17, 166	193, 066	89. 00
00.00	NONREI MBURSABLE COST CENTERS						00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	86	0		- 1	0	90. 00 91. 00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	113	0		=	0	91.00
93. 00	09300 NONPALD WORKERS		0			0	93.00
94. 00	09400 PATIENTS LAUNDRY		0	o c	ol ol	0	94.00
95.00	09500 OTHER NONREIMBURSABLE COST	0	0) c	o	0	95. 00
98. 00	Cross Foot Adjustments			0		0	98. 00
99. 00	Negative Cost Centers	0	0) C	0	0	99. 00
100.00	D TOTAL	181, 113	62, 606	14, 256	17, 166	193, 066	1100.00

				''	0 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
		0.00	SUPPLY	44.00	LI BRARY	40.00	
	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 NURSING ADMINISTRATION	159, 777					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	O	2, 726				10.00
11.00	01100 PHARMACY	O	0	384			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	865		12. 00
13.00	01300 SOCIAL SERVICE	0	0	0	0	2, 320	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	0	0	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			T			
30.00	03000 SKILLED NURSING FACILITY	159, 777	2, 726	384	865	2, 320	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
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	0	0	0	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY		0	0	0	0	40. 00 41. 00
41.00	04200 I NTRAVENOUS THERAPY		0	0	0	0	41.00
43. 00	04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY		0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	0	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ö	0	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o	0	Ö	0	Ō	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	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0	0	0	0 0	71.00
	07400 OTHER REIMBURSEMENT		0	0	0	0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	U		0	U	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	o	0	0	0	Ō	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	o	0	0	0	Ō	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	159, 777	2, 726	384	865	2, 320	89. 00
	NONREI MBURSABLE COST CENTERS	<u>' </u>		•			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	O	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0			98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	159, 777	2, 726	384	865	2, 320	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.: 315464

					-	Γο 12/31/2023	Date/Time Pre 5/10/2024 11:	
				OTHER GENERAL			37 107 2024 11.	JJ dili
		Coat Contar Decement on	NUDCLNC AND	SERVI CE	Cubtatal	Doot Stop Down	Total	
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
			EDUCATI ON			,		
	CENED	AL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1.00		CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00		EMPLOYEE BENEFITS						3.00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS						4. 00 5. 00
6.00	1	LAUNDRY & LINEN SERVICE			•			6. 00
7.00		HOUSEKEEPI NG						7. 00
8. 00 9. 00		DI ETARY NURSI NG ADMINI STRATI ON						8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100	PHARMACY						11. 00
12.00		MEDICAL RECORDS & LIBRARY						12.00
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0					13. 00 14. 00
15. 00	1	ACTI VI TES	0	2, 859				15. 00
		ENT ROUTINE SERVICE COST CENTERS	_			.1		
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	0	2, 859 0	1	4 O	1, 526, 034 0	1
32. 00		ICF/IID	0	0	1		0	1
33. 00	03300	OTHER LONG TERM CARE	0	0	1	0	0	33. 00
40.00		LARY SERVICE COST CENTERS	0	0	1 10		1 102	40.00
40. 00 41. 00		RADI OLOGY LABORATORY	0	0 0	· ·		1, 193 698	
42.00	1	INTRAVENOUS THERAPY	Ö	Ö	1		2, 194	1
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0		0	0	
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0	1		90, 404 17, 805	
46. 00		SPEECH PATHOLOGY	Ö	0	9, 06		9, 068	1
47.00		ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9, 21		9, 217	1
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0	0	16, 87	0	16, 873 0	1
51. 00		SUPPORT SURFACES	0	0		0	0	1
52.00		COMPLEX MEDICAL EQUIPMENT	0	0		0	0	
52. 01 52. 02	1	OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		0 0	0	1
32. 02		TIENT SERVICE COST CENTERS				5 0		32.02
60.00		CLINIC	0	_	1	0	0	
61.00		RURAL HEALTH CLINIC	0	0		0	0	
62. 00 63. 00	06200 06300	DI ALYSI S	0	0		o	0	62. 00 63. 00
	OTHER	REIMBURSABLE COST CENTERS	_	-				
70.00		HOME HEALTH AGENCY COST	0	0	1	0	0	
71. 00 73. 00	07100	AMBULANCE CMHC	0	0	56:		562	71. 00 73. 00
		OTHER REIMBURSEMENT	0	0	l .	0	0	
		AL PURPOSE COST CENTERS	I		1	1		
80. 00 81. 00	1	MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE			•			80. 00 81. 00
82. 00		UTILIZATION REVIEW - SNF						82.00
83. 00		HOSPI CE	0	0		0	0	
84. 00		OTHER SPECIAL PURPOSE COST I	0	0		0	0	
84. 01 89. 00	08401	OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	0	2, 859	1, 674, 04	0	0 1, 674, 048	ı
	NONRE	MBURSABLE COST CENTERS	_	_,,	., ., ., .,		.,,	
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	l .		86	1
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0	0		0 0	113 0	1
93. 00		NONPALD WORKERS	Ö	ő			0	1
94.00	09400	PATIENTS LAUNDRY	0	0)	0	0	94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0			0	
98.00		Negative Cost Centers		0			0	1
100.00)	TOTAL	0	2, 859	1, 674, 24 ⁻	7 O	1, 674, 247	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315464

