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

OMB NO. 0938-0463

Expires: 12/31/2021

			Exp11 03. 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315511	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:35 am

					37 107 2024	1 1 . JJ aiii
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/10/202	4 Time:	11: 35 a
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report en	ter the number	of times the provider	resubmitted this	cost repor	rt
	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	(2) Settled without audit	7.[N] Firs	Cost Report for this	Provider CCN		
		8.[N] Last	Cost Report for this F	Provider CCN		
	(3) Settled with audit	9. NPR Date:	·			
	(4) Reopened	10. [0] I f I i	ne 4, column 1 is "4":	 Enter number of	times reope	ened
	(5) Amended		Vendor Code	4		
	5. Date Received:	12.[F] Medi	care Utilization. Enterno utilization.	 r "F" for full, "l	L" for low,	or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT HANOVER TOWNSHIP (315511) 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 FINANCIAL 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	20, 459	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	20, 459	0	0	100.00
Tho ob	and amounts represent "due to" or "due from" the applicable	program for th	o alamant of t	ha abaya campl	ov indicated	

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 HANOVER TOWNSHIP In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315511 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:35 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 101 WHI PPANY ROAD PO Box: 1.00 2.00 City: WHIPPANY ROAD State: NJ Zi p Code: 07981 2.00 3.00 County: MORRIS CBSA Code: 35084 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT HANOVER 315511 05/21/2012 N Р Ν 4.00 TOWNSHI P 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related Υ 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 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits d 22.00 22.00 Sum of line 20 through 22 Q 23 00 23.00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Υ 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 38 728 0

Heal th	Financial Systems	CARE ONE AT HANOVER	TOWNSHI P	In Lie	u of Form CMS-2	2540-10	
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31551	1 Peri od:	Worksheet S-2		
COMPLE	EX INDENTIFICATION DATA			From 01/01/2023	Part I		
				To 12/31/2023	Date/Time Pre 5/10/2024 11:		
	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 name	e and address of the	home office on the	lines		
	bel ow.						
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contr	actor's Number: 1200	1	45. 00	
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00	
47. 00	City: FORT LEE	State: NJ	Zi p C	ode: 0702	4	47. 00	

Health Financial Systems	C	ARE ONE AT HANOVER	TOWNSHI P		In lie	eu of Form CMS	5-2540-10
SKILLED NURSING FACILITY AND COMPLEX REIMBURSEMENT QUESTI	SKILLED NURSING FACILI			No.: 315511	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S- Part II	-2 repared:
					Y/N	Date	1. 33 aiii
responses the format was	ed Nursing Facilites	es enter in column	1, "Y" fo	r Yes or "N"	1.00 for No. For all	the date	
1.00 Has the provider chan- reporting period? If instructions)	ged ownership immediatel column 1 is "Y", enter t	y prior to the beg he date of the cha	inning of nge in col	umn 2. (see	N		1. 00
				1. 00	2. 00	3. 00	
column 1 is yes, ente	inated participation in r in column 2 the date c or "I" for involuntary.			N			2. 00
contracts, with indiv or medical supply com officers, medical sta	ved in business transact iduals or entities (e.g. panies) that are related ff, management personnel ownership, control, or f nstructions)	, chain home offic I to the provider o , or members of th	es, drug r its e board	Y			3.00
				Y/N 1.00	Type 2. 00	Date 3.00	
Accountant? (Y/N) Col Compiled, or "R" for	oorts nancial statements prepa umn 2: If yes, enter "A" Reviewed. Submit complet . (see instructions) If	for Audited, "C" e copy or enter da	for te	Y	A A	3. 00	4. 00
5.00 Are the cost report to	otal expenses and total nancial statements? If c	revenues different	from	N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
Approved Educational A	Activities claimed for Nursing Scho	ol 2 (V/N) Column 2		nnovi don the	N	N N	/ 00
7.00 legal operator of the Were costs claimed fo		s? (Y/N) see instru	ctions.		N N	IN IN	6. 00 7. 00 8. 00
School and/or Allied	Health Program? (Y/N) se	ee instructions.				Y/N	
0.1011						1. 00	
	ng reimbursement for bad the provider's bad debt				st reporting	Y N	9. 00
	patient deductibles and	I/or coinsurance wa	ived? If "	Y", see instr	ructions.	N	11. 00
12. 00 Have total beds avail.	able changed from prior	cost reporting per	iod?lf"Y			N	12. 00
		Descriptio	n	Y/N	art A Date	Part B Y/N	
PS&R Data		0		1. 00	2. 00	3. 00	
	of the PS&R used to			Y	03/19/2024	Y	13.00
14.00 Was the cost report p for total and the pro allocation? If either enter the paid throug				N		N	14. 00
15.00 If line 13 or 14 is " made to PS&R data for have been billed but	Y", were adjustments additional claims that are not included on the s cost report? If "Y",			N		N	15. 00
16.00 If line 13 or 14 is " adjustments made to P corrections of other information? If yes,	S&R data for PS&R Report see instructions.			N		N	16. 00
17.00 If line 13 or 14 is " adjustments made to P Describe the other ad	S&R data for Other? justments:			N		N	17. 00
	repared only using the f "Y" see Instructions.			N		N	18. 00

Heal th	Financial Systems CA	ARE ONE AT	HANOVER	TOWNSHI P		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILIT	Y HEALTH CA	RE	Provi der		Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
							5/10/2024 11:	
				1.	00	2.	00	
	Cost Report Preparer Contact Information							
19.00	Enter the first name, last name and the title	/posi ti on	CHAR	LES		REED		19. 00
	held by the cost report preparer in columns 1	, 2, and 3,						
	respecti vel y.							
20.00	Enter the employer/company name of the cost re	eport	EXEC	UCARE ASSO	CI ATES			20.00
	preparer.							
21.00	Enter the telephone number and email address	of the cost	(609	738-3200		CRWASSC@NETSCAL	PE. NET	21. 00
	report preparer in columns 1 and 2, respective	el y.						

Health Financial Systems CARE ONE AT HANGE SKILLED NURSING FACILITY HEALTH CARE CARE ONE AT HANOVER TOWNSHIP Provi der No.: 315511

COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 12/31/2023	Date/Time Prepare 5/10/2024 11:35 a	∍d: am
		Part B		· .		
		Date				
		4. 00				
	PS&R Data					
13.00	Was the cost report prepared using the PS&R	03/19/2024			13.	. 00
	only? If either col. 1 or 3 is "Y", enter					
	the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
	4. (see Instructions.)					
14. 00	Was the cost report prepared using the PS&R				14.	. 00
	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					
15 00	4.				1.5	- 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that				15.	. 00
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y",					
	see Instructions.					
16. 00	If line 13 or 14 is "Y", then were				16	. 00
10.00	adjustments made to PS&R data for				10.	. 00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17 00	If line 13 or 14 is "Y", then were				17	. 00
.,, 00	adjustments made to PS&R data for Other?					
	Describe the other adjustments:					
18.00	Was the cost report prepared only using the				18.	. 00
	provider's records? If "Y" see Instructions.					
			3. 00			
	Cost Report Preparer Contact Information		L.,			
19. 00	Enter the first name, last name and the title		VI CE-PRESI DENT		19.	. 00
	held by the cost report preparer in columns 1	, 2, and 3,				
20.00	respectively.	onort			20	
20.00	Enter the employer/company name of the cost r	eport			20.	. 00
21 00	preparer. Enter the telephone number and email address	of the cost			21	. 00
21.00	· ·				21.	. 00
	report preparer in columns 1 and 2, respective	reiy.	l	1	l	

 Heal th Financial
 Systems
 CARE ONE AT HANOVER
 TOWNSHIP

 SKILLED
 NURSING
 FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 Provider
 COMPLEX STATISTICAL DATA

						5/10/2024 11:3	
				I npa	atient Days/Vis	si ts	
	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	94	34, 310		5, 392	17, 146	1.00
2. 00 3. 00	NURSING FACILITY	0	0	-		0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST			0	0		4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC						6. 00
7.00	HOSPICE	0 94	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	Inpatient [34, 310 Davs/Vi si ts	0	5, 392 Di scharges	17, 146	8. 00
		The tront E			Dr Schar ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	SKILLED NURSING FACILITY	6.00	7.00	8. 00	9. 00 189	10.00	1. 00
1. 00 2. 00	NURSING FACILITY	4, 564	27, 102 0		189	53 0	2. 00
3. 00	ICF/IID	0	o	Ĭ		ő	3. 00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00 7. 00	SNF-Based CMHC HOSPI CE		_	0	0	o	6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	4, 564	27, 102	·	189	53	8. 00
0.00	Total (cum of Trinos 1 1)	Di sch			age Length of		0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	SKILLED NURSING FACILITY	168			28. 53		1. 00
2.00	NURSING FACILITY	0	0	0.00		0.00	2. 00
3.00	I CF/IID HOME HEALTH AGENCY COST	0	0			0.00	3. 00
4. 00 5. 00	Other Long Term Care	0	0				4. 00 5. 00
6. 00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	0		0.00		7. 00
8. 00	Total (Sum of lines 1-7)	168			28. 53	323. 51	8. 00
		Average Length of Stay		Admi s	SI ONS		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	T	16. 00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	66. 10		_	29		1. 00
2. 00 3. 00	NURSING FACILITY	0. 00 0. 00			0		2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			O	Ĭ	4. 00
5.00	Other Long Term Care	0. 00				0	5.00
6. 00	SNF-Based CMHC						6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0. 00 66. 10	0	0 216	0 29		7. 00 8. 00
0.00	Total (Sail of Titles 17)	Admi ssi ons	Full Time	Equi val ent	27	107	0.00
	Component	Total	Employees on	Nonnai d			
	Component	TOTAL	Employees on Payroll	Nonpai d Workers			
		21. 00	22. 00	23.00			
1.00	SKILLED NURSING FACILITY	412	82. 28				1. 00
2.00	NURSING FACILITY	0					2.00
3. 00 4. 00	HOME HEALTH AGENCY COST		0. 00 0. 00				3. 00 4. 00
5. 00	Other Long Term Care	0					5. 00
6.00	SNF-Based CMHC		0. 00				6. 00
7.00	HOSPICE	0					7. 00
8. 00	Total (Sum of lines 1-7)	412	82. 28	0.00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provi der No.: 315511

				T	0 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 35 am
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.		Wage (col. 3 ÷	
		'	Worksheet A-6		Salary in col.		
				ŕ	3	,	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	5, 466, 637	0	5, 466, 637	171, 148. 00	31. 94	1. 00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2. 00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3. 00
4.00	Home office personnel	0	0	0	0.00	0.00	4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5. 00
6.00	Revised wages (line 1 minus line 5)	5, 466, 637	0	5, 466, 637	171, 148. 00	31. 94	6. 00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	5, 466, 637	0	5, 466, 637	171, 148. 00	31. 94	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	40, 727	0	40, 727	647. 00		14.00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0. 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)	958, 449	0	958, 449			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	958, 449	0	958, 449			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315511

