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).

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315502	From 01/01/2023 To 12/31/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/10/2024 11:49 am

			37 10	/ 2027 11. 7	/ uiii
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically prepared cost rep	oort	Date: 5/10/2024	Time: 11:	49 am
use only	2. [] Manually prepared cost report				
	3. [0] If this is an amended report ent	er the number of times the provider	resubmitted this cos	t report	
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or leave blank for no.		-	
Contractor	4. [1] Cost Report Status	6. Contractor No.			
use only	(1) As Submitted	7.[N] First Cost Report for this	Provi der CCN		
	(2) Settled without audit	8.[N] Last Cost Report for this F	rovider CCN		
	(3) Settled with audit	9. NPR Date:			
	(4) Reopened	10.[0]If line 4, column 1 is "4":	 Enter number of time	s reopened	d
	(5) Amended	11. Contractor Vendor Code	4	•	
	5. Date Received:	12.[F] Medicare Utilization. Enter	F" for full, "L" fo	or low, or	"N"
		for no utilization.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE ONE AT TEANECK (315502) 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	3, 734	0	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	3, 734	0	0	100.00

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

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

Health Financial Systems CARE ONE AT TEANECK In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315502 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/10/2024 11:49 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 544 TEANECK ROAD PO Box: 1.00 2.00 Ci ty: TEANECK State: NJ Zi p Code: 07666 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 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT TEANECK 315502 04/13/2007 N Р N 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in N 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 698, 914 20.00 Straight Line 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 698, 914 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 SNF-Based FQHC 34.00 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 Υ 38.00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 58 908

Heal th	Financial Systems	CARE ONE AT TEA	NECK	In Lie	u of Form CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315502	Peri od:	Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2023	Part I	
				To 12/31/2023		pared:
					5/10/2024 11:	49 am
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative an	d General cost	N	42. 00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing cost	centers and		
	amounts.		9			
43.00	Are there any home office costs as defi	ned in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and address	of the home	HB0206	44. 00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3. 00		
	If this facility is part of a chain or	ganization, enter the nam	e and address of the h	nome office on the	lines	
	bel ow.					
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contrac	tor's Number: 1200	1	45. 00
	Street: 173 BRIDGE PLAZA NORTH	PO Box:	2 2222112113		•	46. 00
	City: FORT LEE		Zi n. Cod	e: 0702	Λ	47. 00
47.00	City: FORILEE	State: NJ	Zi p Cod	e: 0702	4	47.00

Health Financial Systems CARE ONE AT TEANECK In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315502 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part II Date/Time Prepared: 12/31/2023 5/10/2024 11:49 am Date 1. 00 2.00 General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see 1.00 N 1.00 instructions) Y/N Date V/I 1. 00 2. 00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν column 1 is ves. enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00 Financial Data and Reports 4 00 4 00 Column 1: Were the financial statements prepared by a Certified Public Α Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If column 1 is "Y", submit reconciliation. Y/N Legal Oper. 1.00 2.00 Approved Educational Activities Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the 6.00 N Ν 6.00 legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Health Programs? (Y/N) see instructions Ν 7.00 8.00 Were approvals and/or renewals obtained during the cost reporting period for Nursing 8.00 School and/or Allied Health Program? (Y/N) see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? (Y/N) see instructions. 9.00 9.00 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting 10.00 Ν 10.00 period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. Ν 11.00 Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y" Ν see instructions 12.00 Part B Y/N Date Description Y/N 1.00 3.00 0 2.00 PS&R Data 13.00 Was the cost report prepared using the PS&R Υ 03/19/2024 Υ 13.00 only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R Ν Ν 14 00 for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and If line 13 or 14 is "Y", were adjustments 15.00 Ν Ν 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were 16.00 16.00 Ν Ν adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were Ν Ν 17.00 adjustments made to PS&R data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. N Ν 18.00

Heal th	Financial Systems CARE	ONE AT	TEANECK		In Lieu	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALT	H CARE	Provi der No.		eri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				rom 01/01/2023 o 12/31/2023		pared·
						5/10/2024 11:	
			1. 00		2. (00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position		CHARLES		REED		19. 00
	held by the cost report preparer in columns 1, 2, and	d 3,					
	respecti vel y.	1					
20.00	Enter the employer/company name of the cost report	E	EXECUCARE ASSOCIAT	ΓES			20. 00
	preparer.	1					
21.00	Enter the telephone number and email address of the	cost ((609) 738-3200		CRWASSC@NETSCAP	PE. NET	21.00
	report preparer in columns 1 and 2, respectively.						

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

CARE ONE AT TEANECK
In Lieu of Form CMS-2540-10
Provider No.: 315502
From 01/01/2023
From 01/0

COMPLE	X KELMBOKSEMENT GOESTLONNALKE			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					
	4. (see Instructions.)					
14.00	Was the cost report prepared using the PS&R					14.00
	for total and the provider's records for					
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
45.00	4.					
15. 00	, , , , , , , , , , , , , , , , , , , ,					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						16. 00
16.00	adjustments made to PS&R data for					16.00
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17 00	If line 13 or 14 is "Y", then were					17. 00
17.00	adjustments made to PS&R data for Other?					17.00
	Describe the other adjustments:					
18. 00	Was the cost report prepared only using the					18. 00
	provider's records? If "Y" see Instructions.					
			3. 00			
	Cost Report Preparer Contact Information		L			
19. 00	Enter the first name, last name and the title		VI CE-PRESI DENT			19. 00
	held by the cost report preparer in columns 1	i, 2, and 3,				
20.00	respectively.	anant				20.00
20.00	Enter the employer/company name of the cost r	eport				20. 00
21 00	preparer. Enter the telephone number and email address	of the cost				21. 00
∠1.00	report preparer in columns 1 and 2, respective					21.00
	Trebort brebarer in corumns rand 2, respectiv	very.		1	1	

In Lieu of Form CMS-2540-10 CARE ONE AT TEANECK Provi der No.: 315502

 Health Financial Systems
 CARE ONE AT

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

				10) 12/31/2023	5/10/2024 11: 4	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3.00	4. 00	5.00	
1.00	SKILLED NURSING FACILITY	128	46, 720		15, 082	0	1.00
2. 00 3. 00	NURSING FACILITY	0	0			0 0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		0	0	0	- 1	4. 00
5. 00	Other Long Term Care	0	0		0		5. 00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	128 Inpatient [46, 720	0	15, 082 Di scharges	0	8. 00
		Impatrent	ay37 VI 31 C3		Di Schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1.00	CVILLED NURCING FACILLETY	6.00	7.00	8. 00	9. 00	10.00	4 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	15, 278	30, 360 0	1	464	0 0	1. 00 2. 00
3. 00	ICF/IID	0	0				3. 00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC HOSPICE	0	0		0		6. 00
7. 00 8. 00	Total (Sum of lines 1-7)	15, 278	30, 360	0	0 464	0 0	7. 00 8. 00
0.00	Total (Sam of Tries 1 7)	Di sch			age Length of		0.00
		2.1					
	Component	0ther 11.00	Total 12. 00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
1. 00	SKILLED NURSING FACILITY	569	1, 033		32. 50		1. 00
2. 00	NURSING FACILITY	0	0	1	02.00	0.00	2. 00
3.00	ICF/IID	0	0			0.00	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	0				5. 00 6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	569	1, 033		32. 50	0.00	8. 00
		Average Length of Stay		Admi s	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	29. 39	0		0		1. 00
2. 00 3. 00	NURSING FACILITY	0. 00 0. 00	0		0	0 0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			U		4. 00
5. 00	Other Long Term Care	0.00				О	5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPICE Total (Sum of Lines 1-7)	0. 00 29. 39	0	0 521	0		7. 00
8. 00	Total (Sull of Titles 1-7)	Admi ssi ons	Full Time		0	515	8. 00
	Component	Total	Employees on	Nonpai d			
	oomponent.	1000	Payrol I	Workers			
	T	21.00	22. 00	23. 00			
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	1, 036 0	133. 80 0. 00				1. 00 2. 00
2. 00 3. 00	INDESTING FACILITY	0	0.00				2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	0	0.00	0. 00			5.00
6.00	SNF-Based CMHC		0.00				6.00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	1, 036	0. 00 133. 80				7. 00 8. 00
0.00	Total (Suil Of Titles 1-1)	1,030	133.60	0.00		I	0.00

				Ť	0 12/31/2023	Date/Time Prep 5/10/2024 11:4	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	17 (1111
		Reported		Salaries (col.		Wage (col. 3 ÷	
		'	Worksheet A-6		Salary in col.	col . 4)	
				Í	3	, i	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	8, 597, 303	0	8, 597, 303	278, 313. 00	30. 89	1. 00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	8, 597, 303	0	8, 597, 303	278, 313. 00	30. 89	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11. 00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	8, 597, 303	0	8, 597, 303	278, 313. 00	30. 89	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
	Contract Labor: Patient Related & Mgmt	1, 839, 542	0	1, 839, 542	· ·		14. 00
15. 00		0	0	0	0.00		
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 400, 784	0	1, 400, 784			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20.00	Physician Part A - WRC	0	0	0			20.00
21. 00	Physician Part B - WRC	0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 400, 784	0	1, 400, 784			22. 00
	instructions)		l				

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT TEANECK

				T	o 12/31/2023	Date/Time Prep 5/10/2024 11:4	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.		
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	780, 707	0	780, 707	20, 166. 00	38. 71	2.00
3.00	Plant Operation, Maintenance & Repairs	51, 275	0	51, 275	2, 258. 00	22. 71	3.00
4.00	Laundry & Linen Service	74, 692	0	74, 692	4, 552. 00	16. 41	4.00
5.00	Housekeepi ng	379, 403	0	379, 403	20, 178. 00	18. 80	5.00
6.00	Di etary	845, 585	0	845, 585	38, 106. 00	22. 19	6.00
7.00	Nursing Administration	626, 106	0	626, 106	15, 366. 00	40. 75	7.00
8.00	Central Services and Supply	41, 985	0	41, 985	2, 442. 00	17. 19	8. 00
9.00	Pharmacy	0	0	0	0.00	0. 00	9. 00
10.00	Medical Records & Medical Records Library	41, 069	0	41, 069	2, 202. 00	18. 65	10.00
11. 00	Soci al Servi ce	154, 086	0	154, 086	4, 080. 00	37. 77	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	219, 858	0	219, 858	11, 477. 00	19. 16	13.00
14.00	Total (sum lines 1 thru 13)	3, 214, 766	0	3, 214, 766	120, 827. 00	26. 61	14.00

Health Financial Systems	CARE ONE AT TEANECK	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315502	From 01/01/2023	Worksheet S-3 Part IV Date/Time Prepared:

