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

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

| | | | EMP11 001 127 017 2021 |
|--|-----------------------|-----------------|--|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | Provi der CCN: 315306 | From 01/01/2023 | Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 12:00 pm |

| | | | | 3/ 10/ | 2024 12.00 pili |
|---------------|---|---------------|---------------------------------------|-------------------------|-----------------|
| PART I - COST | REPORT STATUS | | | | |
| Provi der | 1. [X] Electronically prepared cost rep | oort | | Date: 5/10/2024 | Time: 12:00 pr |
| use only | 2. [] Manually prepared cost report | | | | |
| | 3. [0] If this is an amended report ent | ter the numbe | r of times the provide | r resubmitted this cost | report |
| | 3.01 [] No Medicare Utilization. Enter " | Y" for yes o | r Leave blank for no. | | |
| Contractor | 4. [1] Cost Report Status | 6. Contractor | No | | |
| use only | (1) As Submitted | 7.[N] Firs | t Cost Report for this | Provider CCN | |
| | (2) Settled without audit | 8.[N] Last | Cost Report for this I | Provider CCN | |
| | (3) Settled with audit | 9. NPR Date: | • | | |
| | (4) Reopened | 10.[0]If I | ine 4, column 1 is "4": | Enter number of times | reopened |
| | (5) Amended | 11.Contracto | r Vendor Code | 4 | · |
| | 5. Date Received: | | care Utilization. Ente | r "F" for full, "L" for | rlow, or "N" |
| | 1 | | · · · · · · · · · · · · · · · · · · · | | |

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 NEW MILFORD (315306) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

| | | | Title | XVIII | | |
|--------|--|----------------|-----------------|----------------|--------------|--------|
| | Cost Center Description | Title V | Part A | Part B | Title XIX | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | |
| 1.00 | SKILLED NURSING FACILITY | 0 | 43, 973 | -1, 400 | 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 | 43, 973 | -1, 400 | 0 | 100.00 |
| The of | ance amounts represent "due to" or "due from" the applicable | nrogram for th | a alamant of th | ac about compl | 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 NEW MILFORD In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315306 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 12:00 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 800 RIVER ROAD PO Box: 1.00 2.00 City: NEW MILFORD State: NJ Zi p Code: 07646 2.00 3.00 County: BERGEN CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT NEW MILFORD 315306 05/01/2003 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 23.00 Sum of line 20 through 22 d 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 38.00 Υ 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 51, 276

| Heal th I | Financial Systems | CARE ONE AT NEW | MI LFORD | In L | ieu of Form CMS- | 2540-10 |
|-----------|---|---------------------------|-------------------|-----------------------|------------------|---------|
| SKI LLED | NURSING FACILITY AND SKILLED NURSING | FACILITY HEALTH CARE | Provi der No.: 31 | | Worksheet S-2 | |
| COMPLEX | INDENTIFICATION DATA | | | From 01/01/202 | | |
| | | | | To 12/31/202 | | |
| | | | | | 5/10/2024 12: | UU DIII |
| | | | | | Y/N | - |
| | | | | | 1.00 | |
| | Are malpractice premiums and paid loss | | | | N | 42.00 |
| c | center? Enter Y or N. If yes, check box | x, and submit supporting | schedule listing | cost centers and | | |
| a | amounts. | | | | | |
| 43.00 A | Are there any home office costs as defi | ined in CMS Pub. 15-1, Ch | apter 10? | | Y | 43.00 |
| 44. 00 I | f line 43 is yes, enter the home office | ce chain number and enter | the name and add | Iress of the home | HB0206 | 44.00 |
| c | office on lines 45, 46 and 47. | | | | | |
| | 1. 00 | 2. 00 | | 3. 00 | | |
| I | f this facility is part of a chain or | ganization, enter the nam | ne and address of | the home office on t | he lines | |
| k | pel ow. | _ | | | | |
| 45. 00 N | Name: HEALTHBRI DGE | Contractor's Name: NOVITA | AS SOLUTIONS Co. | ntractor's Number: 12 | 001 | 45. 00 |
| 46. 00 5 | Street: 173 NORTH BRIDGE PLAZA | PO Box: | | | | 46. 00 |
| 47.00 | City: FORT LEE | State: NJ | Zi ı | p Code: 07 | 024 | 47. 00 |
| 47.00 | City: FORT LEE | State: NJ | Zi _I | p Code: 07 | 024 | 47. 00 |

| | Financial Systems | CARE ONE AT NEW M | | | | eu of Form CMS- | |
|------------------|--|--|----------------------------|----------------|---|-----------------------|------------------|
| | D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE | IY HEALIH CARE | Provi der | 1 | Period: From 01/01/2023 Fo 12/31/2023 | Date/Time Pre | epared: |
| | | | | | Y/N | 5/10/2024 12: Date | 00 pm |
| | General Instruction: For all column 1 respons | and onton in column | 1 "V" fo | ~ Voc or "N" 4 | 1. 00 | 2.00 | |
| | responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites | ses enter in column | 1, Y 10 | r yes or N I | or No. For all | the date | |
| 1. 00 | Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter | | | | N | | 1.00 |
| | instructions) | | | Y/N | Date | V/I | |
| 2. 00 | Has the provider terminated participation in | the Medicare Progra | am? If | 1. 00 N | 2. 00 | 3. 00 | 2.00 |
| | column 1 is yes, enter in column 2 the date | of termination and i | n column | ,,, | | | |
| 3.00 | 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions) | ., chain home office d to the provider or I, or members of the | es, drug its e board | Υ | | | 3.00 |
| | relationships: (See First detrons) | | | Y/N | Type | Date | |
| | Financial Data and Reports | | | 1. 00 | 2. 00 | 3. 00 | |
| 4.00 | Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple | " for Audited, "C" 1 te copy or enter dat | for te | Y | A | | 4. 00 |
| 5. 00 | available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation. | revenues different | from | N | | | 5. 00 |
| | reconcilitation. | | | | Y/N | Legal Oper. | |
| | Approved Educational Activities | | | | 1. 00 | 2. 00 | |
| 6.00 | Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) | ool? (Y/N) Column 2: | Is the | provider the | N | N | 6. 00 |
| 7. 00 8. 00 | Were costs claimed for Allied Health Program Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s | ng the cost reportir | | for Nursing | N N | | 7. 00 8. 00 |
| | | | | | | Y/N 1.00 | |
| | Bad Debts | 1 1 1 1 0 () (10) | | | | | |
| 9. 00 10. 00 | Is the provider seeking reimbursement for balfline 9 is "Y", did the provider's bad debperiod? If "Y", submit copy. | t collection policy | change du | ring this cost | | Y N | 9.00 |
| 11. 00 | If line 9 is "Y", are patient deductibles and Bed Complement | d/or coinsurance wai | ved? If " | Y", see instru | uctions. | N N | 11. 00 |
| 12. 00 | Have total beds available changed from prior | cost reporting peri | od? If "Y | | | N | 12. 00 |
| | | Description | n | Y/N | rt A Date | Part B Y/N | |
| | DS*D Data | 0 | | 1. 00 | 2. 00 | 3. 00 | |
| 13. 00 | PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) | | | Υ | 03/19/2024 | Y | 13.00 |
| 14. 00 | Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. | | | N | | N | 14. 00 |
| 15. 00 | If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that | | | N | | N | 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 | PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report | | | N | | N | 16.00 |
| 16. 00 17. 00 | PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for | | | N N | | N N | 16. 00 17. 00 |

| Heal th | Financial Systems | CARE ONE AT N | NEW MILFORD | | In Lie | u of Form CMS- | 2540-10 |
|---------|---|---------------|--------------|-----------------|----------------------------------|----------------|---------|
| | D NURSING FACILITY AND SKILLED NURSING FACILIT | Y HEALTH CARE | Provi d | der No.: 315306 | Peri od: | Worksheet S-2 | |
| COMPLEX | X REIMBURSEMENT QUESTIONNAIRE | | | | From 01/01/2023 To 12/31/2023 | | epared: |
| | | | | | | 5/10/2024 12: | |
| | | | | | | | |
| | | | | 1. 00 | 2. | 00 | |
| | Cost Report Preparer Contact Information | | | | | | |
| 19. 00 | Enter the first name, last name and the title, | /posi ti on | CHARLES | | 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 | EXECUCARE A | SSOCI ATES | | | 20.00 |
| | preparer. | | | | | | |
| 21. 00 | Enter the telephone number and email address of | of the cost | (609) 738-32 | 00 | CRWASSC@NETSCAF | PE. NET | 21. 00 |
| | report preparer in columns 1 and 2, respective | el y. | | | | | |

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

CARE ONE AT NEW MILFORD
Provider No.: 315306
Period: From 01/01/2023 Part II

| COMPLE | X REIMBURSEMENT QUESTIONNAIRE | | | To 12/31/2023 | |
|--------|--|--------------|------------------|---------------|--------|
| | | Part B | | | |
| | | Date | | | |
| | | 4. 00 | | | |
| | PS&R Data | | | | |
| 13. 00 | Was the cost report prepared using the PS&R | 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 | | | | |
| 14.00 | 4. (see Instructions.) | | | | 14.00 |
| 14. 00 | Was the cost report prepared using the PS&R for total and the provider's records for | | | | 14.00 |
| | allocation? If either col. 1 or 3 is "Y" | | | | |
| | enter the paid through date of the PS&R used | | | | |
| | to prepare this cost report in columns 2 and | | | | |
| | 4. | | | | |
| 15. 00 | If line 13 or 14 is "Y", were adjustments | | | | 15. 00 |
| | made to PS&R data for additional claims that | | | | |
| | have been billed but are not included on the | | | | |
| | PS&R used to file this cost report? If "Y", | | | | |
| | see Instructions. | | | | |
| 16.00 | If line 13 or 14 is "Y", then were | | | | 16. 00 |
| | adjustments made to PS&R data for | | | | |
| | corrections of other PS&R Report | | | | |
| 47.00 | information? If yes, see instructions. | | | | 17.00 |
| 17.00 | If line 13 or 14 is "Y", then were | | | | 17. 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 |
| 10.00 | provider's records? If "Y" see Instructions. | | | | 10.00 |
| | | | | | |
| | | | 3. 00 | | |
| | Cost Report Preparer Contact Information | | | | |
| 19. 00 | Enter the first name, last name and the title | | VI CE-PRESI DENT | | 19. 00 |
| | held by the cost report preparer in columns 1 | i, 2, and 3, | | | |
| 20. 00 | respectively. Enter the employer/company name of the cost r | conort | | | 20.00 |
| 20.00 | preparer. | epoi t | | | 20.00 |
| 21. 00 | 1. · | of the cost | | | 21.00 |
| 21.00 | report preparer in columns 1 and 2, respective | | | | 21.00 |
| | 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | - J· | ļ | 1 | ! |

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

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

Provider No.: 315306 | Period: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prep

Date/Time Prepared: 5/10/2024 12:00 pm Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 236 86, 140 С 7, 639 48, 115 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 7.00 0 0 8.00 Total (Sum of lines 1-7) 236 86, 140 7.639 48, 115 8.00 Inpatient Days/Visits Di scharges Title XIX Title XVIII Component Other Total Title V 6.00 7.00 8.00 9.00 10.00 1.00 SKILLED NURSING FACILITY 7, 292 63, 046 0 141 141 1. 00 0 2.00 NURSING FACILITY 0 2.00 0 0 ICE/LID 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 0 C 4.00 5.00 Other Long Term Care 0 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 0 7.00 8.00 Total (Sum of lines 1-7) 7, 292 63, 046 141 141 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 341. 24 1.00 138 420 NURSING FACILITY 2.00 0 0.00 0.00 2.00 3.00 ICF/IID 0 C 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 7.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 138 420 0.00 54. 18 341.24 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16.00 17.00 18.00 19.00 20.00 1.00 SKILLED NURSING FACILITY 150. 11 127 82 204 1. 00 NURSING FACILITY 2.00 2.00 0.00 0 0 ICF/IID 0.00 0 3.00 0 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 0.00 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 00 0 7 00 Total (Sum of lines 1-7) 150.11 127 82 204 8.00 8.00 Admi ssi ons Full Time Equivalent Total Component Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 413 0.00 183. 92 1.00 NURSING FACILITY 0.00 2.00 0.00 2.00 0 3.00 ICF/IID 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00

0

Λ

413

0.00

0.00

0.00

183.92

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0.00

0.00

0.00

5.00

6.00

7.00

8.00

5.00

6.00

7.00

8.00

Other Long Term Care

Total (Sum of lines 1-7)

SNF-Based CMHC

HOSPI CE

Provi der No.: 315306

| | 24 12:00 pm |
|--|---------------|
| Amount Reclass of Adjusted Paid Hours Average | |
| Reported Salaries from Salaries (col. Related to Wage (co | |
| Worksheet A-6 1 ± col. 2) Salary in col. col. | 4) |
| | |
| 1.00 2.00 3.00 4.00 5.0 | 0 |
| PART II - DIRECT SALARIES | |
| SALARI ES SALARI ES | |
| 1.00 Total salaries (See Instructions) 10, 995, 669 0 10, 995, 669 382, 557.00 | 28. 74 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 0.00 | 0.00 5.00 |
| 6.00 Revised wages (line 1 minus line 5) 10,995,669 0 10,995,669 382,557.00 | 28. 74 6. 00 |
| 7.00 Other Long Term Care 0 0 0 0 0.00 | 0.00 7.00 |
| 8.00 HOME HEALTH AGENCY COST 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 0.00 | 0.00 11.00 |
| 12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0 0.00 | 0.00 12.00 |
| through 11) | |
| 13.00 Total Adjusted Salaries (line 6 minus line 10,995,669 0 10,995,669 382,557.00 | 28. 74 13. 00 |
| 12) | |
| OTHER WAGES & RELATED COSTS | (0.07) |
| 14.00 Contract Labor: Patient Related & Mgmt 752,148 0 752,148 10,858.00 | 69. 27 14. 00 |
| 15.00 Contract Labor: Physician services-Part A 0 0 0.00 | 0.00 15.00 |
| 16.00 Home office salaries & wage related costs 0 0 0 0 0.00 | 0.00 16.00 |
| WAGE-RELATED COSTS | 47.00 |
| 17. 00 Wage-related costs core (See Part IV) 2, 121, 441 0 2, 121, 441 | 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 0 | 20. 00 |
| 21.00 Physician Part B - WRC 0 0 0 | 21. 00 |
| 22.00 Total Adjusted Wage Related cost (see 2,121,441 0 2,121,441 | 22. 00 |
| instructions) | I |

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT NEW MILFORD

Period: Worksheet S-3
From 01/01/2023 Part III
To 1/21/2022 Part VII'm Propagad: Provi der No.: 315306

| | | | | Т | o 12/31/2023 | Date/Time Prep 5/10/2024 12:0 | |
|--------|--|-------------|---------------|----------------|----------------|-------------------------------|-------|
| | | Amount | Reclass. of | Adj usted | Pai d Hours | Average Hourly | |
| | | Reported | Salaries from | Salaries (col. | Related to | Wage (col. 3 ÷ | |
| | | | Worksheet A-6 | 1 ± col. 2) | Salary in col. | col . 4) | |
| | | | | | 3 | | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - OVERHEAD COST - DIRECT SALARIES | | | | | | |
| 1.00 | Employee Benefits | 0 | 0 | C | 0.00 | 0. 00 | 1.00 |
| 2.00 | Administrative & General | 638, 336 | 0 | 638, 336 | 15, 100. 00 | 42. 27 | 2.00 |
| 3.00 | Plant Operation, Maintenance & Repairs | 216, 939 | 0 | 216, 939 | 9, 869. 00 | 21. 98 | 3.00 |
| 4.00 | Laundry & Linen Service | 143, 967 | 0 | 143, 967 | 8, 369. 00 | 17. 20 | 4.00 |
| 5.00 | Housekeepi ng | 605, 476 | 0 | 605, 476 | 35, 356. 00 | 17. 13 | 5.00 |
| 6.00 | Di etary | 878, 724 | 0 | 878, 724 | 41, 536. 00 | 21. 16 | 6.00 |
| 7.00 | Nursing Administration | 902, 396 | 0 | 902, 396 | 22, 823. 00 | 39. 54 | 7.00 |
| 8.00 | Central Services and Supply | 41, 360 | 0 | 41, 360 | 2, 158. 00 | 19. 17 | 8.00 |
| 9.00 | Pharmacy | 0 | 0 | C | 0.00 | 0. 00 | 9. 00 |
| 10.00 | Medical Records & Medical Records Library | 30, 867 | 0 | 30, 867 | 1, 811. 00 | 17. 04 | 10.00 |
| 11.00 | Soci al Servi ce | 148, 383 | 0 | 148, 383 | 4, 375. 00 | 33. 92 | 11.00 |
| 12.00 | Nursing and Allied Health Ed. Act. | | | | | | 12.00 |
| 13.00 | Other General Service | 415, 937 | 0 | 415, 937 | 21, 763. 00 | 19. 11 | 13.00 |
| 14. 00 | Total (sum lines 1 thru 13) | 4, 022, 385 | 0 | 4, 022, 385 | 163, 160. 00 | 24. 65 | 14.00 |

| Health Financial Systems | CARE ONE AT NEW MILFORD | In Lieu | of Form CMS-2540-10 |
|--------------------------|-------------------------|----------------------------------|--|
| SNF WAGE RELATED COSTS | Provi der No.: 315306 | From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part IV Date/Time Prepared: 5/10/2024 12:00 pm |

| | From 01/01/2023 To 12/31/2023 | | |
|--------|---|-----------------------|---------|
| | | Amount | Jo piii |
| | | Reported | |
| | | 1.00 | |
| | PART IV - WAGE RELATED COSTS | 11.00 | |
| | Part A - Core List | | 1 |
| | RETIREMENT COST | | 1 |
| 1.00 | 401K Employer Contributions | 58, 785 | 1.00 |
| 2. 00 | Tax Shel tered Annui ty (TSA) Employer Contribution | 0 | |
| 3. 00 | Qualified and Non-Qualified Pension Plan Cost | 0 | 3.00 |
| 4.00 | Prior Year Pension Service Cost | 0 | 4.00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | 7.00 |
| 5.00 | 401K/TSA Plan Administration fees | 0 | 5.00 |
| 6.00 | Legal /Accounting/Management Fees-Pension Plan | | 6.00 |
| 7. 00 | Employee Managed Care Program Administration Fees | | 7.00 |
| 7.00 | HEALTH AND INSURANCE COST | | 7.00 |
| 8. 00 | Health Insurance (Purchased or Self Funded) | 849, 352 | 8.00 |
| 9. 00 | Prescription Drug Plan | 047, 332 | 9.00 |
| 10.00 | Dental, Hearing and Vision Plan | | 10.00 |
| 11. 00 | Life Insurance (If employee is owner or beneficiary) | 2, 494 | |
| 12. 00 | Accident Insurance (If employee is owner or beneficiary) | 2, 474 | 12.00 |
| 13. 00 | Disability Insurance (If employee is owner or beneficiary) | | 13.00 |
| 14. 00 | Long-Term Care Insurance (If employee is owner or beneficiary) | | 14.00 |
| | Workers' Compensation Insurance | 1 | |
| | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 276, 384 | 16.00 |
| 16. 00 | Non cumulative portion) | 0 | 16.00 |
| | TAXES | | |
| 17 00 | FICA-Employers Portion Only | 796, 645 | 17. 00 |
| 18. 00 | Medicare Taxes - Employers Portion Only | 7,70, 043 | 18.00 |
| | Unemployment Insurance | 0 | 19.00 |
| | State or Federal Unemployment Taxes | 137, 781 | |
| | OTHER | 137, 781 | 20.00 |
| | Executive Deferred Compensation | 0 | 21. 00 |
| | Day Care Cost and Allowances | 0 | |
| | Tuition Reimbursement | 0 | |
| | | 1 | |
| ∠4. 00 | Total Wage Related cost (Sum of lines 1 - 23) | 2, 121, 441 Amount | 24. 00 |
| | | Reported | |
| | | 1. 00 | |
| | Part B - Other than Core Related Cost | 1.00 | |
| | OTHER WAGE RELATED COST | | 25. 00 |
| ∠3.00 | OTHER WAGE RELATED COST | 1 | I 25.00 |

| | | | | | o 12/31/2023 | Date/Time Prep 5/10/2024 12:0 | |
|--------|---|-------------|-------------|----------------|----------------|----------------------------------|-------------|
| | Occupational Category | Amount | Fri nge | Adjusted | Pai d Hours | Average Hourly | ус р |
| | g , | Reported | | Salaries (col. | | Wage (col. 3 ÷ | |
| | | | | | Salary in col. | col . 4) | |
| | | | | ' | 3 | ĺ ĺ | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | Di rect Sal ari es | | | | | | |
| | Nursing Occupations | | | | | | |
| 1.00 | Registered Nurses (RNs) | 875, 312 | 184, 587 | | · | | 1.00 |
| 2.00 | Licensed Practical Nurses (LPNs) | 2, 017, 446 | 425, 441 | | · | | 2.00 |
| 3.00 | Certified Nursing Assistant/Nursing | 2, 802, 564 | 591, 007 | 3, 393, 571 | 122, 891. 00 | 27. 61 | 3.00 |
| | Assi stants/Ai des | | | | | | |
| 4.00 | Total Nursing (sum of lines 1 through 3) | 5, 695, 322 | 1, 201, 035 | | | | 4. 00 |
| 5.00 | Physical Therapists | 424, 791 | 89, 580 | 514, 371 | · | | 5. 00 |
| 6.00 | Physical Therapy Assistants | 0 | 0 | 0 | 0.00 | | |
| 7. 00 | Physical Therapy Aides | 0 | 0 | 0 | 0.00 | 0.00 | 7. 00 |
| 8.00 | Occupational Therapists | 602, 435 | 127, 042 | 729, 477 | · | | 8. 00 |
| 9.00 | Occupational Therapy Assistants | 0 | 0 | 0 | 0.00 | 0. 00 | 9. 00 |
| 10. 00 | Occupational Therapy Aides | 0 | 0 | 0 | 0.00 | 0.00 | |
| 11. 00 | Speech Therapists | 130, 175 | 27, 451 | 1 | · | 61. 33 | |
| 12. 00 | Respiratory Therapists | 0 | 0 | 0 | | | |
| 13. 00 | Other Medical Staff | 0 | 0 | 0 | 0.00 | 0. 00 | 13.00 |
| | Contract Labor | | | | | | |
| | Nursing Occupations | 10.040 | | 10.010 | 100.00 | 00.00 | |
| 14.00 | Registered Nurses (RNs) | 43, 363 | | 43, 363 | | | 14.00 |
| 15.00 | Licensed Practical Nurses (LPNs) | 503, 530 | | 503, 530 | · | | 15. 00 |
| 16. 00 | Certified Nursing Assistant/Nursing | 193, 315 | | 193, 315 | 3, 515. 00 | 55. 00 | 16. 00 |
| 17. 00 | Assistants/Aides Total Nursing (sum of lines 14 through 16) | 740, 208 | | 740, 208 | 10, 667. 00 | 40.20 | 17. 00 |
| 18.00 | Physical Therapists | 740, 200 | | 740, 200 | 0.00 | | 18. 00 |
| 19. 00 | Physical Therapy Assistants | 0 | | | 0.00 | | 19. 00 |
| 20. 00 | Physical Therapy Aides | 0 | | | 0.00 | | |
| 21. 00 | Occupational Therapists | 0 | | | 0.00 | | 21. 00 |
| 22. 00 | Occupational Therapy Assistants | 0 | | | 0.00 | | |
| 23. 00 | Occupational Therapy Assistants Occupational Therapy Aides | | | | 0.00 | | |
| 24. 00 | Speech Therapists | 7, 200 | | 7, 200 | | | |
| 25. 00 | Respiratory Therapists | 4, 740 | | 4, 740 | | | |
| 26. 00 | Other Medical Staff | 4, 740 | | 4, 740 | | | 26. 00 |
| 20.00 | Total mode out of the last | ١ | | | 3.00 | 0.00 | _0.00 |