							5/10/2024 11:	<u>35 am</u>
		Amount	Recl ass	. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Sal ari es	from	Sal ari es (col	Related to	Wage (col. 3 ÷	
			Workshee	t A-6	1 ± col. 2)	Salary in col.	col . 4)	
						3		
		1. 00	2.0	0	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES							
1.00	Employee Benefits	0		C		0.00	0.00	1.00
2.00	Administrative & General	560, 142		C	560, 14	2 13, 167. 00	42. 54	2.00
3.00	Plant Operation, Maintenance & Repairs	41, 835		C	41, 83	1, 565. 00	26. 73	3.00
4.00	Laundry & Li nen Servi ce	90, 823		C	90, 82	4, 590. 00	19. 79	4.00
5.00	Housekeepi ng	255, 657		C	255, 65	7 13, 263. 00	19. 28	5.00
6.00	Di etary	377, 915		C	377, 91	5 17, 917. 00	21. 09	6.00
7.00	Nursing Administration	442, 724		C	442, 72	4 8, 684. 00	50. 98	7.00
8.00	Central Services and Supply	0		C		0.00	0.00	8. 00
9.00	Pharmacy	0		C		0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0		C		0.00	0.00	10.00
11.00	Soci al Servi ce	66, 431		C	66, 43	1, 914. 00	34. 71	11.00
12.00	Nursing and Allied Health Ed. Act.							12.00
13.00	Other General Service	47, 293		C	47, 29	3, 162. 00	14. 96	13.00
14. 00	Total (sum lines 1 thru 13)	1, 882, 820		C	1, 882, 82	64, 262. 00	29. 30	14. 00

Health Financial Systems	CARE ONE AT HANOVER TOWNSHIP	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315511	Period: Worksheet S-3 From 01/01/2023 Part IV
		To 12/31/2023 Date/Time Prepared:

2.00 Tax Shel tered Annuity (TSA) Employer Contribution 0 2 2 3.00 Qualified and Non-Qualified Pension Plan Cost 0 3 4 4 4 4 4 4 4 4 4		To 12/31/202:		pared: 35 am
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST				
Part A - Core List RETIREMENT COST				
RETIREMENT COST 401K Employer Contributions 25,825 1 1 20 401K Employer Contribution 25,825 1 1 20 401K Employer Contribution 25,825 1 20 401K Employer Contribution 25,825 1 20 401K Employer Contribution 25,825 1 20 40 40 40 40 40 40 40		PART IV - WAGE RELATED COSTS	•	
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00 Qualified and Non-Qualified Pension Plan Cost 0 0 7 10 10 10 10 10	1.00	401K Employer Contributions	25, 825	1.00
3.00 Qualified and Non-Qualified Pension Plan Cost 0 0 7 1 1 1 1 1 1 1 1 1	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
Prior Year Pension Service Cost 0	3.00		0	3. 00
5.00 401K/TSA Plan Administration fees 0 5 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6 6 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6 6 6 6 6 6 6 6 6			0	4. 00
5.00 401K/TSA Plan Administration fees 0 5 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6 6 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6 6 6 6 6 6 6 6 6		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Employee Managed Care Program Administration Fees 0 7	5.00		0	5.00
Employee Managed Care Program Administration Fees 0 7	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6, 00
HEALTH AND INSURANCE COST			0	7. 00
8.00 Health Insurance (Purchased or Self Funded) 426,965 8 9.00 Prescription Drug Plan 0 9 9 10.00				
9. 00 Prescription Drug Plan 0 9 10. 00 Dental, Hearing and Vision Plan 0 10 11. 00 Life Insurance (If employee is owner or beneficiary) 1,055 11 12. 00 Accident Insurance (If employee is owner or beneficiary) 0 12 13. 00 Disability Insurance (If employee is owner or beneficiary) 0 13 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 13 15. 00 Workers' Compensation Insurance 35, 191 15 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16 Non cumulative portion 393, 637 17 18 0 18 17. 00 FICA-Employers Portion Only 393, 637 17 18. 00 Medicare Taxes - Employers Portion Only 0 18 19. 00 Unemployment Insurance 0 19 20. 00 State or Federal Unemployment Taxes 75, 776 20 OTHER 75 20 21 21. 00 Executive Deferred Compensation 0 23 <t< td=""><td>8. 00</td><td></td><td>426, 965</td><td>8. 00</td></t<>	8. 00		426, 965	8. 00
10.00 Dental, Hearing and Vision Plan 0 10 11.00 Life Insurance (If employee is owner or beneficiary) 1,055 11 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14 15.00 Workers' Compensation Insurance 35,191 15 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 393,637 17 18.00 Unemployment Insurance 0 19 19.00 19.00 19.00 19.00 19 19.00				9. 00
11.00 Life Insurance (If employee is owner or beneficiary) 1,055 11 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14 15.00 Workers' Compensation Insurance 35,191 15 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16 Non cumulative portion) 17AXES 17.00 FICA-Employers Portion Only 393,637 17 18.00 Medicare Taxes - Employers Portion Only 0 18 18 19.00 Unemployment Insurance 0 0 19 19.00			0	10.00
12.00			1. 055	
13.00 Disability Insurance (If employee is owner or beneficiary) 0 13 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14 15.00 Workers' Compensation Insurance 35, 191 15 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16 Non cumulative portion) TAXES 17.00 FIGA-Employers Portion Only 393, 637 17 18.00 Medicare Taxes - Employers Portion Only 0 18 18 19.00 Unemployment Insurance 0 19 19.00 19 19.00 19 19.00 19 19.00 19 19.00 19 19.00 19 19.00 19 19.00 19 19.00 19 19.00 19.				
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14 15.00 Workers' Compensation Insurance 35, 191 15 15 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 16 Non cumulative portion 17 NOT 18.00 Medicare Taxes - Employers Portion Only 0 18 18 19 19 19 19 19 19				13. 00
15. 00 Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Empl oyers Portion Only 18. 00 Medicare Taxes - Empl oyers Portion Only 19. 00 Unempl oyment Insurance 20. 00 State or Federal Unempl oyment Taxes OTHER 21. 00 Executive Deferred Compensation Day Care Cost and All owances 22. 00 Day Care Cost and All owances Tuition Reimbursement Amount Reported Amount Reported Amount Reported 1. 00			_	14. 00
Retirement Heal th 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 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported Amount Reported 1. 00			-	
Non cumulative portion TAXES				
TAXES	10.00			10.00
17. 00 FI CA-Employers Portion Only 393,637 17 18. 00 Medicare Taxes - Employers Portion Only 0 18 19. 00 Unemployment Insurance 0 19 20. 00 State or Federal Unemployment Taxes 75,776 20 20 21. 00 Executive Deferred Compensation 0 21 22. 00 Day Care Cost and Allowances 0 22 23. 00 Total Wage Related cost (Sum of lines 1 - 23) 958,449 24 24 24 24 24 24 25 25				
18.00 Medicare Taxes - Employers Portion Only 0 18 19.00 Unemployment Insurance 0 19 20.00 State or Federal Unemployment Taxes 75,776 20 OTHER 21.00 Executive Deferred Compensation 0 21 22.00 Day Care Cost and Allowances 0 22 23.00 Tuition Reimbursement 0 23 24.00 Total Wage Related cost (Sum of lines 1 - 23) 958,449 24 Amount Reported 1.00 1	17. 00	· · · · · · · · · · · · · · · · · · ·	393, 637	17. 00
19.00 Unemployment Insurance 0 19 20.00 State or Federal Unemployment Taxes 75,776 20 OTHER 21.00 Executive Deferred Compensation 0 21 22.00 Day Care Cost and Allowances 0 22 23.00 Tuition Reimbursement 0 23 24.00 Total Wage Related cost (Sum of lines 1 - 23) 958,449 24 Amount Reported 1.00				
20.00 State or Federal Unemployment Taxes 75,776 20 OTHER				19.00
OTHER 21.00 Executive Deferred Compensation 0 21 22.00 Day Care Cost and Allowances 0 22 23.00 Tuition Reimbursement 0 23 24.00 Total Wage Related cost (Sum of lines 1 - 23) 958,449 24 24 24 24 24 24 25 25			-	
Executive Deferred Compensation 0 21	20.00		707770	20.00
22. 00 Day Care Cost and Allowances 0 22 23. 00 Tuition Reimbursement 0 23 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 958, 449 24 Amount Reported 1.00	21 00	·	0	21. 00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00			_	22. 00
24.00 Total Wage Related cost (Sum of lines 1 - 23) 958,449 24 Amount Reported 1.00			_	23. 00
Amount Reported 1.00			-	
Reported	21.00	1.01d. mage		21.00
1.00				
rait b = other than core related cost		Part B - Other than Core Related Cost		
	25. 00		0	25. 00

0.00

0.00

39.00

112.00

0

2, 900

5, 586

0.00

74. 36

49.88

23.00

24.00

25.00

0.00 26.00

SNF REPORTING OF DIRECT CARE EXPENDITURES Provider No.: 315511 Peri od: Worksheet S-3 From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/10/2024 11:35 am Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Sal ari es (col Related to Wage (col. 3 Reported col . 4) 1 + col. 2Salary in col 5. 00 3.00 1.00 2.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 411, 754 78, 304 490, 058 8, 562, 00 57. 24 1.00 Licensed Practical Nurses (LPNs) 876, 247 166, 638 1, 042, 885 22, 251. 00 46.87 2.00 2.00 3.00 Certified Nursing Assistant/Nursing 1, 449, 066 275, 573 1, 724, 639 58, 347. 00 29.56 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 2, 737, 067 520, 515 3, 257, 582 89, 160. 00 36.54 4.00 5.00 Physical Therapists 8, 605. 00 45. 29 5.00 327, 430 389, 698 62, 268 Physical Therapy Assistants 0.00 6.00 C 0.00 6.00 7.00 Physical Therapy Aides 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 58, 638 366, 980 8.00 308.342 7, 012, 00 52.34 8.00 0.00 9.00 C 0.00 9.00 10.00 Occupational Therapy Aides 0.00 0.00 10.00 57. 20 11.00 Speech Therapists 101, 264 19, 258 120, 522 2, 107. 00 11.00 Respiratory Therapists 12.00 0.00 12 00 0 00 C13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 14 00 Registered Nurses (RNs) 0 00 14 00 0 00 15.00 Licensed Practical Nurses (LPNs) 32, 241 32, 241 496.00 65.00 15.00 Certified Nursing Assistant/Nursing 0.00 0.00 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 32, 241 32, 241 496.00 65.00 17.00 18.00 Physical Therapists 0.00 0.00 18.00 0 0 19.00 Physical Therapy Assistants 0 0.00 0.00 19.00 0 Physical Therapy Aides 0 20.00 0 0.00 0.00 20.00 Occupational Therapists 0.00 21.00 0 0 0.00 21.00 Occupational Therapy Assistants 22.00 0 0 0.00 0.00 22.00

0

2,900

5, 586

Occupational Therapy Aides

Respiratory Therapists

Speech Therapists

26.00 Other Medical Staff

23.00

24.00

25.00

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Period: | Worksheet S-/ | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 35 am Provi der No.: 315511