	To 12/31/2023		
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	41, 943	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	l ol	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	l ol	3. 00
4. 00	Prior Year Pension Service Cost	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6. 00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	ا م	7. 00
7.00	HEALTH AND INSURANCE COST		,,,,,
8. 00	Heal th Insurance (Purchased or Self Funded)	481, 995	8. 00
9. 00	Prescription Drug Plan	0	9. 00
10. 00	Dental, Hearing and Vision Plan		10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 983	
12. 00		1, 703	
13. 00	Disability Insurance (If employee is owner or beneficiary)		13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)		14. 00
15. 00		172, 424	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	172, 424	
10.00	Non cumulative portion)	١	10.00
	TAXES		
17 00	FICA-Employers Portion Only	616, 182	17. 00
	Medicare Taxes - Employers Portion Only	010, 102	18. 00
19. 00	Unemployment Insurance		19. 00
	State or Federal Unemployment Taxes	86, 257	
20.00	OTHER	00, 237	20.00
21 00	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances		22. 00
	Tui ti on Rei mbursement		23. 00
	Total Wage Related cost (Sum of lines 1 - 23)	1, 400, 784	
24.00	Total mage nerated cost (sum of fries 1 25)	Amount	24.00
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00		0	25. 00
	1	۱	

					0 12/31/2023		oared:
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	5/10/2024 11: Average Hourly	49 alli
	occupational category	Reported		Sal ari es (col.		Wage (col. 3 ÷	
		Reported	Delle I I IS		Salary in col.	col. 4)	
				1 + COI. 2)	3	COI . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	743, 112	137, 695	880, 807	15, 834. 00	55. 63	1.00
2.00	Licensed Practical Nurses (LPNs)	985, 492	182, 607	1, 168, 099	23, 578. 00	49. 54	2.00
3.00	Certified Nursing Assistant/Nursing	1, 898, 636	351, 808	2, 250, 444	78, 412. 00	28. 70	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 627, 240	672, 110				4.00
5.00	Physical Therapists	817, 618	151, 501	969, 119	·		5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
7.00	Physical Therapy Aides	0	0	0	0.00		
8.00	Occupational Therapists	711, 742	131, 882	843, 624	18, 087. 00		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11. 00	Speech Therapists	115, 079	21, 324	136, 403			
12.00	Respi ratory Therapi sts	0	0	0	0.00		12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	230, 176		230, 176			
15. 00	Licensed Practical Nurses (LPNs)	1, 349, 452		1, 349, 452	·		
16. 00	Certified Nursing Assistant/Nursing	230, 435		230, 435	5, 121. 00	45. 00	16. 00
47.00	Assi stants/Ai des	4 040 040			04 704 00	00.44	47.00
17. 00	Total Nursing (sum of lines 14 through 16)	1, 810, 063		1, 810, 063			
18. 00	Physical Therapists	0		0	0.00		18. 00
19. 00	Physical Therapy Assistants	0		0	0.00		19. 00
20.00	Physical Therapy Aides	0		0	0.00	0.00	
21. 00	Occupational Therapists	0		0	0.00	0.00	
22. 00	Occupational Therapy Assistants	0		0	0.00	0.00	
23. 00	Occupational Therapy Aides	0		0	0.00		
24.00	Speech Therapists	2, 328		2, 328			
25. 00	Respiratory Therapists	27, 151		27, 151			
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

F T	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 49 am

10 127	5/10/2024 11: 49 am
	oup Days
	00 2.00
	UX 1.00
	UL 2. 00 VX 3. 00
	VL 3.00
	HX 5.00
6. 00 RH	
	MX 7. 00
8. 00 RN	ML 8.00
	LX 9.00
	UC 10.00
	UB 11. 00
	UA
	VB 13.00
	VA 15.00
	HC 16. 00
17. 00 RI	HB 17. 00
	HA 18.00
	MC 19. 00
	MB 20.00
21. 00 RN RL RL	MA 21. 00 LB 22. 00
	LB 22.00 LA 23.00
24. 00 ES	
	S2 25.00
26. 00 ES	
	E2 27. 00
	E1 28. 00
	D2 29. 00
30. 00 HE	
31. 00 HC 32. 00 HC	C2 C1 31.00 32.00
	B2 33.00
34. 00 HE	
	E2 35.00
36. 00 LE	E1 36.00
	D2 37. 00
38. 00 LC	
	C2 39. 00
40. 00 LC	
41. 00 LE 42. 00 LE	B2 41. 00 B1 42. 00
	E2 43.00
44.00	
	D2 45. 00
46. 00 CC	
	C2 47. 00
48.00	
	B2 49.00
	B1 50.00 A2 51.00
52. 00 CA	
	E3 53. 00
54. 00 SE	E2 54. 00
55. 00 SE	
56. 00 SS	SC 56.00
57. 00 SS 58. 00 SS	SB 57. 00 SA 58. 00
	B2 59.00
60. 00 I E	
	A2 61.00
62.00	A1 62.00
63. 00 BB	B2 63.00
64. 00 BE	
	A2 65. 00
66. 00	
67. 00 PE 68. 00 PE	E2 67. 00 E1 68. 00
	D2 69.00
70. 00 PD	
	C2 71.00
72. 00 PC	
73. 00 PE	B2 73.00
74. 00 PE	
75. 00 PA	A2 75. 00

Health Financial Systems	CARE ONE AT TEANECK	(In Lieu of Form CMS-2540			
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Pro	ovi der	No.: 315502	Peri od:	Worksheet S	-7
				From 01/01/2023 To 12/31/2023		
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1.00	2. 00	3. 00	
A notice published in the Federal Register payments beginning 10/01/2003. Congress exexpenses. For lines 101 through 106: Enter column 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y" with direct patient care and related exper (See instructions)	spected this increase to be in column 1 the amount of for each category to total for yes or "N" for no if	e used f the e I SNF r the sp	for direct pexpense for er revenue from pending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101. 00 Staffi ng						101. 00
102.00 Recruitment						102.00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104. 00
105. 00 OTHER (SPECIFY)						105.00
106.00 Total SNF revenue (Worksheet G-2, Part I,	line i, column 3)	I				106. 00

	Financial Systems	CARE ONE AT	TEANECK		In Lie	u of Form CMS-2	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 01/01/2023	Worksheet A	
					To 12/31/2023	Date/Time Pre	pared:
						5/10/2024 11:	49 am
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Reclassified Trial Balance	
				+ col . 2)	ons I ncrease/Decre	(col. 3 +-	
					ase (Fr Wkst	col . 4)	
					À-6)	,	
	OFNEDAL CEDILOF OCCT OFNEDO	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES		2, 380, 103	2, 380, 103	3 0	2, 380, 103	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		170, 626			170, 519	2.00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 593, 038			1, 593, 038	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	780, 707	3, 386, 129			4, 166, 836	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	51, 275	527, 843			579, 118	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	74, 692	66, 093			140, 785	6. 00
7.00	00700 HOUSEKEEPI NG	379, 403	50, 989			430, 392	
8. 00 9. 00	OO800 DI ETARY OO900 NURSI NG ADMI NI STRATI ON	845, 585 626, 106	496, 382 80, 265			1, 341, 967 706, 371	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	41, 985	309, 872			351, 634	
11. 00	01100 PHARMACY	0	16, 361			16, 361	
12.00	01200 MEDICAL RECORDS & LIBRARY	41, 069	0	41, 069		41, 069	
13.00	01300 SOCIAL SERVICE	154, 086	0	154, 086	0	154, 086	13. 00
14. 00		0	0	(0	0	14. 00
15. 00	01500 ACTI VI TES	219, 858	14, 573	234, 431	0	234, 431	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	3, 627, 240	1, 905, 090	E E22 220	0	5, 532, 330	30.00
	03100 NURSING FACILITY	3, 627, 240	1, 905, 090 O	5, 532, 330		5, 552, 550 0	31.00
32. 00	03200 CF/IID		0		-	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	d		0	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	135, 715			135, 715	
41.00	04100 LABORATORY	0	100, 773			100, 773	
42.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	243, 342	243, 342	0	243, 342 0	1
44. 00	04400 PHYSI CAL THERAPY	928, 476	36, 173	964, 649		964, 649	
45. 00	04500 OCCUPATI ONAL THERAPY	711, 742	00, 179	711, 742		711, 742	
46. 00	04600 SPEECH PATHOLOGY	115, 079	2, 328			117, 407	
47.00	04700 ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(223	223	
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	693, 146	693, 146	0	693, 146	
50.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	(107	0 107	
	05200 COMPLEX MEDICAL EQUIPMENT		0		107	0	
52. 01	05201 OTHER ANCILLARY SERVICES COST		0			0	
52. 02	05202 MEDI CAL SERVI CES	0	0	d	0	0	
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	(0	0	
61.00	06100 RURAL HEALTH CLINIC	0	0	(0	0	61.00
	06200 FQHC 06300 DI ALYSI S		0	_		0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	l U	0)	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70. 00
71. 00	1 1	0	55, 812	55, 812	0		71.00
	07300 CMHC	0	0	(0	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	(0	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS					0	00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE		0			0	
	08200 UTILIZATION REVIEW - SNF	0	0			0	
83. 00	08300 HOSPI CE	o o	0		o o	0	1
84.00	1 1	0	0		0	0	1
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	(0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	8, 597, 303	12, 264, 653	20, 861, 956	6 0	20, 861, 956	89. 00
00.00	NONREI MBURSABLE COST CENTERS		2 021	2 02		2 024	00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		2, 831 960			2, 831 960	90. 00 91. 00
	09200 PHYSI CLANS PRI VATE OFFI CES		730 N	700		0	
	09300 NONPAID WORKERS		Ö		o o	0	
94.00	09400 PATIENTS LAUNDRY	0	0	(0	0	94. 00
	09500 OTHER NONREIMBURSABLE COST	0	0	(0	0	
100.00	TOTAL	8, 597, 303	12, 268, 444	20, 865, 747	7 0	20, 865, 747	100. 00