Peri od: Worksheet S-7
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/10/2024 12:00 pm

| 100 | | 0 12/31/2023 | 5/10/2024 12: | 00 pm |
|--|--------|--------------|---------------|--------|
| 1,00 | | | | |
| 2.00 Sell | 1.00 | | 2. 00 | 1.00 |
| 2.00 | | | | |
| 4.00 | | | | 1 |
| 5.00 Set | | | | 1 |
| Section Sect | | | | |
| 7.00 MIX. 7.00 MIX. 8.00 MIX. 9.00 10.00 MIX. 1.00 MIX. 1.00 MIX. 1.00 MIX. 1.100 MIX. 1.100 | | | | |
| 9.00 11.00 1 | | | | |
| 10.00 RIUC 10.00 RIUC 11.00 RIUC 11.00 | 8. 00 | RML | | 8. 00 |
| 11.00 RIGH 11.00 RIGH 11.00 RIGH 12.00 RIGH 13.00 RIGH 15.00 RIGH 15.00 RIGH 15.00 RIGH 15.00 RIGH 15.00 RIGH 15.00 RIGH 17.00 RIGH 17.0 | | | | |
| 12.00 RUA 12.00 RUC 13.00 RUC 13.00 RUC 13.00 RUC | | | | |
| 13.00 RVC 11.00 RVG 11.00 RVG 11.00 RVG 11.00 RVG RVG 11.00 RVG | | | | |
| 14.00 RW8 11.6.00 RW6 15.00 RW6 15.00 RW6 15.00 RW6 | | | | |
| 15.00 RVA 15.00 RVA 15.00 RVA 15.00 RVA RVA 15.00 RVA | | | | |
| 16.00 RRC 10.00 RRC 17.00 RRC 18.00 RRA | | | | |
| 17. 00 ReHB | | | | |
| 19.00 8MC | | RHB | | |
| 20.00 RMA | | | | |
| 21.00 RILB 22.00 RILB 23.00 RILB 23.0 | | | | |
| RLB | | | | |
| 23.00 RLA 23.00 SS 24.00 SS 24.00 SS 24.00 SS 24.00 SS 25.00 SS 26.00 SS 26.0 | | | | |
| 24.00 SS | | | | |
| 25.00 ES2 | | | | |
| 26.00 28.00 28.00 28.00 4E1 27.00 4B1 28.00 4B1 29.00 30.00 4B1 30.00 4B1 30.00 4B1 31.00 4B1 31.00 4B2 31.00 4B1 32.00 4B1 32.00 4B1 33.00 4B1 34.00 4B1 34.00 4B1 37.00 37.00 37.00 37.00 37.00 38.00 38.00 4B1 4B2 4B3 4B2 4B3 4B4 4B4 4B4 4B4 4B4 4B4 4B4 4B4 4B4 | | | | |
| 27. 00 28. 00 29. 00 102 29. 00 202 203 203 204 205 207 207 208 208 208 208 208 208 208 208 208 208 | | | | |
| 29.00 HD2 29,00 S1.00 HD1 S0.00 S1.00 S1.00 S1.00 HD1 S0.00 S1.00 S1.00 S1.00 HC1 S2.00 S1.00 S2.00 HC1 S2.00 | 27. 00 | | | 27. 00 |
| 30 00 HD1 | | HE1 | | |
| 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 38.00 39.00 40.00 40.00 40.00 40.00 41.00 42.00 43.00 43.00 44.00 45.00 46.00 46.00 47.00 48.00 48.00 48.00 48.00 49.00 49.00 49.00 49.00 49.00 55.00 56.00 57.00 58.00 | | | | |
| 32.00 34.00 34.00 35.00 36.00 36.00 36.00 37.00 38.00 39.00 39.00 39.00 39.00 39.00 40.00 40.00 41.00 42.00 42.00 43.00 44.00 42.00 44.00 45.00 46.00 47.00 48.00 49.00 49.00 49.00 51.00 52.00 53.00 | | | | |
| 33 00 34 00 35 00 36 00 37 00 38 00 36 00 37 00 37 00 37 00 38 00 37 00 38 00 38 00 38 00 38 00 38 00 38 00 38 00 38 00 39 00 39 00 30 0 | | | | |
| 34 00 35 00 36 00 36 00 37 00 38 00 38 00 38 00 38 00 39 00 40 00 40 00 41 00 42 00 42 00 43 00 44 00 45 00 46 00 47 00 48 00 48 00 49 00 40 00 40 00 40 00 41 00 42 00 43 00 44 00 45 00 46 00 47 00 48 00 48 00 49 00 60 00 | | | | |
| 150 | | | | |
| 10 | | | | |
| 38, 00 39, 00 1.01 38, 80 39, 00 40, 00 41, 00 42, 00 42, 00 42, 00 42, 00 42, 00 42, 00 44, 00 42, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 45, 00 45, 00 45, 00 46, 00 47, 00 46, 00 47, 00 46, 00 47, 00 48, 00 682 49, 00 50, 00 682 49, 00 51, 00 682 49, 00 51, 00 682 49, 00 51, 00 682 49, 00 51, 00 52, 00 682 51, 00 53, 00 54, 00 55, 00 55, 00 55, 00 55, 00 55, 00 56, 00 57, 00 58, 00 59, | | | | |
| 100 | 37. 00 | LD2 | | 37. 00 |
| 40,00 | | | | |
| 11.00 1.82 41.00 1.81 42.00 43.00 43.00 44.00 45.00 62.2 43.00 45.00 62.2 45.00 65.00 67.00 | | | | |
| A2. 00 | | | | |
| 43. 00 CE2 | | | | |
| 44. 00 CE1 | | | | |
| 45.00 46.00 47.00 60.00 47.00 60.00 | | | | |
| 47. 00 48. 00 49. 00 602 49. 00 50. 00 51. 00 52. 00 621 52. 00 63. 00 53. 00 54. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 56. 00 57. 00 58. 00 58. 00 59. 00 60. 00 61. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 00 69. 00 74. 00 69. 00 77. 00 72. 00 72. 00 72. 00 73. 00 74. 00 PB1 74. 00 PB2 73. 00 PB2 73. 00 PB2 73. 00 PB2 74. 00 PB2 74. 00 PB2 74. 00 PB2 74. 00 PB2 77. 00 PB2 PB2 77. 00 PB2 PB2 PB3 PB2 PB3 | | | | |
| 48. 00 | | | | 46. 00 |
| 49. 00 CB2 | | | | |
| 50. 00 CB1 50. 00 51. 00 CA2 51. 00 52. 00 CA1 52. 00 53. 00 SE3 53. 00 54. 00 SE3 53. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSB 57. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 60. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA1 66. 00 67. 00 BA1 66. 00 67. 00 PE1 68. 00 69. 00 PD2 69. 00 70. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PB2 73. 00 74. 00 PB1 74. 00 | | | | |
| 51. 00 CA2 51. 00 52. 00 SE3 53. 00 54. 00 SE2 53. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 I B2 59. 00 61. 00 I B1 60. 00 61. 00 I A2 61. 00 62. 00 I A1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 PE1 68. 00 69. 00 PD1 70. 00 70. 00 PD2 69. 00 70. 00 PC2 71. 00 72. 00 PC1 72. 00 73. 00 PB1 74. 00 | | | | |
| 52. 00 CA1 52. 00 53. 00 SE3 53. 00 54. 00 SE2 54. 00 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA1 66. 00 67. 00 PE2 67. 00 68. 00 PP1 68. 00 69. 00 PD1 70. 00 70. 00 PC2 71. 00 72. 00 PR2 73. 00 74. 00 PP1 74. 00 | | | | 50.00 |
| 53.00 SE3 53.00 54.00 SE1 55.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 IB2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 IA1 62.00 63.00 BB2 63.00 64.00 BB1 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PE2 67.00 68.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PB2 73.00 74.00 PB1 74.00 | | | | |
| 54, 00 SE2 54, 00 55, 00 SE1 55, 00 56, 00 SSC 56, 00 57, 00 SSB 57, 00 58, 00 SSA 58, 00 59, 00 IB2 59, 00 60, 00 IB1 60, 00 61, 00 IA2 61, 00 63, 00 IA1 62, 00 64, 00 BB2 63, 00 66, 00 BA1 64, 00 65, 00 BA1 66, 00 67, 00 BA1 66, 00 69, 00 PE2 67, 00 69, 00 PD1 70, 00 70, 00 PD1 70, 00 71, 00 PC2 71, 00 72, 00 PB2 73, 00 74, 00 PB1 74, 00 | | SE3 | | |
| 55. 00 SE1 55. 00 56. 00 SSC 56. 00 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 IB2 59. 00 60. 00 IB1 60. 00 61. 00 IA2 61. 00 62. 00 IA1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA1 66. 00 67. 00 PE2 67. 00 68. 00 PP1 68. 00 69. 00 PD2 69. 00 70. 00 PP1 70. 00 71. 00 PC2 71. 00 72. 00 PB2 73. 00 74. 00 PB1 74. 00 | | SE2 | | 54.00 |
| 57. 00 SSB 57. 00 58. 00 SSA 58. 00 59. 00 1B2 59. 00 60. 00 1B1 60. 00 61. 00 1A2 61. 00 62. 00 1A1 62. 00 63. 00 BB2 63. 00 64. 00 BB1 64. 00 65. 00 BA2 65. 00 66. 00 BA1 66. 00 67. 00 PE2 67. 00 68. 00 PP1 68. 00 69. 00 PD1 70. 00 70. 00 PC2 71. 00 72. 00 PC1 72. 00 73. 00 PB2 73. 00 74. 00 PB1 74. 00 | | SE1 | | |
| 58. 00 SSA 58. 00 59. 00 1B2 59. 00 60. 00 1B1 60. 00 61. 00 1A2 61. 00 62. 00 1A1 62. 00 63. 00 64. 00 65. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 68. 00 PE1 68. 00 69. 00 PD2 69. 00 70. 00 PD1 70. 00 71. 00 PC2 71. 00 72. 00 PB2 73. 00 74. 00 PB1 74. 00 | | SSC | | |
| 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 00 71. 00 72. 00 73. 00 74. 00 | | | | |
| 60. 00 61. 00 61. 00 62. 00 63. 00 64. 00 65. 00 65. 00 66. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 60. 00 61. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 74. 00 | | | | |
| 61. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 61. 00 62. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60 | | | | |
| 62. 00 63. 00 64. 00 65. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 62. 00 8B2 63. 00 8B1 64. 00 8B41 66. 00 67. 00 PE2 67. 00 PE1 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3. 00 PC3. 00 PB1 74. 00 PB1 74. 00 | | | | |
| 63. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BB2 BB1 64. 00 BB4 65. 00 BA1 66. 00 PE2 67. 00 PE1 68. 00 PD2 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 PC3 PC3 PC3 PC3 PC3 PC3 PC4 PC5 PC7 | | | | |
| 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BB1 64. 00 BA2 65. 00 BA1 66. 00 PE2 67. 00 PE1 68. 00 PP1 70. 00 PD1 70. 00 PC1 72. 00 PC1 72. 00 PB2 73. 00 PB1 74. 00 | | BB2 | | 63. 00 |
| 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 BA1 PE2 67. 00 PE1 68. 00 PP1 70. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 PC3 PC3 PC4 PC7 | 64. 00 | BB1 | | 64. 00 |
| 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PE2 67. 00 PE3 68. 00 PD2 69. 00 PD1 70. 00 PC2 71. 00 PC2 71. 00 PC3 72. 00 PC3 PC4 PC5 PC7 PC7 PC7 PC8 PC8 PC9 | | | | |
| 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 68. 00 PP1 70. 08 PP1 70. 00 PC2 PP1 72. 00 PR2 PR3. 00 PR3. 00 PR3. 00 PR3. 00 PR4. 00 | | | | |
| 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 PD2 PB1 F0. 00 F0. | | | | |
| 70. 00 71. 00 72. 00 73. 00 74. 00 PB1 70. 00 71. 00 PC2 PC1 PC1 PB2 PB1 74. 00 | | | | |
| 71. 00 72. 00 73. 00 74. 00 PB1 71. 00 72. 00 PB2 PB1 74. 00 | | | | |
| 72. 00 73. 00 74. 00 PB1 72. 00 PB1 74. 00 | | | | |
| 73. 00 74. 00 PB1 73. 00 74. 00 | | | | |
| 74. 00 PB1 74. 00 | 73. 00 | | | 73. 00 |
| 75. 00 PA2 75. 00 | 74. 00 | PB1 | | 74. 00 |
| | 75. 00 | PA2 | | 75. 00 |

| Health Financial Systems | CARE ONE AT NEW M | I LFORD | | In Lie | u of Form CMS | -2540-10 | |
|--|-------------------|-----------|-------------|----------------------------------|---------------|--------------------|--|
| PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | | Provi der | No.: 315306 | Peri od: | Worksheet S- | 7 | |
| | | | | From 01/01/2023 To 12/31/2023 | Date/Time Pr | enared: | |
| | | | | | 5/10/2024 12 | | |
| | | | | Group | Days | | |
| | | | | 1. 00 | 2. 00 | | |
| 76. 00 | | | | PA1 | | 76. 00 | |
| 99. 00 | | | | AAA | | 99. 00 | |
| 100. 00 TOTAL | | | _ | _ | | 100. 00 | |
| | | | Expenses | Percentage | Y/N | | |
| | | | 1.00 | 2.00 | 3. 00 | | |
| A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions) | | | | | | | |
| 101. 00 Staffi ng 102. 00 Recrui tment | | | | | | 101. 00 102. 00 | |
| 103.00 Retention of employees | | | | | | 102.00 | |
| 104. 00 Training | | | | | | 104.00 | |
| 105. 00 OTHER (SPECIFY) | | | | | | 105. 00 | |
| 106.00 Total SNF revenue (Worksheet G-2, Part I, Iir | e 1, column 3) | | | | | 106. 00 | |

| Heal th | Financial Systems | CARE ONE AT NEW | / MI LFORD | | In Lie | eu of Form CMS-2 | 2540-10 |
|----------------|--|----------------------|----------------------|-----------------|--------------------------------|----------------------|------------------|
| RECLAS | SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF | EXPENSES | Provi der | | eri od: | Worksheet A | |
| | | | | | rom 01/01/2023 o 12/31/2023 | Date/Time Pre | narod: |
| | | | | 1 | o 12/31/2023 | 5/10/2024 12: | pareu. OO pm |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 | Recl assi fi cati | Reclassi fi ed | <u> Б</u> |
| | μ | | | + col. 2) | ons | Trial Balance | |
| | | | | | Increase/Decre | (col. 3 +- | |
| | | | | | ase (Fr Wkst | col . 4) | |
| | | | | | A-6) | | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | 1 | | T | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | | 2, 008, 278 | | | 2,000,2.0 | 1.00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | 5, 148 | 1 | | l | 2.00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | 0 | 2, 318, 777 | | | 2, 318, 777 | 3. 00 |
| 4.00 | 00400 ADMI NI STRATI VE & GENERAL | 638, 336 | 3, 794, 853 | | 0 | 4, 433, 189 | 4.00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 216, 939 | 863, 452 | | 0 | 1, 080, 391 | 5.00 |
| 6. 00 7. 00 | O0600 LAUNDRY & LINEN SERVICE O0700 HOUSEKEEPING | 143, 967 605, 476 | 134, 451 133, 207 | | | 278, 418 738, 683 | 6. 00 7. 00 |
| 8. 00 | 00800 DI ETARY | 878, 724 | 587, 432 | | | 1, 466, 156 | 8.00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | 902, 396 | 112, 489 | | | 1, 400, 130 | 9. 00 |
| 10. 00 | 01000 CENTRAL SERVICES & SUPPLY | 41, 360 | 163, 623 | | | | 10.00 |
| 11. 00 | 01100 PHARMACY | 41, 300 | 38, 079 | | | 38, 079 | 11. 00 |
| 12. 00 | 01200 MEDICAL RECORDS & LIBRARY | 30, 867 | 30, 07 9 O | 30, 867 | 0 | 30, 867 | 12.00 |
| 13. 00 | 01300 SOCIAL SERVICE | 148, 383 | 0 | 148, 383 | 0 | 148, 383 | 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 1 10, 000 | 0 | 110,000 | 0 | 0 | 14. 00 |
| 15. 00 | 01500 ACTI VI TES | 415, 937 | 16, 303 | 432, 240 | 0 | 432, 240 | 15. 00 |
| 13.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 413, 737 | 10, 303 | 1 432, 240 | o _l | 432, 240 | 13.00 |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 5, 695, 322 | 827, 777 | 6, 523, 099 | 0 | 6, 523, 099 | 30. 00 |
| 31. 00 | 03100 NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 31. 00 |
| 32. 00 | 03200 CF/IID | 0 | 0 | Ö | 0 | 1 | 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 0 | 0 | O | 0 | 0 | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | <u>'</u> | | |
| 40.00 | 04000 RADI OLOGY | 0 | 55, 038 | 55, 038 | 0 | 55, 038 | 40. 00 |
| 41.00 | 04100 LABORATORY | 0 | 126, 680 | 126, 680 | 0 | 126, 680 | 41. 00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | 0 | 88, 111 | 88, 111 | 0 | 88, 111 | 42.00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | 0 | 0 | 0 | 43. 00 |
| 44.00 | 04400 PHYSI CAL THERAPY | 545, 352 | 42, 037 | 587, 389 | 0 | 587, 389 | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 602, 435 | 0 | 602, 435 | | 602, 435 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 130, 175 | 7, 200 | 137, 375 | 0 | 137, 375 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | 0 | - | 0 | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 583 | l | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 0 | 318, 201 | 318, 201 | 0 | 318, 201 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0 | 0 | 0 | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | 0 | 0 | | 238 | l e | 51.00 |
| 52. 00 | 05200 COMPLEX MEDICAL EQUIPMENT | 0 | 0 | | 0 | 0 | 52.00 |
| 52. 01 | 05201 OTHER ANCI LLARY SERVI CES COST | 0 | 0 | 0 | 0 | 0 | 52. 01 52. 02 |
| 52. 02 | 05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS | J U | 0 | ·I · | U | 0 | 52.02 |
| 60. 00 | 06000 CLINIC | O | 0 | 0 | 0 | 0 | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | | 0 | | 0 | 0 | 61.00 |
| 62. 00 | 06200 FQHC | | O | 1 | O | l | 62.00 |
| | 06300 DI ALYSI S | | 0 | | 0 | 0 | |
| 03.00 | OTHER REIMBURSABLE COST CENTERS | l U | | · · · · · · · · | <u> </u> | | 00.00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 | 07100 AMBULANCE | 0 | 58, 345 | 58, 345 | 0 | 58, 345 | |
| 73. 00 | 07300 CMHC | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| | 07400 OTHER REIMBURSEMENT | 0 | 0 | Ö | 0 | l | 74. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 80.00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | 0 | 0 | 0 | 0 | 80. 00 |
| 81.00 | 08100 I NTEREST EXPENSE | | 0 | 0 | 0 | 0 | 81. 00 |
| 82.00 | 08200 UTI LI ZATI ON REVI EW - SNF | o | 0 | 0 | 0 | 0 | 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 | 0 | 0 | 0 | 0 | 0 | 84. 01 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 10, 995, 669 | 11, 699, 481 | 22, 695, 150 | 0 | 22, 695, 150 | 89. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 14, 819 | | | 14, 819 | 90. 00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 0 | 12, 562 | 12, 562 | 0 | 12, 562 | |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | 0 | 0 | 92. 00 |
| | 09300 NONPAI D WORKERS | 0 | 0 | 0 | 0 | 0 | 93. 00 |
| | 09400 PATIENTS LAUNDRY | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| | 09500 OTHER NONREIMBURSABLE COST | 0 | 0 | 0 | 0 | 0 | 95. 00 |
| 100.00 | TOTAL | 10, 995, 669 | 11, 726, 862 | 22, 722, 531 | 0 | 22, 722, 531 | 100.00 |
| | | | | | | | |