	10 12/31/2023	5/10/2024 11: 35 am	
	Group	Days	
1.00	1. 00 RUX	2.00	00
2.00	RUL	2.0	
3.00	RVX	3. (
4.00	RVL	4.0	
5.00	RHX	5.0	
6.00	RHL	6.0	
7. 00	RMX	7.0	
8.00	RML	8. (
9.00	RLX RUC	9. (
10. 00 11. 00	RUB	10. (
12. 00	RUA	12.0	
13. 00	RVC	13. (
14. 00	RVB	14.0	
15. 00	RVA	15.0	00
16. 00	RHC	16.0	
17. 00	RHB	17. (
18.00	RHA	18. (
19. 00 20. 00	RMC RMB	19. (
21. 00	RMA	21. (
22. 00	RLB	22.0	
23. 00	RLA	23. (
24. 00	ES3	24. (
25. 00	ES2	25.0	00
26. 00	ES1	26.0	
27. 00	HE2	27.0	
28. 00	HE1	28.0	
29. 00 30. 00	HD2 HD1	29. (
31. 00	HC2	31. (
32. 00	HC1	32.0	
33.00	HB2	33.0	
34.00	HB1	34.0	
35. 00	LE2	35.0	
36. 00	LE1	36.0	
37. 00	LD2	37. (
38. 00	LD1	38.0	
39. 00 40. 00	LC2 LC1	39. (40. (
41. 00	LB2	41. (
42.00	LB1	42.0	
43.00	CE2	43. (
44.00	CE1	44.0	
45. 00	CD2	45.0	
46. 00	CD1	46.0	
47. 00	CC2	47. (
48. 00 49. 00	CC1	48. (
50. 00	CB2 CB1	49. (
51. 00	CA2	51.0	
52.00	CA1	52.0	
53. 00	SE3	53.0	
54. 00	SE2	54.0	
55. 00	SE1	55. (
56. 00	SSC	56.0	
57. 00 58. 00	SSB SSA	57. (58. (
59. 00	I B2	59.0	
60.00	I B1	60.0	
61.00	I A2	61. (
62. 00	I A1	62.0	00
63. 00	BB2	63. (
64. 00	BB1	64. (
65. 00	BA2	65. (
66. 00 67. 00	BA1 PE2	66. (
68. 00	PE2 PE1	68.0	
69. 00	PD2	69.0	
70. 00	PD1	70.0	
71. 00	PC2	71. (00
72. 00	PC1	72.0	00
73. 00	PB2	73. (
74. 00	PB1	74. (
75. 00	PA2	75. (UU

Health Financial Systems	CARE ONE AT HANOVER TOWN	ISHI P		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Pro	vi der	No.: 315511	Peri od:	Worksheet S-	7
				From 01/01/2023 To 12/31/2023		enared:
				10 12/31/2023	5/10/2024 11:	
				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 payments beginning 10/01/2003. Congress ex expenses. For lines 101 through 106: Enter column 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expen (See instructions)	pected this increase to be in column 1 the amount of for each category to total for yes or "N" for no if	e used the e SNF r the sp	for direct pexpense for erevenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing						101.00
102.00 Recruitment						102. 00 103. 00
103.00 Retention of employees 104.00 Training						104.00
105. 00 OTHER (SPECIFY)						104.00
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)					106. 00

Health Financial Systems	CARE ONE AT HANC	VER TOWNSHIP		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BA	LANCE OF EXPENSES	Provi der		eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 35 am
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons	Trial Balance (col. 3 +-	
				Increase/Decre ase (Fr Wkst	col. 4)	
				A-6)	,	
CENEDAL CEDVICE COST CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 CAP REL COSTS - BLDGS & FIXTURE	S	2, 432, 789	2, 432, 789	0	2, 432, 789	1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPME		165, 419			165, 419	2. 00
3.00 00300 EMPLOYEE BENEFITS	0	1, 039, 606			1, 039, 606	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	560, 142	1, 900, 941			2, 461, 083	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAI		447, 130			488, 965	
6. 00 00600 LAUNDRY & LINEN SERVICE 7. 00 00700 HOUSEKEEPING	90, 823 255, 657	68, 853 38, 191			159, 676 293, 848	
8. 00 00800 DI ETARY	377, 915	287, 355			665, 270	8.00
9. 00 00900 NURSING ADMINISTRATION	442, 724	89, 728			532, 452	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	o	110, 031	110, 031		110, 031	10.00
11. 00 01100 PHARMACY	0	14, 511	14, 511	0	14, 511	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	12. 00
13. 00 01300 SOCIAL SERVICE	66, 431	0	66, 431	0	66, 431	
14.00 01400 NURSI NG AND ALLI ED HEALTH EDUCA 15.00 01500 ACTI VI TES	47, 293	0 11, 829	59, 122	0	0 59, 122	14. 00 15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTER		11, 029	39, 122	U	39, 122	15.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY	2, 737, 067	64, 465	2, 801, 532	0	2, 801, 532	30. 00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32. 00 03200 I CF/I I D	0	0	0	0	0	32. 00
33. 00 O3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY		7, 808	7, 808	0	7, 808	40.00
41. 00 04100 LABORATORY		15, 612			15, 612	1
42. 00 04200 I NTRAVENOUS THERAPY		164, 998			164, 998	
43.00 04300 OXYGEN (INHALATION) THERAPY	o	0	0		0	43. 00
44.00 04400 PHYSI CAL THERAPY	437, 144	8, 669			445, 813	
45. 00 04500 OCCUPATI ONAL THERAPY	308, 342	0	308, 342		308, 342	
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	101, 264	2, 900	104, 164 0		104, 164 0	46. 00 47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PAT	I FNTS	0	0	0	0	48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	223, 452	223, 452	0	223, 452	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	o	0	0	0	0	
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 0THER ANCILLARY SERVICES COST 52. 02 05202 MEDICAL SERVICES	0	0	0	0	0	52. 01 52. 02
52. 02 05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	U U	0	0	U	0	52.02
60. 00 06000 CLINIC	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 O7000 HOME HEALTH AGENCY COST		0	0	0	0	70. 00
71. 00 07100 AMBULANCE		91, 745	91, 745	0	91, 745	
73. 00 07300 CMHC	o	0	0	0	0	
74.00 O7400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS	050		1			
80.00 08000 MALPRACTICE PREMIUMS & PAID LOS 81.00 08100 INTEREST EXPENSE	SES	0	0	0	0 0	
82.00 08200 UTILIZATION REVIEW - SNF		0	0	0	0	
83. 00 08300 HOSPI CE		0	Ö	0	ő	1
84.00 08400 OTHER SPECIAL PURPOSE COST I	o	0	0	0	0	
84. 01 08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89.00 SUBTOTALS (sum of lines 1-84)	5, 466, 637	7, 186, 032	12, 652, 669	0	12, 652, 669	89. 00
NONREI MBURSABLE COST CENTERS	NTEEN	2 407	2 407		2 407	00.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CA 91.00 09100 BARBER AND BEAUTY SHOP	INTEEN	3, 497 7, 366			3, 497 7, 366	1
92. 00 09200 PHYSICIANS PRIVATE OFFICES		,, 500 0	7,300		7,300	
93. 00 09300 NONPALD WORKERS		0	0	0	0	
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	
95. 00 09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	
100. 00 TOTAL	5, 466, 637	7, 196, 895	12, 663, 532	0	12, 663, 532	1100.00

 Heal th Financial
 Systems
 CARE ONE AT RECLASSIFICATION

 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 In Lieu of Form CMS-2540-10 Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der No.: 315511

				To 12/31/2023	
	Cost Center Description	Adjustments to	Net Expenses		5/10/2024 11: 35 am
	'	Expenses (Fr	For Allocation	n	
		Wkst A-8)	(col. 5 +-		
		6. 00	col. 6) 7.00	-	
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-632, 553	1, 800, 236		1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	C	165, 419		2. 00
3.00	00300 EMPLOYEE BENEFITS	0	1, 039, 606		3.00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL	-616, 329	1		4. 00 5. 00
6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	4 C	488, 969 159, 676		6.00
7. 00	00700 HOUSEKEEPI NG		293, 848	•	7. 00
8.00	00800 DI ETARY	C	1	1	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	-2, 314			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	C	110, 031		10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	-1, 161	13, 350	1	11. 00
13. 00	01300 SOCIAL SERVICE		_		13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION		1		14. 00
15. 00	01500 ACTI VI TES	C	59, 122	2	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			
30.00	03000 SKILLED NURSING FACILITY	-13, 722			30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	C		l .	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		1		33. 00
	ANCILLARY SERVICE COST CENTERS				
40. 00	04000 RADI OLOGY	C		1	40. 00
41. 00	04100 LABORATORY	C			41.00
42. 00 43. 00	04200 NTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	-13, 200	1		42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		445, 813		44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		308, 342		45. 00
46.00	04600 SPEECH PATHOLOGY	C	104, 164		46. 00
47. 00	04700 ELECTROCARDI OLOGY	C	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	17.07/	205 574)	48. 00
49. 00 50. 00	05000 DENTAL CARE - TITLE XIX ONLY	-17, 876	205, 576		49. 00 50. 00
51. 00	05100 SUPPORT SURFACES				51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	C	0		52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C			52. 01
52. 02		C	0)	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC) 0		60.00
61. 00	06100 RURAL HEALTH CLINIC		•	l control of the cont	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	Г с) 0	N	70. 00
	07100 AMBULANCE				71.00
	07300 CMHC	C			73. 00
74. 00		C	0		74. 00
	SPECIAL PURPOSE COST CENTERS	1		ı	
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE	C	_		80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF				82.00
83. 00	08300 HOSPI CE				83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	C	0		84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	C	0		84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	-1, 297, 151	11, 355, 518	3	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		3, 497	·	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		7, 366	•	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	C	0		92. 00
93. 00	09300 NONPALD WORKERS	C	0		93. 00
	09400 PATIENTS LAUNDRY				94.00
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST TOTAL	-1, 297, 151	11, 366, 381		95. 00 100. 00
. 55. 50		1,277,131	. 1, 555, 561	1	1100.00

Health Financial Systems (CARE ONE AT HANOVER	TOWNSHI P		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			Increases			
	Cost Cente	r	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	ns 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 HA	ANOVER	TOWNSHI P		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS			Provi der		Peri od:	Worksheet A-6	•
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre	epared:
						5/10/2024 11:	35 am
				Decreases			
	Cost	Cente	r	Li ne #	Sal ary	Non Salary	
	6	5. 00		7.00	8. 00	9. 00	
TOTALS							
100. 00					0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT HANOVER TOWNSHIP In Lieu of Form CMS-2540-10 Provi der No.: 315511

					10 12/31/2023	5/10/2024 11:	
			·	Acqui si ti ons	3		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	0	0		0	0	3. 00
4. 00	Building Improvements	0	0		0	0	4. 00
5. 00	Fi xed Equi pment	0	0		0	0	5. 00
6. 00	Movable Equipment	0	0		0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	0	0		0	0	7. 00
8. 00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	0	0		0 0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		7.00				
1. 00	Land		0				1. 00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures		0				3.00
4. 00	Building Improvements		0				4. 00
5. 00	Fixed Equipment		0				5. 00
6. 00	Movable Equipment		0				6.00
7. 00	Subtotal (sum of lines 1-6)	0	0				7. 00
8. 00	Reconciling Items		0				8.00
9. 00	Total (line 7 minus line 8)		0				9. 00
7.00	Total (Title / milius Title 0)	ı V	U	I			7.00