					lo 12/31/2023	Date/lime Pre 5/10/2024 11:	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3. 00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1	T	1		ı	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	34, 943 0 3, 780 1, 120 249 260	34, 943 (3, 780 1, 120 249	9, 243, 120 591, 459 150, 120 61, 73	5 -2, 835, 777 4 0 8 0	13, 986, 031 690, 577 139, 482 321, 678	6. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	00800 DI ETARY 00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE 01400 NURSI NG AND ALLI ED HEALTH EDUCATI ON	3, 486 2, 920 0 0	3, 486 2, 920	622, 80	1 0 0 0 6 0 0 0	1, 293, 365 933, 353 210, 488 29, 622 66, 795 179, 136	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
15. 00	01500 ACTI VI TES	0	(173, 93:	2 0		1
30. 00 31. 00 32. 00 33. 00	NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	21, 212 0 0	(1 0 0 0 0 0 0 0	0	31. 00 32. 00
40. 00 41. 00 42. 00 43. 00	04000 RADI OLOGY 04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	000000000000000000000000000000000000000	(0 0 0	92, 144 53, 916 169, 398 0	41. 00 42. 00
44. 00 45. 00 46. 00 47. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	1, 400 48 90 0	48 90 0	997, 76: 278, 78: 0	2 0	1, 513, 022 1, 187, 396 348, 762 0	45. 00 46. 00 47. 00
48. 00 49. 00 50. 00 51. 00 52. 00 52. 01	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUSS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	180 198 0 0 0	198	3 () 0 () 0 ()		8, 625 529, 548 0 0 0	49. 00 50. 00 51. 00 52. 00 52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	() (0	0	52. 02
60. 00 61. 00 62. 00 63. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C 06200 FOHC 06300 DI ALYSI S	0000	(0 0	0 0	61. 00 62. 00
	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC 07400 OTHER REIMBURSEMENT	000000000000000000000000000000000000000	(0 0	0 43, 391 0	71. 00 73. 00
80. 00 81. 00	SPECIAL PURPOSE COST CENTERS				5 0		80. 00 81. 00
82. 00 83. 00 84. 00 84. 01 89. 00	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 34, 943	(((34, 94)))) 3 9, 243, 12	0 0 0 0 0 0 6 -2, 835, 777	0 0 0 13, 970, 666	84. 00 84. 01
90. 00 91. 00 92. 00 93. 00 94. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CI ANS PRI VATE OFFI CES 09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY	000000000000000000000000000000000000000			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 697 0 0	91. 00 92. 00 93. 00 94. 00
95. 00 98. 00 99. 00 102. 00	O9500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	1, 499, 021	175, 226	5 1, 735, 43	3	2, 835, 777	98. 00 99. 00
103.00 104.00	Unit cost multiplier (Wkst. B, Part I)	42. 899036	5. 014624	0. 18775	4	0. 202758 181, 113	

Health Financial Systems	CARE ONE A	T EVESHAM		In Lieu of Form CMS-2540-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der No.: 315464		Peri od:	Worksheet B-1		
				From 01/01/2023 Fo 12/31/2023		pared: 33 am_	
	CAPITAL REI	LATED COSTS					
Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
	1.00	2.00	3.00	4A	4. 00		
105.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 012950	105. 00	

	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/10/2024 11: NURSI NG	
	·	OPERATION, MAINT. &	LINEN SERVICE (PATIENT DAYS)		(MEALS SERVED)	ADMI NI STRATI ON	
		REPAIRS (SQUARE FEET)	((PATIENT DAYS)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			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	30, 043	3				5. 00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	249 260	1	29, 534			6. 00 7. 00
7. 00 8. 00	00800 DI ETARY	3, 486	1	3, 486			8.00
9.00	00900 NURSI NG ADMINI STRATI ON	2, 920	0	2, 920		35, 154	
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	C			0	0	10.00
12. 00	01200 MEDICAL RECORDS & LIBRARY				0	ő	12. 00
13.00	01300 SOCI AL SERVI CE	C	0	C	0	0	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES				0	0	14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	21, 212		21, 212	105, 462	35, 154 0	1
32. 00	03200 CF/IID		1		0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	c	0) C	0	0	33. 00
40. 00	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY				0	0	40.00
41. 00	04100 LABORATORY				0	ő	41. 00
42.00	04200 I NTRAVENOUS THERAPY	C	Ί "	C	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	1, 400	Ί) 1, 400	0	0	
45. 00	04500 OCCUPATI ONAL THERAPY	48	l e	48		ő	45. 00
46.00	04600 SPEECH PATHOLOGY	90	l .	90		0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	180	1) C 180	_	0	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	198	l control of the cont	198		ő	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0	C	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT				0	0	51. 00 52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST				0	ő	52. 01
52. 02	05202 MEDI CAL SERVI CES	C	0) <u> </u>	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC) C		0	60.00
61.00	06100 RURAL HEALTH CLINIC	C	1				61.00
62.00	06200 FQHC						62.00
63. 00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	C)[)	0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	C	0	C	0	0	70. 00
	07100 AMBULANCE	C	1	1			
73. 00 74. 00	07300 CMHC 07400 OTHER REI MBURSEMENT	C	1			0	
7 11 00	SPECIAL PURPOSE COST CENTERS						, 55
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 H0SPI CE	C	0	C	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	C			0	0	
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	30, 043	35, 154	29, 534	105, 462	0 35, 154	84. 01 89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	C	1		0	0	90.00
91.00	09200 PHYSICIANS PRIVATE OFFICES		1		0	0	
93. 00	09300 NONPALD WORKERS	C	0	C	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	C	0		0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments				0	0	95. 00 98. 00
99. 00	Negative Cost Centers						99. 00
102.00	Cost to be allocated (per Wkst. B, Part I)	830, 597	174, 647	394, 089	1, 698, 498	1, 242, 290	102.00
103.00	1 1	27. 646939	4. 968055	13. 343570	16. 105308	35. 338511	103.00
104.00	Cost to be allocated (per Wkst. B,	62, 606	l l	1			
105.00	Part II) Unit cost multiplier (Wkst. B, Part	2. 083880	0. 405530	0. 581228	1. 830669	4. 545059	105 00
		2. 303000	0. 100000	0.501220	1. 330007	1. 545057	