CARE ONE AT NEW MILFORD In Lieu of Form CMS-2540-10

 Heal th Financial
 Systems
 CARE ONE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provi der No.: 315306

| COST Center Description | | | | | To 12/31/2023 | Date/Time Prepared: 5/10/2024 12:00 pm |
|--|--------|---------------------------------|----------------|--------------|---------------|--|
| CEMERAL_SERVICE_COST_CENTERS | | Cost Center Description | Adjustments to | Net Expenses | | 37 107 2024 12. 00 pili |
| COL | | · | | | | |
| | | | Wkst A-8) | | | |
| 1.00 00100 CAP REL COSTS - BLOSS S FIXTURES 619.772 2.028,250 1.00 2.00 1.00 2.00 1.00 | | | 6. 00 | | | |
| 2 00 00200 CAP REL COSTS - NOVABLE COUPTIENT 0 4,010 3.00 00300 (PAP REL COSTS - NOVABLE COUPTIENT 0 4,000 3.00 00300 (PAP REL COSTS - NOVABLE COUPTIENT 0 4,000 4.00 00400 (AMINISTRATIVE & CENERAL PAPAIRS) - 1,279,178 3,154,011 4.00 5.00 00500 (PAPAIR) PAPAIRS PAPAIRS - 1,460 1,738,683 7,000 7.00 00700 (NUSSEERIC REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC REL REL RES SERVICE 0 4,000 7.00 00700 (NUSSEERIC RES SERVICE 0 | | | | | | |
| 0.0000 DIFFLOYCE BERFETTS | | | 619, 972 | | • | ı |
| 0.000 0.00 | | | 0 | | • | |
| 0.000 0.000 LANDWY & LINEN SERVICE | | 1 1 | -1, 279, 178 | | • | |
| 0.000 0.0000 0.000 0.01 0.000 0. | | 1 | 0 | 1, 080, 391 | | · · |
| B. OD OBSOD DIETARY | | | -1, 460 | | | |
| 0,000 (0,000 (MURSI INS ADMINI STRATION -4,039 1,010,846 0,0 0 10.0 0 11. | | | 0 | | • | · · |
| 10.00 01000 CENTRAL SERVICES & SUPPLY 0 204, 400 11.00 1 | | | -4.039 | | • | · · |
| 12.00 01200 MEDICAL RECORDS & LIBRARY 0 30, 867 13.00 13.00 13.00 13.00 01300 SOCIAL SERVICE 0 148, 383 13.00 13.00 13.00 01300 SOCIAL SERVICE 0 148, 383 13.00 14.00 15.00 | | 01000 CENTRAL SERVICES & SUPPLY | 0 | | | · · |
| 13.0 0 1350 SOCIAL SERVICE 0 18, 383 13.0 0 14.0 0 14.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 0 0 0 0 0 0 0 0 | | | -3, 047 | | • | l l |
| 14. 00 01400 NURSING AND ALLIED IEALTH EDUCATION 0 432, 240 15. 00 | | | 0 | | • | l l |
| 15. 00 | | | 0 | | | l l |
| 30. 00 | | 1 1 | 0 | | l . | l l |
| 31.00 03100 NURSING FACILITY | | | | | | |
| 32.00 03200 CEF I D MG TERN CARE | | | -30, 191 | | • | |
| 33.00 03300 OTHER LONG TENI CARE 0 0 0 0 0 0 0 0 0 | | | 0 | | | |
| ANCIL LARY SERVICE COST CENTERS | | l l | 0 | | l . | |
| 11.00 04100 LABORATORY 0 126, 680 41.00 42.00 42.00 42.00 43.00 43.00 04300 NYGEN (INHALATION) THERAPY 0 0 0 0 0 0 0 0 0 | | | | | | |
| 42.00 04200 INTRAVENDUS THERAPY | | | 0 | | | |
| 43. 00 04300 0AYSEN (I INFALATION) THERAPY 0 587, 389 44. 00 44. 00 04400 PHYSI CAL THERAPY 0 587, 389 45. 00 45. 00 04500 0SCEICH FATIONAL THERAPY 0 602, 435 45. 00 46. 00 04600 SPEECH FATHOLOGY 0 137, 375 47. 00 47. 00 04700 ELECTROCARDIOLOGY 0 137, 375 48. 00 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 583 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS -25, 456 292, 745 49. 00 50. 00 05000 DRUGS CHARGED TO PATIENTS -25, 456 292, 745 49. 00 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS -25, 456 292, 745 49. 00 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS -25, 456 292, 745 49. 00 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 DRUGS CHARGED TO PATIENTS 0 0 0 50. 00 05000 MALPRACTICLES CHARGED TO PATIENTS 0 0 0 50. 00 05000 MALPRACTICLES CHARGED TO PATIENTS 0 0 0 50. 00 05000 MALPRACTICLES CHARGED TO PATIENTS 0 0 0 50. 00 05000 MALPRACTICLES CHARGED TO PATIENTS 0 0 0 50. 00 05000 MALPRACTICLES CHARGED TO PATIENTS | | 1 | 7 040 | | | |
| 44. 00 | | 1 | -7,049 | | | |
| 46. 00 4400 04400 SPECH PATHOLOGY 0 137, 375 0 46. 00 47. 00 47. 00 47. 00 47. 00 47. 00 480. MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 583 48. 00 49. 00 64900 MEDI CAL SUPPLIES CHARGED TO PATIENTS -25, 456 292, 745 49. 00 50. 00 500. 00 5000 DENTAL CARE - 1 TILE XIX ONLY 0 0 50. 0 | | | 0 | | • | |
| 47.00 04700 124CTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 | | | 0 | | • | ı |
| 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 583 48. 00 04900 DRUGS CHARGED TO PATIENTS -25, 456 292, 745 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50. 00 | | 1 1 | 0 | | 1 | l l |
| 49.00 04900 DRUGS CHARGED TO PATIENTS -25,456 292,745 290 05000 05000 DRITAL CARE - TITLE XIX ONLY 0 | | 1 1 | 0 | | • | l l |
| 51.00 05100 SUPPORT SURFACES 0 238 51.00 52.00 | | | -25, 456 | | • | · · |
| 52. 00 05200 COMPLEX MEDICAL EQUIPMENT | 50.00 | | 0 | 0 | | 50.00 |
| 52. 01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 0 0 0 0 0 0 0 0 | | 1 1 | 0 | | • | · · |
| 52. 02 05202 MEDI CAL SERVI CES 0 0 0 0 0 0 0 0 0 | | | 0 | | | · · |
| OUTPATIENT SERVICE COST CENTERS | | 1 1 | 0 | | | l l |
| 61. 00 06100 RURAL HEALTH CLINIC 0 0 0 62. 00 62. 00 620 FOHC 62. 00 63. 00 06300 DIALYSI S 0 0 0 0 0 0 0 0 0 | | OUTPATIENT SERVICE COST CENTERS | | | | |
| 62. 00 06200 FOHC 0 06300 DI ALYSI S 0 0 0 0 0 0 0 0 0 | | | 0 | 1 | | l l |
| 63.00 06300 DI ALYSIS 0 0 0 0 0 OTHER REI MBURSABLE COST CENTERS 70.00 | | 1 | 0 | 0 | | · · |
| 70. 00 | | | 0 | 0 | | |
| 71. 00 | | | | | | |
| 73. 00 | | | 0 | | | |
| 74. 00 07400 OTHER REI MBURSEMENT 0 0 0 0 0 0 0 0 0 | | 1 | _ | | • | |
| SPECIAL PURPOSE COST CENTERS SO. 00 O O O O O O O O O | | 1 1 | | | | |
| 81. 00 | | | | | | |
| 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 0 0 0 0 0 83. 00 08300 HOSPI CE 0 0 0 0 0 0 83. 00 084. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | | | |
| 83. 00 | | | 0 | 0 | | |
| 84. 00 84. 01 84. 01 89. 00 NONREI MBURSABLE COST CENTERS 90. 00 91. 00 92. 00 92. 00 93. 00 94. 00 93. 00 94. 00 94. 00 95. 00 95. 00 96. 00 97. 00 | | | 0 | 0 | | l l |
| 89. 00 SUBTOTALS (sum of lines 1-84) | | 1 1 | 0 | 0 | | |
| NONRE MBURSABLE COST CENTERS | | 1 1 | 0 | 0 | | l l |
| 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 14,819 90. 00 91. 00 09100 BARBER AND BEAUTY SHOP 0 12,562 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST 0 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 0 0 0 0 0 | 89.00 | | - /30, 448 | 21, 964, 702 | | 89. 00 |
| 91. 00 09100 BARBER AND BEAUTY SHOP 0 12, 562 91. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 95. 00 00 00 00 00 00 00 00 | 90. 00 | | 0 | 14, 819 | | 90.00 |
| 93. 00 09300 NONPALD WORKERS 0 0 0 94.00 94.00 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 0 95.00 09500 09 | | 09100 BARBER AND BEAUTY SHOP | 0 | | • | l l |
| 94. 00 09400 PATI ENTS LAUNDRY 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST 0 0 0 95. 00 | | | 0 | 1 | · | |
| 95. 00 09500 OTHER NONREI MBURSABLE COST 0 0 95. 00 | | | 0 | | | l l |
| | | | | | | l l |
| | 100.00 | TOTAL | -730, 448 | 21, 992, 083 | | 100. 00 |

| Heal th | Financial Systems | CARE ONE AT NEW N | II LFORD | | In Lie | u of Form CMS-2 | 2540-10 |
|---------|----------------------------------|---------------------|------------|-----------|----------------------------------|-----------------------------|---------|
| RECLASS | SI FI CATI ONS | | Provi der | | Peri od: | Worksheet A-6 | |
| | | | | | From 01/01/2023 To 12/31/2023 | Data/Timo Dro | narod: |
| | | | | | 10 12/31/2023 | Date/Time Pre 5/10/2024 12: | |
| | | | | Increases | | 07 107 202 1 121 | р |
| | | Cost Cente | er | Li ne # | Sal ary | Non Salary | |
| | | 2. 00 | | 3.00 | 4. 00 | 5. 00 | |
| | (1) A - RECLASS MED SUPP CHARGED | | | | | | |
| 1.00 | | MEDICAL SUPPLIES CH | HARGED TO | 48.0 | 0 0 | 583 | 1. 00 |
| | | PATI ENTS | | | | | |
| | (1) C - RECLASS SUPPORT SURFACES | | | | | | |
| 2.00 | | SUPPORT SURFACES | | 51. 0 | 0 0 | 238 | 2. 00 |
| | TOTALS | | | | | | |
| 100.00 | | Total Reclassificat | tions (Sum | | 0 | 821 | 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 NEW MIL | _FORD | | In Lie | u of Form CMS-2 | 2540-10 |
|----------------------------------|------------------------------------|--------------|---------|--------------------------|----------------------------------|------------------|
| RECLASSIFICATIONS | F | Provi der No | | eriod: rom 01/01/2023 | Worksheet A-6 | |
| | | | | o 12/31/2023 | Date/Time Prep 5/10/2024 12:0 | pared: 00 pm_ |
| | | Decreases | | | | |
| | Cost Center | | Li ne # | Sal ary | Non Salary | |
| | 6.00 | | 7. 00 | 8. 00 | 9. 00 | |
| (1) A - RECLASS MED SUPP CHARGED | | | | | | |
| 1. 00 | CENTRAL SERVICES & SU | UPPLY | 10. 00 | 0 | 583 | 1.00 |
| (1) C - RECLASS SUPPORT SURFACES | | | | | | |
| | CAP REL COSTS - MOVAE EQUIPMENT | BLE | 2. 00 | 0 | 238 | 2. 00 |
| TOTALS | | | | | | |
| 100.00 | | | | O | 821 | 100. 00 |

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE ONE AT NEW MILFORD Provi der No.: 315306

| | | | | | To 12/31/2023 | Date/Time Prep 5/10/2024 12:0 | pared: 00 pm |
|----------------|--|------------------|-------------|-----------------|---------------|----------------------------------|-----------------|
| | | | | Acqui si ti ons | 5 | | |
| | Description | Begi nni ng | Purchases | Donati on | Total | Di sposal s and | |
| | | Bal ances | | | | Retirements | |
| | T | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES | 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 | | | | |
| | | / 00 | Assets | | | | |
| | ANALYCIC OF CHANCEC IN CARLTAL ACCET DALANCE | 6.00 | 7. 00 | | | | |
| 1. 00 | ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Land | | 0 | | | | 1. 00 |
| 2.00 | Land Improvements | 0 | 0 | | | | 2. 00 |
| 3.00 | · · | 0 | 0 | | | | 3. 00 |
| 4.00 | Buildings and Fixtures | | 0 | | | | |
| | Building Improvements | | 0 | | | | 4. 00 5. 00 |
| 5. 00 6. 00 | Fixed Equipment | | 0 | | | | 6. 00 |
| | Movable Equipment | | 0 | | | | |
| 7.00 | Subtotal (sum of lines 1-6) | | 0 | | | | 7. 00 8. 00 |
| 8.00 | Reconciling Items | | 0 | | | | 8. 00 9. 00 |
| 9.00 | Total (line 7 minus line 8) | ı U | U | l | | ļ | 9.00 |

| ADJUST | MENTS TO EXPENSES | | Provi der | No.: 315306 Peri od: From 01/01/202 To 12/31/202 | Worksheet A-8 3 Date/Time Pre 5/10/2024 12: | pared: |
|------------------|---|-----------------------------|---------------|---|--|----------------|
| | | | | Expense Classification on To/From Which the Amount is | n Worksheet A | |
| | Description (1) | (2) Basis For Adjustment | Amount | Cost Center | Li ne No. | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | |
| 1. 00 | Investment income on restricted funds | В | -2, 935 | CAP REL COSTS - BLDGS & | 1.00 | 1.00 |
| 2.00 | (chapter 2) Trade, quantity, and time discounts (chapter 8) | | O | | 0.00 | 2. 00 |
| 3. 00 | Refunds and rebates of expenses (chapter 8) | | O | | 0.00 | 3. 00 |
| 4. 00 | Rental of provider space by suppliers (chapter 8) | | O | | 0.00 | |
| 5. 00 | Tel ephone services (pay stations excluded) (chapter 21) | | O | | 0.00 | 5. 00 |
| 6.00 | Television and radio service (chapter 21) | | 0 | | 0.00 | 6. 00 |
| 7. 00 8. 00 | Parking lot (chapter 21) Remuneration applicable to provider-based | A-8-2 | 0 | 1 | 0.00 | 7. 00 8. 00 |
| 9. 00 | physician adjustment Home office cost (chapter 21) | | O | | 0.00 | 9.00 |
| 10. 00 | Sale of scrap, waste, etc. (chapter 23) | | 0 | | 0.00 | |
| 11. 00 | Nonallowable costs related to certain | | 0 | | 0.00 | 11. 00 |
| 12. 00 | Capital expenditures (chapter 24) Adjustment resulting from transactions with | A-8-1 | 271, 622 | | | 12. 00 |
| 13. 00 | related organizations (chapter 10) Laundry and linen service | В | -1 460 | LAUNDRY & LINEN SERVICE | 6.00 | 13. 00 |
| 14. 00 | Revenue - Employee meals | | 0 |) | 0.00 | |
| | Cost of meals - Guests | | 0 | l . | 0.00 | |
| 16. 00 | Sale of medical supplies to other than | | 0 | | 0.00 | 16. 00 |
| 17. 00 | patients Sale of drugs to other than patients | | 0 | | 0.00 | 17. 00 |
| | Sale of medical records and abstracts | | 0 | | 0.00 | |
| 19. 00 | 9 | | 0 | | 0.00 | 19. 00 |
| 20. 00 | Income from imposition of interest, finance | | 0 | P | 0.00 | 20. 00 |
| 21. 00 | or penalty charges (chapter 21) Interest expense on Medicare overpayments | | O | | 0.00 | 21.00 |
| 21.00 | and borrowings to repay Medicare overpayments overpayments | | O | , | 0.00 | 21.00 |
| 22. 00 | Utilization reviewphysicians' compensation | | 0 | UTILIZATION REVIEW - SNF | 82.00 | 22. 00 |
| 23. 00 | (chapter 21) Depreciationbuildings and fixtures | | O | CAP REL COSTS - BLDGS & | 1.00 | 23. 00 |
| | | | | FI XTURES | | |
| 24. 00 | Depreciationmovable equipment | | | CAP REL COSTS - MOVABLE EQUIPMENT | 2. 00 | |
| 25. 00 | | A | | ADMINISTRATIVE & GENERAL | 4.00 | |
| | MI SCELLANEOUS EXPENSE | A | | ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL | l e | 25. 01 |
| 25. 02 25. 03 | RESIDENT REPLACEMENT LITEMS MARKETING EXPENSE | A A | | ADMINISTRATIVE & GENERAL | 4. 00 4. 00 | 1 |
| 25. 04 | MARKETI NG CORP EXPENSE | A | | ADMINISTRATIVE & GENERAL | 4.00 | 1 |
| 25. 05 | MARKETING - MEALS | A | | ADMINISTRATIVE & GENERAL | 4.00 | 1 |
| 25.06 | SHOWS & CONFERENCES | A | | ADMINISTRATIVE & GENERAL | 4.00 | 1 |
| 25. 07 | CHARI TABLE CONTRIBUTIONS | A | | ADMINISTRATIVE & GENERAL | 4. 00 | 1 |
| 25. 08 | SPONSORSHI PS | A | | ADMINISTRATIVE & GENERAL | 4. 00 | |
| 25. 09 | BAD DEBT EXPENSE | A | • | ADMI NI STRATI VE & GENERAL | 4.00 | |
| 25. 10 | BAD DEBT EXPENSE - MEDI CARE | A | | ADMINISTRATIVE & GENERAL | 4.00 | 1 |
| 25. 11 | BAD DEBT EXPENSE - OTHER | A | • | ADMINISTRATIVE & GENERAL | 4.00 | |
| 25. 12 25. 13 | OTHER MEDICAL SERVICES EXPENSE OTHER REVENUE | A B | | SKILLED NURSING FACILITY ADMINISTRATIVE & GENERAL | 30. 00 4. 00 | 1 |
| | OTHER INCOME | В | | ADMINISTRATIVE & GENERAL | 4.00 | 1 |
| | Total (sum of lines 1 through 99) (Transfer | | -730, 448 | | 7.00 | 100.00 |
| | to Worksheet A, col. 6, line 100) | | | | | |
| (1) De | scription - all chapter references in this co | lumn pertain to | CMS Pub. 15-1 | ' 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 NEW MILFORD

Health Financial Systems CARE ONE AT NESTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315306 OFFICE COSTS

| | | | | Т | o 12/31/2023 Date/Time Pre 5/10/2024 12: | |
|----------------|---|--------------------|-------------------|----------------|---|----------------|
| | | Line No. | | Center | Expense Items | |
| | | 1. 00 | | 00 | 3. 00 | |
| | PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALIMED HOME OFFICE COSTS: | RED AS A RESULT | OF TRANSACTIO | NS WITH RELATE | D ORGANIZATIONS OR | |
| 1.00 | CLAIMED HOME OFFICE COSTS: | 1 00 | CAP REL COSTS | - BLDGS & | RENT - RELATED PARTY | 1.00 |
| 1.00 | | 1.00 | FI XTURES | DEDGG Q | REENTES TAIRT | 1.00 |
| 2. 00 | | 4. 00 | ADMI NI STRATI VE | & GENERAL | ADMINISTRATIVE FEE - RELATED PARTY | 2. 00 |
| 3. 00 | | 4. 00 | ADMI NI STRATI VE | & GENERAL | IT ALLOCATION - RELATED PARTY | 3. 00 |
| 4.00 | | 4. 00 | ADMI NI STRATI VE | & GENERAL | MANAGEMENT FEES | 4. 00 |
| 5.00 | | 4. 00 | ADMI NI STRATI VE | & GENERAL | REALTY ADMIN | 5. 00 |
| 6.00 | | | NURSING ADMINI | | PHARMACY CONSULTANT | 6. 00 |
| 7.00 | | | CENTRAL SERVIC | | WOUND CARE EXPENSE | 7. 00 |
| 8. 00 | | | PHARMACY | | DRUGS-NON-PRESCRI PTI ON, NON-LEGEND | 8. 00 |
| 9.00 | | | PHARMACY | | PHARMACY SUPPLIES | 9. 00 |
| 9. 01 | | | INTRAVENOUS TH | | IV EXPENSE | 9. 01 |
| 9. 02 | | | DRUGS CHARGED | | DRUGS-PRESCRIPTION, LEGEND DRUGS OTH | 9. 02 |
| 9. 03 | | | DRUGS CHARGED | | DRUGS-PRESCRIPTION, LEGEND DRUGS MAN | 9. 03 |
| 9. 04 | | 49. 00 | DRUGS CHARGED | TO PATIENTS | DRUGS-PRESCRI PTI ON, MEDI CARE | 9. 04 |
| 10. 00 | TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12. | | | | | 10. 00 |
| | | Amount | Amount | Adjustments | | |
| | | Allowable In | Included in | (col. 4 minus | | |
| | | Cost | Wkst. A, col. | col . 5) | | |
| | | 4.00 | 5 5. 00 | 6, 00 | | |
| | PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR | | | | D ORGANIZATIONS OR | |
| | CLAIMED HOME OFFICE COSTS: | | | | | |
| 1.00 | | 2, 173, 198 | 1, 550, 291 | 622, 907 | | 1.00 |
| 2.00 | | 0 | | | | 2. 00 |
| 3.00 | | 0 | 0,200 | | | 3. 00 |
| 4.00 | | 1, 006, 304 | | 1 | | 4. 00 |
| 5.00 | | 459 | | 1 .0, | | 5. 00 |
| 6.00 | | 46, 450 | | | | 6.00 |
| 7. 00 8. 00 | | 21, 840 32, 769 | | 1 | | 7. 00 8. 00 |
| 9. 00 | | 2, 263 | | | | 9.00 |
| 9. 01 | | 81, 062 | | l . | | 9. 01 |
| 9. 02 | | 46, 429 | | , | | 9. 02 |
| 9. 03 | | 103, 098 | | 1 | | 9. 03 |
| 9. 04 | | 143, 218 | | | | 9. 04 |
| 10. 00 | TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line | 3, 657, 090 | | 1 | | 10.00 |
| | 12. | | | | | |

OFFICE COSTS

Parts I-II Date/Time Prepared:

5/10/2024 12:00 pm

12/31/2023

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00 PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

| 1.00 | Α | DANI EL STRAUS | 70. 00 | 1. 00 |
|--|---|----------------------------|--------|---------|
| 2.00 | Α | MOSHAEL STRAUS | 4.00 | 2. 00 |
| 3.00 | Α | DES 2009 FAMILY TRUST | 24.00 | 3. 00 |
| 4.00 | Α | LJJ INVESTIMENTS | 1.00 | 4. 00 |
| 5. 00 | Α | 1997 TRUST REMAINDER | 1.00 | 5. 00 |
| 6.00 | Α | DANI EL STRAUS | 70. 00 | 6. 00 |
| 7. 00 | Α | DANI EL STRAUS | 70. 00 | 7. 00 |
| 8. 00 | F | DES HOLDING CO. INC. | 0.00 | 8. 00 |
| 9. 00 | F | PARTNERS PHARMACY SERVICES | 0.00 | 9. 00 |
| | | LLC | | |
| 10. 00 | | | 0. 00 | 10.00 |
| 100.00 G. Other (financial or non-financial) | | | 0.00 | 100. 00 |
| speci fy: | | | | |
| | | | | |

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

| | Rel ated Organi | Related Organization(s) and/or Home Office | | | | | | |
|--|-----------------------------|--|------------------|--|--|--|--|--|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Name | Percentage of | Type of Business | | | | | |
| | | Ownershi p | | | | | | |
| | 4. 00 | 5. 00 | 6. 00 | | | | | |
| DADT II INTERRELATIONOULD TO BELATER ORGANIE | ATLONICO AND OD HOME OFFICE | | | | | | | |

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 | THCI OF NEW JERSEY LLC | 70.00 | REALTY | 1.00 |
|--|-----------------------------|--------|------------|--------|
| 2.00 | THCI OF NEW JERSEY LLC | 4.00 | REALTY | 2.00 |
| 3.00 | THCI OF NEW JERSEY LLC | 24.00 | REALTY | 3.00 |
| 4. 00 | THCI OF NEW JERSEY LLC | 1.00 | REALTY | 4.00 |
| 5. 00 | THCI OF NEW JERSEY LLC | 1.00 | REALTY | 5. 00 |
| 6.00 | HEALTHBRIDGE MANAGEMENT LLC | 100.00 | MANAGEMENT | 6.00 |
| 7. 00 | TOTALCARE LLC | 99.00 | WOUND CARE | 7.00 |
| 8.00 | TOTALCARE LLC | 1.00 | WOUND CARE | 8.00 |
| 9. 00 | PARTNERS PHARMACY LLC | 100.00 | PHARMACY | 9.00 |
| 10. 00 | | 0.00 | | 10.00 |
| 100.00 G. Other (financial or non-financial) | | 0.00 | | 100.00 |
| speci fy: | | | | |
| | | | | |