Worksheet A-8 From 01/01/2023 | Wul Kalleet A-0 | To 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	5/10/2024 11: 3	
			<u> </u>	Expense Classification on		
				To/From Which the Amount is		
					,	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1. 00	2. 00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-3, 746	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		C		0.00	2.00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		C		0.00	3.00
4.00	Rental of provider space by suppliers		C		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		C		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		C		0.00	6. 00
7.00	Parking Lot (chapter 21)		C		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	C			8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		C		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	10.00
11.00	Nonallowable costs related to certain		C		0.00	11. 00
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	-655, 999			12. 00
	related organizations (chapter 10)					
13.00	Laundry and linen service		C		0.00	13.00
14.00	Revenue - Employee meals		C		0.00	14.00
15.00	Cost of meals - Guests		C		0.00	15. 00
16.00	Sale of medical supplies to other than		C		0.00	16. 00
	patients					
17.00	Sale of drugs to other than patients		C		0.00	17. 00
18.00	Sale of medical records and abstracts		C		0.00	18. 00
19.00	Vending machines		C		0.00	19. 00
20.00	Income from imposition of interest, finance		C		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		C		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		C	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)					
23.00	Depreciationbuildings and fixtures		C	CAP REL COSTS - BLDGS &	1.00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE	2.00	24.00
				EQUI PMENT		
25.00	MI SCELLANEOUS EXPENSE	Α	-1, 500	ADMINISTRATIVE & GENERAL	4.00	25.00
25. 01	PATIENT TRANSPORT - NON-AMBULANCE	A	-45	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	RESIDENT REPLACEMENT ITEMS	A	-8, 057	ADMINISTRATIVE & GENERAL	4.00	25. 02
25.03	REFERAL FEES	A	6, 628	BADMINISTRATIVE & GENERAL	4.00	25. 03
25. 04	MARKETI NG EXPENSE	A	-37, 713	BADMINISTRATIVE & GENERAL	4.00	25. 04
25. 05	MARKETING CORP EXPENSE	A		ADMINISTRATIVE & GENERAL	1	25. 05
25. 06	MARKETING - MEALS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 07	SPONSORSHI PS	A		BADMINISTRATIVE & GENERAL	4.00	
25. 08	BAD DEBT EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 09	BAD DEBT EXPENSE - MEDICARE	A		BADMINISTRATIVE & GENERAL	4.00	
25. 10	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	
25. 11	RESIDENT PERSONAL ITEMS	В		ADMINISTRATIVE & GENERAL	4.00	
	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL		25. 12
	Total (sum of lines 1 through 99) (Transfer		-1, 297, 151			100. 00
	to Worksheet A, col. 6, line 100)		., = ,			
(1) De	scription - all chapter references in this co	lumn nertain to	CMS Pub 15_1	' 1	'	

⁽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 HANOVER TOWNSHIP

Health Financial Systems CARE ONE AT HANDSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315511 OFFICE COSTS

				Т	o 12/31/2023 Date/Time Pre 5/10/2024 11:	
		Li ne No.		Center	Expense Items	
		1. 00		00	3. 00	
	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:	1 00	CAP REL COSTS	- BLDGS &	RENT - RELATED PARTY	1.00
			FI XTURES	52500 u	TETT TEETTES THE T	
2.00		4. 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	2. 00
3. 00			ADMI NI STRATI VE		ANNUAL REPORT FEES	3. 00
4. 00		5. 00	PLANT OPERATIO	N, MAINT. &	MAINTENANCE SUPPLIES	4. 00
5. 00		0.00	REPAIRS NURSING ADMINI	CTDATION	PHARMACY CONSULTANT	F 00
6.00			CENTRAL SERVIC		WOUND CARE EXPENSE	5. 00 6. 00
7. 00			PHARMACY	L3 & SUFFLI	DRUGS-NON-PRESCRI PTI ON,	7.00
7.00		11.00			NON-LEGEND	7.00
8. 00		11. 00	PHARMACY		PHARMACY SUPPLIES	8. 00
9.00		42. 00	INTRAVENOUS TH	ERAPY	IV EXPENSE	9. 00
9. 01		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRI PTI ON, LEGEND	9. 01
			551100 01145055	TO DATE ENTO	DRUGS OTH	
9. 02		49.00	DRUGS CHARGED	10 PATTENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	9. 02
9. 03		49 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE	9. 03
7.03		47.00	DRUGS CHARGED	10 TATTENTS	A	7.03
10.00 1	FOTALS (sum of lines 1-9). Transfer column					10.00
	5, line 100 to Worksheet A-8, column 3, line					
	12.					
		Amount Allowable In	Amount Included in	Adjustments (col. 4 minus		
		Cost	Wkst. A, col.	col. 5)		
		0031	5	001. 0)		
		4. 00	5. 00	6. 00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
_	CLAIMED HOME OFFICE COSTS:					
1.00		1, 481, 994				1.00
2. 00 3. 00		508, 979 147	501, 771	7, 208 147		2.00
4. 00		Δ	1 0	147		4.00
5. 00		26, 614	28, 928	-2, 314		5.00
6. 00		40, 198				6. 00
7.00		12, 796	13, 909	-1, 113		7. 00
8. 00		554	602			8. 00
9. 00		151, 798	l			9. 00
9. 01		17, 155	1			9. 01
9. 02		72, 672				9. 02
9. 03 10. 00	TOTALS (sum of lines 1-9). Transfer column	115, 749 2, 428, 660				10.00
	5, line 100 to Worksheet A-8, column 3, line	2,420,000	3,004,009	-000, 999		10.00
	12.					
,		•	•	•	•	•

Worksheet A-8-1

From 01/01/2023 Parts I-II Date/Time Prepared: 12/31/2023 5/10/2024 11:35 am

 Symbol (1)	Name	Percentage of	
		Ownershi p	
1.00	2. 00	3. 00	

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

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

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

1.00	A	DANI EL STRAUS	41. 00	1.00
2.00	A	MOSHAEL STRAUS	5. 00	2.00
3.00	A	DES 2009 GST TRUST	9. 00	3.00
4.00	A	BETHIA STRAUS	2. 00	4.00
5. 00	A	JOEL JAFFE FAMILY TRUST	0.00	5. 00
6. 00	A	DES HOLDING CO. INC. & DES	43.00	6. 00
		2009 FAM		
7. 00	A	DANI EL STRAUS	41.00	7. 00
8. 00	A	DANI EL STRAUS	41.00	8. 00
9. 00	A	DES HOLDING CO. INC.	22. 00	9. 00
10. 00	F	PARTNERS PHARMACY SERVICES	0.00	10.00
		LLC		
100.00 G. Other (financial or non-financial)			0.00	100. 00
speci fy:				

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

		Rel ated Organi	zation(s) and/	or Home Office	
		Name	Percentage of Ownership	Type of Business	
		4.00	5. 00	6.00	1
PART I	I. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(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		101 WHI PPANY ROAD	41. 00 REALTY	1.00
2.00		101 WHI PPANY ROAD	5. 00 REALTY	2. 00
3.00		101 WHI PPANY ROAD	9. 00 REALTY	3. 00
4.00		101 WHI PPANY ROAD	2. 00 REALTY	4.00
5.00		101 WHI PPANY ROAD	O. OO REALTY	5. 00
6.00		101 WHI PPANY ROAD	43. 00 REALTY	6. 00
7.00		HEALTHBRIDGE MANAGEMENT LLC	100. 00 MANAGEMENT	7.00
8.00		TOTALCARE LLC	99.00 WOUND CARE	8. 00
9.00		TOTALCARE LLC	1.00WOUND CARE	9. 00
10.00		PARTNERS PHARMACY LLC	100.00 PHARMACY	10.00
100.00	G. Other (financial or non-financial)		0.00	100. 00
	speci fy:			

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315511

			То	12/31/2023	Date/Time Prep 5/10/2024 11:	
		CAPITAL REL	ATED COSTS		07 107 2021 11.	30 4111
Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
	for Cost	FIXTURES	EQUI PMENT	BENEFITS		
	Allocation (from Wkst A					
	col. 7)					
OFFICE ASSESSMENT OFFICE OFFICE OF THE OFFICE OF THE OFFICE OFFIC	0	1. 00	2. 00	3. 00	3A	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FLXTURES	1, 800, 236	1, 800, 236				1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	165, 419	1, 000, 200	165, 419			2. 00
3.00 00300 EMPLOYEE BENEFITS	1, 039, 606	0	0	1, 039, 606		3. 00
4.00 OO400 ADMINISTRATIVE & GENERAL 5.00 OO500 PLANT OPERATION, MAINT. & REPAIRS	1, 844, 754	76, 973	7, 073	106, 524	2, 035, 324	4. 00 5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	488, 969 159, 676	158, 814 21, 330	14, 593 1, 960	7, 956 17, 272	670, 332 200, 238	6. 00
7. 00 00700 HOUSEKEEPI NG	293, 848	0	0	48, 619	342, 467	7. 00
8. 00 00800 DI ETARY	665, 270	152, 508	14, 014	71, 869	903, 661	8. 00
9.00 00900 NURSI NG ADMINI STRATI ON 10.00 01000 CENTRAL SERVI CES & SUPPLY	530, 138 110, 031	13, 772	1, 265	84, 194	629, 369 110, 031	9. 00 10. 00
11. 00 01100 PHARMACY	13, 350	o	ő	o	13, 350	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	11, 963	1, 099	0	13, 062	12.00
13. 00 01300 SOCIAL SERVICE	66, 431	10, 201	937	12, 633	90, 202 0	13. 00 14. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITES	59, 122	22, 535	2, 071	8, 994	92, 722	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS		,,	_,	5,		
30. 00 03000 SKILLED NURSING FACILITY	2, 787, 810	1, 286, 096	118, 176	520, 516	4, 712, 598	30.00
31.00 03100 NURSING FACILITY 32.00 03200 CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00 03300 OTHER LONG TERM CARE		o	0	o	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	7, 808 15, 612	0	0	0	7, 808 15, 612	40. 00 41. 00
42. 00 04200 I NTRAVENOUS THERAPY	151, 798	ol	0	0	151, 798	41.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	o	0	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	445, 813	12, 102	1, 112	83, 133	542, 160	44.00
45.00 04500 OCCUPATI ONAL THERAPY 46.00 04600 SPEECH PATHOLOGY	308, 342 104, 164	12, 102 12, 102	1, 112 1, 112	58, 638 19, 258	380, 194 136, 636	45. 00 46. 00
47. 00 04700 ELECTROCARDI OLOGY	104, 104	12, 102	1, 112	14, 230	130, 030	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o	0	0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	205, 576	0	0	0	205, 576	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES		0	0	0	0	50. 00 51. 00
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	o o	Ö	0	Ö	0	52. 00
52. 01 05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02 05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	52. 02
60. 00 06000 CLI NI C	0	0	0	0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	o	o	0	0	0	61.00
62. 00 06200 FOHC					0	62. 00
63. 00 06300 DI ALYSI S OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	U	<u> </u>	0	63. 00
70.00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	91, 745	0	0	0	91, 745	71.00
73. 00 07300 CMHC 74. 00 07400 OTHER REI MBURSEMENT	0	0	0	0	0	73. 00 74. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	o _l		0	7 1. 00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 08100 INTEREST EXPENSE 82.00 08200 UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00 08300 HOSPI CE	o	o	0	0	0	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST I	O	o	0	0	0	84.00
84. 01 08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	11, 355, 518	1, 790, 498	164, 524	1, 039, 606	11, 344, 885	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	3, 497	0	0	0	3, 497	90.00
91.00 09100 BARBER AND BEAUTY SHOP	7, 366	9, 738	895	0	17, 999	91. 00
92.00 09200 PHYSI CI ANS PRI VATE OFFI CES 93.00 09300 NONPAI D WORKERS	0	0	0	0	0	92. 00 93. 00
94. 00 09400 PATI ENTS LAUNDRY		ol Ol	0	0	0	93.00
95.00 09500 OTHER NONREIMBURSABLE COST		o	o	ō	0	95.00
98.00 Cross Foot Adjustments	0	0	0	0	0	98. 00
99.00 Negative Cost Centers 100.00 TOTAL	11, 366, 381	0 1, 800, 236	165, 419	1, 039, 606	0 11, 366, 381	99. 00 100. 00
· · · · · · · · · · · · · · · · · · ·	, 500, 001	., 300, 200	.00, .17	., 307, 600	, 500, 001	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315511 | Peri od: | From 01/01/202