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

CENTRAL SERVICE SERVIC					1	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
CATIFATI DAYS PARTIE DAYS		Cost Center Description				SOCIAL SERVICE	NURSI NG AND	
OAT I BEST DAYS CAST OF THE TOP				(PATIENT DAYS)		(DATI ENT DAVE)		
CARGORAL SERVICE COST CEMISICS 10.00 11.00 12.00 13.00 14.00 10.00 10.00 10.00 11.00 11.00 12.00 13.00 14.00 10.						(PATTENT DAYS)		
			(IAIILNI DAIS)		(IAIILNI DAIS)			
1.00 00100 CAP REL COSIS - SILEGS & FIXIBRES			10.00	11.00	12. 00	13.00		
2 00 000000 CAP PILL COSTS - MINVAILE FOULIPRENTS 3.00 000000000000000000000000000000000				T				
3.00 OSSOD DEPLOYEE BENEFITS 3.00 3.								1.00
4.00 0.000 AUMINISTRATIVE & CENERAL								
0.00500 P.ART OPERATION, MAINT, & REPAIRS		1						
0.000 DOGOOD AURION Y ALL NEN SERVICE		1						
7.00 0.0700 0.05EKEEPIN IG		1						6.00
9 90 00 0000 MURSING ABM NISTRATION 11.00 01000 CHIRIN LISTRATE CS. & SUPPLY 35, 154 11.00 01000 PARAMACY 0 35, 154 11.00 01000 PARAMACY 0 0 35, 154 11.00 01000 PARAMACY 0 0 0 0 0 0 0 0 0 0 0 12.00 11.00 PARAMACY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								7. 00
10.00 01000 CRITIKAL SERVICES & SUPPLY 35, 154 11.00 0100 MIRGS INE ABOVE ALLEBRARY 0 0 0 35, 154 11.00 11.00 0100 MIRGS INE ABOVE ALLEBRARY 0 0 0 0 0 0 0 0 11.00 11.00 11.00 0100 MIRGS INE ABOVE ALLEBRARY 0 0 0 0 0 0 0 0 0								8.00
11.00 01100 PIANMANCY 0 35.154 11.00	9.00	00900 NURSING ADMINISTRATION						9. 00
12.00 01/200 MEDICAL RECORDS & LIBRARY 0 0 35, 154 12.00 14.00 15.00	10.00	01000 CENTRAL SERVICES & SUPPLY	35, 154					10.00
13.00 01300 SOZIAL SERVICE 0 0 0 0 0 0 13.01		1	0	35, 154				11. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 15.00			0	0				12.00
15.00 0.1500 ACTIVITIES 0. 0 0 0 0 0 0 15.00			0	0	1	35, 154	0	
IMPATT ENT ROUTINE SERVICE COST CENTERS 35,154 35,154 35,154 35,154 30,00 300 300 31		1 1	~		1	0		1
30.00	15.00			0	1	U	0	15.00
33.0 0 3100 JURSI NOR FACILITY 0 0 0 0 0 0 31 10 33 10 33 20 3320 10 17 10 10 0 0 0 0 0 0 0	30 00		35 154	35 154	35 154	35 154	0	30 00
32.00 03200 CF/T I D 0 0 0 0 0 0 23.00				33, 134	1	0		31.00
33 00 03300 OTHER LONG TERM CARE			_			o	_	32. 00
## AMCILLARY SERVICE COST CENTERS 41.00				_	1			33. 00
1.0 0.4100 LABORATORY]
42 00 04200 NTRAVENOUS THERAPY	40.00		0	C) C	0		40. 00
43.00 04300 0XYGEN (I INHALATION) THERAPY		1	0	0	1	-		41. 00
44. 00 04400 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 45.00 46. 00 04600 OCCUPATI ONLA THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 45.00 48. 00 04600 DELECTROCABIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0) C	0		42. 00
45.00 04500 04500 04500 04500 04500 050 050 04500 04600 04			0			0		
46. 00 04600 SPEECH PATHOLOGY		1	0			0		
47.00 04700 CLECTROCARDIOLOGY		1				0		
AB 00 O4800 MEDIC CAL SUPPLIES CHARGED TO PATIENTS		1				0		
49.00 04990 DRINGL SCHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1				0		1
SOLO 05000 DENTAL CARE - TITLE XIX ONLY 0						0		
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51.00						0		50.00
S2.00 GS200 COMPLEX MEDICAL EQUI PMENT 0 0 0 0 5.2.0						o		51.00
S2.02 S202 MEDICAL SERVICE COST CENTERS			0	o c		0	0	52.00
OUTPATLENT SERVICE COST CENTERS O	52. 01		0	O) c	0	0	52. 01
60.00 06000 CLINIC 0 0 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 61.00 62.00 06200 FOHC 0 0 0 0 0 0 61.00 63.00 06300 DIALYSIS 0 0 0 0 0 0 0 0 OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 0 0 0 71.00 07100 OTHER REI MBURSEMENT 0 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08300 UTILIZATION REVIEW - SNF 82.00 83.00 08300 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.01 08401 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.01 08401 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.01 08401 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.01 08401 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.02 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 84.03 OSBORO SUBTOTALS (sum of lines 1-84) 35,154 35,154 35,154 35,154 35,154 0 90.00 NORREI MBURSABLE COST CENTERS 0 0 0 0 0 0 90.00 O9700 O9700 DARBER AND BEAUTY SHOP 0 0 0 0 0 0 91.00 O9700 DARBER AND BEAUTY SHOP 0 0 0 0 0 0 92.00 O9700 OTHER NORREI MBURSABLE COST 0 0 0 0 0 0 93.00 O9300 ONTHEI S LAUNDRY 0 0 0 0 0 0 94.