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

| Peri od: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315306

| | | | | | To | 12/31/2023 | Date/Time Pre | |
|------------------|-------|--|----------------------------|----------------------|------------|----------------------|----------------------------|------------------|
| | | | | CAPI TAL REL | ATED COSTS | | 5/10/2024 12:0 | JO PIII |
| | | Cost Center Description | Net Expenses | BLDGS & | MOVABLE | EMPLOYEE | Subtotal | |
| | | oost center bescription | for Cost | FIXTURES | EQUI PMENT | BENEFITS | Subtotal | |
| | | | Allocation | | | | | |
| | | | (from Wkst A col. 7) | | | | | |
| | | | 0 | 1. 00 | 2.00 | 3. 00 | 3A | |
| 1. 00 | | AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES | 2, 628, 250 | 2, 628, 250 | | | | 1. 00 |
| 2.00 | 1 | CAP REL COSTS - MOVABLE EQUIPMENT | 4, 910 | 2, 020, 230 | 4, 910 | | | 2. 00 |
| 3.00 | | EMPLOYEE BENEFITS | 2, 318, 777 | 41, 708 | | 2, 360, 563 | | 3. 00 |
| 4. 00 5. 00 | | ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS | 3, 154, 011 1, 080, 391 | 65, 497 91, 885 | | 137, 039 46, 573 | 3, 356, 669 1, 219, 021 | 4. 00 5. 00 |
| 6. 00 | | LAUNDRY & LINEN SERVICE | 276, 958 | 59, 693 | | 30, 907 | 367, 670 | 6. 00 |
| 7.00 | 1 | HOUSEKEEPI NG | 738, 683 | 27, 805 | | 129, 984 | 896, 524 | 7. 00 |
| 8. 00 9. 00 | | DI ETARY NURSI NG ADMINI STRATI ON | 1, 466, 156 1, 010, 846 | 281, 053 177, 291 | | 188, 645 193, 727 | 1, 936, 379 1, 382, 195 | 8. 00 9. 00 |
| 10.00 | 01000 | CENTRAL SERVICES & SUPPLY | 204, 400 | 18, 492 | | 8, 879 | 231, 806 | 10. 00 |
| 11. 00 12. 00 | | PHARMACY MEDICAL RECORDS & LIBRARY | 35, 032 30, 867 | 0 8, 436 | | 0 6, 627 | 35, 032 45, 946 | 11. 00 12. 00 |
| 13. 00 | | SOCIAL SERVICE | 148, 383 | 133, 761 | 250 | 31, 855 | 314, 249 | 13. 00 |
| 14. 00 | | NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | | 0 | 0 | 14. 00 |
| 15. 00 | | ACTIVITES LENT ROUTINE SERVICE COST CENTERS | 432, 240 | 0 | 0 | 89, 294 | 521, 534 | 15. 00 |
| 30. 00 | | SKILLED NURSING FACILITY | 6, 492, 908 | 1, 666, 479 | 3, 112 | 1, 222, 679 | 9, 385, 178 | 30. 00 |
| 31. 00 | | NURSING FACILITY | 0 | 0 | | 0 | 0 | 31. 00 |
| 32. 00 33. 00 | | ICF/IID OTHER LONG TERM CARE | 0 | 0 | | 0 | 0 | 32. 00 33. 00 |
| 00.00 | | LARY SERVICE COST CENTERS | <u> </u> | | | <u> </u> | 0 | 00.00 |
| 40.00 | 1 | RADI OLOGY | 55, 038 | 0 | | 0 | 55, 038 | 40.00 |
| 41. 00 42. 00 | 1 | LABORATORY INTRAVENOUS THERAPY | 126, 680 81, 062 | 0 | | 0 | 126, 680 81, 062 | 41. 00 42. 00 |
| 43.00 | 04300 | OXYGEN (INHALATION) THERAPY | 0 | 0 | 0 | O | 0 | 43.00 |
| 44.00 | 1 | PHYSI CAL THERAPY OCCUPATI ONAL THERAPY | 587, 389 | 36, 477 | | 117, 077 | 741, 011 | 44.00 |
| 45. 00 46. 00 | 1 | SPEECH PATHOLOGY | 602, 435 137, 375 | 11, 068 2, 160 | | 129, 331 27, 946 | 742, 855 167, 485 | 45. 00 46. 00 |
| 47. 00 | 04700 | ELECTROCARDI OLOGY | 0 | 0 | 1 | 0 | 0 | 47. 00 |
| 48. 00 49. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS | 583 292, 745 | 0 | 0 | 0 | 583 292, 745 | 48. 00 49. 00 |
| 50.00 | | DENTAL CARE - TITLE XIX ONLY | 272, 743 | 0 | 0 | o | 272, 743 | 50.00 |
| 51.00 | | SUPPORT SURFACES | 238 | 0 | 0 | 0 | 238 | 51.00 |
| 52. 00 52. 01 | | COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST | 0 | 0 | 0 | 0 | 0 | 52. 00 52. 01 |
| 52. 02 | | MEDICAL SERVICES | Ö | 0 | | Ö | 0 | 52. 02 |
| (0.00 | | TIENT SERVICE COST CENTERS | | 0 | | ما | - | , o oo |
| 60. 00 61. 00 | | CLINIC RURAL HEALTH CLINIC | 0 | 0 | | 0 | 0 | 60. 00 61. 00 |
| 62.00 | 06200 | FQHC | | | | | | 62. 00 |
| 63. 00 | | DI ALYSI S DEL MOLIDSADI E COST CENTEDS | 0 | 0 | 0 | 0 | 0 | 63. 00 |
| 70. 00 | | REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 | | AMBULANCE | 58, 345 | 0 | | 0 | 58, 345 | |
| 73. 00 74. 00 | 07300 | CMHC OTHER REI MBURSEMENT | 0 | 0 | | 0 | 0 | 73. 00 74. 00 |
| 74.00 | | AL PURPOSE COST CENTERS | <u> </u> | 0 | <u> </u> | <u> </u> | 0 | 74.00 |
| 80.00 | | MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80.00 |
| 81. 00 82. 00 | 1 | INTEREST EXPENSE UTILIZATION REVIEW - SNF | | | | | | 81. 00 82. 00 |
| 83.00 | 08300 | HOSPI CE | 0 | 0 | 0 | 0 | 0 | 83. 00 |
| 84. 00 | | OTHER SPECIAL PURPOSE COST I | 0 | 0 | 0 | 0 | 0 | 84. 00 |
| 84. 01 89. 00 | 08401 | OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84) | 21, 964, 702 | 2, 621, 805 | 4, 898 | 2, 360, 563 | 0 21, 958, 245 | 84. 01 89. 00 |
| | | MBURSABLE COST CENTERS | | | | | | |
| 90. 00 91. 00 | | GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP | 14, 819 12, 562 | 0 6, 445 | | 0 | 14, 819 19, 019 | 90. 00 91. 00 |
| 92. 00 | | PHYSICIANS PRIVATE OFFICES | 0 | 0, 445 | 0 | o | 19, 019 | 92.00 |
| 93.00 | | NONPALD WORKERS | 0 | 0 | 0 | o | 0 | 93.00 |
| 94. 00 95. 00 | | PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST | 0 | 0 |] 0 | 0 0 | 0 | 94. 00 95. 00 |
| 98. 00 | | Cross Foot Adjustments | | 0 | _ | ő | 0 | 98. 00 |
| 99.00 | | Negative Cost Centers | 0 | 0 | 0 | 2 2/0 5/3 | 0 | 99.00 |
| 100.00 | וי | TOTAL | 21, 992, 083 | 2, 628, 250 | 4, 910 | 2, 360, 563 | 21, 992, 083 | 100.00 |

Provi der No.: 315306

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

| | | | | T | 0 12/31/2023 | Date/Time Pre 5/10/2024 12: | pared: |
|------------------|--|----------------------|------------------------|-------------------|-------------------|-----------------------------|------------------|
| | Cost Center Description | ADMI NI STRATI VE | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | OO piii |
| | · | & GENERAL | OPERATI ON, | LINEN SERVICE | | | |
| | | | MAINT. & | | | | |
| | | 4.00 | REPAI RS 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| | GENERAL SERVICE COST CENTERS | 4.00 | 3.00 | 0.00 | 7.00 | 0.00 | |
| 1.00 | 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 | 3, 356, 669 | 1 420 505 | | | | 4.00 |
| 5. 00 6. 00 | 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE | 219, 574 66, 226 | 1, 438, 595 35, 351 | | | | 5. 00 6. 00 |
| 7. 00 | 00700 HOUSEKEEPI NG | 161, 485 | 16, 467 | | 1, 074, 476 | | 7. 00 |
| 8. 00 | 00800 DI ETARY | 348, 786 | 166, 445 | | 128, 962 | 2, 580, 572 | 8. 00 |
| 9.00 | 00900 NURSI NG ADMI NI STRATI ON | 248, 965 | 104, 995 | | 81, 350 | 0 | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 41, 754 | 10, 951 | | 8, 485 | 0 | 10.00 |
| 11. 00 | 01100 PHARMACY | 6, 310 | 4 004 | · · · · · · · · · | 2 071 | 0 | 11.00 |
| 12. 00 13. 00 | O1200 MEDICAL RECORDS & LIBRARY O1300 SOCIAL SERVICE | 8, 276 56, 603 | 4, 996 79, 216 | | 3, 871 61, 377 | 0 | 12. 00 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 77, 210 | ő | 01, 377 | 0 | 14. 00 |
| 15. 00 | 01500 ACTI VI TES | 93, 940 | 0 | 0 | 0 | 0 | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 1 1 | 1, 690, 489 | 986, 920 | | 764, 666 | 2, 580, 572 | |
| 31. 00 | 03100 NURSING FACILITY | 0 | 0 | 0 | | 0 | |
| 32.00 | 03200 CF/IID 03300 OTHER LONG TERM CARE | 0 | 0 | 0 | | 0 | |
| 33.00 | ANCI LLARY SERVI CE COST CENTERS | ١ | | 1 0 | 0 | | 33.00 |
| 40.00 | 04000 RADI OLOGY | 9, 914 | 0 | 0 | 0 | 0 | 40. 00 |
| 41. 00 | 04100 LABORATORY | 22, 818 | 0 | 0 | 0 | 0 | 41. 00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | 14, 601 | 0 | 0 | 0 | 0 | 42. 00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 122 472 | 21 (02 | 0 | 14 720 | 0 | 43.00 |
| 44. 00 45. 00 | 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY | 133, 473 133, 805 | 21, 603 6, 555 | | 16, 738 5, 079 | 0 | 44. 00 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 30, 168 | 1, 279 | | 991 | 0 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 105 | 0 | 0 | 0 | 0 | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 52, 730 | 0 | 0 | 0 | 0 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0 | 0 | 0 | 50.00 |
| 51. 00 52. 00 | O5100 SUPPORT SURFACES O5200 COMPLEX MEDI CAL EQUI PMENT | 43 | 0 | 0 | 0 | 0 | 51. 00 52. 00 |
| 52. 00 | 05201 OTHER ANCILLARY SERVICES COST | 0 | 0 | 0 | 0 | 0 | ı |
| 52. 02 | 05202 MEDI CAL SERVI CES | Ö | 0 | ő | - | 0 | ł |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60.00 | 06000 CLINIC | 0 | 0 | _ | | 0 | |
| 61. 00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61.00 |
| 62. 00 63. 00 | 06200 F0HC 06300 DI ALYSI S | | 0 | 0 | 0 | 0 | 62. 00 63. 00 |
| 03.00 | OTHER REIMBURSABLE COST CENTERS | <u> </u> | | 1 0 | <u> </u> | | 03.00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0 | 0 | 70.00 |
| | 07100 AMBULANCE | 10, 509 | 0 | 0 | 0 | 0 | |
| 73.00 | 07300 CMHC | 0 | 0 | 0 | 0 | 0 | |
| 74.00 | 07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | U | 0 | 74. 00 |
| 80. 00 | | | | | | | 80. 00 |
| | 08100 NTEREST EXPENSE | | | | | | 81.00 |
| 82. 00 | | | | | | | 82. 00 |
| | 08300 H0SPI CE | 0 | 0 | 0 | 0 | 0 | |
| 84.00 | 08400 OTHER SPECIAL PURPOSE COST I | 0 | 0 | 0 | 0 | 0 | |
| 84. 01 89. 00 | 08401 OTHER SPECIAL PURPOSE COST II | 2 250 574 | 1 424 770 | 0 469, 247 | 1 071 510 | 2 500 573 | |
| 09.00 | SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS | 3, 350, 574 | 1, 434, 778 | 407, 247 | 1, 071, 519 | 2, 580, 572 | 09.00 |
| 90. 00 | | 2, 669 | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 3, 426 | 3, 817 | 0 | 2, 957 | 0 | 91. 00 |
| | 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | 0 | 0 | |
| 93.00 | 09300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | |
| 94. 00 95. 00 | O9400 PATIENTS LAUNDRY O9500 OTHER NONREIMBURSABLE COST | | 0 | 0 | 0 | 0 | |
| 98. 00 | Cross Foot Adjustments | | 0 | 0 | ol | 0 | 98.00 |
| 99. 00 | Negative Cost Centers | 0 | 0 | 0 | o | 0 | 99. 00 |
| 100.00 | TOTAL | 3, 356, 669 | 1, 438, 595 | 469, 247 | 1, 074, 476 | 2, 580, 572 | 100. 00 |
| | | | | | | | |

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315306 | Peri od: From 01/01/20

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

5/10/2024 12:00 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 1,817,505 9 00 01000 CENTRAL SERVICES & SUPPLY 292, 996 10.00 10.00 01100 PHARMACY 11.00 0 41, 342 11.00 63, 089 12.00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 13.00 01300 SOCIAL SERVICE 0 0 511, 445 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 0 14.00 C 0 0 15.00 01500 ACTI VI TES 0 Ω 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 1, 817, 505 292, 996 41, 342 63, 089 511, 445 30.00 03100 NURSING FACILITY 31 00 C Ω 31.00 32.00 03200 | CF/IID 0 C 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 0 33.00 0 0 33.00 ANCILLARY SERVICE COST CENTERS 04000 RADI OLOGY 40.00 0 0 0 Λ 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0 0 0 0 0 0 0 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 04400 PHYSI CAL THERAPY 0 44.00 0 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0 45.00 46.00 04600 SPEECH PATHOLOGY 00000 0 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 0 47 00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY O 50 00 0 05100 SUPPORT SURFACES 0 51.00 0 0 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 52.00 52.00 0 ol 52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 52 02 0 0 52.02 OUTPATIENT SERVICE COST CENTERS 06000 CLI NI C 0 0 60.00 60.00 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 o 0 61.00 06200 FOHC 62.00 62 00 06300 DI ALYSI S 0 0 63.00 63.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 C 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSEMENT 0 ol 0 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80 00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 08300 H0SPLCE 83.00 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 84.01 SUBTOTALS (sum of lines 1-84) 63, 089 511, 445 1,817,505 292, 996 41, 342 89.00 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 0 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 0 91.00 0 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 C 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 95.00 09500 OTHER NONREIMBURSABLE COST 0 0 95.00 C Cross Foot Adjustments 98.00 0 98 00 99.00 Negative Cost Centers 0 99.00 511, 445 100. 00 100.00 1, 817, 505 292, 996 41, 342 63, 089

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315306

| | | | | | | To 12/31/2023 | Date/Time Pre 5/10/2024 12: | pared: OO nm |
|-------------------|-------|---|------------------------------|---------------|-------------|---------------------------|-----------------------------|-------------------|
| | | | | OTHER GENERAL | | | 37 107 2024 12. | OO piii |
| | | Coat Contar Decement on | NUDCLNC AND | SERVI CE | Cubtatal | Doot Standown | Total | |
| | | Cost Center Description | NURSING AND ALLIED HEALTH | ACTI VI TES | Subtotal | Post Stepdown Adjustments | Total | |
| | | | EDUCATI ON | | | , | | |
| | CENED | AL SERVICE COST CENTERS | 14. 00 | 15. 00 | 16. 00 | 17. 00 | 18. 00 | |
| 1.00 | | CAP REL COSTS - BLDGS & FLXTURES | | | | | | 1.00 |
| 2.00 | 00200 | CAP REL COSTS - MOVABLE EQUIPMENT | | | | | | 2. 00 |
| 3.00 | | EMPLOYEE BENEFITS | | | | | | 3.00 |
| 4. 00 5. 00 | 1 | ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS | | | | | | 4. 00 5. 00 |
| 6. 00 | 1 | LAUNDRY & LINEN SERVICE | | | | | | 6.00 |
| 7.00 | | HOUSEKEEPI NG | | | | | | 7. 00 |
| 8. 00 | | DIETARY | | | | | | 8. 00 |
| 9. 00 10. 00 | | NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY | | | | | | 9. 00 10. 00 |
| 11. 00 | | PHARMACY | | | | | | 11.00 |
| 12. 00 | 1 | MEDICAL RECORDS & LIBRARY | | | | | | 12. 00 |
| 13. 00 | 1 | SOCIAL SERVICE | | | | | | 13.00 |
| 14. 00 15. 00 | 1 | NURSING AND ALLIED HEALTH EDUCATION ACTIVITES | 0 | /15 474 | | | | 14. 00 15. 00 |
| 13.00 | | IENT ROUTINE SERVICE COST CENTERS | 0 | 615, 474 | · | | | 15.00 |
| 30.00 | | SKILLED NURSING FACILITY | 0 | 615, 474 | 19, 218, 92 | 3 0 | 19, 218, 923 | 30.00 |
| 31. 00 | | NURSING FACILITY | 0 | 0 | • | 0 0 | 0 | 31. 00 |
| 32. 00 33. 00 | | ICF/IID OTHER LONG TERM CARE | 0 | 0 | • | 0 0 | 0 | 32. 00 33. 00 |
| 33.00 | | LARY SERVICE COST CENTERS | 0 | | <u>'l</u> | 0 0 | 0 | 33.00 |
| 40.00 | | RADI OLOGY | 0 | 0 | 64, 95 | 2 0 | 64, 952 | 40. 00 |
| 41. 00 | 1 | LABORATORY | 0 | 0 | | | 149, 498 | |
| 42. 00 43. 00 | | INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY | 0 | 0 | 1 | 0 0 | 95, 663 0 | 1 |
| 44. 00 | 1 | PHYSI CAL THERAPY | | | 1 | - | 912, 825 | • |
| 45.00 | 1 | OCCUPATI ONAL THERAPY | 0 | 0 | 1 | | 888, 294 | 1 |
| 46. 00 | | SPEECH PATHOLOGY | 0 | 0 | 1 | | 199, 923 | 1 |
| 47. 00 48. 00 | | ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 68 | 0 8 0 | 0 688 | 47. 00 48. 00 |
| 49. 00 | 1 | DRUGS CHARGED TO PATIENTS | | | | | 345, 475 | ł |
| 50.00 | 1 | DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 1 | 0 | 0 | 50.00 |
| 51.00 | | SUPPORT SURFACES | 0 | 0 | 28 | | 281 | 51.00 |
| 52. 00 52. 01 | | COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST | 0 | 0 | 1 | 0 0 0 | 0 | |
| 52. 01 | 1 | MEDICAL SERVICES | 0 | | | 0 0 | 0 | 52. 02 |
| | OUTPA | TIENT SERVICE COST CENTERS | | | | | | |
| 60.00 | | CLINIC | 0 | · - | 1 | 0 | 0 | 60.00 |
| 61. 00 62. 00 | 06200 | RURAL HEALTH CLINIC | 0 | 0 | 1 | 0 0 | 0 | 61. 00 62. 00 |
| 63. 00 | 1 | DIALYSIS | 0 | 0 | | 0 0 | 0 | 1 |
| | | REIMBURSABLE COST CENTERS | | | | | | |
| 70.00 | | HOME HEALTH AGENCY COST AMBULANCE | 0 | 0 | | 0 | 0 | |
| 71. 00 73. 00 | 07100 | | 0 | | 68, 85 | 0 0 | 08,854 | 71. 00 73. 00 |
| | | OTHER REIMBURSEMENT | Ö | Ö | • | 0 0 | 0 | 1 |
| | | AL PURPOSE COST CENTERS | | | | | | |
| 80. 00 81. 00 | 1 | MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE | | | | | | 80. 00 81. 00 |
| 82. 00 | | UTILIZATION REVIEW - SNF | | | | | | 82.00 |
| 83. 00 | | HOSPI CE | 0 | 0 | | 0 0 | 0 | • |
| 84. 00 | | OTHER SPECIAL PURPOSE COST I | 0 | 0 | | 0 | 0 | |
| 84. 01 89. 00 | 08401 | OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84) | 0 | 0 615, 474 | 21, 945, 37 | 0 6 0 | 0 21, 945, 376 | |
| 69.00 | NONRE | IMBURSABLE COST CENTERS | 0 | 015, 474 | 21, 940, 37 | 0 | 21, 745, 370 | 09.00 |
| 90.00 | | GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | 17, 48 | 8 0 | 17, 488 | 90. 00 |
| 91. 00 | | BARBER AND BEAUTY SHOP | 0 | 0 | 29, 21 | 9 0 | 29, 219 | |
| 92. 00 93. 00 | | PHYSICIANS PRIVATE OFFICES NONPAID WORKERS | 0 | | | 0 | 0 | |
| 94. 00 | | PATIENTS LAUNDRY | | | | o o | 0 | |
| 95.00 | | OTHER NONREIMBURSABLE COST | 0 | 0 | | 0 0 | 0 | 95. 00 |
| 98.00 | | Cross Foot Adjustments | 0 | 0 | | 0 0 | 0 | 98. 00 |
| 99. 00 100. 00 | | Negative Cost Centers TOTAL | | 615, 474 | 21, 992, 08 | 0 3 0 | 0 21, 992, 083 | 99. 00 100. 00 |
| 100.00 | 1 | 1.0 | 1 | 1 013, 474 | 21, //2, 00 | ٥ - | 21, //2, 003 | 1.00.00 |