| Peri od: | Worksheet B | From 01/01/2023 | Part | 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	35 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, 035, 324					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	146, 215	816, 547	•			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	43, 677	11, 133	1	l l		6. 00
7.00	00700 HOUSEKEEPI NG	74, 700	70.400	1	,	1 221 (00	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	197, 110 137, 280	79, 600 7, 188	1	41, 229 3, 723	1, 221, 600 0	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	24, 000	7, 100	1	3, 723	0	10.00
11. 00	01100 PHARMACY	2, 912	0		ol ol	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	2, 849	6, 244	C	3, 234	0	12. 00
13.00	01300 SOCIAL SERVICE	19, 675	5, 324	. c	2, 758	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	20, 225	11, 762	2 C	6, 092	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 007 000	/74 0/0	055.040	0.47 (0.0	4 004 (00	00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	1, 027, 929	671, 263	255, 048	347, 683	1, 221, 600 0	30. 00 31. 00
32. 00	03200 CF/IID	0	0			0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	1	-	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		,	1 o		00.00
40.00	04000 RADI OLOGY	1, 703	0) C	0	0	40. 00
41.00	04100 LABORATORY	3, 405	0) c	o	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	33, 111	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	118, 258	6, 317	1	-,	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	82, 929	6, 317	•	0,2,2	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	29, 804	6, 317		3, 272	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	44, 841	0		ol ol	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	o c	o	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		0	0) C	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0) C	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		-	0	61. 00
62. 00	06200 FQHC		O	,	Ĭ	O	62. 00
63.00	06300 DI ALYSI S	0	0) c	o	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0		-	0	70. 00
	07100 AMBULANCE	20, 012	0	0	0	0	71. 00
	07300 CMHC	0	0		0	0	73.00
74. 00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	<u> </u>	0) <u> </u>	ıl U	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			I			80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE	0	0) c	o	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0) C	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	2, 030, 635	811, 465	255, 048	414, 535	1, 221, 600	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	763) C	ا	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	3, 926	5, 082		-	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0, 720	0,002			0	92. 00
93. 00	09300 NONPALD WORKERS		0		ol ol	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0) c	ol	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0) C	o o	0	95. 00
98. 00	Cross Foot Adjustments	0	0) C	이	0	98. 00
99.00	Negative Cost Centers	0	01/ 543	0	0	1 221 400	99.00
100.00	D TOTAL	2, 035, 324	816, 547	255, 048	417, 167	1, 221, 600	100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315511

				'`	J 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINI STRATTON	SUPPLY		LI BRARY		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPING						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	777, 560					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	134, 031				10. 00
11. 00	01100 PHARMACY	0	0	16, 262			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	25, 389		12.00
13.00	01300 SOCIAL SERVICE	0	0	0	0	117, 959	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						
30. 00	03000 SKILLED NURSING FACILITY	777, 560	134, 031	16, 262	25, 389	117, 959	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 I CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	U	0	U	0	33. 00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	Ö	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	o o	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	0	0	0	Ö	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	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01 52. 02	05201 OTHER ANCILLARY SERVICES COST		0] 0	0	0	52. 01 52. 02
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	<u> </u>	U	U	U	U	52. 02
60. 00	06000 CLINIC	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	o o	0	0	0	Ö	61. 00
62. 00	06200 FQHC		J	J	ŭ		62. 00
63.00	06300 DI ALYSI S	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
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
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REI MBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID 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 HOSPI CE		0	0	Ō	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I		0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	o o	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	777, 560	134, 031	16, 262	25, 389	-	89. 00
	NONREI MBURSABLE COST CENTERS	,,	,			,	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98. 00	Cross Foot Adjustments	0	0		0		98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	0 777, 560	134, 031	16, 262	25, 389	0 117, 959	99.00
100.00	, ITOTAL	111,000	134, 031	10, 202	20, 369	117, 939	100.00

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

Part I

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/10/2024 11:35 am OTHER GENERAL SERVI CE NURSING AND ACTI VI TES Post Stepdown Total Cost Center Description Subtotal ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TES 15.00 0 130, 801 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 130, 801 9, 438, 123 0 9, 438, 123 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 0 32.00 0 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 O 33 00 Ω 0 0 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 9, 511 9, 511 40.00 0 41.00 04100 LABORATORY 000000000000 0 19,017 19,017 41.00 04200 I NTRAVENOUS THERAPY 184, 909 42 00 42 00 Ω 184, 909 0 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 04400 PHYSI CAL THERAPY 670,007 0 670,007 44.00 44.00 0 04500 OCCUPATIONAL THERAPY 472, 712 472, 712 45.00 45.00 04600 SPEECH PATHOLOGY 46.00 Ω 176, 029 176, 029 46.00 0 47.00 04700 ELECTROCARDI OLOGY 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 48 00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 250, 417 250, 417 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 C Λ 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 0 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 52.01 0 0 52.01 C 0 52.02 05202 MEDICAL SERVICES O 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 Λ 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 0 o 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 111, 757 0 111, 757 71.00 0 o 73.00 07300 CMHC 73.00 C 0 C07400 OTHER REIMBURSEMENT 0 74.00 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 0 0 83.00 0 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 84.00 0 84 01 08401 OTHER SPECIAL PURPOSE COST II 0 O 0 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 0 130, 801 11, 332, 482 0 11, 332, 482 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 4, 260 0 4, 260 90.00 09100 BARBER AND BEAUTY SHOP 0 91 00 000000 29, 639 29, 639 91 00 Ω 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 92.00 09300 NONPALD WORKERS 0 0 93.00 93.00 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 O 09500 OTHER NONREIMBURSABLE COST 95 00 95 00 Ω 0 0 98.00 Cross Foot Adjustments C 0 0 98.00 0 99.00 Negative Cost Centers 99.00 100.00 TOTAL 130, 801 11, 366, 381 ol 11, 366, 381 100. 00

Peri od:

1, 965, 655

0 100.00

165, 419

ALLOCATION OF CAPITAL RELATED COSTS

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:35 am CAPITAL RELATED COSTS Directly BLDGS & MOVABLE Subtotal **EMPLOYEE** Cost Center Description Assigned New **FLXTURES FOUL PMENT BENEFITS** Capi tal Related Costs 1.00 2.00 2A 3.00 0 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 0 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 0 0 0 76, 973 7,073 84, 046 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5 00 158, 814 14 593 173 407 5 00 0 00600 LAUNDRY & LINEN SERVICE 6.00 21, 330 1,960 23, 290 0 6.00 7.00 00700 HOUSEKEEPI NG 7.00 00800 DI ETARY 0 0 8.00 8 00 152 508 14 014 166 522 0 00900 NURSING ADMINISTRATION 9.00 13, 772 1, 265 15, 037 0 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 0 0 0 11.00 C 0 01200 MEDICAL RECORDS & LIBRARY 11, 963 1,099 13 062 12 00 12 00 01300 SOCIAL SERVICE 13.00 10, 201 937 11, 138 0 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 14.00 01500 ACTI VI TES 15.00 15.00 22, 535 2,071 24,606 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 1, 286, 096 118, 176 1, 404, 272 0 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 03200 | CF/IID 0 0 0 32.00 32.00 0 0 03300 OTHER LONG TERM CARE 0 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 0 40.00 04000 RADI OLOGY 0 0 0 40.00 0 04100 LABORATORY 41.00 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY O 42.00 Ω 0 0 42 00 04300 OXYGEN (INHALATION) THERAPY 43.00 43.00 0 0 0 0 0 04400 PHYSI CAL THERAPY 44.00 12, 102 1, 112 13, 214 44.00 04500 OCCUPATIONAL THERAPY 12, 102 1, 112 13, 214 45.00 45.00 0 46.00 04600 SPEECH PATHOLOGY 12, 102 1, 112 13, 214 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49 00 49 00 C Λ 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 05100 SUPPORT SURFACES 0 51.00 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 52.00 52.00 0 0 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 0 0 52.01 52.02 05202 MEDICAL SERVICES 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 60.00 0 Ω 0 0 Λ 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 DI ALYSI S 63.00 63.00 0 0 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 07100 AMBULANCE 0 0 0 71.00 0 0 71.00 0 o 73 00 107300 CMHC Ω 0 73.00 0 74.00 07400 OTHER REIMBURSEMENT 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81 00 81 00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 H0SPI CE 83.00 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 84.00 08401 OTHER SPECIAL PURPOSE COST II 0 84.01 0 84 01 89.00 SUBTOTALS (sum of lines 1-84) 1, 790, 498 164, 524 1, 955, 022 0 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 09100 BARBER AND BEAUTY SHOP 0 9,738 895 10, 633 91.00 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 92.00 C 0 93.00 09300 NONPALD WORKERS 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 94.00 94.00 C 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 95.00 0 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 0

1,800,236

TOTAL

100.00

				T	o 12/31/2023	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/10/2024 11: DI ETARY	35 am
		& GENERAL	OPERATION, MAINT. &	LINEN SERVICE			
			REPAI RS				
	1	4.00	5. 00	6. 00	7. 00	8. 00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			1 00
1. 00 2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	84, 046					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	6, 038	179, 445	1			5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	1, 804 3, 085	2, 447 0	1	3, 085		6. 00 7. 00
8. 00	00800 DI ETARY	8, 139	17, 493	1	3, 085	192, 459	8.00
9. 00	00900 NURSING ADMINISTRATION	5, 669	1, 580	1	28	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	991	0	0	o	0	10.00
11. 00	01100 PHARMACY	120	0	0	0	0	11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	118 812	1, 372 1, 170	i	24 20	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	012	1, 170	0	0	0	14.00
15. 00	01500 ACTIVITES	835	2, 585	ő	45	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	42, 448	147, 517		2, 572	192, 459	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0	0		0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		0			0	33. 00
	ANCILLARY SERVICE COST CENTERS	-			- 1		
40. 00	04000 RADI OLOGY	70	0	_		0	40. 00
41. 00	04100 LABORATORY	141	0	0	0	0	41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	1, 367	0	0	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	4, 883	1, 388	0	24	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	3, 424	1, 388		24	0	45. 00
46.00	04600 SPEECH PATHOLOGY	1, 231	1, 388	0	24	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	1, 852	0	0	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	1, 852	0	0		0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	ő	o	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	o	0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0		0	52. 01
52. 02	05202 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	52. 02
60. 00	06000 CLINIC	l ol	0	0	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	Ö	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 07000 HOME HEALTH AGENCY COST	l ol	0	0	ol	0	70. 00
	07100 AMBULANCE	826	0		· ·		71.00
73. 00	07300 CMHC	0	0	0	o	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS			I			00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF			•			82.00
83. 00	08300 H0SPI CE	0	0	О	o	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	o	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)	83, 853	178, 328	27, 541	3, 066	192, 459	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	31	0	0	٥١	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	162	1, 117	_		0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	. 0	0	l .	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments	0	0	0	0	0	95. 00 98. 00
99. 00	Negative Cost Centers	0	0	0		0	99.00
100.00		84, 046	179, 445	27, 541	3, 085		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS CARE ONE AT HANOVER TOWNSHIP Provi der No.: 315511