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 95.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 96.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 97.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 97.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 97.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 97.00 O9500 OTHER NORREI MBURSABLE COST 0 0 0 0 0 97.00 O9500 OT	52.02	05202 MEDI CAL SERVI CES	0	O) c	0	0	52. 02
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 62.00 06200 FOHC 0 0 0 0 0 62.00 63.00 06300 DIALYSIS 0 0 0 0 0 0 62.00 63.00 06300 DIALYSIS 0 0 0 0 0 0 63.00 63.00 06300 DIALYSIS 0 0 0 0 0 0 0 62.00 OTHER REI MBURSABLE COST CENTERS			1					
62. 00 06200 FOHC 06300 DI ALYSIS 0 0 0 0 0 0 0 0 0						0		60.00
63.00			0	0) C	0	0	61.00
OTHER REIMBURSABLE COST CENTERS								62.00
70. 00 07000 10ME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0	63.00) (0	0	63.00
71. 00	70.00						0	70.00
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 73. 00 074. 00 0 0 0 0 0 0 0 0 0						0		
74. 00 07400 OTHER REIMBURSEMENT O O O O O O O O O						0		
SPECIAL PURPOSE COST CENTERS 80. 00						O		74. 00
81. 00								1
82. 00 08200 UTILIZATION REVIEW - SNF 83. 00 08300 HOSPICE								80.00
83. 00 08300 HOSPICE 0 0 0 0 0 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 0 84. 00 84. 01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 0 0 84. 00 89. 00 SUBTOTALS (sum of lines 1-84) 35, 154 35, 154 35, 154 35, 154 0 0 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1			81. 00
84. 00								82. 00
84. 01			0	0		0		83. 00
SUBTOTALS (sum of lines 1-84) 35,154 35,154 35,154 35,154 0 89.00			0			0		
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0		1	25 154	25 154	25 154	0 25 154		
90. 00	69.00		35, 154	35, 154	33, 134	33, 134	U	09.00
91. 00	90 00					n n	n	90 00
92. 00				_				
93. 00			0	n		n		92.00
94. 00				l o) c	o		93.00
98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 106.00 Cost to be allocated (per Wkst. B, Part I) 107.00 Unit cost multiplier (Wkst. B, Part I) 108.00 Unit cost multiplier (Wkst. B, Part II) 109.00 000000 1000000				0) c	O	0	94.00
99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 7.201627 1.013484 2.285316 6.128947 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 0.007545 0.010923 0.024606 0.065995 0.000000 105.00			0	0) c	o	0	95. 00
102.00 Cost to be allocated (per Wkst. B, Part I) T. 201627 T. 013484 S. 285316		1 1			1			98. 00
Part I) Unit cost multiplier (Wkst. B, Part I) 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 103.00 104.00 105.00 Unit cost multiplier (Wkst. B, Part I) 0.0077545 0.010923 0.024606 0.065995 0.000000 105.00								99. 00
103.00 Unit cost multiplier (Wkst. B, Part I) 7.201627 1.013484 2.285316 6.128947 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 2,726 384 865 2,320 0.000000 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 0.077545 0.010923 0.024606 0.065995 0.000000 105.00	102.00	71	253, 166	35, 628	80, 338	215, 457	0	102. 00
104.00 Cost to be allocated (per Wkst. B, Part 105.00 Unit cost multiplier (Wkst. B, Part 0.077545 0.010923 0.024606 0.065995 0.000000 105.00	100 0-	1 1 1	7 001/-	4 0101-	0.0000	, ,,,,,,,,	0 00005	100 05
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.077545 0.010923 0.024606 0.065995 0.000000 105.00			1	l .				
105.00 Unit cost multiplier (Wkst. B, Part 0.077545 0.010923 0.024606 0.065995 0.000000 105.00	104.00		2, /26	384	865	2, 320	0	104.00
	105 00		0 077545	0 010022	0 024604	0 065005	0 000000	105 00
	100.00	I a second and a second a second and a second a second and a second a second and a second and a second and a	0.077545	0.010723	0.024000	0.005775	0.00000	100.00
		1 /	1	1	•	<u> </u>	i 	•