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

 Heal th Financial
 Systems
 CARE OF

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315502

			To 12/31/2023 Date/Time Pre	
Cost Center Description	Adjustments to	Net Expenses	07.107.202.1.11	, <u></u>
		For Allocation		
	Wkst A-8)	(col. 5 +-		
	6.00	col . 6) 7.00		
GENERAL SERVI CE COST CENTERS	0.00	7.00		
1. 00 O0100 CAP REL COSTS - BLDGS & FIXTURES	-4, 025	2, 376, 078		1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	170, 519		2. 00
3.00 00300 EMPLOYEE BENEFITS	0	1, 593, 038		3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	-1, 152, 032	3, 014, 804	1	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	0	579, 118	•	5. 00
6.00 00600 LAUNDRY & LI NEN SERVI CE 7.00 00700 HOUSEKEEPI NG	0	140, 785	•	6.00
7. 00 00700 HOUSEKEEPI NG 8. 00 00800 DI ETARY	0	430, 392 1, 341, 967		7. 00 8. 00
9. 00 00900 NURSI NG ADMINI STRATI ON	-2, 741	703, 630	•	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0	351, 634		10.00
11. 00 01100 PHARMACY	-1, 309	15, 052	I .	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	41, 069		12. 00
13. 00 01300 SOCI AL SERVI CE	0	154, 086		13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	l .	14. 00
15. 00 01500 ACTIVITES	0	234, 431		15. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 SKILLED NURSING FACILITY	-27, 119	5, 505, 211		30.00
31. 00 03100 NURSI NG FACILITY	-27,119	5, 505, 211		31.00
32. 00 03200 CF/IID	0	o	1	32. 00
33.00 03300 OTHER LONG TERM CARE	0	0	l .	33. 00
ANCILLARY SERVICE COST CENTERS				
40. 00 04000 RADI OLOGY	0	135, 715		40. 00
41. 00 04100 LABORATORY	0	100, 773		41. 00
42. 00 04200 I NTRAVENOUS THERAPY	-19, 467	223, 875	1	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	0(4,440	l .	43.00
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 OCCUPATI ONAL THERAPY	0	964, 649 711, 742	1	44. 00 45. 00
46. 00 04600 SPEECH PATHOLOGY	0	117, 407		46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	1	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	223		48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	-55, 453	637, 693		49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0		50. 00
51. 00 05100 SUPPORT SURFACES	0	107	•	51.00
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	0	0	1	52.00
52. 01 05201 0THER ANCILLARY SERVICES COST 52. 02 05202 MEDICAL SERVICES	0 0	0	I .	52. 01 52. 02
OUTPATIENT SERVICE COST CENTERS	0	U		32.02
60. 00 06000 CLI NI C	0	0		60.00
61.00 06100 RURAL HEALTH CLINIC	0	o		61.00
62. 00 06200 FQHC				62. 00
63. 00 06300 DI ALYSI S	0	0		63. 00
OTHER REIMBURSABLE COST CENTERS		ما		70.00
70.00 07000 HOME HEALTH AGENCY COST 71.00 07100 AMBULANCE	0 0	0 55, 812	1	70. 00 71. 00
73. 00 07300 CMHC	0	00, 612		73.00
74. 00 07400 OTHER REIMBURSEMENT	0	o		74.00
SPECIAL PURPOSE COST CENTERS		- 1		
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80. 00
81.00 08100 INTEREST EXPENSE	0	0		81. 00
82.00 08200 UTILIZATION REVIEW - SNF	0	0		82. 00
83. 00 08300 HOSPI CE	0	0		83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST I	0	0		84.00
84.01 08401 OTHER SPECIAL PURPOSE COST II 89.00 SUBTOTALS (sum of lines 1-84)	-1, 262, 146	19, 599, 810		84. 01 89. 00
NONREI MBURSABLE COST CENTERS	1, 202, 140	17, 377, 010		07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	2, 831		90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	960	•	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	o		92. 00
93. 00 09300 NONPALD WORKERS	0	0		93. 00
94. 00 09400 PATI ENTS LAUNDRY	0	0		94.00
95. 00 09500 OTHER NONREI MBURSABLE COST	1 242 144	10 402 401		95.00
100. 00 TOTAL	-1, 262, 146	19, 603, 601		100. 00

CARE ONE AT TEA	NECK		In Lie	u of Form CMS-	2540-10
Provi der				Worksheet A-6	
				Date/Time Pre	pared:
				5/10/2024 11:	49 am_
		Increases			
Cost Cente	r	Li ne #	Sal ary	Non Salary	
2.00	2.00		4. 00	5. 00	
MEDICAL SUPPLIES CH PATIENTS	MEDICAL SUPPLIES CHARGED TO PATIENTS		00 0	223	1. 00
SUPPORT SURFACES		51. 0	0 0	107	2. 00
Total Reclassificat	tions (Sum		0	330	100. 00
of columns 4 and 5	must				
	ns 8 and				
	Cost Cente 2.00 MEDICAL SUPPLIES CH PATIENTS SUPPORT SURFACES Total Reclassificat of columns 4 and 5	Cost Center 2.00 MEDICAL SUPPLIES CHARGED TO PATIENTS SUPPORT SURFACES Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and	Provider No.: 315502 Increases Cost Center Line # 2.00 3.00 MEDICAL SUPPLIES CHARGED TO 48.0 PATIENTS SUPPORT SURFACES 51.0 Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and	Provider No.: 315502 Period: From 01/01/2023 To 12/31/2023 Period: From 01/01/2023 Per	Provider No.: 315502 Period: From 01/01/2023 Date/Time Pre 5/10/2024 11: Increases Cost Center

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

Health Financial Systems	CARE ONE AT TEANECK			In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi der		No.: 315502	Peri od: From 01/01/2023	Worksheet A-6	
			To 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 49 am	
			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 & SUPPLY		10.	00	223	1. 00
(1) C - RECLASS SUPPORT SURFACES						
2. 00	CAP REL COSTS - MOVABLE EQUI PMENT		2. (00 0	107	2. 00
TOTALS						
100. 00				0	330	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 TEANECK In Lieu of Form CMS-2540-10

				To	12/31/2023	Date/Time Prep 5/10/2024 11:4	
	·			Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
	·	Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2, 551, 086	0	0	0	0	1.00
2.00	Land Improvements	59, 565	0	0	0	0	2. 00
3.00	Buildings and Fixtures	14, 451, 493	3, 650	0	3, 650	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	456, 699	85, 596		85, 596	0	5. 00
6.00	Movable Equipment	3, 098, 145	7, 442		7, 442	0	6. 00
7.00	Subtotal (sum of lines 1-6)	20, 616, 988	96, 688	0	96, 688	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	20, 616, 988	96, 688	0	96, 688	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1. 00	Land	2, 551, 086	0				1. 00
2.00	Land Improvements	59, 565	0				2. 00
3.00	Buildings and Fixtures	14, 455, 143	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	542, 295	0				5. 00
6. 00	Movable Equipment	3, 105, 587	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	20, 713, 676	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	20, 713, 676	0				9. 00

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

				10 12/31/2023	5/10/2024 11:	
				Expense Classification on		17 (1111
				To/From Which the Amount is		
				10,110	to be maj deted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	• • • • •	Adjustment				
		1.00	2.00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-4, 025	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5. 00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
/ 00	(chapter 21)		0		0.00	4 00
6.00	Television and radio service (chapter 21)		0		0.00	6. 00
7. 00 8. 00	Parking Lot (chapter 21)	A-8-2	0		0.00	7. 00 8. 00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	U			8.00
9. 00	Home office cost (chapter 21)		0		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
11.00	Capital expenditures (chapter 24)		U		0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	-175, 906			12. 00
12.00	related organizations (chapter 10)	701	173, 700			12.00
13. 00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0		0.00	14. 00
15. 00	Cost of meals - Guests	В	0	DI ETARY	8.00	15. 00
16. 00	Sale of medical supplies to other than	_	0		0.00	16. 00
	pati ents					
17.00	Sale of drugs to other than patients		0		0.00	17. 00
18.00	Sale of medical records and abstracts		0		0.00	18. 00
19.00	Vending machines		0		0.00	19. 00
20.00	Income from imposition of interest, finance		0		0.00	20.00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
	(chapter 21)		_			
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
04.00			•	FI XTURES	0.00	04.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
25 00	DECLIDENT DEDLACEMENT LITENC		400	EQUI PMENT	4.00	25 00
25. 00	RESIDENT REPLACEMENT ITEMS	A		ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02 25. 03	MARKETING EXPENSE	A		ADMINISTRATIVE & GENERAL	4. 00 4. 00	25. 02
	MARKETING CORP EXPENSE	A A		ADMINISTRATIVE & GENERAL		
	MARKETING - MEALS	1		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4.00	
25. 05 25. 06	SPONSORSHI PS BAD DEBT EXPENSE	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4. 00 4. 00	25. 05 25. 06
25. 06 25. 07	BAD DEBT EXPENSE - MEDICARE	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	4.00	25. 06 25. 07
25. 07 25. 08	DENTAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	25. 07 25. 08
25. 08	OTHER MEDICAL SERVICES EXPENSE	A		SKILLED NURSING FACILITY	30.00	
25. 10	RESIDENT PERSONAL ITEMS	B		ADMINISTRATIVE & GENERAL	4.00	
25. 10	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	4.00	
	OTHER INCOME	В		ADMINISTRATIVE & GENERAL	4.00	25. 11
	Total (sum of lines 1 through 99) (Transfer		-1, 262, 146	•	4.00	100. 00
100.00	to Worksheet A, col. 6, line 100)		1,202,140			. 50. 55
(1) Do	scription all chapter references in this co	ı Lump portoin to	CMC Dub 1E 1	1	ı	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.

Health Financial Systems CARE ONE AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME In Lieu of Form CMS-2540-10 CARE ONE AT TEANECK Provi der No.: 315502

OFFICE COSTS

				1	0 12/31/2023 Date/IIMe Pre 5/10/2024 11:	
		Li ne No.	Cost	Center	Expense Items	
		1. 00	2.	00	3.00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
	CLAIMED HOME OFFICE COSTS:		T		I	1
1.00			ADMI NI STRATI VE		MANAGEMENT FEES	1.00
2.00			NURSING ADMINI	PHARMACY CONSULTANT	2. 00	
3.00			CENTRAL SERVIC		WOUND CARE EXPENSE	3. 00
4.00		11. 00	PHARMACY		DRUGS-NON-PRESCRI PTI ON,	4. 00
F 00		44.00	DUADAA OV		NON-LEGEND	F 00
5.00			PHARMACY		PHARMACY SUPPLIES	5.00
6.00			INTRAVENOUS TH DRUGS CHARGED		IV EXPENSE	6.00
7. 00		49. 00	DRUGS CHARGED	TO PATTENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	7. 00
8. 00		40 00	DRUGS CHARGED	TO DATIENTS	DRUGS-PRESCRIPTION, LEGEND	8.00
0.00		47.00	DROGS CHARGED	10 TATTENTS	DRUGS MAN	0.00
9.00		49 00	DRUGS CHARGED	TO PATLENTS	DRUGS-PRESCRIPTION, MEDICARE	9.00
7.00		171.00	511000 011111025		A	,, 00
10.00	TOTALS (sum of lines 1-9). Transfer column					10.00
	6, line 100 to Worksheet A-8, column 3, line					
	12.					
		Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col . 5)		
			5			
	DART I COCTO INCHERED AND AD HICTMENTO RECHIE	4. 00	5. 00	6. 00	D ODCANI ZATLONC OD	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1. 00	CLAIMED HOME OFFICE COSTS:	935, 226	1, 032, 162	-96, 936		1.00
2.00		31, 524				2.00
3.00		131, 303				3.00
4. 00		14, 481		•		4.00
5.00		571				5.00
6. 00		223, 875				6.00
7. 00		35, 851				7.00
8. 00		264, 276				8.00
9. 00		337, 566				9. 00
10.00	TOTALS (sum of lines 1-9). Transfer column	1, 974, 673				10.00
10.00	6, line 100 to Worksheet A-8, column 3, line	1, 7, 1, 073	2, 100, 377	1,3,700		10.00
	12.					
	'		'	'	1	

Worksheet A-8-1

From 01/01/2023 Parts I-II Date/Time Prepared: 12/31/2023

				3/10/2024 1	1.47		
	Symbol (1)	Name	Percentage of				
			Ownershi p				
	1.00	2. 00	3. 00				

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

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

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

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

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

	Rel ated Organi	zation(s) and/	or Home Office
	Name	Percentage of Ownership	Type of Business
DART LL LATERDE ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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