				To	12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	00 4111
	·	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LIBRARY		
	CENEDAL CEDVICE COCT CENTEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	22, 314					9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	991				10. 00
11. 00	01100 PHARMACY	0	0	120	44.57/		11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	14, 576	10 140	12.00
13. 00 14. 00	01300 SOCIAL SERVICE	0	0	0	0	13, 140 0	13. 00 14. 00
15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	0	0	0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	O	0	<u> </u>	0	13.00
30. 00	03000 SKILLED NURSING FACILITY	22, 314	991	120	14, 576	13, 140	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200 CF/IID	o	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0		0	0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	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	l o	0	Ö	Ö	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o	0	o	O	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	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
40.00	OUTPATIENT SERVICE COST CENTERS		0		O	0	(0.00
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC	١	U	U	U	0	62.00
63. 00	06300 DI ALYSI S	o	0	0	0	0	63.00
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	<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	o	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74.00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID 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 HOSPI 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	l o	0	Ö	Ö	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	22, 314	991	120	14, 576	13, 140	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	j Š	0	0	93.00
94. 00 95. 00	09400 PATIENTS LAUNDRY		0	0	0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments		0		Y	U	95. 00 98. 00
99. 00	Negative Cost Centers		0		n	0	99.00
100.00	1 1 9	22, 314	991	120	14, 576		100.00
	•			1	.,		

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

Part II

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/10/2024 11:35 am OTHER GENERAL SERVI CE NURSING AND ACTI VI TES Post Step-Down Total Cost Center Description Subtotal ALLIED HEALTH Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 ACTI VI TES 15.00 0 28, 071 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 28, 071 1, 896, 021 0 1, 896, 021 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 0 32.00 0 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 O O 33 00 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 70 70 40.00 0 0 41.00 04100 LABORATORY 000000000000 0 141 141 41.00 04200 I NTRAVENOUS THERAPY 42 00 42 00 Ω 1, 367 1, 367 0 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 Ω 04400 PHYSI CAL THERAPY 19, 509 0 19, 509 44.00 44.00 0 04500 OCCUPATIONAL THERAPY 45.00 18, 050 18, 050 45.00 04600 SPEECH PATHOLOGY 46.00 Ω 15, 857 15, 857 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 C 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 1,852 1,852 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 C Ω 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 0 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 0 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 0 52.01 C 0 05202 MEDICAL SERVICES 52.02 O 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 61.00 0 C 0 0 61.00 Λ 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 826 0 826 71.00 0 o 73.00 07300 CMHC C 73.00 0 0 07400 OTHER REIMBURSEMENT 0 74.00 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 C 0 0 83.00 0 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 84 01 08401 OTHER SPECIAL PURPOSE COST II 0 O 0 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 0 28,071 1, 953, 693 0 1, 953, 693 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 31 31 90.00 0 09100 BARBER AND BEAUTY SHOP 0 91 00 000000 11, 931 11, 931 91 00 Ω 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 92.00 09300 NONPALD WORKERS 0 93.00 93.00 0 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST O 95 00 95 00 Ω 0 0 98.00 Cross Foot Adjustments C 0 0 98.00 0 99.00 Negative Cost Centers 99.00 100.00 TOTAL 28.071 1, 965, 655 1, 965, 655 100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315511

				Т	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
		CAPITAL REL	ATED COSTS			07 107 202 1 11.	oo uiii
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		,	`	SALARI ES)		, ,	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4A	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	38, 824					1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	_	38, 824				2. 00
3. 00 4. 00	OO300	1, 660	0 1, 660	5, 466, 637		9, 331, 057	3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	3, 425		560, 142 41, 835		670, 332	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	460	460	90, 823		200, 238	6. 00
7. 00	00700 HOUSEKEEPI NG	0	0	255, 657		342, 467	7. 00
8. 00 9. 00	OO8OO DI ETARY OO9OO NURSI NG ADMI NI STRATI ON	3, 289 297	3, 289 297	377, 915 442, 724		903, 661 629, 369	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	297	297	442, 724		110, 031	10.00
11. 00	01100 PHARMACY	0	O	0	C	13, 350	1
12.00	01200 MEDICAL RECORDS & LIBRARY	258	258	0	C	13, 062	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	220	220	66, 431		90, 202	13. 00 14. 00
15. 00	01500 ACTIVITES	486	486	47, 293		1	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1		
30. 00 31. 00	03000 SKI LLED NURSI NG FACILITY	27, 736	27, 736	2, 737, 067	C		30.00
31.00	03100 NURSING FACILITY 03200 CF/IID	0	0	0		0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	Ö	0	C	1	33. 00
	ANCILLARY SERVICE COST CENTERS	1 -			I -		
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	0	0	C	1,	40. 00 41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0		151, 798	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	C	0	43.00
44. 00	04400 PHYSI CAL THERAPY	261	261	437, 144		542, 160	44.00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	261 261	261 261	308, 342 101, 264		380, 194 136, 636	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	C	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	0	C	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	C	205, 576	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0		0	50. 00 51. 00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	Ö	0	C	o o	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	C	0	52. 01
52. 02	05202 MEDICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0	0	0	C) 0	52. 02
60. 00	06000 CLINIC	0	O	0	C	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	O	0	C	0	61. 00
62.00	06200 FQHC			0			62.00
63. 00	06300 DI ALYSI S OTHER REIMBURSABLE COST CENTERS	0	0	0	C	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	C	'l	
	07100 AMBULANCE	0	0	0	C	91, 745	
73. 00 74. 00	07300 CMHC 07400 OTHER REI MBURSEMENT	0	0 0	0		0	
, 00	SPECIAL PURPOSE COST CENTERS		9			,	7 00
80.00	08000 MALPRACTICE PREMIUMS & PAID 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 HOSPI CE	0	0	0	C	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	o	0	C	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	2 025 224	0 200 5(1	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	38, 614	38, 614	5, 466, 637	-2, 035, 324	9, 309, 561	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	C	3, 497	90. 00
	09100 BARBER AND BEAUTY SHOP	210	210	0	C	17, 999	
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0		0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	C	o o	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	О	0	C	0	95. 00
98. 00	Cross Foot Adjustments						98. 00 99. 00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 800, 236	165, 419	1, 039, 606		2, 035, 324	
	Part I)						
103.00		46. 369153	4. 260741	0. 190173		0. 218124	
104.00	Cost to be allocated (per Wkst. B, Part II)			0		84, 046	104.00
	1	1	'		ı	1	•

Health Financial Systems	CARE ONE AT HAN	NOVER TOWNSHIP		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Prep 5/10/2024 11:	pared: 35 am
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL	
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
			SALARI ES)			
	1.00	2.00	3.00	4A	4.00	
105.00 Unit cost multiplier (Wkst. B, Part			0.00000	D	0. 009007	105. 00

	Cost Center Description	PLANT OPERATION,	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/10/2024 11: NURSI NG	
		I OPFRATION					
			LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(PATIENT DAYS)			(PATIENT DAYS)	
		(SQUARE FEET)				(
-		5. 00	6. 00	7. 00	8. 00	9. 00	
	SENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
	00200 CAP REL COSTS - BLDGS & FIXTURES						2.00
	00300 EMPLOYEE BENEFITS						3. 00
	00400 ADMINISTRATIVE & GENERAL						4. 00
1	00500 PLANT OPERATION, MAINT. & REPAIRS	33, 739	l .				5. 00
	00600 LAUNDRY & LINEN SERVICE	460	27, 102				6.00
	00700 HOUSEKEEPI NG	0	0	33, 279			7.00
1	00800 DIETARY 00900 NURSING ADMINISTRATION	3, 289 297	0	3, 289 297	81, 306	27, 102	8. 00 9. 00
	01000 CENTRAL SERVICES & SUPPLY	0	Ö	0	0	0	1
11.00 0	01100 PHARMACY	0	0	0	0	0	11.00
	01200 MEDICAL RECORDS & LIBRARY	258		258	0	0	
	01300 SOCIAL SERVICE	220	0	220	0	0	
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0 486	0	0 486	0	0	
_	NPATIENT ROUTINE SERVICE COST CENTERS	400	0	400	0	0	15.00
	03000 SKILLED NURSING FACILITY	27, 736	27, 102	27, 736	81, 306	27, 102	30.00
	03100 NURSING FACILITY	0	0	0	0	0	1
1	03200 CF/IID	0	0	0	0		•
	03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
	NCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY				0	0	40.00
	04100 LABORATORY	0	0	0	0		
	04200 I NTRAVENOUS THERAPY	0	Ö	ő	0	Ö	
43.00 0	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
	04400 PHYSI CAL THERAPY	261	0	261	0	0	
	04500 OCCUPATI ONAL THERAPY	261	0	261	0	0	1
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	261	0	261 0	0	0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		
	04900 DRUGS CHARGED TO PATIENTS	0	Ö	Ö	0	Ö	
50.00 0	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
	05100 SUPPORT SURFACES	0	0	0	0	0	
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	
	05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES	0		0	0	0	
<u> </u>	DUTPATIENT SERVICE COST CENTERS	0	0] 0	0	0	32.02
	06000 CLI NI C	0	0	0		0	60.00
61.00 0	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
	06200 FQHC						62. 00
	06300 DI ALYSI S	0	0	0	0	0	63. 00
_	OTHER REIMBURSABLE COST CENTERS OTOOO HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	07100 AMBULANCE						
1	07300 CMHC	0		Ō	-	0	
	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS	İ	1				
1	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00
	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPI CE	0	0	0	0	0	1
84. 00 0	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	33, 529	27, 102	33, 069	81, 306	27, 102	89. 00
	IONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	210		210		0	
	09200 PHYSICIANS PRIVATE OFFICES	0	Ö	0	Ö	ő	
	9300 NONPALD WORKERS	0	0	0	0	0	
	9400 PATIENTS LAUNDRY	0	0	0	0	0	
	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98.00
102.00	Cost to be allocated (per Wkst. B,	816, 547	255, 048	417, 167	1, 221, 600	777, 560	
102.00	Part I)	010, 347	255, 046	417, 107	1, 221, 000	,,,,,,,,,,	1.02.00
103. 00	Unit cost multiplier (Wkst. B, Part I)	24. 201873	l .	12. 535443		28. 690134	
104. 00	Cost to be allocated (per Wkst. B,	179, 445	27, 541	3, 085	192, 459	22, 314	104.00
10E 00	Part II)	E 210/22	1 01/100	0.002701	2 2/7005	0.000004	105 00
105.00	Unit cost multiplier (Wkst. B, Part	5. 318622	1. 016198	0. 092701	2. 367095	0. 823334	105.00
			1	1	İ	1	1