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315306

| | | | | | To | 12/31/2023 | Date/Time Pre 5/10/2024 12: | |
|------------------|--------|--|--------------------------|----------------------|-----------------------|---------------------|--------------------------------|------------------|
| | | | | CAPI TAL REL | ATED COSTS | | 37 107 2024 12. | JO pili |
| | | | 5 | DI DOC A | MOVARIE | | ENDLOVEE | |
| | | Cost Center Description | Directly Assigned New | BLDGS & FI XTURES | MOVABLE EQUI PMENT | Subtotal | EMPLOYEE BENEFITS | |
| | | | Capi tal | | 240112.11 | | DEMENT TO | |
| | | | Related Costs | 1 00 | 2.00 | 2.4 | 2.00 | |
| | GENER | AL SERVICE COST CENTERS | 0 | 1. 00 | 2. 00 | 2A | 3. 00 | |
| 1.00 | | CAP REL COSTS - BLDGS & FLXTURES | | | | | | 1. 00 |
| 2.00 | | CAP REL COSTS - MOVABLE EQUIPMENT | | | | | | 2. 00 |
| 3.00 | 1 | EMPLOYEE BENEFITS | 0 | 41, 708 | | 41, 786 | 41, 786 | 3. 00 |
| 4. 00 5. 00 | | ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS | 0 | 65, 497 91, 885 | | 65, 619 92, 057 | 2, 426 824 | 4. 00 5. 00 |
| 6.00 | | LAUNDRY & LINEN SERVICE | O | 59, 693 | | 59, 805 | 547 | 6. 00 |
| 7. 00 | 1 | HOUSEKEEPI NG | 0 | 27, 805 | | 27, 857 | 2, 301 | 7. 00 |
| 8. 00 9. 00 | 1 | DI ETARY NURSI NG ADMI NI STRATI ON | 0 | 281, 053 | 525 331 | 281, 578 | 3, 339 | 8. 00 9. 00 |
| 10.00 | 1 | CENTRAL SERVICES & SUPPLY | 0 | 177, 291 18, 492 | | 177, 622 18, 527 | 3, 429 157 | 9. 00 10. 00 |
| 11. 00 | | PHARMACY | O | 0 | 0 | 0 | 0 | 11. 00 |
| 12. 00 | | MEDICAL RECORDS & LIBRARY | 0 | 8, 436 | 16 | 8, 452 | 117 | 12. 00 |
| 13. 00 14. 00 | | SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION | 0 | 133, 761 0 | 250 0 | 134, 011 0 | 564 0 | 13. 00 14. 00 |
| 15. 00 | 1 | ACTIVITES | 0 | 0 | | 0 | 1, 581 | 15. 00 |
| | | IENT ROUTINE SERVICE COST CENTERS | | | - 1 | | | |
| 30.00 | | SKILLED NURSING FACILITY | 0 | 1, 666, 479 | _ | 1, 669, 591 | 21, 645 | 30. 00 |
| 31. 00 32. 00 | | NURSING FACILITY ICF/IID | 0 | 0 | - 1 | 0 | 0 | 31. 00 32. 00 |
| 33. 00 | | OTHER LONG TERM CARE | 0 | 0 | - 1 | o | 0 | 33. 00 |
| | ANCI L | LARY SERVICE COST CENTERS | | | | | | |
| 40.00 | | RADI OLOGY | 0 | 0 | | 0 | 0 | 40.00 |
| 41. 00 42. 00 | | LABORATORY I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 41. 00 42. 00 |
| 43. 00 | | OXYGEN (INHALATION) THERAPY | o | 0 | o o | ő | 0 | 43. 00 |
| 44.00 | 04400 | PHYSI CAL THERAPY | 0 | 36, 477 | 68 | 36, 545 | 2, 072 | 44. 00 |
| 45. 00 | | OCCUPATIONAL THERAPY | 0 | 11, 068 | 21 | 11, 089 | 2, 289 | 45. 00 |
| 46. 00 47. 00 | | SPEECH PATHOLOGY ELECTROCARDI OLOGY | 0 | 2, 160 0 | 4 | 2, 164 0 | 495 0 | 46. 00 47. 00 |
| 48. 00 | 1 | MEDICAL SUPPLIES CHARGED TO PATIENTS | o | 0 | Ö | Ö | 0 | 48. 00 |
| 49. 00 | | DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | О | 0 | 49. 00 |
| 50.00 | | DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0 | 0 | 0 | 50.00 |
| 51. 00 52. 00 | 1 | SUPPORT SURFACES COMPLEX MEDICAL EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 51. 00 52. 00 |
| 52. 01 | | OTHER ANCILLARY SERVICES COST | o | 0 | - | Ö | 0 | 52. 01 |
| 52. 02 | | MEDI CAL SERVI CES | 0 | 0 | 0 | 0 | 0 | 52. 02 |
| 60. 00 | | TIENT SERVICE COST CENTERS CLINIC | 0 | 0 | O | ol | 0 | 60. 00 |
| 61.00 | | RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61. 00 |
| 62. 00 | 06200 | | | | _ | | | 62. 00 |
| 63. 00 | | DI ALYSI S | 0 | 0 | 0 | 0 | 0 | 63. 00 |
| 70. 00 | 07000 | REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST | | 0 | | ol | 0 | 70. 00 |
| 71. 00 | | AMBULANCE | o | 0 | Ö | o | 0 | 71. 00 |
| 73. 00 | 07300 | | 0 | 0 | 0 | o | 0 | 73. 00 |
| 74. 00 | | OTHER REIMBURSEMENT | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| 80. 00 | | AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81. 00 | | INTEREST EXPENSE | | | | | | 81. 00 |
| 82. 00 | 1 | UTILIZATION REVIEW - SNF | _ | _ | _ | | _ | 82. 00 |
| 83. 00 84. 00 | | HOSPICE OTHER SPECIAL PURPOSE COST I | 0 | 0 | 0 | 0 | 0 | 83. 00 84. 00 |
| 84. 01 | | OTHER SPECIAL PURPOSE COST II | 0 | 0 | 0 | 0 | 0 | 84. 00 |
| 89. 00 | | SUBTOTALS (sum of lines 1-84) | 0 | 2, 621, 805 | 4, 898 | 2, 626, 703 | 41, 786 | 89. 00 |
| 00.00 | | IMBURSABLE COST CENTERS | | | | - | | 00.00 |
| 90. 00 91. 00 | | GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP | 0 | 0 6, 445 | - 1 | 0 6, 457 | 0 | 90. 00 91. 00 |
| 92.00 | 1 | PHYSICIANS PRIVATE OFFICES | | 0, 443 | 0 | 0, 437 | 0 | 92. 00 |
| 93. 00 | 09300 | NONPALD WORKERS | o | 0 | o | o | 0 | 93. 00 |
| 94. 00 | | PATIENTS LAUNDRY | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 95. 00 98. 00 | 09500 | OTHER NONREIMBURSABLE COST Cross Foot Adjustments | 0 | O | 0 | 0 | 0 | 95. 00 98. 00 |
| 99. 00 | | Negative Cost Centers | | 0 | О | ő | 0 | 99. 00 |
| 100.00 |) | TOTAL | o | 2, 628, 250 | 4, 910 | 2, 633, 160 | 41, 786 | 100. 00 |
| | | | | | | | | |

Period: Worksheet B
From 01/01/2023 Part II
To 1/21/2022 Part II
To 1/21/2022 Part II
To 1/21/2022 Part II
To 1/21/2022 Part III
To 1/21/2022 Part III Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315306

| | | | | T | o 12/31/2023 | | pared: |
|------------------|---|-------------------|---------------------|---------------|---------------|---------------------------|------------------|
| | Cost Center Description | ADMI NI STRATI VE | PLANT | LAUNDRY & | HOUSEKEEPI NG | 5/10/2024 12: DI ETARY | OO pm |
| | | & GENERAL | OPERATION, | LINEN SERVICE | | | |
| | | | MAINT. & REPAIRS | | | | |
| | | 4.00 | 5. 00 | 6.00 | 7. 00 | 8. 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | I | | | 1 00 |
| 1. 00 2. 00 | 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | | | | | 1. 00 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | | | | 3.00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | 68, 045 | | | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 4, 451 | 97, 332 | 1 | | | 5. 00 |
| 6. 00 7. 00 | 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING | 1, 342 3, 273 | 2, 392 1, 114 | | 34, 545 | | 6. 00 7. 00 |
| 8. 00 | 00800 DI ETARY | 7,070 | 11, 261 | 0 | 4, 146 | 307, 394 | 8.00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | 5, 046 | 7, 104 | Ō | 2, 615 | 0 | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 846 | 741 | 0 | 273 | 0 | 10.00 |
| 11.00 | 01100 PHARMACY | 128 | 0 | _ | 0 | 0 | 11.00 |
| 12. 00 13. 00 | 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE | 168 1, 147 | 338 5, 360 | 1 | 124 1, 973 | 0 | 12. 00 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 1, 147 | 3, 300 | 0 | 1, 7/3 | 0 | 14.00 |
| 15. 00 | 01500 ACTI VI TES | 1, 904 | 0 | 0 | o | 0 | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | 1 | | | |
| 30.00 | 03000 SKILLED NURSING FACILITY | 34, 274 | 66, 772 | | 24, 586 | 307, 394 | 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 | | | 0 | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40. 00 | 04000 RADI OLOGY | 201 | 0 | _ | | 0 | 40.00 |
| 41. 00 | 04100 LABORATORY 04200 I NTRAVENOUS THERAPY | 463 296 | 0 | 0 | 0 | 0 | 41.00 |
| 42. 00 43. 00 | 04200 THIRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY | 296 | 0 | 0 | | 0 | 42. 00 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 2, 705 | 1, 462 | Ö | 538 | 0 | 44. 00 |
| 45.00 | 04500 OCCUPATI ONAL THERAPY | 2, 712 | 443 | 0 | 163 | 0 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 611 | 87 | | 32 | 0 | 46. 00 |
| 47. 00 48. 00 | 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 0 | 0 | 0 | 0 | 47. 00 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATTENTS | 1, 069 | 0 | 0 | | 0 | 49.00 |
| 50. 00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | Ö | o | 0 | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | 1 | 0 | 0 | o | 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 05202 MEDICAL SERVICES | 0 | 0 | 0 | | 0 | 52. 01 52. 02 |
| 32. 02 | OUTPATIENT SERVICE COST CENTERS | <u> </u> | 0 | <u> </u> | <u> </u> | 0 | 32.02 |
| 60.00 | 06000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61. 00 |
| 62. 00 | 06200 FOHC | | 0 | | | 0 | 62.00 |
| 63. 00 | O6300 DI ALYSI S OTHER REIMBURSABLE COST CENTERS | 0 | 0 | 0 | <u> </u> | 0 | 63. 00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | 0 | o | 0 | 70.00 |
| 71. 00 | 07100 AMBULANCE | 213 | 0 | 0 | О | 0 | 71. 00 |
| 73. 00 | 07300 CMHC | 0 | 0 | | · · | | 73. 00 |
| 74. 00 | 07400 OTHER REIMBURSEMENT | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| 80. 00 | SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80.00 |
| 81. 00 | 08100 I NTEREST EXPENSE | | | • | | | 81.00 |
| 82. 00 | 08200 UTILIZATION REVIEW - SNF | | | | | | 82. 00 |
| 83. 00 | 08300 H0SPI CE | 0 | 0 | 1 | 0 | 0 | 83. 00 |
| 84. 00 84. 01 | 08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II | 0 | 0 | 0 | 0 | 0 | 84. 00 84. 01 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 67, 922 | 97, 074 | 64, 086 | 34, 450 | 307, 394 | 89. 00 |
| 07.00 | NONREI MBURSABLE COST CENTERS | 0.7.22 | ,,,,,,, | 0 17 000 | 3 1,7 133 | 33,737, | 07.00 |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 54 | 0 | 0 | 0 | 0 | 90.00 |
| 91.00 | 09100 BARBER AND BEAUTY SHOP | 69 | 258 | | 95 | 0 | 91.00 |
| 92. 00 93. 00 | 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS | 0 | 0 | 0 | 0 | 0 | 92. 00 93. 00 |
| 94.00 | 09400 PATIENTS LAUNDRY | | 0 | 0 | | 0 | 94.00 |
| 95. 00 | 09500 OTHER NONREIMBURSABLE COST | 0 | Ö | Ö | o | 0 | 95. 00 |
| 98. 00 | Cross Foot Adjustments | | | 0 | 0 | 0 | 98. 00 |
| 99.00 | Negative Cost Centers | 0 | 07.000 | 0 | 0 | 0 | 99.00 |
| 100.00 | D TOTAL | 68, 045 | 97, 332 | 64, 086 | 34, 545 | 307, 394 | 1100.00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315306

In Lieu of Form CMS-2540-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time Prepared: | 5/10/2024 | 12:00 pm

| | | | | '' | 0 12/31/2023 | 5/10/2024 12: | |
|------------------|--|---------------------------------------|------------------------|----------|-----------------------|----------------|------------------|
| | Cost Center Description | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & | PHARMACY | MEDI CAL RECORDS & | SOCIAL SERVICE | |
| | | | SUPPLY | 44.00 | LI BRARY | 10.00 | |
| | CENEDAL CEDVICE COCT CENTERS | 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 - BEDGS & FIXTURES | | | | | | 2.00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | | | | 3.00 |
| | 1 · · | | | | | | l |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | | | | | | 4.00 |
| 5. 00 6. 00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | | | | 5. 00 |
| 7. 00 | 00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG | | | | | | 6. 00 7. 00 |
| 8. 00 | 00800 DI ETARY | | | | | | 8. 00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | 195, 816 | | | | | 9. 00 |
| 10. 00 | 01000 CENTRAL SERVICES & SUPPLY | 173,010 | 20, 544 | | | | 10.00 |
| 11. 00 | 01100 PHARMACY | | 20, 344 | 128 | | | 11.00 |
| 12. 00 | 01200 MEDICAL RECORDS & LIBRARY | | 0 | 0 | 9, 199 | | 12. 00 |
| 13. 00 | 01300 SOCIAL SERVICE | 0 | 0 | 0 | ,,,,, | 143, 055 | • |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | 0 | 0 | 0 | 14. 00 |
| 15. 00 | 01500 ACTI VI TES | o | 0 | Ö | 0 | 0 | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | · · · · · · · · · · · · · · · · · · · | - | | | | |
| 30.00 | 03000 SKILLED NURSING FACILITY | 195, 816 | 20, 544 | 128 | 9, 199 | 143, 055 | 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 | 03300 OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | 1 | | 1 | | | |
| 40.00 | 04000 RADI OLOGY | 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 44. 00 | 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY | | 0 | 0 | 0 | 0 | 43. 00 44. 00 |
| 45. 00 | 04500 OCCUPATIONAL THERAPY | | 0 | 0 | 0 | 0 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | | 0 | | 0 | 0 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | | 0 | | 0 | 0 | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0 | 0 | 0 | 0 | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | | 0 | 0 | 0 | Ö | 49. 00 |
| 50. 00 | 05000 DENTAL CARE - TITLE XIX ONLY | | 0 | 0 | 0 | Ö | 50.00 |
| 51. 00 | 05100 SUPPORT SURFACES | o | 0 | Ö | 0 | 0 | 51.00 |
| 52.00 | 05200 COMPLEX MEDICAL EQUIPMENT | o | 0 | 0 | 0 | 0 | 52.00 |
| 52. 01 | 05201 OTHER ANCILLARY SERVICES COST | 0 | 0 | 0 | 0 | 0 | 52. 01 |
| 52. 02 | 05202 MEDI CAL SERVI CES | 0 | 0 | 0 | 0 | 0 | 52. 02 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60.00 | 06000 CLINIC | 0 | 0 | 0 | _ | 0 | 60.00 |
| 61.00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61.00 |
| 62.00 | 06200 FQHC | | 0 | | | | 62.00 |
| 63. 00 | 06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 63. 00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | l ol | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 | 07100 AMBULANCE | | 0 | 0 | 0 | 0 | 71.00 |
| | 07300 CMHC | o | 0 | Ö | 0 | Ö | 73. 00 |
| 74.00 | 07400 OTHER REIMBURSEMENT | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 80.00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81.00 | 08100 NTEREST EXPENSE | | | | | | 81. 00 |
| 82. 00 | 08200 UTILIZATION REVIEW - SNF | | | | | | 82. 00 |
| 83. 00 | 08300 H0SPI CE | 0 | 0 | 0 | 0 | 0 | 83. 00 |
| 84. 00 | 08400 OTHER SPECIAL PURPOSE COST I | 0 | 0 | 0 | 0 | 0 | 84. 00 |
| 84. 01 | 08401 OTHER SPECIAL PURPOSE COST II | 105 014 | 00 544 | 0 | 0 | 0 | 84. 01 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 195, 816 | 20, 544 | 128 | 9, 199 | 143, 055 | 89. 00 |
| 90. 00 | NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | l ol | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | | 0 | 1 | _ | | 91.00 |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | | 0 | 0 | _ | Ö | 92.00 |
| 93. 00 | 09300 NONPALD WORKERS | | 0 | 0 | _ | ő | 93. 00 |
| 94. 00 | 09400 PATIENTS LAUNDRY | | 0 | Ö | _ | 0 | 94.00 |
| 95. 00 | 09500 OTHER NONREIMBURSABLE COST | | O | Ō | 0 | 0 | 95. 00 |
| 98. 00 | Cross Foot Adjustments | 0 | 0 | 0 | | | 98. 00 |
| 99. 00 | Negative Cost Centers | 0 | O | 0 | 0 | 0 | 99. 00 |
| 100.00 | TOTAL | 195, 816 | 20, 544 | 128 | 9, 199 | 143, 055 | 100. 00 |
| | | | | | | | |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315306

| | | | | 7 | Го 12/31/2023 | Date/Time Pre 5/10/2024 12: | |
|------------------|--|------------------------------|---------------|--------------------|-------------------------------|-----------------------------|------------------|
| | | | OTHER GENERAL | | | | |
| | Coot Conton Decemintion | NUDCI NO AND | SERVI CE | Cubtatal | Doot Stan Down | Total | |
| | Cost Center Description | NURSING AND ALLIED HEALTH | ACTI VI TES | Subtotal | Post Step-Down Adjustments | Total | |
| | | EDUCATI ON | | | riaj as timorres | | |
| | T | 14. 00 | 15. 00 | 16. 00 | 17. 00 | 18. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES | | T | I | T | | 1.00 |
| 2.00 | 00200 CAP REL COSTS - BEDGS & FIXTURES | | | • | | | 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 7. 00 | 00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG | | | | | | 6. 00 7. 00 |
| 8. 00 | 00800 DI ETARY | | | | | | 8. 00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | | | | | | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | | | | | | 10.00 |
| 11. 00 12. 00 | 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY | | | • | | | 11. 00 12. 00 |
| 13. 00 | 01300 SOCI AL SERVI CE | | | | | | 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | | | | | 14. 00 |
| 15. 00 | 01500 ACTIVITES | 0 | 3, 485 | | | | 15. 00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY | | 3, 485 | 2, 560, 575 | 5 0 | 2, 560, 575 | 30.00 |
| 31. 00 | 03100 NURSING FACILITY | 0 | 0 | 1 | 0 | | 1 |
| 32. 00 | 03200 CF/IID | 0 | 0 | | | | 1 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 0 | 0 | | 0 | 0 | 33. 00 |
| 40. 00 | ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY | | 0 | 20 | 1 0 | 201 | 40. 00 |
| 41. 00 | 04100 LABORATORY | 0 | Ö | 1 | | | 1 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | 296 | | | 1 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | | 0 | 0 | 43.00 |
| 44. 00 45. 00 | 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY | 1 0 | | 43, 322 16, 696 | | 43, 322 16, 696 | 1 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | Ö | 3, 389 | | 3, 389 | 1 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | (| | 0 | 1 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 1 0/0 | 48. 00 |
| 49. 00 50. 00 | 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY | | | 1, 069 | 0 | 1, 069 0 | 49. 00 50. 00 |
| 51. 00 | 05100 SUPPORT SURFACES | 0 | Ö | | 0 | 1 | 51.00 |
| 52.00 | 05200 COMPLEX MEDICAL EQUIPMENT | 0 | 0 | | 0 | 0 | |
| 52. 01 | 05201 OTHER ANCILLARY SERVICES COST | 0 | 0 | l . | 0 0 | | |
| 52. 02 | 05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS | | | 1 | <u> </u> | 0 | 52. 02 |
| 60.00 | 06000 CLINI C | 0 | 0 | (| 0 | 0 | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | (| 0 | 0 | 61. 00 |
| 62.00 | 06200 FQHC | | | | | 0 | 62.00 |
| 63. 00 | O6300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS | 0 | 0 | | 0 | 0 | 63. 00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | (| 0 | | |
| | 07100 AMBULANCE | 0 | 0 | 1 - ' ' | | | 71. 00 |
| 73. 00 74. 00 | O7300 CMHC O7400 OTHER REIMBURSEMENT | 0 | 0 | 1 | 0 0 | | |
| 74.00 | SPECIAL PURPOSE COST CENTERS | | | | <u>)</u> | 0 | 74.00 |
| 80. 00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81. 00 | 08100 I NTEREST EXPENSE | | | | | | 81. 00 |
| 82. 00 83. 00 | 08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE | | , | , | 0 | 0 | 82. 00 83. 00 |
| 84. 00 | 08400 OTHER SPECIAL PURPOSE COST I | | | | | | 1 |
| 84. 01 | 08401 OTHER SPECIAL PURPOSE COST II | 0 | Ö | | o o | Ö | 1 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 0 | 3, 485 | 2, 626, 227 | 7 0 | 2, 626, 227 | 89. 00 |
| 90. 00 | NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | | Ιο | 54 | 4 0 | 54 | 90. 00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | | | 6, 879 | | 6, 879 | 1 |
| 92. 00 | 09200 PHYSI CI ANS PRI VATE OFFI CES | | 0 | 3, 3, | o o | 0,0,7 | 92. 00 |
| 93. 00 | 09300 NONPAI D WORKERS | 0 | 0 | (| 0 | 0 | |
| 94. 00 95. 00 | 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST | 0 | 0 | | 0 | 0 | |
| 98. 00 | Cross Foot Adjustments | 0 | 0 | | o o | 0 | 1 |
| 99. 00 | Negative Cost Centers | | 0 | | o o | 0 | 99. 00 |
| 100.00 | TOTAL | 0 | 3, 485 | 2, 633, 160 | o o | 2, 633, 160 | 100.00 |
| | | | | | | | |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315306

| | | | | | lo 12/31/2023 | Date/lime Pre 5/10/2024 12: | |
|--|---|--|--|---|---|--|---|
| | | CAPITAL REI | LATED COSTS | | | | |
| | Cost Center Description | BLDGS & FIXTURES (SQUARE FEET) | MOVABLE EQUI PMENT (SQUARE FEET) | EMPLOYEE BENEFITS (GROSS SALARIES) | Reconciliation | ADMINISTRATIVE & GENERAL (ACCUM COST) | |
| | | 1.00 | 2. 00 | 3.00 | 4A | 4.00 | |
| | GENERAL SERVICE COST CENTERS | 1 | T | | | | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 | 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY | 77, 888 1, 236 1, 941 2, 723 1, 769 824 8, 329 | 77, 888 1, 236 1, 941 2, 723 1, 769 824 | 10, 995, 66 638, 336 216, 93 143, 96 605, 476 | 5 -3, 356, 669 9 0 7 0 5 0 | 18, 635, 414 1, 219, 021 367, 670 896, 524 1, 936, 379 | 5. 00 6. 00 7. 00 |
| 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 | 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES | 5, 254 548 0 250 3, 964 0 | 5, 254 548 0 | 902, 396 3 41, 360 0 30, 86 | 6 0 0 0 7 0 3 0 | 1, 382, 195 231, 806 35, 032 45, 946 314, 249 | 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 |
| 30. 00 | INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY | 49, 386 | 49, 386 | 5, 695, 322 | 2 0 | 9, 385, 178 | 30.00 |
| 31. 00 32. 00 33. 00 | 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS | 0 0 0 0 | C | | 0 | 0 | 31. 00 32. 00 |
| 40. 00 41. 00 42. 00 | ANCI LLARY SERVICE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY | 0 0 0 | C | | 0 0 | 55, 038 126, 680 81, 062 | 41.00 |
| 43. 00 44. 00 45. 00 46. 00 47. 00 | 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY | 0 1, 081 328 64 | 1, 081 328 | 602, 43 | 5 0 | 0 741, 011 742, 855 167, 485 0 | 44. 00 45. 00 46. 00 |
| 48. 00 49. 00 50. 00 51. 00 52. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT | 000000000000000000000000000000000000000 | | | | 583 292, 745 0 238 0 | 48. 00 49. 00 50. 00 51. 00 52. 00 |
| 52. 01 52. 02 60. 00 | 05201 OTHER ANCILLARY SERVICES COST 05202 MEDICAL SERVICES 0UTPATIENT SERVICE COST CENTERS 06000 CLINIC | 0 0 | C | | 0 0 | 0 0 | 52. 02 |
| 61. 00 62. 00 63. 00 | 06100 RURAL HEALTH CLINIC 06200 FQHC 06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS | 0 | C | | | 0 | 61. 00 62. 00 |
| 70. 00 71. 00 73. 00 74. 00 | 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC 07400 OTHER REIMBURSEMENT | 0 0 0 0 | C | | 0 0 0 | 0 58, 345 0 0 | 71. 00 73. 00 |
| 80. 00 81. 00 82. 00 83. 00 84. 00 84. 01 89. 00 | SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84) | 0 0 0 77, 697 | 77, 697 |) () () () () () () | 0 0 0 0 0 0 0 -3, 356, 669 | 0 0 0 18, 601, 576 | 84. 00 84. 01 |
| 90. 00 91. 00 92. 00 93. 00 94. 00 | NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY | 0 191 0 0 | 1 | | 0 | | 90. 00 91. 00 92. 00 93. 00 |
| 95. 00 98. 00 99. 00 102. 00 | 09500 OTHER NONREIMBURSABLE COST Cross Foot Adjustments Negative Cost Centers | 2, 628, 250 | 4, 910 | 2, 360, 56 | 0 | 3, 356, 669 | 95. 00 98. 00 99. 00 |
| 103.00 104.00 | Unit cost multiplier (Wkst. B, Part I) | 33. 743966 | 0. 063039 | 0. 21468 41, 786 | | 0. 180123 68, 045 | 103. 00 104. 00 |

| Health Financial Systems | CARE ONE AT I | NEW MILFORD | | 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 Pre 5/10/2024 12: | |
| | CAPITAL REI | LATED COSTS | | | 37 107 2024 12. | oo piii |
| Cost Center Description | BLDGS & | MOVABLE | EMPLOYEE | Reconciliation | | |
| | FIXTURES (SQUARE FEET) | (SQUARE FEET) | BENEFITS (GROSS | | & GENERAL (ACCUM COST) | |
| | | | SALARI ES) | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4A | 4. 00 | |
| 105.00 Unit cost multiplier (Wkst. B, Part | | | 0. 00380 | D | 0. 003651 | 105. 00 |