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

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

1.00		HEALTHBRI DGE	100.00	HOME OFFICE	1.00
2.00		PARTNERS PHARMACY	64. 87	PHARMACY	2. 00
3.00		TOTAL CARE LLC	100.00	WOUND CARE	3. 00
4.00			0.00		4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100.00
	speci fy:				

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| 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.: 315502

			To	12/31/2023	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/10/2024 11:	49 alli
		DI DOC A	MOVARIE	ENDLOVEE		
Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TTATORES	EQUIT MENT	DENETTIO		
	(from Wkst A					
	col. 7) 0	1. 00	2.00	3. 00	3A	
GENERAL SERVICE COST CENTERS	0 [1.00	2.00	3.00	SA SA	
1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES	2, 376, 078	2, 376, 078				1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT	170, 519		170, 519			2. 00
3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENERAL	1, 593, 038 3, 014, 804	29, 638 69, 094	2, 127 4, 958	1, 624, 803 147, 546	3, 236, 402	3. 00 4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	579, 118	108, 367	4, 936 7, 777	9, 690	704, 952	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	140, 785	58, 178		14, 116	217, 254	6. 00
7. 00 00700 HOUSEKEEPI NG	430, 392	0	0	71, 703	502, 095	7. 00
8. 00 00800 DI ETARY	1, 341, 967	320, 465	22, 998	159, 807	1, 845, 237	8. 00
9.00 00900 NURSI NG ADMI NI STRATI ON 10.00 01000 CENTRAL SERVI CES & SUPPLY	703, 630 351, 634	51, 104 5, 488	3, 667 394	118, 328 7, 935	876, 729 365, 451	9. 00 10. 00
11. 00 01100 PHARMACY	15, 052	0, 100	0	0	15, 052	11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	41, 069	7, 318		7, 762	56, 674	12. 00
13. 00 01300 SOCI AL SERVI CE	154, 086	5, 610	403	29, 121	189, 220	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITES	234, 431	196, 121	0 14, 075	41, 551	0 486, 178	14. 00 15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	234, 431	170, 121	14, 075	41, 331	400, 170	13.00
30.00 03000 SKILLED NURSING FACILITY	5, 505, 211	1, 410, 230	101, 206	685, 510	7, 702, 157	30. 00
31. 00 03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200 CF/IID 33.00 03300 OTHER LONG TERM CARE	0	0	0	0	0	32. 00 33. 00
ANCILLARY SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	0	33.00
40. 00 04000 RADI OLOGY	135, 715	0	0	0	135, 715	40. 00
41. 00 04100 LABORATORY	100, 773	0	0	0	100, 773	41.00
42. 00 04200 I NTRAVENOUS THERAPY 43. 00 04300 0XYGEN (I NHALATION) THERAPY	223, 875	0	0	0	223, 875 0	42. 00 43. 00
44. 00 04400 PHYSI CAL THERAPY	964, 649	46, 469	3, 335	175, 473		44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	711, 742	28, 845	2, 070	134, 512	877, 169	45. 00
46.00 04600 SPEECH PATHOLOGY	117, 407	13, 416	963	21, 749	153, 535	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49.00 04900 DRUGS CHARGED TO PATIENTS	637, 693	6, 708	481	0	223 644, 882	48. 00 49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	Ö	0	50. 00
51.00 05100 SUPPORT SURFACES	107	0	0	0	107	51. 00
52. 00 05200 COMPLEX MEDICAL EQUIPMENT 52. 01 05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 00 52. 01
52. 01 05201 OTHER ANCI LLARY SERVI CES COST 52. 02 05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>		0	02. 02
60. 00 06000 CLI NI C	0	0	0	0	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC 62. 00 06200 FOHC	0	0	0	0	0	61. 00 62. 00
63. 00 06300 DI ALYSI S	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS	j	Ÿ.	<u> </u>	٧.	J	00.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE 73. 00 07300 CMHC	55, 812	0	0	0	55, 812 0	71. 00 73. 00
74. 00 07400 OTHER REI MBURSEMENT		0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		-	-		
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 08100 INTEREST EXPENSE 82. 00 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST I	O	0	Ö	o	0	84. 00
84. 01 08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	19, 599, 810	2, 357, 051	169, 154	1, 624, 803	19, 579, 418	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	2, 831	0	O	0	2, 831	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	960	19, 027	1, 365	Ö	21, 352	91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00 09300 NONPALD WORKERS	0	0	0	0	0	93.00
94. 00 09400 PATI ENTS LAUNDRY 95. 00 09500 OTHER NONREI MBURSABLE COST		O O	0	O O	0	94. 00 95. 00
98.00 Cross Foot Adjustments		o	Ö	ő	0	98. 00
99.00 Negative Cost Centers	0	0	0	o	0	99. 00
100. 00 TOTAL	19, 603, 601	2, 376, 078	170, 519	1, 624, 803	19, 603, 601	100.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provi der No.: 315502

CONST. CONT.OF. DESCRIPTION					T	0 12/31/2023		
CERETRAL SERVICE COST CENTERS	Cost Cen	ter Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG		49 alli
SIPMINS SERVICE CONT. SENTERS					LINEN SERVICE			
CEMERAL SERVICE COST CENTERS								
EXERCIAL SERVICE COST CENTERS 1,00 00100 CAP NEL COSTS - BLOSS & HATURES 2,00 00200 CAP NEL COSTS - BLOSS & FLATURES 3,20 00200 CAP NEL COSTS - BLOSS & FLATURES 4,00 00200 CAP NEL COSTS - GENERAL 4,00 00200 CAP NEL COSTS - GENERAL 5,00 00200 CAP NEL COSTS - GENERAL 5,00 00200 CAP NEL COSTS - GENERAL 6,00 00200 CAP NEL COSTS - GENERAL 7,00 00200 CAP NEL COSTS - GENERAL 7,0 00200 CAP NEL COSTS - GENERAL 7,00 00200 CAP NEL COSTS - GENE			4.00		6.00	7 00	9 00	
1.00	GENERAL SERVIC	F COST CENTERS	4.00	5.00	0.00	7.00	8.00	
0.0000 DIMIDIVE BENEFITS 3.236, 402 4.00 0.0000 0.000 DIMIDIVE BENEFITS 3.236, 402 4.00 0.0000 0.0000 DIATI OPERATION, MAINT & REPAIRS 139, 395 844, 347 22, 248 282, 861 6.00 0.0000 DIATI OPERATION, MAINT & REPAIRS 139, 395 844, 347 22, 248 282, 861 6.00 0.0000 DIATI OPERATION, MAINT & REPAIRS 139, 395 844, 347 282, 861 6.00 0.0000 DIATI OPERATION, MAINT & REPAIRS 139, 395 844, 347 282, 2861 6.00 0.0000 DIATI OPERATION, MAINT SIRATION 173, 367 19, 1944 0.00 1, 500 0.000 0.0000 0.0000 DIATI OPERATION, MAINT SIRATION 173, 367 19, 1944 0.00 1, 564 0.0000 0.0000 0.0000 DIATI OPERATION, MAINT SIRATION 17, 20, 2949 0.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000								1.00
0.000 0.00	2.00 00200 CAP REL (COSTS - MOVABLE EQUIPMENT						2. 00
0.0000 CALANT OPERATION, MAINT, & REPAIRS	3.00 00300 EMPLOYEE	BENEFITS						3. 00
0.000 0.0000 LANDRY & LINEN SERVICE			1					
7.00 00700			1					1
0.000 0.0000 DIETARY 344, 872 124, 752 0 91,302 2, 426, 163 8. 00 0.000 0.000 DIESTARY 173, 362 19, 804 0 14, 560 0 0. 00 0.				22, 648		401 270		1
9.00 0.9900 NURSI NA ADMINISTINATION 173, 362 19, 894 0	, ,	PING		124 752			2 426 163	1
10.00 01000 CENTRAL SERVICES & SUPPLY 72, 263 2, 137 0 1, 964 0 10.0		ADMI NI STRATI ON	1		1			1
12.00 01200 MEDICAL RECORDS & LIBRARY 11, 207 2, 849 0 2, 0885 0 12, 00 13.00 13.00 01400 MURSI NG AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 14.00 15.00 15.00 15.00 01400 MURSI NG AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 14.00 15.00 15.00 01500 MURSI NG FACILITY 1.523,002 548,976 282,861 401,782 2, 426,163 30.00 30.00 30.00 30.00 30.00 50.00 50.00 50.00 50.00 30.00			1		1			1
13.00 01300 SOCIAL SERVICE 37,416 2,184 0 1,596 0 13.00 10	11.00 01100 PHARMACY		2, 976	0	0	0	0	11. 00
14. 00 01400 MURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 15. 00			1					
15. 00			1	2, 184	0	1, 598		
INPATI ENT ROUTINE SERVICE COST CENTERS			1	77 247	0	U FF 074		
30. 00			90, 135	70, 347		55, 870	0	15.00
31.00 03100 NURSING FACILITY			1, 523, 002	548, 976	282, 861	401, 782	2, 426, 163	30.00
33. 00 03300 OTHER LONG TENI CARE 0 0 0 0 0 33. 00	, ,			0				
ANCILLARY SERVICE COST CENTERS	32.00 03200 ICF/IID		0	0	0	0	0	32. 00
A0			0	0	0	0	0	33. 00
14. 00 04100 LABORATORY					1			
42.00 0.4200 INTRAVENOUS THERAPY				0	0	0		
43. 00 04300 04300 04500 1.0 1.0 0 0 0 0 0 0 0 0 0	1 1			0		0		•
44. 00 04400 PHYSI CAL THERAPY 235, 292 18, 090 0 13, 239 0 44, 00 45. 00 04600			1	0	0	0		•
45. 00 04500	,		1	18. 090	0	13, 239		•
47.00 04700 ELECTROCARDIOLOCY					1			•
48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 44 0 0 0 0 0 48. 00 49. 00 49.00 07400 07400 07400 07400 07400 07400 50. 00 05000 05000 05000 0 0 0	46.00 04600 SPEECH PA	ATHOLOGY	30, 360	5, 223	0	3, 822	0	46. 00
49.00 04900 DRIVES CHARGED TO PATIENTS 127,517 2,611 0 1,911 0 49.00			0	0	0	0		•
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 55.00			1	0	0	0	-	
51.00 05100 SUPPORT SURFACES 21			127, 517	2, 611	0	1, 911		
52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 52.00			21	0		0		1
52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 0 0 0 0 0 0 52.01			1	0	0	0		1
52. 02 05.202 MEDICAL SERVICES 0 0 0 0 0 0 52. 02			-	0	ő	o		1
60.00			0	0	o	0	0	
61. 00		VICE COST CENTERS						
62. 00 06200 FOHC			- 1	0		0		
063.00 06300 DI ALYSIS 0 0 0 0 0 0 63.00		ALTH CLINIC	0	0	0	0	0	•
OTHER REIMBURSABLE COST CENTERS O				0		0	0	•
70.00		ARI E COST CENTERS	ı o	U	<u> </u>	U	0	03.00
71. 00			0	0	0	0	0	70.00
74.00						_		•
SPECIAL PURPOSE COST CENTERS SO. 00 00 00 00 00 00 00 00	73.00 07300 CMHC		0	0	0	0	0	73. 00
80. 00			0	0	0	0	0	74. 00
81. 00			1		1			
82. 00 82.00 08200 UTILIZATION REVIEW - SNF								1
83. 00 08300 HOSPI CE 0 0 0 0 0 0 83. 00 84. 00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 84. 00 84. 01 08401 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 84. 01 89. 00 SUBTOTALS (sum of lines 1-84) 3, 231, 620 836, 940 282, 861 595, 957 2, 426, 163 89. 00 NONREI MBURSABLE COST CENTERS								1
84. 00		ION REVIEW - SINI		0	0	0	0	1
84. 01		ECLAL PURPOSE COST I	o	0	ő	o		
NONRE MBURSABLE COST CENTERS			O	0	Ō	Ō		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 560 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 92. 00 93. 00 93. 00 93. 00 94. 00 94. 00 94. 00 94. 00 95. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 95. 00 09500 OTHER NONREI MBURSABLE COST 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 0 99. 00 0 0 0 0 0 0 0 0 0	89. 00 SUBTOTALS	S (sum of lines 1-84)	3, 231, 620	836, 940	282, 861	595, 957	2, 426, 163	89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 4, 222 7, 407 0 5, 421 0 91. 00 92. 00 93. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 92. 00 93. 00 94. 00 094. 00 094. 00 094. 00 094. 00 094. 00 095.								
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92. 00 93. 00 94. 00 94. 00 95. 00 95. 00 0 0 0 95. 00 97. 00 0 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0			1	0	0	0		•
93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 93. 00 94. 00 95. 00 095.00 074cm Nonrei Mbursable Cost 0 0 0 0 0 0 0 95. 00 95. 00 075cm Foot Adjustments 0 0 0 0 0 0 0 0 98. 00 075cm Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	, ,		4, 222	7, 407	0	5, 421		
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 94. 00 95. 00 95. 00 0 0 0 95. 00 0 0 95. 00 0 0 0 96. 00 0 97. 00 0 0 0 0 0 0 0 0 0	1 1			0		0		
95. 00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 95. 00 98. 00 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0				0	0	0		1
98.00 Cross Foot Adjustments				0	l ő	ol ol		
			0	0	Ō	o		
100. 00 TOTAL 3, 236, 402 844, 347 282, 861 601, 378 2, 426, 163 100. 00		Cost Centers	0	0	0	o		
	100. 00 TOTAL		3, 236, 402	844, 347	282, 861	601, 378	2, 426, 163	100. 00