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

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.: 315464

				To 12/31/2023 Date/Time Pre	
			OTHER GENERAL		
		Cost Center Description	SERVI CE ACTI VI TES		
		Cost center bescription	(PATIENT DAYS)		
			15. 00		
1 00		AL SERVICE COST CENTERS			1 00
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT			1. 00 2. 00
3.00	1	EMPLOYEE BENEFITS			3. 00
4.00		ADMINISTRATIVE & GENERAL			4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6. 00 7. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING			6. 00 7. 00
8.00		DI ETARY			8. 00
9.00	00900	NURSING ADMINISTRATION			9. 00
10.00	1	CENTRAL SERVICES & SUPPLY			10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY			11. 00 12. 00
13. 00	1	SOCIAL SERVICE			13. 00
14.00		NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00		ACTIVITES	35, 154		15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	35, 154		30. 00
31. 00		NURSING FACILITY	0		31. 00
32. 00		ICF/IID	0		32. 00
33. 00		OTHER LONG TERM CARE	0		33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	0		40. 00
41. 00		LABORATORY	o		41. 00
42.00	1	INTRAVENOUS THERAPY	0		42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0		44. 00 45. 00
46. 00		SPEECH PATHOLOGY	o		46. 00
47.00	04700	ELECTROCARDI OLOGY	0		47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0		49. 00 50. 00
51. 00		SUPPORT SURFACES	o		51.00
52.00	1	COMPLEX MEDICAL EQUIPMENT	0		52. 00
52. 01	1	OTHER ANCILLARY SERVICES COST	0		52. 01
52. 02		MEDICAL SERVICES TIENT SERVICE COST CENTERS	<u> </u>		52. 02
60.00		CLI NI C	0		60.00
61. 00		RURAL HEALTH CLINIC	0		61. 00
62. 00 63. 00	06200	FQHC DI ALYSI S	o		62. 00 63. 00
03.00		REIMBURSABLE COST CENTERS	J O		03.00
70. 00		HOME HEALTH AGENCY COST	0		70. 00
		AMBULANCE	0		71. 00
	07300	OTHER REIMBURSEMENT	0		73. 00 74. 00
74.00		AL PURPOSE COST CENTERS	0		74.00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81. 00		INTEREST EXPENSE			81.00
82. 00 83. 00	1	UTILIZATION REVIEW - SNF HOSPICE	o		82. 00 83. 00
84. 00		OTHER SPECIAL PURPOSE COST I	o		84. 00
84. 01	08401	OTHER SPECIAL PURPOSE COST II	0		84. 01
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	35, 154		89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91. 00		BARBER AND BEAUTY SHOP	0		91. 00
92. 00		PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00 94. 00		NONPALD WORKERS	0		93. 00 94. 00
94. 00 95. 00		PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST			95.00
98. 00		Cross Foot Adjustments			98. 00
99. 00		Negative Cost Centers			99. 00
102.00	ו	Cost to be allocated (per Wkst. B, Part I)	265, 516		102. 00
103.00		Unit cost multiplier (Wkst. B, Part I)	7. 552938		103. 00
104.00	1	Cost to be allocated (per Wkst. B,	2, 859		104. 00
105 00		Part II)	0.001333		105 00
105.00	1	Unit cost multiplier (Wkst. B, Part	0. 081328		105. 00
	1	,	ı I		•

Health Financial Systems	CARE ONE AT EVESHAM	In Lieu of F	Form CMS-2540-10
RATIO OF COST TO CHARGES FOR	R ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 31546	Period: Works	sheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:33 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 110, 827 230, 360 0. 481103 40.00 04100 LABORATORY 64, 848 134, 790 0. 481104 41.00 41.00 460, 320 0. 442616 42.00 04200 I NTRAVENOUS THERAPY 203, 745 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 877, 186 4, 219, 429 0.444891 44.00 04500 OCCUPATIONAL THERAPY 45.00 1, 430, 117 4, 115, 663 0. 347482 45.00 04600 SPEECH PATHOLOGY 1, 397, 862 0.302723 46.00 423, 165 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 17, 752 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 1, 413, 207 0. 456433 49.00 49.00 645, 034 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 0 50.00 51.00 05100 SUPPORT SURFACES 0 0.000000 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0 0.000000 0 52.01 05202 MEDICAL SERVICES 0 0.000000 52.02 52.02 OUTPATIENT SERVICE COST CENTERS 0 0 0. 000000 60.00 06000 CLI NI C 60.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62. 00 06200 FQHC 62.00 63. 00 06300 DI ALYSI S 0.000000 63.00 71. 00 07100 AMBULANCE 52, 189 108, 478 0. 481102 71.00

4, 824, 863

12, 080, 109

100. 00

100.00

Total

Health Financial Systems	CARE ONE A	T EVESHAM		In Lie	eu of Form CMS-	2540-1
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: 33 am
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		
		Health Care Pr	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 OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0. 481103	38, 520		0 18, 532	0	40.00
41. 00 04100 LABORATORY	0. 481104	35, 916		0 17, 279	0	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0. 442616			0 14, 991	0	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0	0	43.00
44.00 04400 PHYSI CAL THERAPY	0. 444891	1, 120, 510		0 498, 505	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 347482			0 407, 573	0	
46. 00 04600 SPEECH PATHOLOGY	0. 302723			0 98, 851	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	1		0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	0	
49.00 04900 DRUGS CHARGED TO PATIENTS	0. 456433			0 69, 917	0	, ,,, ,,
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	1		0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000			0	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		1			1	4
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	1	
71. 00 07100 AMBULANCE (2)	0. 481102	1		0	0	
100.00 Total (Sum of Lines 40 - 71)	1	2, 881, 469		0 1, 125, 648	1 0	100. 00