Provi der No.: 315306

| | | | | ' | o 12/31/2023 | Date/Time Pre 5/10/2024 12: | |
|---|-------------------------|--------------------------|----------------------------|---------------|----------------------------|-----------------------------|------------------|
| Cost Center Des | scription | PLANT OPERATION. | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | DI ETARY (MEALS SERVED) | NURSI NG | |
| | | MAINT. & | (PATIENT DAYS) | (SQUARE TEET) | (WLALS SERVED) | | |
| | | REPAIRS (SQUARE FEET) | | | | (PATIENT DAYS) | |
| | | 5. 00 | 6.00 | 7. 00 | 8. 00 | 9. 00 | |
| 1.00 GENERAL SERVICE COST 1.00 OO100 CAP REL COSTS - | | | 1 | I | | I | 1.00 |
| 2.00 00200 CAP REL COSTS - | | | | | | | 2.00 |
| 3.00 00300 EMPLOYEE BENEFI | | | | | | | 3. 00 |
| 4. 00 00400 ADMI NI STRATI VE 5. 00 00500 PLANT OPERATI ON | | 71, 988 | , | | | | 4. 00 5. 00 |
| 6. 00 00600 LAUNDRY & LINEN | | 1, 769 | 1 | | | | 6.00 |
| 7. 00 00700 HOUSEKEEPI NG | | 824 | 1 | 69, 395 | 5 | | 7. 00 |
| 8. 00 00800 DI ETARY | TD 4 T 1 O 1 1 | 8, 329 | 1 | 8, 329 | | l e | 8. 00 |
| 9.00 00900 NURSI NG ADMINIS 10.00 01000 CENTRAL SERVI CE | | 5, 254 548 | 1 | 5, 254 548 | | 63, 046 | 9.00 |
| 11. 00 01100 PHARMACY | .5 & 5011 L1 | 340 | 1 | 340 | | 0 | 11.00 |
| 12.00 01200 MEDICAL RECORDS | S & LI BRARY | 250 | 1 | 250 | | 0 | 12. 00 |
| 13. 00 01300 SOCIAL SERVICE | LED HEALTH EDHOATION | 3, 964 | 1 | 3, 964 | | 0 | 13.00 |
| 14.00 01400 NURSI NG AND ALL 15.00 01500 ACTIVITES | TED HEALTH EDUCATION | C | | | 1 | 0 | 14. 00 15. 00 |
| I NPATI ENT ROUTI NE SEI | RVICE COST CENTERS | | , | | ,, | | 13.00 |
| 30. 00 03000 SKI LLED NURSI NO | | 49, 386 | 1 | 1 | | 1 | |
| 31.00 03100 NURSING FACILIT 32.00 03200 CF/IID | Υ | C | | | , | 0 | 31. 00 32. 00 |
| 33. 00 03300 OTHER LONG TERM | 1 CARE | | | | | 1 | 33.00 |
| ANCILLARY SERVICE CO | | | | | | | |
| 40. 00 04000 RADI OLOGY | | C | 0 | C | , | 0 | 40.00 |
| 41. 00 04100 LABORATORY 42. 00 04200 INTRAVENOUS THE | ΡΔΡΥ | | | | 0 | 0 1 0 | 41. 00 42. 00 |
| 43. 00 04300 0XYGEN (I NHALAT | | Č | Ö | | o o | ő | 43. 00 |
| 44. 00 04400 PHYSI CAL THERAF | | 1, 081 | | 1, 081 | | 0 | 44. 00 |
| 45. 00 04500 0CCUPATI ONAL TH | | 328 | 1 | 328 | | 0 | 45. 00 |
| 46. 00 04600 SPEECH PATHOLOG 47. 00 04700 ELECTROCARDI OLG | | 64 | l . | 64 | | 0 | 46. 00 47. 00 |
| | ES CHARGED TO PATIENTS | C | Ö | | o o | Ö | 48. 00 |
| 49. 00 04900 DRUGS CHARGED | | C | 0 | C | 0 | 0 | 49. 00 |
| 50. 00 05000 DENTAL CARE - 7 51. 00 05100 SUPPORT SURFACE | | C | | | 0 | 0 | 50. 00 51. 00 |
| 52. 00 05200 COMPLEX MEDICAL | | | | | | 0 | 52.00 |
| 52. 01 05201 OTHER ANCILLARY | SERVICES COST | C | 0 | d | 0 | 0 | 52. 01 |
| 52. 02 05202 MEDI CAL SERVI CE | | C | 0 | (| 0 | 0 | 52. 02 |
| 60. 00 O6000 CLINIC | JST CENTERS | T C | 0 | | | 0 | 60.00 |
| 61. 00 06100 RURAL HEALTH CL | INIC | | | | | Ö | 61.00 |
| 62. 00 06200 FQHC | | | | | | | 62. 00 |
| 63. 00 06300 DI ALYSI S OTHER REI MBURSABLE CO | OCT CENTEDS | C |) 0 | |) 0 | 0 | 63.00 |
| 70. 00 07000 HOME HEALTH AGE | | | 0 | | 0 | 0 | 70.00 |
| 71.00 07100 AMBULANCE | | c | 0 | C | 0 | 0 | |
| 73. 00 07300 CMHC | MENT | C | l . | | | | |
| 74. 00 07400 OTHER REIMBURSE SPECIAL PURPOSE COST | | C | 0 | (|) 0 | 0 | 74.00 |
| 80. 00 08000 MALPRACTI CE PRE | | | | | | | 80.00 |
| 81. 00 08100 I NTEREST EXPENS | | | | | | | 81.00 |
| 82. 00 08200 UTI LI ZATI ON RE\ 83. 00 08300 HOSPI CE | /IEW - SNF | | | | | 0 | 82. 00 83. 00 |
| 84. 00 08400 OTHER SPECIAL F | PURPOSE COST I | | | | | | |
| 84. 01 08401 OTHER SPECIAL F | | C | 1 | d | 0 | 0 | 84. 01 |
| 89.00 SUBTOTALS (sum | | 71, 797 | 63, 046 | 69, 204 | 189, 138 | 63, 046 | 89. 00 |
| 90. 00 09000 GIFT, FLOWER, 0 | COFFEE SHOPS & CANTEEN | T C | | | | 0 | 90.00 |
| 91. 00 09100 BARBER AND BEAU | | 191 | | 191 | | ő | |
| 92. 00 09200 PHYSI CLANS PRI \ | | C | 0 | C | 0 | 0 | 92. 00 |
| 93. 00 09300 NONPALD WORKERS 94. 00 09400 PATLENTS LAUNDE | | C | 0 | | 0 | 0 | |
| 95. 00 09500 OTHER NONREI MBL | | | | | | | 95.00 |
| 98.00 Cross Foot Adju | | | | | | | 98. 00 |
| 99.00 Negative Cost (| | 4 400 505 | | | 0 500 570 | 4 047 505 | 99. 00 |
| 102.00 Cost to be allo | ocated (per Wkst. B, | 1, 438, 595 | 469, 247 | 1, 074, 476 | 2, 580, 572 | 1, 817, 505 | 102.00 |
| 1 1 | plier (Wkst. B, Part I) | 19. 983817 | 7. 442931 | 15. 483479 | 13. 643858 | 28. 828237 | 103. 00 |
| | ocated (per Wkst. B, | 97, 332 | 64, 086 | 34, 545 | 307, 394 | 195, 816 | 104. 00 |
| Part II) | | | | 0 407000 | 1 (25227 | 2 105022 | 105 00 |
| 105.00 Unit cost multi | plier (Wkst. B, Part | 1. 352059 | 1. 016496 | 0. 497802 | 2 1. 625237 | 3. 105923 | |

Provi der No.: 315306

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

| COST CONTINUE DISSOCIAL SERVICE OST CONTINUE SUPPLY OST CONTINUE SUPPLY OST CONTINUE | | | | | Ť | 0 12/31/2023 | Date/Time Pre 5/10/2024 12: | |
|--|--------|-------------------------|-----------|----------------|-----------|----------------|-----------------------------|----------|
| SIEPLY CATTENT DAYS | | Cost Center Description | | | | SOCIAL SERVICE | NURSI NG AND | DO PIII |
| STRIPBAL SPRINGE COST CENTERS 10,000 12,000 13,000 14,000 12,000 13,000 14,000 14,000 12,000 13,000 14,00 | | | | (PATIENT DAYS) | | (PATLENT DAYS) | | |
| 10.000 11.00 12.00 13.00 14.00 13.00 14.00 13.00 14.00 15.00 15.00 14.00 15. | | | | | | (| (ASSI GNED | |
| CREATION SERVICE DOST CENTERS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 10.00 | 11.00 | 12.00 | 13.00 | | |
| 2.00 | | | 10.00 | | 12.00 | 10.00 | | |
| 3.00 000000 EMPLOYEE SEREFITS | | | | | | | | 1.00 |
| 4.00 00000 ADMINISTRATIVE & GENERAL 5.00 00000 PLANDING PLANT OWN AND T. & REPAIRS 6.00 00000 PLANDING PLANT OWN AND T. | | | | | • | | | |
| 6.00 000000 LIAMORY & LINEN SERVICE | | 1 | | | | | | 4. 00 |
| 7. 0.0 0.0000 DOTON DOTON | | 1 1 | | | | | | 5. 00 |
| 8.00 000000 IEFFARY 0.00 00000 JUSEN OAWIN IN STATION 10.00 01000 CANIRAL SERVICES & SUPPLY 10.00 01000 CANIRAL SERVICES & SUPPLY 10.00 01000 SOCIAL SERVICES 10.00 01000 SOCIAL SERVICE COST CENTERS 10.00 01000 SOCIAL SERVICE CENTERS 10.00 01000 SOCI | | 1 1 | | | | | | |
| 9.00 0.000 MIRSING ADMINISTRATION 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000 | | 1 | | | • | | | 1 |
| 11.00 101100 PHARMACY 0 0 0 0 0 0 0 0 12.00 | | 1 1 | | | | | | 9. 00 |
| 12 00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 13.00 13 | | 1 1 | 63, 046 | 1 | | | | 10.00 |
| 13.00 01300 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0 | | l l | | 63, 046 | 1 | | | |
| 14.00 01400 MURSI NG AND ALLIED HEACHT EDICATION 0 0 0 0 0 0 0 0 0 | | 1 1 | | | 03, 040 | | | |
| IMPATIENT ROUTHE SERVICE COST CENTERS | | | 0 | O | 0 | | 0 | 14. 00 |
| 30.00 | 15. 00 | | 0 | 0 | 0 | 0 | 0 | 15. 00 |
| 31.00 | 30 00 | | 63 046 | 63 046 | 63 046 | 63 046 | 0 | 30 00 |
| 33.00 03300 OTHER LONG TERM CARE | | | 1 | 1 | 1 | | _ | 31. 00 |
| ACCILLARY SERVICE COST CENTERS 41.00 | | 1 1 | 0 | o | O | 0 | 0 | 1 |
| 40.00 04000 RADIOLOGY | 33. 00 | | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| 1.00 0.100 LABORATORY 0 0 0 0 0 0 0 0 0 | 40.00 | | | | 1 | 0 | 0 | 40.00 |
| 42.00 04200 NYERA (YINHALATION) THERAPY | | | | _ | | 0 | _ | 41. 00 |
| 44.00 04400 PHYSICAL THERAPY 0 0 0 0 0 0 45.00 | | 1 1 | 0 | o | O | 0 | 0 | 42. 00 |
| 45.00 04500 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0 0 45.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 47.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 47.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 47.00 47.00 04800 DRILGAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 1 7 | 0 | 0 | 0 | 0 | _ | 43.00 |
| 46.00 04600 SPECEH PATHOLOGY 0 0 0 0 0 0 0 0 0 | | 1 1 | 0 | 0 | 0 | 0 | _ | 1 |
| 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 47.00 49.00 04900 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 49.00 04900 DRUIS CHARGED TO PATIENTS 0 0 0 0 0 0 0 51.00 05000 DRIAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 52.01 05200 OTHER ANGI LLARY SERVICES COST 0 0 0 0 0 0 52.01 05201 OTHER ANGI LLARY SERVICES COST 0 0 0 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 0 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 0 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 0 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 0 0 0 52.01 05202 MEDICAL SERVICES 0 0 0 0 0 0 52.01 05203 MEDICAL SERVICES 0 0 0 0 0 0 53.00 OTHER RESERVICES 0 0 0 0 0 0 0 54.00 05400 CLINIC 0 0 0 0 0 0 54.00 05400 CLINIC 0 0 0 0 0 0 55.00 OTHER RELIBBURSABLE COST CENTERS 0 0 0 0 0 0 0 56.00 05400 MEDICAL PROBES 0 0 0 0 0 0 57.00 07000 HOME HEALTH ASSENCY COST 0 0 0 0 0 0 0 57.00 07000 HOME HEALTH ASSENCY COST 0 0 0 0 0 0 0 57.00 07000 OTHER RESIMBURSSMENT 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 07000 OTHER SECULAR SERVICES 0 0 0 0 0 0 0 57.00 | | 1 | | | | 0 | _ | 46. 00 |
| 49.00 04900 DRUSC CHARGED TO PATLENTS 0 0 0 0 0 49.00 | | 1 | 0 | o | Ö | 0 | _ | 47. 00 |
| 50.00 05000 05000 05000 05000 05 | | 1 1 | 0 | 0 | 0 | 0 | 0 | 48. 00 |
| 51.00 OS100 SUPPORT SURFACES 0 0 0 0 0 51.00 52.00 OS200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 52.00 52.01 OS201 | | 1 1 | 0 | 0 | 0 | 0 | 0 | |
| 52.00 05200 COMPLEX MEDICAL EQUI PMENT 0 0 0 0 0 52.00 | | 1 1 | | | | 0 | 0 | 1 |
| 52.02 DS202 MEDICAL SERVICES 0 0 0 0 52.02 | | 1 1 | 0 | Ö | Ö | 0 | 0 | 52.00 |
| OUTPATIENT SERVICE COST CENTERS O | | 1 1 | - | | | - | | 52. 01 |
| 60.00 06000 CLINIC 0 0 0 0 0 0 0 0 0 | 52. 02 | | 0 | 0 | 0 | 0 | 0 | 52.02 |
| 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 61.00 62.00 62.00 62.00 630.00 06300 DIALYSIS 0 0 0 0 0 0 0 63.00 | 60. 00 | | 0 | | 1 0 | 0 | 0 | 60.00 |
| 63.00 | | l l | 0 | 0 | 0 | 0 | 0 | 61. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | _ | _ | _ | _ | _ | 62.00 |
| 70.00 | 63. 00 | | 0 |) 0 | 0 | 0 | 0 | 63.00 |
| 71. 00 07100 AMBULANCE 0 0 0 0 0 0 71. 00 73. 00 07300 CMHC 0 0 0 0 0 0 0 73. 00 74. 00 07400 OTHER REIMBURSEMENT 0 0 0 0 0 0 0 74. 00 07400 OTHER REIMBURSEMENT 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80. 00 80. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08200 UTI LI ZATI ON REVIEW - SNF 82. 00 83. 00 08300 HOSPI CE 0 0 0 0 0 0 83. 00 84. 01 08401 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 84. 01 89. 00 WASHINGTON ON THE SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 89. 00 OSHOOL OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 0 0 0 0 | 70. 00 | | 0 | 0 | 0 | 0 | 0 | 70.00 |
| 74. 00 07400 0THER REIMBURSEMENT 0 0 0 0 0 0 0 0 0 | | 07100 AMBULANCE | 0 | o | O | 0 | 0 | l |
| SPECIAL PURPOSE COST CENTERS 80. 00 | | 1 1 | 1 | l . | | _ | | |
| 80.00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 80.00 81.00 | 74.00 | | |) 0 | 0 | 0 | 0 | 74.00 |
| 82. 00 08200 UTILIZATION REVIEW - SNF 82. 00 83.00 Hospice 0 0 0 0 0 0 0 83.00 84.00 08400 Other Special Purpose Cost 1 0 0 0 0 0 0 0 0 84.01 08401 Other Special Purpose Cost 1 0 0 0 0 0 0 0 0 0 | 80. 00 | | | | | | | 80.00 |
| 83.00 08300 HOSPICE 0 0 0 0 0 0 83.00 84.01 08401 OTHER SPECIAL PURPOSE COST 0 0 0 0 0 0 84.01 08401 OTHER SPECIAL PURPOSE COST 1 0 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 63,046 6 | | 1 1 | | | | | | 81. 00 |
| 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 0 0 84.00 84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 0 0 0 84.00 89.00 | | 1 1 | | | | 0 | 0 | 82.00 |
| 84. 01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 0 0 84. 01 89. 00 | | 1 1 | 0 | | 0 | 0 | _ | |
| NONREI MBURSABLE COST CENTERS O O O O O O O O O | | | | Ö | Ö | 0 | _ | 1 |
| 90. 00 | 89. 00 | | 63, 046 | 63, 046 | 63, 046 | 63, 046 | 0 | 89. 00 |
| 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 0 0 92.00 09300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 0 93.00 09300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 0 0 94.00 09500 07HER NONREIMBURSABLE COST 0 0 0 0 0 0 0 0 0 95.00 098.00 Cross Foot Adjustments 99.00 Negative Cost Centers 99.00 Negative Cost Centers 2 99.00 Unit cost multiplier (Wkst. B, Part I) 4.647337 0.655743 1.000682 8.112251 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 4.647337 0.655743 1.000682 8.112251 0.000000 103.00 104.00 Unit cost multiplier (Wkst. B, Part I) 0.325857 0.002030 0.145909 2.269058 0.000000 105. | 00.00 | | | | | | 0 | 00.00 |
| 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 0 0 93.00 93.00 09300 NONPAID WORKERS 0 0 0 0 0 0 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | 0 | _ | |
| 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 94.00 95.00 9500 OTHER NONREIMBURSABLE COST 0 0 0 0 0 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 4.647337 0.655743 1.000682 8.112251 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000 0.000000 0.000000 0.0000 | | 1 | 0 | Ö | Ö | 0 | _ | 1 |
| 95. 00 | | | 0 | 0 | 0 | 0 | _ | |
| 98.00 99.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII | | 1 1 | | 0 | 0 | 0 | 0 | |
| 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 4.647337 0.655743 1.000682 8.112251 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 20,544 128 9,199 143,055 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 20,325857 0.002030 0.145909 2.269058 0.000000 105.00 20.0000000000 | | 1 1 | | <u></u> | T o | | 0 | 98.00 |
| Part I) Unit cost multiplier (Wkst. B, Part I) 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) 105.00 Part I) 4.647337 0.655743 1.000682 9, 199 143, 055 0 104.00 105.00 0.145909 2.269058 0.000000 105.00 | | 1 1 | 1 | | | | | 99. 00 |
| 103.00 Unit cost multiplier (Wkst. B, Part I) 4.647337 0.655743 1.000682 8.112251 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 20,544 128 9,199 143,055 0.000000 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 | 102.00 | 71 | 292, 996 | 41, 342 | 63, 089 | 511, 445 | 0 | 102. 00 |
| 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 | 103 00 | 1 1 ' | 1 617227 | 0 655742 | 1 000693 | Q 1122E1 | 0 000000 | 103 00 |
| Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.325857 0.002030 0.145909 2.269058 0.000000 105.00 | | | 1 | l | l . | | | |
| | | Part II) | | | | | | |
| (יין ן <u>'</u> | 105.00 | | 0. 325857 | 0. 002030 | 0. 145909 | 2. 269058 | 0. 000000 | 105. 00 |
| | |) | <u> </u> | 1 | I . | <u> </u> | <u> </u> | <u> </u> |