				''	J 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		9. 00	10.00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	1, 084, 545				•	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	441, 415				10.00
11. 00	01100 PHARMACY	0	0	18, 028			11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	0	72, 815		12. 00
13.00	01300 SOCIAL SERVICE	0	0	0	0	230, 418	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES		0	0	0	0 0	14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	l of	U	0	U	0	13.00
30. 00	03000 SKILLED NURSING FACILITY	1, 084, 545	441, 415	18, 028	72, 815	230, 418	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200 CF/IID	0	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	_	40. 00
41. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY		0	0	0	0 0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		0	0	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	ő	0	l ő	0	Ö	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	O	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0 0	52. 00 52. 01
52. 01	05201 OTHER ANCIELARY SERVICES COST		0	0	0	0	52. 01
32. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		<u> </u>		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 FQHC						62.00
63. 00	06300 DI ALYSI S	0	0	0	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS		0		0		70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0	0	0	70. 00 71. 00
73.00	07300 CMHC		0	0	0	0	73.00
	07400 OTHER REI MBURSEMENT	ő	0	Ö	0	Ö	74. 00
	SPECIAL PURPOSE COST CENTERS	-,					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 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 89. 00	08401 OTHER SPECIAL PURPOSE COST II SUBTOTALS (sum of lines 1-84)	1, 084, 545	441, 415	18, 028	72, 815	0 230, 418	84. 01 89. 00
07.00	NONREI MBURSABLE COST CENTERS	1,004,545	441, 415	10,020	72,013	230, 410	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98.00	Cross Foot Adjustments	0	0	_	0	_	98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	1, 084, 545	441, 415	18, 028	0 72, 815	0 230, 418	99. 00 100. 00
100.00) I TOTAL	1,004,040	441,410	10,020	12,013	230,410	100.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315502

					0 12/31/2023	5/10/2024 11:	
			OTHER GENERAL			37 107 2024 11.	77 (1111
			SERVI CE				
	Cost Center Description	NURSING AND	ACTI VI TES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION 14.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	10.00	
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						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 8. 00	OO7OO HOUSEKEEPI NG OO8OO DI ETARY						7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10. 00	01000 CENTRAL SERVI CES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY						12. 00
	01300 SOCI AL SERVI CE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTI VI TES	0	714, 536				15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	714, 536	15, 446, 698	3 0	15, 446, 698	30.00
	03100 NURSING FACILITY	0		15, 440, 090			
32. 00	03200 CF/11D	0			o o	1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0		Ċ	-		33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	1	162, 551			1
41. 00	04100 LABORATORY	0	1	120, 700		120, 700	1
	04200 I NTRAVENOUS THERAPY	0	1	268, 143		268, 143	1
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	1 154 51	,	1 454 547	43. 00 44. 00
44. 00 45. 00	04500 OCCUPATIONAL THERAPY	0	0	1, 456, 547 1, 070, 065		1, 456, 547 1, 070, 065	1
46. 00	04600 SPEECH PATHOLOGY	0	0	192, 940		192, 940	1
47. 00	04700 ELECTROCARDI OLOGY	0	O	(0	1
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	О	267	0	267	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	776, 921	0	776, 921	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(-	0	
	05100 SUPPORT SURFACES	0	0	128		128	1
52. 00 52. 01	05200 COMPLEX MEDICAL EQUIPMENT 05201 OTHER ANCILLARY SERVICES COST	0				0	
	05202 MEDI CAL SERVI CES	0			1		1
02.02	OUTPATIENT SERVICE COST CENTERS		<u> </u>		,		02.02
60.00	06000 CLI NI C	0	0	(0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	(0	0	61. 00
62.00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0	(0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0				l	70. 00 71. 00
73. 00	07300 CMHC		1	00, 846		1	1
	07400 OTHER REIMBURSEMENT	0	1			l .	1
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF			_			82. 00
	08300 HOSPI CE	0	0	(0	0	
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST 08401 OTHER SPECIAL PURPOSE COST	0	0			0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)		714, 536	19, 561, 808	0	19, 561, 808	1
07.00	NONREI MBURSABLE COST CENTERS		7.17000	1770017000	,	1770017000	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	3, 391	0	3, 391	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	38, 402	0	38, 402	91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0	(0	0	
93. 00	09300 NONPAI D WORKERS	0	0	(0	0	1
94. 00 95. 00	09400 PATI ENTS LAUNDRY 09500 OTHER NONREI MBURSABLE COST			(0	0	
95. 00 98. 00	Cross Foot Adjustments						98.00
99. 00	Negative Cost Centers				o o	0	99.00
100.00		0	714, 536	19, 603, 601	Ó		1
	1	•			•	•	•

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315502

				10	5 12/31/2023	Date/IIme Pre 5/10/2024 11:	
			CAPI TAL REI	_ATED COSTS		07 107 202 1 11.	T CIII
			DI DOC 0	140144 51 5		ENDL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	TIXTURES	LQUIFWLINI		DENETTIS	
		Related Costs					
	1	0	1. 00	2.00	2A	3. 00	
1 00	GENERAL SERVICE COST CENTERS						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	o	29, 638	2, 127	31, 765	31, 765	3.00
4. 00	00400 ADMI NI STRATI VE & GENERAL		69, 094		74, 052	2, 885	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	108, 367		116, 144	189	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	58, 178	4, 175	62, 353	276	6. 00
7.00	00700 HOUSEKEEPI NG	0	0	0	0	1, 402	7. 00
8.00	00800 DI ETARY	0	320, 465		343, 463	3, 124	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	51, 104	3, 667	54, 771	2, 313	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	5, 488	394	5, 882	155 0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY		7, 318	525	7, 843	152	1
13. 00	01300 SOCI AL SERVI CE	o	5, 610		6, 013	569	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	o	0	14. 00
15. 00	01500 ACTI VI TES	0	196, 121	14, 075	210, 196	812	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			404.00/	4 544 404	40.400	
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	1, 410, 230	101, 206	1, 511, 436	13, 402 0	30.00
31.00	03200 CF/IID		0	0	O O	0	31.00
33. 00	03300 OTHER LONG TERM CARE		0	ĺ	Ö	0	33.00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		- 1	- 1		
40.00	04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43. 00 44. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	46, 469	3, 335	49, 804	0 3, 431	43. 00 44. 00
45. 00	04500 OCCUPATIONAL THERAPY		28, 845	2, 070	30, 915	2, 630	45. 00
46. 00	04600 SPEECH PATHOLOGY		13, 416		14, 379	425	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	6, 708	481	7, 189	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 COMPLEX MEDI CAL EQUI PMENT		0	0	0	0	51. 00 52. 00
52. 00	05201 OTHER ANCILLARY SERVICES COST		0	0	0	0	52. 00
52. 02	05202 MEDI CAL SERVI CES	o	0	Ö	Ö	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200 FQHC 06300 DI ALYSI S	o	0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	J U	0	<u> </u>	<u> </u>	0	03.00
70. 00		0	0	0	0	0	70.00
71. 00	07100 AMBULANCE	0	0	0	o	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 HOSPI CE	0	0	0	o	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	2, 357, 051	169, 154	2, 526, 205	31, 765	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	l ol	0		٥	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		19, 027	1, 365	20, 392	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	o	0	0	0	0	
93. 00	09300 NONPALD WORKERS		0	o	ō	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	o	0	
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98.00	Cross Foot Adjustments		^		O	^	98.00
99. 00 100. 00	Negative Cost Centers TOTAL	o	0 2, 376, 078	170, 519	2, 546, 597	0 31 765	99. 00 100. 00
100.00	ITOTAL	ı oj	2,310,010	170, 317	2, 340, 377	31, 703	1.00.00