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

PORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315464	Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023	Parts II-III	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1. 00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
OD Drugs charged to patients - ratio of o	cost to charges	(From Workshee	t C, column 3	, line 49)	0. 456433	1.00
00 Program vaccine charges (From your red	ords, or the PS&	&R)		·	1, 642	2.00
Program costs (Line 1 x line 2) (Title E, Part I, line 18)	XVIII, PPS prov	viders, transfe	er this amoun	t to Worksheet	749	3. 00
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
'	(From Wkst. B,	Allied Health	Nursing &	Cost (From	& Allied	
	Part I, Col.	(From Wkst. B,			Health Costs	
	18		Costs to Tota		for Pass	
		.,	Costs - Part		Through (Col.	
			(Col . 2 / Col 1)		3 x Col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
PART III - CALCULATION OF PASS THROUGH COSTS	S FOR NURSING &	ALLIED HEALTH				
ANCILLARY SERVICE COST CENTERS						
. 00 04000 RADI OLOGY	110, 827				0	
. 00 04100 LABORATORY	64, 848		0. 00000			
. 00 04200 I NTRAVENOUS THERAPY	203, 745	0	0. 00000		0	
.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0. 00000		0	
. 00 04400 PHYSI CAL THERAPY	1, 877, 186	0	0. 00000		0	
. 00 04500 OCCUPATI ONAL THERAPY	1, 430, 117	0	0. 00000		0	
. 00 04600 SPEECH PATHOLOGY	423, 165	0	0. 00000		0	
. 00 04700 ELECTROCARDI OLOGY	0	0	0. 00000		0	
. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 752	0	0.0000		0	
. 00 04900 DRUGS CHARGED TO PATIENTS	645, 034	0	0.00000		0	
. 00 05000 DENTAL CARE - TITLE XIX ONLY		0	0.00000		0	
. 00 05100 SUPPORT SURFACES . 00 05200 COMPLEX MEDICAL EQUIPMENT		0	0. 00000 0. 00000		0	
. 00 05200 COMPLEX MEDICAL EQUIPMENT . 01 05201 OTHER ANCILLARY SERVICES COST		0	0.0000		0	
. 01 05201 OTHER ANCITLLARY SERVICES COST . 02 05202 MEDICAL SERVICES		0	0.0000		0	
.02 05202 MEDICAL SERVICES 0.00 Total (Sum of Lines 40 - 52)	4, 772, 674	0		1, 125, 648	_	100.00

Heal th	Financial Systems CARE 0	NE AT EVESHAM	In Li∈	u of Form CMS-2	2540-10
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315464	Period: From 01/01/2023 To 12/31/2023		pared:
		Title XVIII	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days including private room days			35, 154	1.00
2.00	Private room days			0	2.00
3.00	Inpatient days including private room days applicable	3		8, 266	
4.00	Medically necessary private room days applicable to the	e Program		0	1
5.00	Total general inpatient routine service cost			11, 978, 465	5.00
6. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			10 720 100	6.00
7. 00	General inpatient routine service charges [General inpatient routine service cost/charge ratio (]	ine 5 divided by Line 6)		18, 720, 190 0. 639869	
8.00	Enter private room charges from your records	ine 3 divided by Time 0)		0.037007	
9. 00	Average private room per diem charge (Private room char	rges line 8 divided by private	room days. line	0.00	
	2)	g			
10.00	Enter semi-private room charges from your records	0	1		
11. 00					11.00
12. 00	semi-private room days)	O minus line 11)		0.00	12.00
13. 00	1.3. 1. 1. 1. 1. 1. 1. 1				
14. 00	Private room cost differential adjustment (Line 2 times			0.00	
15. 00	General inpatient routine service cost net of private		minus line 14)	11, 978, 465	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	·	•		
16.00	Adjusted general inpatient service cost per diem (Line	15 divided by line 1)		340. 74	
	Program routine service cost (Line 3 times line 16)			2, 816, 557	
	Medically necessary private room cost applicable to pro	<i>'</i>		0	
20.00	Total program general inpatient routine service cost		at II aalumn 10	2, 816, 557	
20.00	Capital related cost allocated to inpatient routine ser line 30 for SNF; line 31 for NF, or line 32 for ICF/III		et II column 18,	1, 526, 034	20.00
21. 00	Per diem capital related costs (Line 20 divided by line)			43. 41	21.00
22. 00	Program capital related cost (Line 3 times line 21)	.5 .,		358, 827	
23. 00	, , , , , , , , , , , , , , , , , , , ,)		2, 457, 730	
24. 00	O Aggregate charges to beneficiaries for excess costs (From provider records)				24.00
25. 00	O Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)				25. 00
	Enter the per diem limitation (1)				26. 00
	Inpatient routine service cost limitation (Line 3 times				27. 00
28. 00	Reimbursable inpatient routine service costs (Line 22 p		line 27)		28. 00
(1) !!	(Transfer to Worksheet E, Part II, line 4) (See instruc	*	+: +1 - VIV		I
(I) LI	nes 26 and 27 are not applicable for title XVIII, but ma	ay be used for title v and or	LI LI E XIX		
				1 00	
				1 ()()	

Ī			
		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH	·	
	1.00 Total SNF inpatient days	35, 154	1.00
	2.00 Program inpatient days (see instructions)	8, 266	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. 235137	4. 00
	5.00 Program nursing & allied health costs for pass-through. (line 3 times line 4)	1 0	5.00