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

Cost Centrer Description							5/10/2024 11:	
Company Comp		Cost Center Description				SOCIAL SERVICE		
				(PATTENT DAYS)		(DATIENT DAVE)		
						(FAITENT DATS)		
FUND STREAM STRIVET COST CENTERS			((
1.00 DUSIDE CAP FILL CESTS - PURISS & FIXINES 2.00			10.00	11. 00	12.00	13.00	14. 00	
2.00 DODGO LAND PRICE ISS - MOWABLE LOUPHENIN 3.00 DODGO LAND PRICE ISS - MOWABLE LOUPHENIN 3.30 DOGGO LAND PRICE	1 00							1 00
3.00 000000								
4.00 0.000 ADMINISTRATIVE & CENERAL		1						
5.00		1						
0.000 0.0000 LAURDEY A LITENS SERVICE 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000					•			
0.000 0.000 DETARY	6.00							6.00
0.000 0.0000 DIRESTING ABUNINSTRATION	7.00	00700 HOUSEKEEPI NG						7. 00
10.00 01000 CENTRAL SERVICES & SUPPLY 27, 102 10.00 10100 MARBIACY 0 27, 102 12.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 0								
11.00 01100								
12.00 07200 MEDICAL RECORDS & LIBRARY 0 0 0 27,102 13,00 1300 01400 01400 01400 0 0 0 0 0 0 0 0 0			27, 102	27 102				
13.00 01300 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0			0	27, 102	1			
14.00 01400 MURSING AND ALLIED HEACHT EDUCATION 0 0 0 0 0 0 15.00			0	0	1			
15.00 0.500 ACTIVITES 0.0 0			0	0	1		0	
IMPATIENT ROUTINE SERVICE COST CENTERS				0		0		1
31.00		INPATIENT ROUTINE SERVICE COST CENTERS						
32.00 03200 CEP/II D	30.00	03000 SKILLED NURSING FACILITY	27, 102	27, 102	27, 102	27, 102	0	30.00
33.00 03300 THER LONG TERM CARE		l l	0	0	0	0		
MINISTRATE SERVICE COST CENTERS		1		0		0		
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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315511

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19.00			Cost Center Description			
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Health Financial Systems	CARE ONE AT HANOVER	TOWNSHI P	In Lieu	ı of Form CMS-2540-10
RATIO OF COST TO CHARGES FO	R ANCILLARY AND OUTPATIENT COST CENTERS	Provi der No.: 315511	Peri od:	Worksheet C

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/10/2024 11:35 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col . 18 col. 2 3. 00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 9, 511 19, 520 0. 487244 40.00 04100 LABORATORY 19,017 39, 030 0. 487241 41.00 41.00 0. 448270 42.00 04200 I NTRAVENOUS THERAPY 184, 909 412, 495 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 670,007 1, 466, 290 0.456940 44.00 04500 OCCUPATIONAL THERAPY 1, 534, 374 45.00 472, 712 0.308081 45.00 04600 SPEECH PATHOLOGY 176, 029 758, 862 0. 231964 46.00 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 250, 417 558, 630 0.448270 49.00 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0.000000 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0 0.000000 0 52.01 05202 MEDICAL SERVICES 0 0.000000 52.02 52.02 OUTPATIENT SERVICE COST CENTERS 0 0 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 229, 362 111, 757 0. 487252 71.00

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Total

ealth Financial Systems PPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS	CARE ONE AT HAN		No.: 315511	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared 35 am
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pr	rogram Charge		Program Cost	
	Ratio of Cost to Charges	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	(Fr. Wkst. C				ŕ	
	Col umn 3) 1.00	2.00	3.00	4. 00	5. 00	
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1. 00 04100 LABORATORY	0. 487241			0 9, 293		41. (
2. 00 04200 INTRAVENOUS THERAPY	0. 448270	38, 559		0 17, 285	0	42.
3.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.
4. 00 04400 PHYSI CAL THERAPY	0. 456940	623, 935		0 285, 101	0	44.
5. 00 04500 OCCUPATIONAL THERAPY	0. 308081	590, 490		0 181, 919	0	45.
6.00 04600 SPEECH PATHOLOGY	0. 231964	278, 874		0 64, 689	0	46.
7. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.
8.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48.
9.00 04900 DRUGS CHARGED TO PATIENTS	0. 448270	77, 538		0 34, 758	0	49.
O.OO 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.
1.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.
2.00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000	0		0 0	0	52.
2. 01 05201 OTHER ANCILLARY SERVICES COST	0. 000000			0	0	
2. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52.
OUTPATIENT SERVICE COST CENTERS						
0. 00 06000 CLI NI C	0. 000000	0		0	0	1 00.
1. 00 06100 RURAL HEALTH CLINIC						61.
2. 00 06200 FQHC	0.000000					62.
3. 00 06300 DI ALYSI S	0. 000000			0 0		63.
1. 00 07100 AMBULANCE (2)	0. 487252			0 594 754		71.
00.00 Total (Sum of lines 40 - 71) 1) For title V and XIX use columns 1, 2, and 4 or		1, 631, 977		0 594, 754	l 0	100.

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

Heal th	Financial Systems (CARE ONE AT HAN	OVER TOWNSHIP		In lie	eu of Form CMS-2	2540-10
	I ONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315511	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III Date/Time Prep 5/10/2024 11:3	pared:
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
	PART II - APPORTIONMENT OF VACCINE COST					1. 00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C column 3	line 49)	0. 448270	1. 00
2.00	Program vaccine charges (From your reco			,	,,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	vi ders, transfo	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health (From Wkst. B,		Cost (From h Wkst. D Part	& Allied Health Costs	
		18		Costs to Tota		for Pass	
		10		Costs to Tota		Through (Col.	
				(Col. 2 / Col		3 x Col . 4)	
				1)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS		i				
40. 00	04000 RADI OLOGY	9, 511	0	0.0000			40. 00
41.00	04100 LABORATORY	19, 017		0.00000		0	41.00
42.00	04200 I NTRAVENOUS THERAPY	184, 909	0	0.00000		1	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	(70.007	0	0. 00000 0. 00000		0	43. 00 44. 00
45. 00	04500 OCCUPATIONAL THERAPY	670, 007 472, 712	l e	0.00000			45. 00
46. 00	04600 SPEECH PATHOLOGY	176, 029	l e	0.00000			46. 00
	04700 ELECTROCARDI OLOGY	170,029	0	0.00000			47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000		l ől	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	250, 417	Ö	0.00000		Ö	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	O	0.00000		O	50.00
51.00	05100 SUPPORT SURFACES	0	0	0. 00000	00	0	51. 00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0.00000		0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0. 00000		0	
	05202 MEDI CAL SERVI CES	0	0	0. 00000		0	
100.00	Total (Sum of lines 40 - 52)	1, 782, 602	0	1	594, 754	, 0	100. 00

	Financial Systems CARE ONE AT HANOVER	TOWNSHI P	In Lie	u of Form CMS-2	2540-1
			From 01/01/2023 To 12/31/2023		pared:
				5/10/2024 11:	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				1
. 00	Inpatient days including private room days			27, 102	1.0
2. 00	Private room days			0	
. 00	Inpatient days including private room days applicable to the Pr			5, 392	1
. 00	Medically necessary private room days applicable to the Program	l		0	•
. 00	Total general inpatient routine service cost			9, 438, 123	5.0
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges			12, 197, 859	6.0
. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 773752	
. 00	Enter private room charges from your records	vided by Title 0)		0.773732	8.0
2.00 Average private room per diem charge (Private room charges line 8 divided by private room days, line				0.00	
	2)	b a.v. asa sy pvats	. com dayo,c	0.00	/. 0
0. 00	Enter semi-private room charges from your records			0	10.0
1. 00	Average semi-private room per diem charge (Semi-private room c	harges line 10, divide	d by	0.00	11. 0
	semi -private room days)				
2.00	Average per diem private room charge differential (Line 9 minus			l	12. 00 13. 00
3. 00 4. 00	Average per diem private room cost differential (Line 7 times I Private room cost differential adjustment (Line 2 times line 13			0.00	14.0
	General inpatient routine service cost net of private room cost		minus line 14)	9, 438, 123	
0. 00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Eine 6	iii nas i i ne i i j	7, 100, 120	10.0
6. 00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		348. 24	16.0
7. 00	Program routine service cost (Line 3 times line 16)	•		1, 877, 710	17.0
8. 00	Medically necessary private room cost applicable to program (I			0	
9. 00	Total program general inpatient routine service cost (Line 17			1, 877, 710	
0. 00	Capital related cost allocated to inpatient routine service cos	ts (From Wkst. B, Par	t II column 18,	1, 896, 021	20. 0
1. 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1)			69. 96	21. 0
2. 00	Program capital related costs (Line 3 times line 21)			377, 224	
3. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 500, 486	
1. 00					24.0
5. 00	Total program routine service costs for comparison to the cost		nus line 24)	1, 500, 486	
5. 00	Enter the per diem limitation (1)	, a = -		, ,	26.0
7. 00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)		27.0
3. 00	Reimbursable inpatient routine service costs (Line 22 plus the	lesser of line 25 or	line 27)		28. C
	(Transfer to Worksheet E, Part II, line 4) (See instructions)				l
1) Li	nes 26 and 27 are not applicable for title XVIII, but may be use	ed for title V and or t	itle XIX		
				1. 00	

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	27, 102	1.00
2.00	Program inpatient days (see instructions)	5, 392	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. 198952	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

	Financial Systems CARE ONE AT HANGATION OF INPATIENT ROUTINE COSTS	OVER TOWNSHIP Provi der No.: 315511	Peri od: 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				4
00	Inpatient days including private room days			27, 102	
00	Private room days	- D		17.14/	
00 00	Inpatient days including private room days applicable to th Medically necessary private room days applicable to the Pro			17, 146 0	
00	Total general inpatient routine service cost	gi alli		9, 438, 123	
50	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			7, 430, 123	~
00	General inpatient routine service charges			12, 197, 859	6
00	General inpatient routine service cost/charge ratio (Line	5 divided by line 6)		0. 773752	7
00					8
00	Average private room per diem charge (Private room charges 2)	line 8 divided by private	room days, line	0. 00	9
00	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private rosemi-private room days)		ed by	0.00	
00	Average per diem private room charge differential (Line 9 m	,		0.00	
00	Average per diem private room cost differential (Line 7 tim			0.00	
00	Private room cost differential adjustment (Line 2 times lin			0 420 122	
00	General inpatient routine service cost net of private room PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	minus iine 14)	9, 438, 123	15
00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		348. 24	1 16
00	Program routine service cost (Line 3 times line 16)	divided by Time 1)		5, 970, 923	
00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0, 770, 720	1
00	Total program general inpatient routine service cost (Line			5, 970, 923	
00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	1, 896, 021	20
00	Per diem capital related costs (Line 20 divided by line 1)			69. 96	21
00	Program capital related cost (Line 3 times line 21)			1, 199, 534	
00	Inpatient routine service cost (Line 19 minus line 22)			4, 771, 389	
00	Aggregate charges to beneficiaries for excess costs (From			0	1
00	Total program routine service costs for comparison to the c	ost limitation (Line 23 mi	nus iine 24)	4, 771, 389	
00	Enter the per diem limitation (1)	por diam limitation line	26) (1)	0.00	
. 00					

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	27, 102	1.00
2.00	Program inpatient days (see instructions)	17, 146	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. 632647	4. 00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	CARE ONE AT HANOVER	TOWNSHI P	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	R TITLE XVIII	Provi der No.: 315511	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:35 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMFNT		1.00	
1.00	Inpatient PPS amount (See Instructions)			3, 968, 169	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	3		3, 968, 169	
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			556, 000	5. 00
6.00	Allowable bad debts (From your records)			223, 293	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		90, 828	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			145, 140	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)			3, 557, 309	11.00
12.00	Interim payments (See instructions)			3, 465, 704	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			2, 903	14. 75
14. 99	Sequestration amount (see instructions)			68, 243	14. 99
15.00	Balance due provider/program (see Instructions)			20, 459	
16.00					16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - 1	TITLE XVIII ONLY		
17. 00	Ancillary services Part B				17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	
20. 00	Medicare Part B ancillary charges (See instructions)			0	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	
23. 00	Coi nsurance and deducti bl es			0	
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
24. 02	Adjusted reimbursable bad debts (see instructions)			0	
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26.00	Interim payments (See instructions)			0	
27. 00	Tentative adjustment			0	27. 00
28. 00					28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99 29. 00	Sequestration amount (see instructions)			0	
	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 115 2	0	
30.00	Triotested amounts (Nonarrowanie cost report itells) ili accordanc	e with two rub. 15-2,	36011011 110. 2	υĮ	30.00