				T	o 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	T GIII
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS 5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	6.00	
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	76, 937					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	3, 314	119, 647				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 021	3, 209	1	0.740		6.00
7.00	00700 HOUSEKEEPI NG	2, 360	17 (70	0		272 510	7.00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	8, 674 4, 122	17, 678 2, 819		571 91	373, 510 0	8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	1, 718	303		10	0	10.00
11. 00	01100 PHARMACY	71	0		0	0	11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	266	404	0	13	0	12.00
13.00	01300 SOCIAL SERVICE	890	309	0	10	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TES	2, 286	10, 819	0	350	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	24 000	77.700		0.540	070 540	00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	36, 202	77, 792			373, 510	30. 00 31. 00
31.00	03200 CF/IID		0	· -	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	-	0	33. 00
33. 00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		,	<u> </u>	0	33.00
40. 00	04000 RADI OLOGY	638	C	0	0	0	40. 00
41.00	04100 LABORATORY	474	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	1, 052	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	5, 594	2, 563		83	0	44. 00
45. 00	04500 OCCUPATIONAL THERAPY	4, 124	1, 591		51	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	722	740 0		24	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	3, 032	370	o o	12	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	O	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	1	0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	52. 02
60. 00	06000 CLINIC	l ol	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	o	0	1	· ·	0	61.00
62. 00	06200 FQHC						62. 00
63.00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	262	0	0	0	0	71.00
74.00	07300 CMHC 07400 OTHER REIMBURSEMENT		0		0	0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	110 503	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	76, 824	118, 597	66, 859	3, 728	373, 510	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	13	0	0	O	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	100	1, 050		34	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	o	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	o	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95. 00	09500 OTHER NONREI MBURSABLE COST	0	0	0	이	0	95. 00
98.00	Cross Foot Adjustments		_	1 0	0	0	98.00
99. 00 100. 00	Negative Cost Centers TOTAL	76, 937	119, 647	66, 859	3, 762		99.00
100.00	DI LIVIAL	10,737	117,047	1 00,009	3, 702	3/3,310	1100.00

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 12/31/2024

					0 12/31/2023	5/10/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		9.00	SUPPLY 10. 00	11. 00	12. 00	13.00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
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						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG						6.00
7. 00 8. 00	00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	64, 116					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	04,110	8, 068				10.00
11. 00	01100 PHARMACY	0	0, 000	71			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	c	8, 678		12.00
13.00	01300 SOCIAL SERVICE	0	0	C	0	7, 791	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. 00
15. 00	01500 ACTI VI TES	0	0	C	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30.00	03000 SKILLED NURSING FACILITY	64, 116	8, 068	71	1		30.00
31. 00	03100 NURSING FACILITY 03200 CF/IID	0 0	0	C	_	0	31.00
32. 00 33. 00	03300 OTHER LONG TERM CARE		0		-		32. 00 33. 00
33.00	ANCI LLARY SERVICE COST CENTERS	J O) 0	0	33.00
40. 00	04000 RADI OLOGY	0	0	C	0	0	40. 00
41. 00	04100 LABORATORY	0	0	Č	-	Ö	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	C	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	C	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0	C	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	C	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	C	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	0				51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		0				52. 00
52. 01	05201 OTHER ANCI LLARY SERVICES COST	0	0	ď	o o	Ö	52. 01
52. 02	05202 MEDI CAL SERVI CES	O	0	d	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	C	-		60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	61. 00
62.00	06200 FQHC						62.00
63. 00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	0	C) 0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	l ol	0	(0	0	70. 00
71.00	07100 AMBULANCE		0	ď	0	Ö	71. 00
	07300 CMHC	0	0	d	Ö	Ö	73. 00
74.00	07400 OTHER REIMBURSEMENT	0	0	C	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF		0	_			82.00
83.00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I		0		0	0	83.00
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST I		0			0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	64, 116	8, 068	71	_		89. 00
07.00	NONREI MBURSABLE COST CENTERS	01,110	0,000	, ,	0,070	7,771	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	C	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	C	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	2	0	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST	0	0		O	0	95. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	O			0	98. 00 99. 00
100.00		64, 116	8, 068	_	_		100.00
. 55. 50	1	31,110	3, 330	' '	5,570	1	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315502

				7	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
			OTHER GENERAL				
	Coot Conton Decemintion	NUIDCLNC AND	SERVI CE	Cubtatal	Doot Cton Down	Total	
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		EDUCATI ON			riaj de timerre		
	T	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1	T	I			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 & LINEN SERVICE 00700 HOUSEKEEPING						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 MEDICAL RECORDS & LIBRARY			•			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	O1500 ACTIVITES	0	224, 463				15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY		224, 463	2, 394, 90	0	2, 394, 901	30.00
31. 00	03100 NURSING FACILITY	0	0			0	31. 00
32.00	03200 CF/IID	0	0			0	
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	638	3 0	638	40. 00
41. 00	04100 LABORATORY	0	Ö	1		474	1
42.00	04200 I NTRAVENOUS THERAPY	0	0	1, 052		1, 052	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(1 47	-	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY			61, 475 39, 31		61, 475 39, 311	1
46. 00	04600 SPEECH PATHOLOGY		Ö	16, 290		16, 290	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	(-	0	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10 (0)	0	10 (02	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY			10, 603		10, 603 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES	0	Ö		o o	1	51. 00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	(0	0	
52. 01	05201 OTHER ANCI LLARY SERVICES COST	0	0			0	
52. 02	05202 MEDI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS			1	<u>) </u>	0	52. 02
60.00	06000 CLINIC	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	0	
	07100 AMBULANCE	0	0	1 202			71. 00
73. 00 74. 00	O7300 CMHC O7400 OTHER REIMBURSEMENT	0	0			0	1
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					0	1
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	Ö		o o	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	224, 463	2, 525, 008	0	2, 525, 008	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		Ιο	13	3 0	13	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP			21, 576		21, 576	1
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0	2., 5,	o o	21, 373	
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	0	1
99. 00	Negative Cost Centers		0	i c	o o	0	99. 00
100.00	TOTAL	0	224, 463	2, 546, 597	0	2, 546, 597	100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315502

					1	o 12/31/2023	Date/Time Pre 5/10/2024 11:	pared: 49 am
			CAPITAL REI	LATED COSTS			7 07 107 2021 111	, , <u></u>
		Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		· ·	FIXTURES	EQUI PMENT	BENEFITS		& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM COST)	
	1		1.00	2.00	3.00	4A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	38, 963					1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT	00,700	38, 963				2. 00
3.00		EMPLOYEE BENEFITS	486				1/ 2/7 100	3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	1, 133 1, 777				16, 367, 199 704, 952	4. 00 5. 00
6.00	00600	LAUNDRY & LINEN SERVICE	954	954	74, 692	2 0	217, 254	6. 00
7. 00 8. 00		HOUSEKEEPI NG DI ETARY	5, 255	0 5, 255			502, 095 1, 845, 237	7. 00 8. 00
9. 00		NURSING ADMINISTRATION	838				876, 729	1
10.00		CENTRAL SERVICES & SUPPLY	90		41, 985	0	365, 451	10.00
11. 00 12. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	120	_	· ·		15, 052 56, 674	1
13. 00		SOCIAL SERVICE	92	l .			189, 220	
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	_	1	_	1	14. 00
15. 00		ACTIVITES LENT ROUTINE SERVICE COST CENTERS	3, 216	3, 216	219, 858	<u>0</u>	486, 178	15. 00
30. 00	03000	SKILLED NURSING FACILITY	23, 125	23, 125	3, 627, 240	0	7, 702, 157	30. 00
		NURSING FACILITY	0	0			0	31.00
32. 00 33. 00				0			l	32. 00 33. 00
	ANCI L	LARY SERVICE COST CENTERS	-	-				
40. 00 41. 00	1	RADI OLOGY LABORATORY	0	0				
42. 00		INTRAVENOUS THERAPY	0	ő			223, 875	1
43.00		OXYGEN (INHALATION) THERAPY	0	0	000 17	_	0	43.00
44. 00 45. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	762 473				1, 189, 926 877, 169	44. 00 45. 00
46. 00		SPEECH PATHOLOGY	220				153, 535	1
47. 00	1	ELECTROCARDI OLOGY	0	_			0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	110	0 110		_	223 644, 882	48. 00 49. 00
50. 00	05000	DENTAL CARE - TITLE XIX ONLY	0	0		Ö	0	50.00
51.00		SUPPORT SURFACES	0	0	C	0	107	51.00
52. 00 52. 01	1	COMPLEX MEDICAL EQUIPMENT OTHER ANCILLARY SERVICES COST		0			0	52. 00 52. 01
52. 02	05202	MEDICAL SERVICES	0	0	<u> </u>	0	0	52. 02
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	0		0	0	60.00
61. 00	1	RURAL HEALTH CLINIC	Ö	ő				1
62.00	06200							62.00
63. 00		DIALYSIS REIMBURSABLE COST CENTERS] 0	0	[C	0	0	63.00
	07000	HOME HEALTH AGENCY COST	0	0	١	,	١	70. 00
	07100	AMBULANCE CMHC	0	0			55, 812 0	71. 00 73. 00
		OTHER REIMBURSEMENT	0	Ö			l	
00.00		AL PURPOSE COST CENTERS	I	T				00.00
80. 00 81. 00	1	MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00	08200	UTILIZATION REVIEW - SNF						82. 00
83. 00 84. 00		HOSPICE OTHER SPECIAL PURPOSE COST I	0	0		0	0	1
84. 01		OTHER SPECIAL PURPOSE COST II		0		0	0	1
89. 00		SUBTOTALS (sum of lines 1-84)	38, 651	38, 651	8, 597, 303	-3, 236, 402	16, 343, 016	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0) 0	2, 831	90.00
	09100	BARBER AND BEAUTY SHOP	312	_			21, 352	1
92.00	1	PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0	0	l c	0	0	93. 00 94. 00
95.00	1	OTHER NONREIMBURSABLE COST	0	0	C	0	0	95. 00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00		Cost to be allocated (per Wkst. B,	2, 376, 078	170, 519	1, 624, 803	3	3, 236, 402	1
		Part I)						
103. 00 104. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	60. 982933	4. 376434	0. 188990 31, 765		0. 197737 76, 937	103.00
		Part II)]	

Health Financial Systems	CARE ONE A	T TEANECK		In Lie	u of Form CMS-2	2540-10
COST ALLOCATION - STATISTICAL BASIS		Provi der No.: 315502		Peri od:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/10/2024 11:	
	CAPITAL REL	LATED COSTS				
Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	1. 00	2. 00	3. 00	4A	4. 00	
105.00 Unit cost multiplier (Wkst. B, Part			0. 00369!	D .	0. 004701	105. 00