	Financial Systems CAF ATION OF INPATIENT ROUTINE COSTS	RE ONE AT EVES	Provider No.: 315464	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				35, 154	1
00	Private room days				0	2
00	Inpatient days including private room days applicat		gram		14, 946	3
00	Medically necessary private room days applicable to	the Program			0	Ι.
00	Total general inpatient routine service cost				11, 978, 465	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				40 700 400	Ι,
0	General inpatient routine service charges	/I: F -I:-			18, 720, 190	
0	General inpatient routine service cost/charge ratio	(Line 5 div	rided by rine 6)		0. 639869	
00	Enter private room charges from your records	aharaaa lina	O divided by privets	room doug line	0	1 ~
0	Average private room per diem charge (Private room 2)	charges iine	8 divided by private	room days, line	0. 00	,
00						10
00						١.,
00	semi -pri vate room days)	Tvate Toolii Cii	larges fille 10, divide	a by	0. 00	' '
00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12
00	Average per diem private room cost differential (Li				0.00	13
00	Private room cost differential adjustment (Line 2 t	imes line 13)	•		0	14
00	General inpatient routine service cost net of priva	ite room cost	differential (Line 5	minus line 14)	11, 978, 465	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS					
00	Adjusted general inpatient service cost per diem (L		led by line 1)		340. 74	16
00	Program routine service cost (Line 3 times line 16)			5, 092, 700	17
00	Medically necessary private room cost applicable to				0	1
00	Total program general inpatient routine service cos	, ,	,		5, 092, 700	
00	Capital related cost allocated to inpatient routine line 30 for SNF; line 31 for NF, or line 32 for ICF		s (From Wkst. B, Par	t II column 18,	1, 526, 034	20
00	Per diem capital related costs (Line 20 divided by	line 1)			43. 41	21
00	Program capital related cost (Line 3 times line 21)			648, 806	22
00	Inpatient routine service cost (Line 19 minus line	,			4, 443, 894	
00	Aggregate charges to beneficiaries for excess costs				0	
00	Total program routine service costs for comparison	to the cost I	imitation (Line 23 mi	nus line 24)	4, 443, 894	
00	Enter the per diem limitation (1)				0. 00	
. 00	Inpatient routine service cost limitation (Line 3 t			, , ,	0	1 -
. 00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) 5,092,700					28

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH Total SNF inpatient days

Program nursing & allied health costs for pass-through. (line 3 times line 4)

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)

1.00

35, 154

14, 946

0. 425158

0

2. 00 3. 00

4.00

MCRI F32 - 10	ነ 17 178 በ

1.00

2.00

4.00

5.00

Health Financial Systems	CARE ONE AT EVE	In Lie	u of Form CMS-2540-10	
CALCULATION OF REIMBURSEMENT	SETTLEMENT FOR TITLE XVIII	Provi der No.: 315464	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:33 am
		Title XVIII	Skilled Nursing	PPS

		T		3/10/2024 11.	ss alli
		Title XVIII	Skilled Nursing Facility	PPS	
	T			1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS				
1.00	Inpatient PPS amount (See Instructions)			6, 054, 127	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)			0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)			6, 054, 127	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			837, 545	5. 00
6.00	Allowable bad debts (From your records)			314, 784	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ıcti ons)		213, 410	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			204, 610	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)			5, 421, 192	•
12. 00	Interim payments (See instructions)			5, 361, 496	
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			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			4, 092	14. 75
14. 99				104, 332	14. 99
15. 00	Balance due provider/program (see Instructions)			-48, 728	1
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	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			749	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			749	
20. 00	Medicare Part B ancillary charges (See instructions)			1, 642	ı
21. 00	Cost of covered services (Lesser of line 19 or line 20)			749	
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ictions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			749	
26. 00				858	
27. 00				0	27. 00
28. 00				0	28. 00
28. 50	1			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			15	
29. 00	Balance due provider/program (see instructions)	' II ONG D I 45 G	445.0	-124	
30.00	Protested amounts (Nonallowable cost report items) in accordance	e wrth CMS Pub. 15-2,	section 115.2	0	30.00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/10/2024 11: 33 am PPS Title XVIII

		liti	e XVIII S	Killed Nursing	PPS	
		Innatien	t Part A	Facility Par	t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I=	1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		5, 112, 250		858	1.00
2.00	Interim payments payable on individual bills, either		266, 293		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter 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		<u> </u>	<u> </u>		
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			T		
3.50	ADJUSTMENTS TO PROGRAM	06/15/2023	17, 047		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53 3. 54
3. 54 3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-17, 047		0	3. 54 3. 99
3. 99	- 3.98)		-17,047		ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 361, 496		858	4. 00
1. 00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		0,001,170			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)					
E 04	Program to Provider					E 04
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0		0	5. 02
5.05	Provider to Program				U	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			o o		0	5. 51
5. 52			0		o	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		0		0	6. 01
6. 02	PROVI DER TO PROGRAM		48, 728		124	6. 02
7.00	Total Medicare program liability (see instructions)		5, 312, 768		734	7. 00
			Contract	tor Name	Contractor Number	
			1.	00	2. 00	
8. 00	Name of Contractor		1.		2.00	8. 00
00	1		1			00

^{8.00 |} Name of Contractor | | | (1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Health Financial Systems

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

Provi der No.: 315464 | Peri od: | From 01/01/2023 | To 12/31/2023

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 33 am

ectible notes and accounts Flines 1 - 10) on on on on on on e ole ines 12 - 27)	1.00 1.00 1.00 1.00 1.00 1.00 2,242,849 0 -269,081 0 37,227 403,304 02,580,104 1,399,702 1,113,119 -347,573 10,620,367 -8,171,529 0 463,335 -433,499 12,686 -12,686 2,999,170 -2,640,267 0 15,720 5,018,545	Speci fi c Purpose Fund 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
on	165, 805 0 2, 242, 849 0 -269, 081 0 37, 227 403, 304 0 2, 580, 104 1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	
on	2, 242, 849 0 2, 242, 849 0 -269, 081 0 37, 227 403, 304 0 2, 580, 104 1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720		0 0 0 0 0 0 0 0 0	
on	2, 242, 849 0 2, 242, 849 0 -269, 081 0 37, 227 403, 304 0 2, 580, 104 1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720		0 0 0 0 0 0 0 0 0	
on	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	
on	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	
on	0	0 0 0 0 0 0 0 0 0 0 0 0	0 0	
on	1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720	0 0 0 0 0 0 0 0 0 0 0 0	0 0	
on	1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	
on on on on on on e	403, 304 0 2, 580, 104 1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	
on on on on on on e	403, 304 0 2, 580, 104 1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720	0 0 0 0 0 0 0 0 0 0 0	0 0	
on on on on on on e	1, 399, 702 1, 113, 119 -347, 573 10, 620, 367 -8, 171, 529 0 463, 335 -433, 499 12, 686 -12, 686 2, 999, 170 -2, 640, 267 0 0 15, 720	0 0 0 0 0 0 0 0 0 0 0	0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
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11, 28, and 33)	7, 686, 259	0	0	0
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Sum of lines 35 - 42)	2, 605, 547	0	0	0
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	-29, 541, 478	0	O	0
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(Sum of lines 44 - 49	-21, 085, 557	0	0	0
nes 43 and 50)	-18, 480, 010	0	0	0
	2/ 1// 2/0			
	26, 166, 269	0		
und halance - restricted		U	ام	
			ol	
dowment fund balance			ŏl	
ed in plant			-	0
e for plant improvement,				0
•				
	1 26, 166, 269		ol	o
lines 52 thru 58) BALANCES (Sum of lines 51 and	7, 686, 259	0	-1	o
	(Sum of lines 35 - 42) (Sum of lines 44 - 49 nes 43 and 50) and balance - restricted and balance - unrestricted downent fund balance ed in plant e for plant improvement,	1,483,270 254,439 -6,665 1	1,483,270 0 254,439 0 665	1,483,270