In Lieu of Form CMS-2540-10 CARE ONE AT NEW MILFORD

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315306

| | | | | 5/10/2024 12 | |
|-------------------|-------|---|----------------|--------------|-------------------|
| | | | OTHER GENERAL | | |
| | | | SERVI CE | | |
| | | Cost Center Description | ACTI VI TES | | |
| | | | (PATIENT DAYS) | | |
| | CENED | AL SERVICE COST CENTERS | 15. 00 | | |
| 1.00 | | CAP REL COSTS - BLDGS & FLXTURES | | | 1.00 |
| 2. 00 | | CAP REL COSTS - MOVABLE EQUIPMENT | | | 2. 00 |
| 3.00 | 1 | EMPLOYEE BENEFITS | | | 3. 00 |
| 4.00 | 00400 | ADMINISTRATIVE & GENERAL | | | 4. 00 |
| 5.00 | 1 | PLANT OPERATION, MAINT. & REPAIRS | | | 5. 00 |
| 6.00 | | LAUNDRY & LINEN SERVICE | | | 6. 00 |
| 7.00 | | HOUSEKEEPI NG | | | 7. 00 |
| 8. 00 9. 00 | | DI ETARY NURSI NG ADMI NI STRATI ON | | | 8. 00 9. 00 |
| 10.00 | 1 | CENTRAL SERVICES & SUPPLY | | | 10.00 |
| 11. 00 | 1 | PHARMACY | 1 | | 11. 00 |
| 12. 00 | 1 | MEDICAL RECORDS & LIBRARY | | | 12. 00 |
| 13.00 | 1 | SOCIAL SERVICE | | | 13. 00 |
| 14.00 | 01400 | NURSING AND ALLIED HEALTH EDUCATION | | | 14. 00 |
| 15. 00 | | ACTI VI TES | 63, 046 | | 15. 00 |
| | | I ENT ROUTI NE SERVI CE COST CENTERS | | | |
| 30.00 | 1 | SKILLED NURSING FACILITY | 63, 046 | | 30.00 |
| 31. 00 32. 00 | | NURSING FACILITY CF/ D | 0 | | 31. 00 32. 00 |
| 33. 00 | 1 | OTHER LONG TERM CARE | 0 | | 33. 00 |
| 00.00 | | LARY SERVICE COST CENTERS | <u> </u> | | - 55. 55 |
| 40.00 | | RADI OLOGY | 0 | | 40. 00 |
| 41.00 | 04100 | LABORATORY | 0 | | 41. 00 |
| 42.00 | 1 | INTRAVENOUS THERAPY | 0 | | 42. 00 |
| 43.00 | 1 | OXYGEN (INHALATION) THERAPY | 0 | | 43. 00 |
| 44. 00 | 1 | PHYSI CAL THERAPY | 0 | | 44. 00 |
| 45. 00 46. 00 | | OCCUPATI ONAL THERAPY SPEECH PATHOLOGY | 0 | | 45. 00 46. 00 |
| 47. 00 | 1 | ELECTROCARDI OLOGY | 0 | | 47. 00 |
| 48. 00 | 1 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 48. 00 |
| 49. 00 | 1 | DRUGS CHARGED TO PATIENTS | o o | | 49. 00 |
| 50.00 | | DENTAL CARE - TITLE XIX ONLY | O | | 50.00 |
| 51.00 | 05100 | SUPPORT SURFACES | 0 | | 51. 00 |
| 52.00 | 1 | COMPLEX MEDICAL EQUIPMENT | 0 | | 52. 00 |
| 52. 01 | 1 | OTHER ANCILLARY SERVICES COST | 0 | | 52. 01 |
| 52. 02 | | MEDICAL SERVICES TIENT SERVICE COST CENTERS | 0 | | 52. 02 |
| 60. 00 | | CLINIC | O | | 60.00 |
| 61. 00 | 1 | RURAL HEALTH CLINIC | 0 | | 61. 00 |
| 62. 00 | 06200 | | | | 62. 00 |
| 63.00 | 06300 | DI ALYSI S | 0 | | 63. 00 |
| | | REIMBURSABLE COST CENTERS | | | |
| 70. 00 | | HOME HEALTH AGENCY COST | 0 | | 70. 00 |
| | 1 | AMBULANCE | 0 | | 71.00 |
| 73. 00 74. 00 | 1 | l . | 0 | | 73. 00 74. 00 |
| 74.00 | | OTHER REIMBURSEMENT AL PURPOSE COST CENTERS | <u> </u> | | 14.00 |
| 80. 00 | | MALPRACTICE PREMIUMS & PAID LOSSES | | | 80.00 |
| 81. 00 | | INTEREST EXPENSE | | | 81. 00 |
| 82.00 | | UTILIZATION REVIEW - SNF | | | 82. 00 |
| 83.00 | 1 | HOSPI CE | 0 | | 83. 00 |
| 84. 00 | | OTHER SPECIAL PURPOSE COST I | 0 | | 84. 00 |
| 84. 01 | 08401 | OTHER SPECIAL PURPOSE COST II | 0 | | 84. 01 |
| 89. 00 | NONDE | SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS | 63, 046 | | 89. 00 |
| 90. 00 | | GIFT, FLOWER, COFFEE SHOPS & CANTEEN | O | | 90.00 |
| 91. 00 | | BARBER AND BEAUTY SHOP | 0 | | 91. 00 |
| 92. 00 | | PHYSICIANS PRIVATE OFFICES | o | | 92.00 |
| 93.00 | 09300 | NONPALD WORKERS | 0 | | 93. 00 |
| 94. 00 | 1 | PATIENTS LAUNDRY | 0 | | 94. 00 |
| 95.00 | 09500 | OTHER NONREIMBURSABLE COST | 0 | | 95. 00 |
| 98. 00 | | Cross Foot Adjustments | | | 98. 00 |
| 99. 00 102. 00 | | Negative Cost Centers Cost to be allocated (per Wkst. B, | 615 474 | | 99. 00 102. 00 |
| 102. UL | 1 | Part I) | 615, 474 | | 102.00 |
| 103.00 | | Unit cost multiplier (Wkst. B, Part I) | 9. 762301 | | 103. 00 |
| 104.00 | 1 | Cost to be allocated (per Wkst. B, | 3, 485 | | 104. 00 |
| | | Part II) | | | |
| 105.00 | | Unit cost multiplier (Wkst. B, Part | 0. 055277 | | 105. 00 |
| | 1 | [11] | 1 | | I |
| | | | | | |

| Health Financial Systems | CARE ONE AT NEW M | II LFORD | _FORD In Lieu | | |
|--------------------------|---|-----------------------|---------------|-------------|--|
| RATIO OF COST TO CHARGES | FOR ANCILLARY AND OUTPATIENT COST CENTERS | Provi der No.: 315306 | Peri od: | Worksheet C | |

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/10/2024 12:00 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 64, 952 137, 595 0. 472052 40.00 04100 LABORATORY 149, 498 316, 700 0.472049 41.00 41.00 0. 434285 42.00 04200 I NTRAVENOUS THERAPY 95, 663 220, 277 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 912, 825 2, 003, 887 0. 455527 44.00 04500 OCCUPATIONAL THERAPY 2, 880, 917 45.00 888, 294 0.308337 45.00 04600 SPEECH PATHOLOGY 199, 923 618, 966 0.322995 46.00 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 688 1, 457 0.472203 48.00 04900 DRUGS CHARGED TO PATIENTS 345, 475 795, 503 0. 434285 49.00 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 Λ 50.00 51.00 05100 SUPPORT SURFACES 281 594 0.473064 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0.000000 52.00 0 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 0 52.01 05202 MEDICAL SERVICES 0.000000 52.02 0 52.02 OUTPATIENT SERVICE COST CENTERS 0. 000000 60.00 06000 CLI NI C 0 0 60.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62. 00 06200 FQHC 62.00 63. 00 06300 DI ALYSI S 0.000000 63.00 71. 00 07100 AMBULANCE 68, 854 145, 862 0. 472049 71.00

2, 726, 453

7, 121, 758

100. 00

100.00

Total

| Health Financial Systems | CARE ONE AT N | | | | u of Form CMS- | 2540-10 |
|---|--|----------------|--------------|--|-----------------------------|------------------|
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS | | | No.: 315306 | Peri od: From 01/01/2023 To 12/31/2023 | Date/Time Pre 5/10/2024 12: | epared: 00 pm |
| | | Title | XVIII (1) | Skilled Nursing Facility | PPS | |
| | | Health Care Pr | ogram Charge | | Program Cost | |
| | | | | | | |
| | Ratio of Cost to Charges (Fr. Wkst. C Column 3) | Part A | Part B | Part A (col. 1 x col. 2) | Part B (col. 1 x col. 3) | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| PART I - CALCULATION OF ANCILLARY AND OUTPAT | LENT COST | | | - | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | Ī |
| 40. 00 04000 RADI OLOGY | 0. 472052 | 13, 844 | | 0 6, 535 | 0 | 40.00 |
| 41. 00 04100 LABORATORY | 0. 472049 | 19, 886 | | 0 9, 387 | 0 | 41.00 |
| 42. 00 04200 I NTRAVENOUS THERAPY | 0. 434285 | 0 | | 0 0 | 0 | 42.00 |
| 43.00 O4300 OXYGEN (INHALATION) THERAPY | 0. 000000 | 0 | | 0 | 0 | 1 |
| 44. 00 O4400 PHYSI CAL THERAPY | 0. 455527 | 780, 261 | | 0 355, 430 | 0 | |
| 45. 00 04500 OCCUPATI ONAL THERAPY | 0. 308337 | 1, 039, 191 | | 0 320, 421 | 0 | |
| 46. 00 04600 SPEECH PATHOLOGY | 0. 322995 | 300, 897 | | 0 97, 188 | | |
| 47. 00 04700 ELECTROCARDI OLOGY | 0. 000000 | 0 | | 0 | 0 | 1 |
| 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 472203 | 1, 457 | | 0 688 | 0 | |
| 49. 00 04900 DRUGS CHARGED TO PATIENTS | 0. 434285 | 92, 464 | | 0 40, 156 | 0 | 1 |
| 50. 00 05000 DENTAL CARE - TITLE XIX ONLY | 0. 000000 | 0 | | 0 | | 50.00 |
| 51. 00 05100 SUPPORT SURFACES | 0. 473064 | 594 | | 0 281 | 0 | |
| 52. 00 05200 COMPLEX MEDICAL EQUIPMENT | 0. 000000 | 0 | | 0 | 0 | |
| 52. 01 05201 OTHER ANCILLARY SERVICES COST | 0. 000000 | 0 | | 0 | 0 | |
| 52. 02 05202 MEDI CAL SERVI CES | 0. 000000 | 0 | | 0 0 | 0 | 52. 02 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60. 00 06000 CLI NI C | 0. 000000 | 0 | | 0 0 | 0 | |
| 61. 00 06100 RURAL HEALTH CLINIC | | | | | | 61.00 |
| 62. 00 06200 FQHC | | | | | | 62.00 |
| 63. 00 06300 DI ALYSI S | 0. 000000 | 0 | | 0 0 | 0 | |
| 71. 00 07100 AMBULANCE (2) | 0. 472049 | | | 0 | 0 | |
| 100.00 Total (Sum of lines 40 - 71) | | 2, 248, 594 | | 0 830, 086 | 0 | 100.00 |
| (1) For title V and XIX use columns 1, 2, and 4 onl | ٧. | | | | | |

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

| Health Financial Systems | CARE ONE AT I | NEW MILEORD | | In Lie | u of Form CMS-2 | 2540-10 | |
|--|--------------------------------------|----------------|-------------------------------|--|-------------------------------|-------------------------|--|
| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS | SHILL SHILL THE | Provi der | | Peri od: From 01/01/2023 To 12/31/2023 | Worksheet D Parts II-III | pared: | |
| | Title XVIII Skilled Nursing Facility | | | | | | |
| Cost Center Description | | | | | 1. 00 | | |
| PART II - APPORTIONMENT OF VACCINE COST | | | | | 1.00 | | |
| 1.00 2.00 Program vaccine charges (From your red 3.00 Program costs (Line 1 x line 2) (Title | ords, or the PS | &R) | | , | 0. 434285 4, 525 1, 965 | 1. 00 2. 00 3. 00 | |
| Cost Center Description | Total Cost | Nursing & | Ratio of | Program Part A | | | |
| | | Allied Health | Nursing & | Cost (From | & Allied | | |
| | · · | (From Wkst. B, | | | Heal th Costs | | |
| | 18 | | Costs to Tota Costs - Part | | for Pass Through (Col. | | |
| | | 14) | (Col. 2 / Col | | 3 x Col . 4) | | |
| | | | 1) | | 3 x coi . 4) | | |
| | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | |
| PART III - CALCULATION OF PASS THROUGH COSTS | FOR NURSING & | ALLI ED HEALTH | | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 40. 00 04000 RADI OLOGY | 64, 952 | | | | 0 | | |
| 41. 00 04100 LABORATORY | 149, 498 | | 0. 00000 | | 0 | | |
| 42. 00 04200 I NTRAVENOUS THERAPY | 95, 663 | | 0. 00000 | | 0 | | |
| 43.00 04300 OXYGEN (INHALATION) THERAPY | 0 | Ĭ | 0. 00000 | | 0 | | |
| 44. 00 04400 PHYSI CAL THERAPY | 912, 825 | 0 | 0. 00000 | | 0 | 44. 00 | |
| 45. 00 04500 OCCUPATI ONAL THERAPY | 888, 294 | 0 | 0. 00000 | | 0 | | |
| 46. 00 04600 SPEECH PATHOLOGY | 199, 923 | 0 | 0. 00000 | | 0 | | |
| 47. 00 04700 ELECTROCARDI OLOGY | 0 | 0 | 0. 00000 | | 0 | | |
| 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 688 | 0 | 0. 00000 | | 0 | | |
| 49. 00 04900 DRUGS CHARGED TO PATIENTS | 345, 475 | 0 | 0. 00000 | | 0 | 49. 00 | |
| 50. 00 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0. 00000 | | 0 | | |
| 51. 00 05100 SUPPORT SURFACES | 281 | 0 | 0. 00000 | | 0 | | |
| 52. 00 05200 COMPLEX MEDICAL EQUIPMENT | 0 | 0 | 0. 00000 | | 0 | | |
| 52. 01 05201 OTHER ANCILLARY SERVICES COST | 0 | 0 | 0. 00000 | | 0 | | |
| 52. 02 05202 MEDI CAL SERVI CES | 0 | 0 | | | 0 | | |
| 100.00 Total (Sum of lines 40 - 52) | 2, 657, 599 | l 0 | I | 830, 086 | · ^ | 100.00 | |

| | Financial Systems CARE O | ONE AT NEW MIL | FORD Provi der No.: 315306 | In Lie Period: From 01/01/2023 To 12/31/2023 | u of Form CMS- Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 12: | pared |
|----------|---|------------------|-------------------------------|---|---|-------|
| | | | Title XVIII | Skilled Nursing Facility | PPS | 00 pi |
| | | | | | 1. 00 | |
| | PART I CALCULATION OF INPATIENT ROUTINE COSTS | | | | | |
| | I NPATI ENT DAYS | | | | | |
| 00 | Inpatient days including private room days | | | | 63, 046 | |
| OC | Private room days | | | | 0 | 1 |
| 00 | Inpatient days including private room days applicable | J | ram | | 7, 639 | |
| 00 | Medically necessary private room days applicable to | the Program | | | 0 | 1 |
| 00 | Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | 19, 218, 923 | 5 |
| 0 | General inpatient routine service charges | | | | 25, 488, 953 | 6 |
| 0 | General inpatient routine service charge ratio | (Line 5 divi | ded by line 6) | | 0. 754010 | |
| 0 | Enter pri vate room charges from your records | (Line 5 divi | ded by Title 0) | | 0. 754010 | 1 |
| 0 | Average private room per diem charge (Private room cl | harges line 8 | divided by private | room days. Line | 0.00 | |
| _ | 2) | 9 | | | | |
| 00 | Enter semi-private room charges from your records | | | | 0 | 10 |
| 00 | | | | | | 11 |
| | semi -pri vate room days) | | | | | |
| 00 | Average per diem private room charge differential (Lin | | , | | 0. 00 0. 00 | |
| 00 | Average per diem private room cost differential (Line Private room cost differential adjustment (Line 2 til | | e 12) | | 0.00 | |
| 00 | General inpatient routine service cost net of private | , | ifferential (line 5 | minus line 14) | 19, 218, 923 | 1 |
| 00 | PROGRAM INPATIENT ROUTINE SERVICE COSTS | C 1 00111 0031 0 | THE CITTURE (ETTIC C | iii nas i i ne i i j | 17,210,720 | 1 |
| 00 | Adjusted general inpatient service cost per diem (Li | ne 15 divide | d by line 1) | | 304.84 | 16 |
| 00 | Program routine service cost (Line 3 times line 16) | | | | 2, 328, 673 | 17 |
| 00 | Medically necessary private room cost applicable to | | , | | 0 | 1 |
| 00 | Total program general inpatient routine service cost | | | | 2, 328, 673 | |
| 00 | Capital related cost allocated to inpatient routine | | (From Wkst. B, Par | t II column 18, | 2, 560, 575 | 20 |
| 00 | line 30 for SNF; line 31 for NF, or line 32 for ICF/ | | | | 10 41 | 21 |
| 00 00 | Per diem capital related costs (Line 20 divided by Program capital related cost (Line 3 times line 21) | | | | 40. 61 310, 220 | |
| 00 | Inpatient routine service cost (Line 19 minus line : | | | | 2, 018, 453 | |
| 00 | Aggregate charges to beneficiaries for excess costs | | er records) | | 2, 010, 433 | |
| 00 | Total program routine service costs for comparison to | ` ' | , | nus line 24) | 2, 018, 453 | |
| 00 | Enter the per diem limitation (1) | | , , | , | ,, | 26 |
| 00 | Inpatient routine service cost limitation (Line 3 times) | mes the per d | iem limitation line | 26) (1) | | 27 |
| 00 | Reimbursable inpatient routine service costs (Line 2 | | esser of line 25 or | line 27) | | 28 |
| | (Transfer to Worksheet E, Part II, line 4) (See inst | ructions) | | | | |

| | | 1. 00 | |
|------|--|-----------|-------|
| | PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH | | |
| 1.00 | Total SNF inpatient days | 63, 046 | 1.00 |
| 2.00 | Program inpatient days (see instructions) | 7, 639 | 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. 121165 | 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 ATION OF INPATIENT ROUTINE COSTS | Provi der No.: 315306 | Peri od: From 01/01/2023 To 12/31/2023 | u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Prep 5/10/2024 12:0 | pare |
|------|---|-----------------------------|--|--|----------|
| | | Title XIX | Skilled Nursing Facility | | |
| | | | | 1. 00 | |
| | PART I CALCULATION OF INPATIENT ROUTINE COSTS | | | | |
| | I NPATI ENT DAYS | | | | 1 |
| 00 | Inpatient days including private room days | | | 63, 046 | 1 |
| 00 | Private room days | | | 0 | 2 |
| 00 | Inpatient days including private room days applicable to t | | | 48, 115 | 3 |
| 0 | Medically necessary private room days applicable to the Pr | ogram | | 0 | 4 |
| 00 | Total general inpatient routine service cost | | | 19, 218, 923 | 5 |
| 0 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges | | | 25, 488, 953 | 1 6 |
| 0 | General inpatient routine service charges General inpatient routine service cost/charge ratio (Line | E divided by Line 6) | | 0. 754010 | |
| 0 | Enter private room charges from your records | 5 divided by Title 6) | | 0. 754010 | 1 |
| 0 | Average private room per diem charge (Private room charges | line 8 divided by private | room days line | 0.00 | 1 - |
| 0 | 2) | Time of anythada by private | room days, rriic | 0.00 | |
| 00 | Enter semi-private room charges from your records | | | 0 | 10 |
| 00 | Average semi -pri vate room per di em charge (Semi -pri vate r | oom charges line 10, divide | ed by | 0.00 | 11 |
| | semi -pri vate room days) | | , | | |
| 00 | Average per diem private room charge differential (Line 9 | | | 0. 00 | 12 |
| 00 | Average per diem private room cost differential (Line 7 ti | , | | 0. 00 | |
| 00 | Private room cost differential adjustment (Line 2 times li | | | 0 | |
| 00 | General inpatient routine service cost net of private room | cost differential (Line 5 | minus line 14) | 19, 218, 923 | 15 |
| 00 | PROGRAM INPATIENT ROUTINE SERVICE COSTS | divided by Line 1) | | 204.04 | 16 |
| 00 | Adjusted general inpatient service cost per diem (Line 15 Program routine service cost (Line 3 times line 16) | divided by Title 1) | | 304. 84 14, 667, 377 | |
| 00 | Medically necessary private room cost applicable to progra | m (line / times line 13) | | 14, 667, 377 | |
| 00 | Total program general inpatient routine service cost (Lin | | | 14, 667, 377 | |
| 00 | Capital related cost allocated to inpatient routine service | | t II column 18 | 2, 560, 575 | |
| | line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) | (| | 2, 300, 575 | - |
| 00 | Per diem capital related costs (Line 20 divided by line 1 |) | | 40. 61 | 21 |
| 00 | Program capital related cost (Line 3 times line 21) | - | | 1, 953, 950 | |
| 00 | Inpatient routine service cost (Line 19 minus line 22) | | | 12, 713, 427 | 23 |
| 00 | Aggregate charges to beneficiaries for excess costs (From | | | 0 | 24 |
| 00 | Total program routine service costs for comparison to the | cost limitation (Line 23 mi | nus line 24) | 12, 713, 427 | 25 |
| 00 | Enter the per diem limitation (1) | | | 0. 00 | |
| 00 | Inpatient routine service cost limitation (Line 3 times th | • | , , , | 0 | |
| . 00 | Reimbursable inpatient routine service costs (Line 22 plus | the lesser of line 25 or | line 27) | 14, 667, 377 | 28 |