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

				Ť	To 12/31/2023	Date/Time Pre 5/10/2024 11:	
	Cost Center Description	PLANT OPERATION,	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	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	
	GENERAL SERVICE COST CENTERS	1	I	I		I	1 00
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FLXTURES OO200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3. 00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMI NI STRATI VE & GENERAL	25 5/7	,				4.00
5. 00 6. 00	OO5OO PLANT OPERATION, MAINT. & REPAIRS OO6OO LAUNDRY & LINEN SERVICE	35, 567 954	l .				5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	0	0	34, 613	3		7. 00
8. 00	00800 DI ETARY	5, 255	1	5, 255			8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	838		838 90		30, 360	
	01100 PHARMACY	90	 	90		0	
12. 00	01200 MEDICAL RECORDS & LIBRARY	120		120	o o	0	
	01300 SOCI AL SERVI CE	92	 	92		0	
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	3, 216	1	3, 216		0	
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	3,210	<u>, </u>	3, 210	<u> </u>		13.00
	03000 SKILLED NURSING FACILITY	23, 125		23, 125	91, 080		1
	03100 NURSING FACILITY 03200 CF/IID	0	1	0	1	0	
	03300 OTHER LONG TERM CARE				-	1	
00.00	ANCILLARY SERVICE COST CENTERS		,		,]
	04000 RADI OLOGY	0	1	1	-	0	
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	1		0	0	
	04300 OXYGEN (INHALATION) THERAPY		Ί ,			0	
44. 00	04400 PHYSI CAL THERAPY	762		762		0	
	04500 OCCUPATI ONAL THERAPY	473	l control of the cont	473		0	
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	220	1	220		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			-	Ö	
	04900 DRUGS CHARGED TO PATIENTS	110	0	110	0	0	
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	
	05100 SUPPORT SURFACES 05200 COMPLEX MEDICAL EQUIPMENT					0	
	05201 OTHER ANCILLARY SERVICES COST	0	o	Č	o o	Ö	
52. 02	05202 MEDI CAL SERVI CES	0	0	(0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC) 0			0	60.00
	06100 RURAL HEALTH CLINIC					0	
62. 00	06200 FQHC						62. 00
63. 00	06300 DI ALYSI S	0	0		0	0	63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST) 0) 0	0	70.00
	07100 AMBULANCE	0	o	Č	o o	Ö	1
	07300 CMHC	0	1		-		
74. 00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0) 0	() 0	0	74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE			,			82.00
83. 00 84. 00	08400 OTHER SPECIAL PURPOSE COST I					0	
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	d	o o	0	
89. 00	SUBTOTALS (sum of lines 1-84)	35, 255	30, 360	34, 301	91, 080	30, 360	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0				0	90.00
	09100 BARBER AND BEAUTY SHOP	312		312		Ö	
	09200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	
93. 00 94. 00	09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY	0	0	0	0	0	
95. 00 95. 00	09500 OTHER NONREIMBURSABLE COST					0	
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102. 00	Cost to be allocated (per Wkst. B, Part I)	844, 347	282, 861	601, 378	2, 426, 163	1, 084, 545	102.00
103. 00	1 1 '	23. 739618	9. 316897	17. 374339	26. 637714	35. 722826	103. 00
		119, 647	l .	1			104. 00
104.00							
104.00	Part II)	3. 363989	2. 202207	0. 108687	4. 100900	2. 111858	105 00

				1	0 12/31/2023	Date/lime Pre 5/10/2024 11:	
	Cost Center Description	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATLENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)		
		10.00	11.00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9. 00 10. 00	OO9OO NURSI NG ADMINI STRATI ON O1OOO CENTRAL SERVI CES & SUPPLY	30, 360					9.00
11. 00	01100 PHARMACY	30, 300	30, 360				11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	30, 300	30, 360			12.00
13. 00	01300 SOCIAL SERVICE	0	0	30, 300	30, 360		13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		30, 300	0	14. 00
	01500 ACTIVITES	0	0	0	0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	<u> </u>	0	13.00
30. 00	03000 SKILLED NURSING FACILITY	30, 360	30, 360	30, 360	30, 360	0	30.00
31. 00	03100 NURSING FACILITY	0	30, 300	30, 300	30, 300	0	31.00
32. 00	03200 CF/11D	0	0	Ö	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE		0	0	0	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			0		00.00
40. 00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	0	0	0	0	Ö	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	Ö	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	Ö	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0	0	0	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0		0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62. 00
63.00	06300 DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0			0	
	07100 AMBULANCE	0	0		0	J	
	07300 CMHC	0	0	0	0	0	
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74.00
00 00	SPECIAL PURPOSE COST CENTERS						00 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
82.00	08300 HOSPI CE	_	^	_	0	0	
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0	0		0	0	
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0		0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	30, 360	30, 360	30, 360	30, 360	0	89. 00
07.00	NONREI MBURSABLE COST CENTERS	30, 300	30, 300	30, 300	30, 300	0	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	Λ	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	n	١	n	0	1
93. 00	09300 NONPALD WORKERS	0	n	ا آ	n	0	
94. 00	09400 PATI ENTS LAUNDRY	0	0	0	o	0	
95. 00	09500 OTHER NONREIMBURSABLE COST	0	n	l o	o	0	95. 00
98. 00	Cross Foot Adjustments				Ĭ		98.00
99. 00	Negative Cost Centers						99.00
102.00		441, 415	18, 028	72, 815	230, 418	0	102. 00
50	Part I)		,				
103.00		14. 539361	0. 593808	2. 398386	7. 589526	0. 000000	103. 00
104.00		8, 068	71	8, 678			104. 00
	Part II)						
105.00	Unit cost multiplier (Wkst. B, Part	0. 265744	0. 002339	0. 285837	0. 256621	0. 000000	105. 00

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315502

			10 12/31/202	5/10/2024 11: 49 am
		OTHER GENERAL		
		SERVI CE		
	Cost Center Description	ACTI VI TES		
		(PATIENT DAYS)		
	I	15. 00		
4 00	GENERAL SERVICE COST CENTERS			1.00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT			1.00
2. 00 3. 00	i i			2.00
4. 00	00300 EMPLOYEE BENEFITS			3.00
5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS			4.00
6. 00	00600 LAUNDRY & LINEN SERVICE			6. 00
7. 00	00700 HOUSEKEEPING			7. 00
8. 00	00800 DI ETARY			8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00	01100 PHARMACY			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY			12. 00
13.00	01300 SOCIAL SERVICE			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15.00	01500 ACTI VI TES	30, 360		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	I I	30, 360		30.00
31. 00	03100 NURSING FACILITY	0		31.00
32. 00	03200 CF/IID	0		32. 00
33. 00	03300 OTHER LONG TERM CARE	0		33. 00
	ANCILLARY SERVICE COST CENTERS			
40.00	04000 RADI OLOGY	0		40.00
41. 00	04100 LABORATORY	0		41.00
42.00	04200 I NTRAVENOUS THERAPY	0		42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY	0		43. 00 44. 00
45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00	04600 SPEECH PATHOLOGY			46. 00
47. 00	04700 ELECTROCARDI OLOGY			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	05100 SUPPORT SURFACES	0		51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	O		52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	O		52. 01
52.02	05202 MEDI CAL SERVI CES	0		52. 02
	OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLI NI C	0		60.00
61.00	06100 RURAL HEALTH CLINIC	0		61.00
62.00	06200 FQHC			62.00
63. 00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0		63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0		70. 00
	07100 AMBULANCE	l o		71.00
	07300 CMHC	0		73.00
	07400 OTHER REIMBURSEMENT	0		74. 00
	SPECIAL PURPOSE COST CENTERS	'		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81. 00	08100 INTEREST EXPENSE			81.00
82.00	08200 UTILIZATION REVIEW - SNF			82.00
83.00	08300 H0SPI CE	0		83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0		84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	30, 360		89. 00
00.00	NONREI MBURSABLE COST CENTERS			20.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES			91. 00 92. 00
92.00	09300 NONPALD WORKERS			93. 00
94.00	09400 PATI ENTS LAUNDRY	0		93.00
95.00	09500 OTHER NONREIMBURSABLE COST			95. 00
98. 00	Cross Foot Adjustments			98.00
99. 00	Negative Cost Centers	1		99.00
102.00	1 1 0	714, 536		102. 00
	Part I)			
103.00	I I '	23. 535441		103. 00
104.00		224, 463		104.00
	Part II)			
105.00		7. 393379		105. 00
	11)	1		I

Health Financial Systems	CARE ONE AT TEANECK		In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES F	OR ANCILLARY AND OUTPATIENT COST CENTERS Provide	r No.: 315502 Per	iod: Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/10/2024 11:49 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 162, 551 339, 288 0. 479094 40.00 04100 LABORATORY 120, 700 251, 932 0.479098 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 268, 143 608, 355 0. 440767 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 456, 547 3, 498, 377 0.416349 44.00 04500 OCCUPATIONAL THERAPY 45.00 1,070,065 3, 827, 372 0. 279582 45.00 04600 SPEECH PATHOLOGY 0. 247013 46.00 192, 940 781, 092 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 267 558 0.478495 48.00 04900 DRUGS CHARGED TO PATIENTS 1, 732, 865 0.448345 49.00 49.00 776, 921 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 Ω 50.00 51.00 05100 SUPPORT SURFACES 128 267 0.479401 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 0 52.01 05202 MEDICAL SERVICES 0.000000 52.02 0 52.02 OUTPATIENT SERVICE COST CENTERS 0. 000000 60.00 06000 CLI NI C 0 0 60.00 06100 RURAL HEALTH CLINIC 61.00 61.00 62. 00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0.000000 63.00 139, 530 71. 00 07100 AMBULANCE 66, 848 0. 479094 71.00

4, 115, 110

11, 179, 636

100. 00

100.00

Total

PPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		D: -I				
			No.: 315502	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/10/2024 11:	
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Heal th Care Pi	rogram 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 OUTPA	ATLENT COST		•	-		
ANCILLARY SERVICE COST CENTERS						
0. 00 04000 RADI OLOGY	0. 479094	52, 190		0 25, 004	•	
1. 00 04100 LABORATORY	0. 479098	61, 397		0 29, 415		
2.00 04200 I NTRAVENOUS THERAPY	0. 440767	58, 889		0 25, 956	l	
3.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0	0	
4. 00 04400 PHYSI CAL THERAPY	0. 416349			0 810, 156	•	
5. 00 04500 OCCUPATI ONAL THERAPY	0. 279582	2, 160, 254		0 603, 968	l	
6. 00 04600 SPEECH PATHOLOGY	0. 247013	454, 356		0 112, 232		
7. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
8. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 478495			0 267	0	
9.00 04900 DRUGS CHARGED TO PATIENTS	0. 448345			0 89, 544	0	
0.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
1.00 05100 SUPPORT SURFACES	0. 479401	267		0 128	l	
2. 00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000			0	0	
2.01 05201 OTHER ANCILLARY SERVICES COST	0. 000000			0	0	
2. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52. 02
OUTPATIENT SERVICE COST CENTERS		_	l	_1		4
0. 00 06000 CLI NI C	0. 000000	0		0 0	0	
1.00 06100 RURAL HEALTH CLINIC						61.00
2. 00 06200 FQHC						62. 00
3. 00 06300 DI ALYSI S	0.000000			0	0	
1. 00 07100 AMBULANCE (2)	0. 479094			0 4 (0) (73	0	
00.00 Total (Sum of lines 40 - 71)		4, 933, 491	l	0 1, 696, 670	J 0	100. 00
1) For title V and XIX use columns 1, 2, and 4 o	nl y.					