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES CARE ONE AT EVESHAM In Lieu of Form CMS-2540-10

Provi der No.: 315464

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

					То	12/31/2023	Date/Time Prep 5/10/2024 11:3	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	30 a
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	26, 063, 036			4.00		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		103, 231			· ·		2. 00
3.00	Total (sum of line 1 and line 2)		26, 166, 267			0		3. 00
4.00	Additions (credit adjustments)							4.00
5.00	ROUNDI NG	2			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	T. I.	0			0		0	9. 00
10.00	Total additions (sum of line 5 - 9)		2			0		10.00
11.00	Subtotal (line 3 plus line 10)		26, 166, 269			0		11.00
12. 00 13. 00	Deductions (debit adjustments)				0		o	12. 00 13. 00
14. 00					0			14. 00
15. 00					0			15. 00
16. 00					0		l ől	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)	1	0		_	0	_	18. 00
19. 00	Fund balance at end of period per balance		26, 166, 269			0		19.00
	sheet (Line 11 - line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	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	ROUNDI NG		0					5.00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 5 - 9)		U		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments)				U			12. 00
13. 00	boddetrons (debr t day detiments)		0					13. 00
14. 00			0					14. 00
15.00			o					15.00
16.00]	o					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)	1						

	Financial Systems CARE ONE AT EVE				u of Form CMS-2	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315464	Peri od: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		18, 720, 1	90	18, 720, 190	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)		18, 720, 1	90	18, 720, 190	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		12, 080, 1	09 0	12, 080, 109	6. 00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11.00	CMHC			0	0	11. 00
12.00	HOSPI CE			0 0	0	12. 00
13. 00	OTHER (SPECIFY)			0 0	0	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	30, 800, 2	99 0	30, 800, 299	14. 00
	Worksheet G-3, Line 1)					
	Cost Contor Doscription					

	WOLKSHEEL G-3, LITTE 1)			
	Cost Center Description			
		1. 00	2.00	
	PART II - OPERATING EXPENSES			
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		17, 321, 867	1.00
2.00	Add (Specify)	0		2.00
3.00		0		3.00
4.00		0		4.00
5.00		0		5.00
6.00		0		6.00
7. 00		0		7.00
8. 00	Total Additions (Sum of lines 2 - 7)		0	8. 00
9. 00	Deduct (Specify)	0		9.00
10. 00		0		10.00
11. 00		0		11.00
12. 00		0		12.00
13. 00		0		13.00
14. 00	Total Deductions (Sum of lines 9 - 13)		0	14.00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)		17, 321, 867	15.00

Heal th	Financial Systems CARE ONE	CARE ONE AT EVESHAM			In Lie	u of Form CMS-	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES				Peri od:		Worksheet G-3	3
					01/01/2023 12/31/2023	Date/Time Pre 5/10/2024 11:	
						1. 00	
1.00	00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)					30, 800, 299	1.00
2.00	.00 Less: contractual allowances and discounts on patients accounts					13, 404, 806	2.00
3.00	8.00 Net patient revenues (Line 1 minus line 2)				17, 395, 493	3. 00	
4.00	.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)			17, 321, 867	4.00		
5.00						73, 626	5. 00
Other income:							

		5/10/2024 11: \	33 alli
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	30, 800, 299	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	13, 404, 806	•
3.00	Net patient revenues (Line 1 minus line 2)	17, 395, 493	1
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17, 321, 867	1
5.00	Net income from service to patients (Line 3 minus 4)	73, 626	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6. 00
7.00	Income from investments	3, 245	1
8.00	Revenues from communications (Telephone and Internet service)	0	
9.00	Revenue from television and radio service	0	
10.00	Purchase di scounts	0	
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	11, 976	1
	Revenue from meals sold to employees and guests	142	14. 00
	Revenue from rental of living quarters	0	
	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
	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	Rental of vending machines	0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23.00	Governmental appropriations	0	23. 00
24.00	BARBER AND BEAUTY	9, 087	24. 00
24. 01	OTHER REV	5, 453	24. 01
24. 02		0	24. 02
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25.00	Total other income (Sum of lines 6 - 24)	29, 903	25. 00
26.00	Total (Line 5 plus line 25)	103, 529	26. 00
27. 00	OTHER I NCOME	298	27. 00
28. 00		0	28. 00
29.00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	298	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	103, 231	31.00