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

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

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

1.00

63, 046

48, 115

0.763173

0

2. 00 3. 00

4.00

| MCRI F32 | - | 10. | 17. | 178. | 0 |
|----------|---|-----|-----|------|---|

1.00

2.00

4.00

5.00

| Health Financial Systems | CARE ONE AT NEW M | II LFORD | In Lie | u of Form CMS-2540-10 |
|-------------------------------------|-----------------------|-----------------------|-----------------|--|
| CALCULATION OF REIMBURSEMENT SETTLE | EMENT FOR TITLE XVIII | Provi der No.: 315306 | From 01/01/2023 | Worksheet E Part I Date/Time Prepared: 5/10/2024 12:00 pm |
| | | Title XVIII | Skilled Nursing | PPS |

| | | Title XVIII | Skilled Nursing | PPS | |
|--------|--|-----------------------|------------------|-------------|--------|
| | | | Facility | | |
| | | | | 1. 00 | |
| | PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS | EMENT | | 11 00 | |
| 1.00 | Inpatient PPS amount (See Instructions) | | | 6, 804, 413 | 1. 00 |
| 2.00 | Nursing and Allied Health Education Activities (pass through pa | yments) | | 0 | 2. 00 |
| 3.00 | Subtotal (Sum of lines 1 and 2) | , | | 6, 804, 413 | 3. 00 |
| 4.00 | Primary payor amounts | | | 0 | 4. 00 |
| 5.00 | Coinsurance | | | 1, 102, 200 | 5. 00 |
| 6.00 | Allowable bad debts (From your records) | | | 555, 614 | 6. 00 |
| 7.00 | Allowable Bad debts for dual eligible beneficiaries (See instru | ctions) | | 404, 415 | 7. 00 |
| 8.00 | Adjusted reimbursable bad debts. (See instructions) | | | 361, 149 | 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) | | | 6, 063, 362 | 11. 00 |
| 12.00 | Interim payments (See instructions) | | | 5, 891, 108 | |
| 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 | | | 7, 014 | 14. 55 |
| 14. 75 | Sequestration for non-claims based amounts (see instructions) | | | 7, 223 | 14. 75 |
| 14. 99 | Sequestration amount (see instructions) | | | 114, 044 | 14. 99 |
| 15. 00 | Balance due provider/program (see Instructions) | | | 43, 973 | 15. 00 |
| 16.00 | Protested amounts (Nonallowable cost report items in accordance | | | 0 | 16. 00 |
| | PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (| OF COST OR CHARGES - | TITLE XVIII ONLY | | |
| 17. 00 | Ancillary services Part B | | | 0 | |
| 18. 00 | Vaccine cost (From Wkst D, Part II, line 3) | | | 1, 965 | |
| 19. 00 | Total reasonable costs (Sum of lines 17 and 18) | | 1 | 1, 965 | |
| 20. 00 | Medicare Part B ancillary charges (See instructions) | | | 4, 525 | |
| 21. 00 | Cost of covered services (Lesser of line 19 or line 20) | | | 1, 965 | |
| 22. 00 | Pri mary payor amounts | | | 0 | 22. 00 |
| 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. 01 |
| 24. 02 | Adjusted reimbursable bad debts (see instructions) | | | 0 | 24. 02 |
| 25. 00 | Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) | | | 1, 965 | |
| 26. 00 | Interim payments (See instructions) | | | 3, 326 | |
| 27. 00 | Tentative adjustment | | | 0 | 27. 00 |
| 28. 00 | Other Adjustments (See instructions) Specify | | | 0 | 28. 00 |
| 28. 50 | Demonstration payment adjustment amount before sequestration | | | 0 | 28. 50 |
| 28. 55 | Demonstration payment adjustment amount after sequestration | | | 0 39 | 28. 55 |
| 28. 99 | Sequestration amount (see instructions) | | | -1, 400 | |
| 29. 00 | Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance | o with CMS Dub 15 2 | soction 115 2 | -1, 400 | |
| 30.00 | Triorested amounts (Monariowable cost report items) in accordance | e with two rub. 13-2, | SECTION 113. 2 | υĮ | 30.00 |

Worksheet E-1
From 01/01/2023
To 12/31/2023 Date/Time Prepared:
5/10/2024 12:00 pm

Title XVIII Skilled Nursing PPS

| | | liti | e XVIII S | Facility | PPS | |
|----------------|--|------------|-------------|------------|------------|----------------|
| | | Innation | t Part A | | t B | |
| | | прастеп | t rait A | Fai | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1. 00 | 2. 00 | 3. 00 | 4.00 | |
| 1.00 | Total interim payments paid to provider | | 5, 581, 155 | | 3, 326 | 1. 00 |
| 2.00 | Interim payments payable on individual bills, either | | 309, 953 | | 0 | 2.00 |
| | submitted or to be submitted to the contractor for | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | |
| 0.00 | enter zero | | | | | 0.00 |
| 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) Program to Provider | | | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | | 0 | | 0 | 3. 01 |
| 3. 01 | ADJUSTIMENTS TO PROVIDER | | | | | 3. 01 |
| 3. 02 | | | 0 | | 0 | 3. 02 |
| 3. 04 | | | 0 | | | 3. 04 |
| 3. 05 | | | 0 | | 0 | 3. 05 |
| 5.05 | Provider to Program | | <u> </u> | | 0 | 3. 03 |
| 3.50 | ADJUSTMENTS TO PROGRAM | | 0 | | 0 | 3. 50 |
| 3. 51 | ABSOSTMENTS TO TROOK IIII | | 0 | | Ö | 3. 51 |
| 3. 52 | | | 0 | | ام | 3. 52 |
| 3. 53 | | | 0 | | l ol | 3. 53 |
| 3. 54 | | | 0 | | ا | 3. 54 |
| 3. 99 | Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 | | 0 | | ا | 3. 99 |
| 0. ,, | - 3.98) | | Ĭ | | | 0. ,, |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 5, 891, 108 | | 3, 326 | 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 |
| | desk review. Also show date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | | |
| 5. 01 | TENTATI VE TO PROVI DER | | 0 | | 0 | 5. 01 |
| 5.02 | | | 0 | | 0 | 5. 02 |
| 5. 03 | | | 0 | | 0 | 5. 03 |
| | Provi der to Program | | | | | |
| 5.50 | TENTATI VE TO PROGRAM | | 0 | | 0 | 5. 50 |
| 5. 51 | | | 0 | | 0 | 5. 51 |
| 5. 52 5. 99 | C. ht-t-1 (C. m6 1; 5 01 | | 0 | | 0 | 5. 52 5. 99 |
| 5. 99 | Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98) | | 0 | | l 0 | 5. 99 |
| 6. 00 | Determined net settlement amount (balance due) based on | | | | | 6. 00 |
| 0.00 | the cost report. (1) | | | | | 0.00 |
| 6. 01 | PROGRAM TO PROVIDER | | 43, 973 | | 0 | 6. 01 |
| 6. 02 | PROVIDER TO PROGRAM | | 43, 9/3 | | 1, 400 | |
| 7. 00 | Total Medicare program liability (see instructions) | | 5, 935, 081 | | 1, 926 | |
| 7.00 | Total modificate program traditivity (see instructions) | | Contract | tor Name | Contractor | 7.00 |
| | | | Contract | TO NUME | Number | |
| | | | 1. | 00 | 2. 00 | |
| 8. 00 | Name of Contractor | | | | | 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.

| | | ONE AT NEW | MI LFORD | | In Lie | u of Form CMS-: | 2540-10 |
|------------------|---|------------|------------------------|----------------------|----------------------------------|-----------------|------------------|
| | E SHEET (If you are nonproprietary and do not mainta | | Provi der | | Peri od: | Worksheet G | |
| | ype accounting records, complete the "General Fund" | col umn | | | From 01/01/2023 To 12/31/2023 | Date/Time Pre | epared: |
| onl y) | | | | | | 5/10/2024 12: | 00 pm |
| | | Ge | neral Fund | Speci fi c | Endowment Fund | Plant Fund | |
| | | | 1. 00 | Purpose Fund 2.00 | 3. 00 | 4. 00 | |
| | Assets | <u> </u> | 1.00 | 2.00 | 3.00 | 4.00 | |
| | CURRENT ASSETS | | | | | | |
| 1.00 | Cash on hand and in banks | | 65, 005 | | 이 | 0 | |
| 2.00 | Temporary investments | | 0 | | 0 0 | 0 | |
| 3. 00 4. 00 | Notes recei vabl e Accounts recei vabl e | | 2, 218, 544 | ŀ | 0 0 | 0 | |
| 5. 00 | Other receivables | | 2, 210, 344 | | ol ol | 0 | |
| 6.00 | Less: allowances for uncollectible notes and account | ts | -70, 469 | | o o | 0 | |
| | recei vabl e | | | | | | |
| 7.00 | Inventory | | 0 | | 0 0 | 0 | |
| 8. 00 9. 00 | Prepaid expenses Other current assets | | 44, 192 85, 533 | | | 0 | |
| 10. 00 | Due from other funds | | 05, 555 | 1 | ol ol | 0 | |
| 11. 00 | TOTAL CURRENT ASSETS (Sum of lines 1 - 10) | | 2, 342, 805 | | o o | 0 | |
| | FIXED ASSETS | | | | | | |
| 12.00 | Land | | 0 | | 0 0 | 0 | |
| 13.00 | Land improvements Less: Accumulated depreciation | | 0 | | 0 0 | 0 | |
| 14. 00 15. 00 | Buildings | | 0 | | | 0 | |
| 16. 00 | Less Accumulated depreciation | | 0 | | | 0 | 1 |
| 17. 00 | Leasehold improvements | | 0 | | o o | 0 | |
| 18. 00 | Less: Accumulated Amortization | | 0 | | o o | 0 | 18. 00 |
| 19. 00 | Fi xed equipment | | 0 | | 이 | 0 | |
| 20. 00 | Less: Accumulated depreciation | | 0 | | 0 0 | 0 | |
| 21. 00 | Automobiles and trucks | | 0 | | 0 0 | 0 | |
| 22. 00 23. 00 | Less: Accumulated depreciation Major movable equipment | | 0 | | | 0 | |
| 24. 00 | Less: Accumulated depreciation | | 0 | | | 0 | 1 |
| 25. 00 | Mi nor equi pment - Depreci abl e | | 0 | | ol ol | 0 | 1 |
| 26. 00 | Mi nor equi pment nondepreci abl e | | 0 | | o o | 0 | 1 |
| 27. 00 | Other fixed assets | | 0 | | 0 0 | 0 | |
| 28. 00 | TOTAL FIXED ASSETS (Sum of lines 12 - 27) | | 0 | | 0 0 | 0 | 28. 00 |
| 20.00 | OTHER ASSETS Investments | | 0 | | ol ol | | 20.00 |
| 29. 00 30. 00 | Deposits on Leases | | 0 | 1 | | 0 | |
| 31. 00 | Due from owners/officers | | 0 | • | | 0 | |
| 32. 00 | Other assets | | 10, 291 | | o o | 0 | |
| 33.00 | TOTAL OTHER ASSETS (Sum of lines 29 - 32) | | 10, 291 | | 0 0 | 0 | 33. 00 |
| 34. 00 | TOTAL ASSETS (Sum of lines 11, 28, and 33) | | 2, 353, 096 | | 0 0 | 0 | 34.00 |
| | Liabilities and Fund Balances | | | | | | - |
| 35. 00 | CURRENT LIABILITIES Accounts payable | | 1, 397, 084 | | ol ol | 0 | 35. 00 |
| 36. 00 | Salaries, wages, and fees payable | | 1, 230, 915 | | ol ol | 0 | |
| 37. 00 | Payrol I taxes payable | | -10, 067 | | o o | 0 | |
| 38. 00 | Notes & Loans payable (Short term) | | 0 | | o o | 0 | 38. 00 |
| 39. 00 | Deferred income | | 0 | | 이 | 0 | |
| 40.00 | Accel erated payments | | 0 | | | | 40.00 |
| 41. 00 42. 00 | Due to other funds Other current liabilities | | 85, 533 1, 362, 545 | | 0 0 0 0 | 0 | 1 |
| 43. 00 | TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) | | 4, 066, 010 | | | 0 | |
| 10.00 | LONG TERM LIABILITIES | | 1,000,010 | | 01 01 | <u> </u> | 10.00 |
| 44.00 | Mortgage payable | T | 0 | | 0 0 | 0 | 44. 00 |
| 45. 00 | Notes payable | | 0 | • | 0 0 | 0 | |
| 46. 00 | Unsecured Loans | | 0 | • | 이 | 0 | 1 |
| 47. 00 | Loans from owners: | | 0 | | 0 0 | 0 | |
| 48. 00 49. 00 | Other long term liabilities OTHER (SPECIFY) | | -4, 123, 523 | ı | 0 0 | 0 | |
| 50. 00 | TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 | | -4, 123, 523 | | | 0 | |
| 51. 00 | TOTAL LIABILITIES (Sum of lines 43 and 50) | | -57, 513 | | ol ol | 0 | |
| | CAPITAL ACCOUNTS | | | | - 1 | | |
| 52.00 | General fund balance | | 2, 410, 609 | | | | 52. 00 |
| 53.00 | Specific purpose fund | | | | 0 | | 53.00 |
| 54.00 | Donor created - endowment fund balance - restricted | l l | | | 0 | | 54.00 |
| 55. 00 56. 00 | Donor created - endowment fund balance - unrestricte Governing body created - endowment fund balance | eu | | | | | 55. 00 56. 00 |
| 57. 00 | Plant fund balance - invested in plant | | | | | 0 | |
| 58. 00 | Plant fund balance - reserve for plant improvement, | | | | | 0 | |
| | repl acement, and expansion | | | | | | |
| 59.00 | TOTAL FUND BALANCES (Sum of lines 52 thru 58) | | 2, 410, 609 | | 이 | 0 | 1 |
| 60. 00 | TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 57) | ı and | 2, 353, 096 | | 이 | 0 | 60.00 |
| | <i>~'/</i> | l | | I | ı | | I |
| | | | | | | | |

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

Provi der No.: 315306

| | | | | | 0 12/31/2023 | 5/10/2024 12: | |
|------------------|---|----------------|-------------|------------|--------------|----------------|------------------|
| | | General | Fund | Special Pu | urpose Fund | Endowment Fund | OO piii |
| | | | | | | | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 1.00 | Fund balances at beginning of period | 11.00 | 1, 961, 755 | 0.00 | 0 | | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 31) | | 448, 859 | | | | 2.00 |
| 3.00 | Total (sum of line 1 and line 2) | | 2, 410, 614 | | 0 | | 3. 00 |
| 4.00 | Additions (credit adjustments) | | | | | | 4. 00 |
| 5.00 | | 0 | | C |) | 0 | 5. 00 |
| 6.00 | | 0 | | C | | 0 | 6. 00 |
| 7.00 | | 0 | | C | | 0 | 7. 00 |
| 8.00 | | 0 | | C | 1 | 0 | 8. 00 |
| 9.00 | | 0 | _ | C |) | 0 | 9. 00 |
| 10.00 | Total additions (sum of line 5 - 9) | | 0 | | 0 | | 10.00 |
| 11.00 | Subtotal (line 3 plus line 10) | | 2, 410, 614 | | 0 | | 11.00 |
| 12.00 | Deductions (debit adjustments) | | | | | | 12.00 |
| 13. 00 14. 00 | ROUNDI NG | 5 | | C | | 0 | 13.00 |
| 15. 00 | | | | | | 0 | 14. 00 15. 00 |
| 16. 00 | | | | | | | 16.00 |
| 17. 00 | | | | | | 0 | 17. 00 |
| 18. 00 | Total deductions (sum of lines 13 - 17) | | 5 | | ĺ | · | 18.00 |
| 19. 00 | Fund balance at end of period per balance | | 2, 410, 609 | | 0 | | 19.00 |
| . , | sheet (Line 11 - line 18) | | 2, 110, 007 | | | | ., |
| | | Endowment Fund | PI ant | Fund | | | |
| | | | | | | | |
| 4 00 | | 6.00 | 7. 00 | 8. 00 | | | 4 00 |
| 1. 00 2. 00 | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) | 0 | | C |) | | 1. 00 2. 00 |
| 3.00 | Total (sum of line 1 and line 2) | 0 | | (| | | 3.00 |
| 4. 00 | Additions (credit adjustments) | | | | , | | 4.00 |
| 5.00 | Additions (credit adjustments) | | 0 | | | | 5.00 |
| 6. 00 | | | 0 | | | | 6.00 |
| 7. 00 | | | Ö | | | | 7. 00 |
| 8.00 | | i | ol | | | | 8.00 |
| 9. 00 | | | o | | | | 9. 00 |
| 10.00 | Total additions (sum of line 5 - 9) | O | | C | | | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | o | | C | | | 11. 00 |
| 12.00 | Deductions (debit adjustments) | | | | | | 12.00 |
| 13.00 | ROUNDI NG | | 0 | | | | 13. 00 |
| 14.00 | | | 0 | | | | 14. 00 |
| 15. 00 | | | 0 | | | | 15. 00 |
| 16. 00 | | | 0 | | | | 16. 00 |
| 17. 00 | | [| 0 | | | | 17. 00 |
| 18. 00 | Total deductions (sum of lines 13 - 17) | 0 | | C | | | 18. 00 |
| 19.00 | Fund balance at end of period per balance | | | | | | |
| . , | sheet (Line 11 - Line 18) | 0 | | C |) | | 19. 00 |

| Heal th | Financial Systems C | CARE ONE AT NEW MI | LFORD | | In Lie | u of Form CMS-2 | 2540-10 |
|---------|--|--------------------|-----------|-------------|---|--------------------------------|---------|
| | MENT OF PATIENT REVENUES AND OPERATING EXPENSES | | Provi der | | Period: From 01/01/2023 Fo 12/31/2023 | Date/Time Pre 5/10/2024 12: | pared: |
| | Cost Center Description | | | I npati ent | Outpati ent | Total | |
| | | | | 1. 00 | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | | | | |
| | General Inpatient Routine Care Services | | | | | | |
| 1.00 | SKILLED NURSING FACILITY | | | 25, 488, 95 | 3 | 25, 488, 953 | 1. 00 |
| 2.00 | NURSING FACILITY | | | |) | 0 | 2. 00 |
| 3.00 | ICF/IID | | | | O | 0 | 3. 00 |
| 4.00 | OTHER LONG TERM CARE | | | | O | 0 | 4. 00 |
| 5.00 | Total general inpatient care services (Sum of I | ines 1 - 4) | | 25, 488, 95 | 3 | 25, 488, 953 | 5. 00 |
| | All Other Care Services | | | | | | |
| 6.00 | ANCI LLARY SERVI CES | | | 7, 121, 75 | 3 0 | 7, 121, 758 | 6.00 |
| 7.00 | CLINIC | | | | 0 | 0 | 7. 00 |
| 8.00 | HOME HEALTH AGENCY COST | | | | 0 | 0 | 8. 00 |
| 9. 00 | AMBULANCE | | | | 0 | 0 | 9. 00 |
| 10.00 | RURAL HEALTH CLINIC | | | | 0 | 0 | 10.00 |
| 10. 10 | FQHC | | | | 0 | 0 | 10. 10 |
| 44 00 | LOUIS CONTRACTOR OF THE PROPERTY OF THE PROPER | | | 1 | | | |

| 11. 00 | CMHC | | 0 | 0 | 11. 00 |
|--------|--|--------------|-------|--------------|--------|
| 12.00 | HOSPI CE | 0 | o | 0 | 12.00 |
| 13.00 | OTHER (SPECIFY) | 0 | o | 0 | 13.00 |
| 14.00 | Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to | 32, 610, 711 | o | 32, 610, 711 | 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) | | | 22, 722, 531 | 1. 00 |
| 2.00 | Add (Specify) | | 0 | | 2. 00 |
| 3.00 | | | 0 | | 3. 00 |
| 4.00 | | | 0 | | 4. 00 |
| 5.00 | | | 0 | | 5. 00 |
| 6.00 | | | 0 | | 6. 00 |
| 7. 00 | | | 0 | | 7. 00 |
| 8. 00 | Total Additions (Sum of lines 2 - 7) | | | 0 | 8. 00 |
| 9. 00 | Deduct (Specify) | | 0 | | 9. 00 |
| 10. 00 | | | 0 | | 10.00 |
| 11. 00 | | | 0 | | 11. 00 |
| 12.00 | | | 0 | | 12.00 |
| 13. 00 | | | 0 | | 13.00 |
| 14.00 | Total Deductions (Sum of lines 9 - 13) | | | 0 | 14.00 |
| 15. 00 | Total Operating Expenses (Sum of lines 1 and 8, minus line 14) | | | 22, 722, 531 | 15. 00 |

11. 00 12. 00 13. 00

11.00

CMHC

| Heal th | Financial Systems CARE ONE AT I | NEW MILFORD | In Lie | u of Form CMS-2 | 2540-10 |
|---------|---|-----------------------|-----------------|-----------------|---------|
| STATE | MENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provi der No.: 315306 | Peri od: | Worksheet G-3 | |
| | | | From 01/01/2023 | | |
| | | | To 12/31/2023 | Date/Time Prep | |
| | | | | 5/10/2024 12: (| JO pm |
| | | | ļ. | | |
| | | | | 1. 00 | |
| 1.00 | Total patient revenues (From Wkst. G-2, Part I, col. 3, Ii | ne 14) | | 32, 610, 711 | 1.00 |
| 2.00 | Less: contractual allowances and discounts on patients acco | ounts | | 9, 579, 922 | 2.00 |
| 3.00 | Net patient revenues (Line 1 minus line 2) | | | 23, 030, 789 | 3.00 |
| 4.00 | Less: total operating expenses (From Worksheet G-2, Part II | , line 15) | | 22, 722, 531 | 4.00 |
| 5.00 | Net income from service to patients (Line 3 minus 4) | | | 308, 258 | 5.00 |
| | Other income: | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | 0 | 6.00 |
| 7 00 | Income from investments | | | 2 035 | 7 00 |

| 1.00 | Total patient revenues (From Wkst. G-2, Part I, col. 3, Tine 14) | 32, 610, 711 | 1. 00 |
|--------|---|--------------|--------|
| 2.00 | Less: contractual allowances and discounts on patients accounts | 9, 579, 922 | 2.00 |
| 3.00 | Net patient revenues (Line 1 minus line 2) | 23, 030, 789 | 3.00 |
| 4.00 | Less: total operating expenses (From Worksheet G-2, Part II, line 15) | 22, 722, 531 | 4. 00 |
| 5.00 | Net income from service to patients (Line 3 minus 4) | 308, 258 | 5.00 |
| | Other income: | | |
| 6.00 | Contributions, donations, bequests, etc | 0 | 6.00 |
| 7.00 | Income from investments | 2, 935 | 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 | 1, 460 | 13.00 |
| 14.00 | Revenue from meals sold to employees and guests | 0 | 14.00 |
| 15. 00 | Revenue from rental of living quarters | 0 | 15.00 |
| 16.00 | Revenue from sale of medical and surgical supplies to other than patients | 0 | 16.00 |
| 17. 00 | Revenue from sale of drugs to other than patients | 0 | 17.00 |
| 18. 00 | Revenue from sale of medical records and abstracts | 0 | 18.00 |
| 19. 00 | Tuition (fees, sale of textbooks, uniforms, etc.) | 0 | 19.00 |
| 20.00 | Revenue from gifts, flower, coffee shops, canteen | 0 | 20.00 |
| 21. 00 | 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 | 5, 060 | 24.00 |
| 24. 01 | OTHER REVENUE | 128, 939 | 24. 01 |
| 24. 02 | OTHER I NCOME | 2, 207 | 24. 02 |
| 24. 50 | COVI D-19 PHE Funding | 0 | 24. 50 |
| 25. 00 | Total other income (Sum of lines 6 - 24) | 140, 601 | 25.00 |
| 26.00 | Total (Line 5 plus line 25) | 448, 859 | 26.00 |
| 27. 00 | Other expenses (specify) | 0 | 27.00 |
| 28. 00 | | 0 | 28. 00 |
| 29. 00 | | 0 | 29. 00 |
| | Total other expenses (Sum of lines 27 - 29) | 0 | 30.00 |
| 31.00 | Net income (or loss) for the period (Line 26 minus line 30) | 448, 859 | 31.00 |
| | | | |