Provi der No.: 315511 Peri od:

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

Date/Time Prepared: 5/10/2024 11:35 am PPS

Title XVIII Skilled Nursing

		11 (1)	e Aviii	Facility	FF3	
		I npati en	t Part A		t B	
		/ /		/ 1.1./		
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	3, 343, 926	3.00	4.00	1. 00
2.00	Interim payments payable on individual bills, either		116, 800		0	2.00
2.00	submitted or to be submitted to the contractor for		110, 000		٥	2.00
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider	07 (00 (0000	4 070			0.04
3. 01	ADJUSTMENTS TO PROVIDER	06/09/2023	4, 978		0	
3. 02			0		0	
3.03			0		0	3. 03 3. 04
3. 04 3. 05			0		0	
3.03	Provider to Program		U		0	3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	THE TO THOUSE IN		o		Ö	1
3. 52			Ö		Ō	
3. 53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		4, 978		0	3. 99
	- 3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 465, 704		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider				•	
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program				-	
5. 50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	
5. 52 5. 99	Subtatal (Sum of Lines F O1 F 40 minus sum of Lines F FO		0		0 0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		U		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6.00
5. 55	the cost report. (1)					0.00
6. 01	PROGRAM TO PROVIDER		20, 459		0	6. 01
6. 02	PROVI DER TO PROGRAM		O		0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 486, 163		0	7. 00
			Contract	or Name	Contractor	
					Number	
0.00	Name of Contractor		1. (00	2. 00	0.00
8.00	Name of Contractor				l	8. 00

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

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/10/2024 | 11: 35 am | |

Provi der No.: 315511

In Lieu of Form CMS-2540-10

Assets	oni y)				12, 01, 2020	5/10/2024 11:	35 am
Name			General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
CURRENT ASSETS			1.00			4. 00	
Cash on hand and in banks							+
Notes receivable 0	. 00		572, 454	. (0 0	С	1.00
Accounts receivable	2. 00	Temporary investments	0		0 0		
O			0		0 0	1	1
Less: allowances for uncollectible notes and accounts -373,557 0			1, 635, 660	1	0	0	
receivable			272 557	1	0	0	1
Inventorry	5. 00		-3/3,55/		J	O	6.00
Propal of expenses	7 00				0	O	7.00
Other current assets		•	20, 815		0	Ö	
TOTAL CURRENT ASSETS (Sum of Lines 1 - 10)	0.00	Other current assets			0 0	0	9.00
FIXED ASSETS	0. 00		0		0 0	O	
12.00 Land improvements	1. 00		2, 083, 116		0 0	0	11.00
13.00 Land improvements	0.00		1	, I			10.00
14.00 Less: Accumulated depreciation 0 0 0 0 0 16.00 Less Accumulated depreciation 0 0 0 0 16.00 Less Accumulated Amortization 0 0 0 0 17.00 Leasehold improvements 0 0 0 0 0 17.00 Leasehold improvements 0 0 0 0 0 17.00 Leasehold improvements 0 0 0 0 0 0 17.00 Lease Accumulated Amortization 0 0 0 0 0 0 0 0 0				1		1	1
15.00 Buildings		•		1	-	· ·	
16.00 Less Accumul atted depreciation 0 0 0 0 19.00 19		•		1	-		1
17.00 Leasehold Improvements 0 0 0 0 0 19.00 Fixed equipment 0 0 0 0 0 0 0 0 0					0	ĺ	
19.00 Fixed equipment			0		0	Ö	
20.00 Less: Accumulated depreciation 0 0 0 0 0 0 0 0 0	8. 00	Less: Accumulated Amortization	0		0 0	0	18.00
21. 0.0 Automobil es and trucks	9. 00	Fi xed equipment	0) (0 0	C	
22.00 Less: Accumulated depreciation 0 0 0 0 0 0 0 0 0			0		0	0	
23.00 Major movable equipment			0	1	-	0	
24.00 Less: Accumulated depreciation		•	0		0	0	
25.00 Minor equipment - Depreciable 0 0 0 0 0 0 0 0 0		, ,			0		
26. 00 Minor equipment nondepreciable 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		·			0		
27. 00				ól ö	0	Ö	
OTHER ASSETS Investments 0 0 0 0 0 0 0 0 0		· ·	0		0	Ö	
29.00 Investments	28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0		0 0	0	28. 00
30. 00 Deposits on Leases 0 0 0 0 0 0 0 0 0							
31.00 Due from owners/officers 0 0 0 0 0 0 0 0 0			0	1		1	1
32. 00		·	0	1	-	1	
33.00 TOTAL OTHER ASSETS (Sum of lines 29 - 32) 5,000 0 0 0 0 0 0 0 0 0			F 000	Ί `	ا	0	
TOTAL ASSETS (Sum of lines 11, 28, and 33) 2,088, 116 0 0					ا		
Liabilities and Fund Balances CURRENT LIABILITIES 35.00 Accounts payable 982, 246 0 0 0 0 0 0 0 0 0		, ,		1	-		
CURRENT LIABILITIES	71.00		2,000,110	ή	<u> </u>		01.00
36. 00 Salaries, wages, and fees payable							1
37.00 Payroll taxes payable 12,720 0 0 0 0 0 0 0 0 0	35. 00	Accounts payable	982, 246) (0 0	C	35. 00
38.00 Notes & Ioans payable (Short term) 0 0 0 0 0 0 0 0 0					0		1
39.00 Deferred income 0 0 0 0 0 0 0 0 0			12, 720		0	0	
40.00 Accelerated payments 0 1.00 0 1.00 0 0 0 0 0 0 0 0 0			0		0	0	
41.00 Due to other funds 227, 744 0 0 0 0 0 0 0 0 0					J	O	39. 00 40. 00
42.00 Other current liabilities			227 744	íl ,	0	o	
A3.00 TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) 2,397,065 0 0			•	1	-	l	1
LONG TERM LIABILITIES						1	
45.00 Notes payable					-, -,	-	1
46.00 Unsecured Loans 47.00 Loans from owners: 48.00 Other Long term Liabilities 48.00 OTHER (SPECIFY) 50.00 TOTAL LONG TERM LIABILITIES (Sum of Lines 44 - 49	4. 00	Mortgage payable	0) (0 0	C	44.00
47.00 Loans from owners: 48.00 Other long term liabilities 49.00 OTHER (SPECIFY) 50.00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	5. 00	Notes payable	0) (0 0	0	45. 00
48.00 Other long term liabilities			0) (0	0	
49.00 OTHER (SPECIFY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	1	0 0	0	
50.00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 11,054,561 0 0 0 13,451,626 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			11, 054, 561		0	0	
51.00 TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS 52.00 General fund balance Specific purpose fund 54.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Coverning body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) 13, 451, 626 0 0 0 -11, 363, 510 0 0 0 0 0 0 0 0 0 0 0 0			11 054 5/1	1		0	1
CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0 -11,363,510 0		· ·		1		0 0	
52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0 -11,363,510 0 0 -11,363,510 0	1.00		13, 431, 626	9	J U		31.00
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) 0 -11,363,510 0 0	2. 00		-11, 363, 510				52.00
54.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Fr.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0				1	o		53. 00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0		•			0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0	5.00	Donor created - endowment fund balance - unrestricted			0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0	6. 00				0		56.00
replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0		•				0	
59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) -11,363,510 0 0	8. 00					0	58.00
	0.00		11 242 510	,		,	J EO 00
OUTO TO THE ELIMPLETITES AND LOND INCOMED (Suill OFFICES STAIR) Z,000, 1101 UI UI UI UI UI				1			
59)	.0.00		2,000,110	1 '			00.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315511 Peri od: Worksheet G-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/10/2024 11:35 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -9, 881, 091 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -1, 482, 416 2.00 3.00 Total (sum of line 1 and line 2) -11, 363, 507 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) -11, 363, 507 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 ROUNDI NG 0 13.00 0 0 0 14.00 0 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance -11, 363, 510 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00 ROUNDI NG 13.00 13.00 14.00 0 14.00 15.00 0 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0

0

0

19.00

Fund balance at end of period per balance

sheet (Line 11 - line 18)

Health Financial Systems	CARE	ONE AT HANOVER	TOWNSHI P	In Lieu	u of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND	OPERATING EXPENSES		Provi der No.:		Worksheet G-2
				From 01/01/2023	Parts I-II
				To 10/01/0000	Data/Tima Dranarada

	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		12, 197, 85	9	12, 197, 859	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)		12, 197, 85	9	12, 197, 859	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		5, 018, 56	3	5, 018, 563	6. 00
7.00	CLINIC			C	0	7. 00
8.00	HOME HEALTH AGENCY COST			C	0	8. 00
9.00	AMBULANCE			C	0	9. 00
10.00	RURAL HEALTH CLINIC			C	0	10.00
10. 10	FQHC			C	0	10. 10
11.00	CMHC			C	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	17, 216, 42	2 0	17, 216, 422	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description					
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				12, 663, 532	1. 00
2.00	Add (Specify)			C		2. 00
3.00				C		3. 00
4.00				C)	4.00
5.00				C)	5. 00
6.00				C)	6.00
7.00				C)	7.00
8.00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9.00	Deduct (Specify)			C		9. 00
10.00				C		10.00
11.00				C		11. 00
12.00				C		12.00
13.00				C		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)				12, 663, 532	15. 00

Heal th	Financial Systems	CARE ONE AT HA	NOVER TOW	WNSHI P		In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXP	ENSES	Pro	ovider No.	: 315511	Peri od: From 01/01/2023	Worksheet G-3	
						To 12/31/2023	Date/Time Prep 5/10/2024 11:	
							1. 00	
1.00	1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)				17, 216, 422	1. 00		
2.00 Less: contractual allowances and discounts on patients accounts				6, 014, 861	2.00			
3.00	Net patient revenues (Line 1 minus line 2	2)					11, 201, 561	3. 00

	10 12/31/2023	5/10/2024 11:3	
		37 107 2024 11.	33 alli
		1.00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17, 216, 422	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	6, 014, 861	2.00
3.00	Net patient revenues (Line 1 minus line 2)	11, 201, 561	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	12, 663, 532	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-1, 461, 971	5.00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6. 00
7.00	Income from investments	3, 746	7.00
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase discounts	0	10. 00
11. 00	Rebates and refunds of expenses	0	11. 00
12. 00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14. 00	Revenue from meals sold to employees and guests	0	14.00
15. 00	5 1	0	15.00
16. 00		0	16. 00
17. 00		0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20. 00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21. 00	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	3, 941	24.00
24. 01	RESIDENT PERSONAL ITEMS	134	24. 01
24. 02	OTHER REV	3, 662	24. 02
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)	11, 483	25. 00
26. 00	Total (Line 5 plus line 25)	-1, 450, 488	
27. 00	OTHER I NCOME	31, 928	
28. 00		0	28. 00
29. 00		0	29. 00
	Total other expenses (Sum of lines 27 - 29)	31, 928	
31. 00	Net income (or loss) for the period (Line 26 minus line 30)	-1, 482, 416	31. 00