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

Heal th	Financial Systems	CARE ONE A	Γ TEANECK		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS				Peri od: From 01/01/2023 To 12/31/2023	5/10/2024 11:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		·			1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					11.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	0. 448345	1. 00
2.00	Program vaccine charges (From your reco				·	0	2. 00
3. 00	Program costs (Line 1 x line 2) (Title E, Part I, line 18)	XVIII, PPS pro	viders, transfe	er this amoun	t to Worksheet	0	3. 00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
		(From Wkst. B,		Nursing &	Cost (From	& Allied	
			(From Wkst. B,	Allied Healt	h Wkst. D Part	Health Costs	
		18	Part I, Col.	Costs to Tota	al I, Col. 4)	for Pass	
				Costs - Part		Through (Col.	
				(Col. 2 / Col		3 x Col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS			3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	TOK NOKSTNO &	ALLIED HEALTH				
40.00	04000 RADI OLOGY	162, 551	0	0.00000	25, 004	0	40.00
41.00	04100 LABORATORY	120, 700	0	0. 00000			41.00
42.00	04200 I NTRAVENOUS THERAPY	268, 143	0	0. 00000	25, 956	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0.00000	00	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 456, 547	0	0. 00000	00 810, 156	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	1, 070, 065	0	0. 00000	00 603, 968	0	45. 00
46.00	04600 SPEECH PATHOLOGY	192, 940	0	0.00000	00 112, 232	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0	0.00000		0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	267	0	0.00000		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	776, 921	0	0. 00000		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0. 00000		0	50.00
51.00	05100 SUPPORT SURFACES	128	0	0. 00000		0	51.00
	05200 COMPLEX MEDICAL EQUIPMENT	0	0	0. 00000		0	52.00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	0. 00000		0	52. 01
52. 02		0	0	0. 00000		0	52. 02
100.00	Total (Sum of lines 40 - 52)	4, 048, 262	0	I	1, 696, 670	0	100. 00

	Financial Systems CARE ONE AT	TEANECK	In Lie	u of Form CMS-2	2540-
OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315502	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	pared
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			30, 360	
0	Private room days	- D		15.000	2
0	Inpatient days including private room days applicable to th Medically necessary private room days applicable to the Pro			15, 082 0	3
)O)O	Total general inpatient routine service cost	gi alii		15, 446, 698	
U	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			15, 440, 070	1 3
0	General inpatient routine service charges			16, 364, 590	6
0	General inpatient routine service cost/charge ratio (Line	5 divided by line 6)		0. 943910	
0				0	8
0	Average private room per diem charge (Private room charges 2)	line 8 divided by private	room days, line	0.00	9
00	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private rosemi-private room days)		d by	0. 00	
00	Average per diem private room charge differential (Line 9 m			0.00	
00	Average per diem private room cost differential (Line 7 tim Private room cost differential adjustment (Line 2 times lin			0.00	14
00	General inpatient routine service cost net of private room		minus line 14)	15, 446, 698	
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	cost differential (Line 5	III IIus IIIie 14)	13, 440, 070	'3
00	Adjusted general inpatient service cost per diem (Line 15	divided by line 1)		508. 78	16
00	Program routine service cost (Line 3 times line 16)			7, 673, 420	
00	Medically necessary private room cost applicable to program	,		0	
00	Total program general inpatient routine service cost (Line			7, 673, 420	
00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	T II COLUMN 18,	2, 394, 901	20
00	Per diem capital related costs (Line 20 divided by line 1)			78. 88	21
00	Program capital related costs (Line 3 times line 21)			1, 189, 668	1
00	Inpatient routine service cost (Line 19 minus line 22)			6, 483, 752	1
00	Aggregate charges to beneficiaries for excess costs (From	provi der records)		0	
00	Total program routine service costs for comparison to the c		nus line 24)	6, 483, 752	25
00	Enter the per diem limitation (1)				26
00	Inpatient routine service cost limitation (Line 3 times the				27
00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instruction		line 27)		28

20.00	(Transfer to Worksheet E, Part II, line 4) (See instructions)						
(1) Li	(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX						
		1.00					
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH						
1.00	Total SNF inpatient days	30, 360	1.00				
2.00	Program inpatient days (see instructions)	15, 082	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. 496772	4.00				
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00				

	Financial Systems CARE O ATION OF INPATIENT ROUTINE COSTS	NE AT TEANECK Provi der No.: 315502	In Lie Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Parts I-II Date/Time Pre 5/10/2024 11:	pare
		Title XIX	Skilled Nursing Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			30, 360	
00	Private room days	5		0	2
0	Inpatient days including private room days applicable			0	3
00	Medically necessary private room days applicable to the Total general inpatient routine service cost	e Program		15, 446, 698	5
iU	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			13, 440, 090	1 3
0	General inpatient routine service charges			16, 364, 590	6
0	General inpatient routine service cost/charge ratio (I	Line 5 divided by line 6)		0. 943910	
0	Enter private room charges from your records				8
0	Average private room per diem charge (Private room charges line 8 divided by private room days, line				9
	2)	3	, , , , , , , , , , , , , , , , , , ,		
00					
00	0 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 0.00				
00	Average per diem private room charge differential (Line			0.00	
00	Average per diem private room cost differential (Line			0.00	
00	Private room cost differential adjustment (Line 2 times			0	
00		room cost differential (Line 5	minus line 14)	15, 446, 698	15
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line	1E divided by Line 1)		508. 78	16
00	Program routine service cost (Line 3 times line 16)	15 divided by Title 1)		0.76	
00	Medically necessary private room cost applicable to pro	noram (line 4 times line 13)		0	18
00	Total program general inpatient routine service cost	9 (0	
00	Capital related cost allocated to inpatient routine ser	` '	rt II column 18.	2, 394, 901	
00	line 30 for SNF; line 31 for NF, or line 32 for ICF/III			2,071,701	-
00	Per diem capital related costs (Line 20 divided by lin			78. 88	21
00	Program capital related cost (Line 3 times line 21)	•		0	22
00	Inpatient routine service cost (Line 19 minus line 22))		0	23
00	Aggregate charges to beneficiaries for excess costs (I			0	24
00	Total program routine service costs for comparison to	the cost limitation (Line 23 mi	nus line 24)	0	
00	Enter the per diem limitation (1)			0.00	
00	Inpatient routine service cost limitation (Line 3 times			0	27
00	Reimbursable inpatient routine service costs (Line 22	plus the lesser of line 25 or	line 27)	0	28

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	30, 360	1.00
2.00	Program inpatient days (see instructions)	0	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3. 00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.000000	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	CARE ONE AT TEA	NECK	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTL	EMENT FOR TITLE XVIII	Provi der No.: 315502	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/10/2024 11:49 am
		Title XVIII	Skilled Nursing	PPS

		II tie xviii	Facility	PP5			
			raciiity				
				1. 00			
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT						
1.00	Inpatient PPS amount (See Instructions)			13, 463, 057	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)			13, 463, 057	3. 00		
4.00	Primary payor amounts			0	4. 00		
5.00	Coinsurance			1, 673, 200	5. 00		
6.00	Allowable bad debts (From your records)			220, 209	6. 00		
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00		
8.00	Adjusted reimbursable bad debts. (See instructions)			143, 136	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)			11, 932, 993			
12.00	Interim payments (See instructions)			11, 690, 599	12.00		
13.00	Tentati ve adjustment			0	13. 00		
14. 00	OTHER adjustment (See instructions)			0			
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50		
14. 55	Demonstration payment adjustment amount after sequestration			0			
14. 75	Sequestration for non-claims based amounts (see instructions)			2, 863			
14. 99	Sequestration amount (see instructions)			235, 797			
15. 00	Balance due provider/program (see Instructions)			3, 734			
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00		
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	ITTLE XVIII ONLY		4 - 00		
17. 00	Ancillary services Part B			0			
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0			
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.00		
20.00	Medicare Part B ancillary charges (See instructions)			0			
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00		
22. 00 23. 00	Primary payor amounts Coinsurance and deductibles			0			
24.00	Allowable bad debts (From your records)			0	24.00		
24. 00	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 00		
24. 01	Adjusted reimbursable bad debts (see instructions)	ctrons)		0	24. 01		
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00		
26. 00	Interim payments (See instructions)			0			
27. 00	Tentati ve adjustment			0			
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	28. 55		
28. 99	Sequestration amount (see instructions)			0	28. 99		
29. 00	Balance due provider/program (see instructions)			0			
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	0			
50.00	1	2 2 33 . 42 2,		٥١			

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

Title XVIII Skilled Nursing PPS

To 12/31/2023 Date/Time Prepared: 5/10/2024 11: 49 am

PPS

		11 (1)	e Aviii Ji	Facility	FF3	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		11, 554, 060		0	
2.00	Interim payments payable on individual bills, either		140, 396		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provi der to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/01/2023	3, 857		0	
3. 51			0		0	
3. 52			0		_	
3. 53 3. 54			0		0	3. 53 3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-3, 857		0	3. 99
3. 77	- 3.98)		-3,057		U	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		11, 690, 599		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line		, ,		_	
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider				0	 1
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	
5. 02			0		0	
5.05	Provider to Program		U _I		0	3.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			Ö		0	
5. 52			Ö		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		3, 734		0	6. 01
6. 02	PROVI DER TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		11, 694, 333	NI .	0	7. 00
			Contract	or Name	Contractor Number	
			1. (nn	2. 00	
8. 00	Name of Contractor		1. (2.00	8. 00
3. 00	Thems of contractor				ı	0.00

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

Health Financial Systems

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

Provider No.: 315502 | Period: | From 01/01/2023 | To 12/31/2023

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/10/2024 11: 49 am

oni y)		General Fund	Specific E	ndowment Fund	5/10/2024 11: Plant Fund	
			Purpose Fund			
	Assets	1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	90, 074	0	0	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	3, 558, 430	-	0	0	
5. 00	Other recei vables	3, 330, 430	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	-1, 066, 006	I - 1	Ö	0	
	recei vabl e					
7. 00	Inventory	0	0	0	0	
8.00	Prepai d expenses	41, 892	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	10, 868		0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 635, 258	-	0	0	
11.00	FIXED ASSETS	2,000,200	J J	<u> </u>		1
12. 00	Land	2, 551, 086	0	0	0	12.0
13. 00	Land improvements	59, 565	0	0	0	13.0
14. 00	Less: Accumulated depreciation	-27, 797	0	0	0	
15.00	Bui I di ngs	14, 455, 143		0	0	
16.00	Less Accumulated depreciation	-8, 027, 753		0	0	
17. 00 18. 00	Leasehold improvements Less: Accumulated Amortization	0	0	0	0	
19. 00	Fi xed equi pment	542, 295	-	0	0	
20. 00	Less: Accumulated depreciation	-414, 769		0	0	
21. 00	Automobiles and trucks	63, 985	0	o	0	1
22. 00	Less: Accumulated depreciation	-63, 985	0	0	0	22. C
23. 00	Maj or movable equipment	3, 041, 602	0	0	0	23.0
24. 00	Less: Accumulated depreciation	-2, 762, 226	0	0	0	1
25. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	
26. 00	Mi nor equi pment nondepreci abl e	0	0	0	0	1
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	9, 417, 146	0	0	0	
20.00	OTHER ASSETS	7,417,140	<u> </u>	<u> </u>		20.0
29. 00	Investments	0	0	0	0	29. C
30. 00	Deposits on Leases	0	0	0	0	30.0
31. 00	Due from owners/officers	0	0	0	0	31.0
32. 00	Other assets	763, 218		0	0	1
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	763, 218		0	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	12, 815, 622	0	0	0	34.0
	CURRENT LIABILITIES					+
35. 00	Accounts payable	2, 291, 713	0	0	0	35.0
36. 00	Salaries, wages, and fees payable	305, 680		0	0	36.0
37. 00	Payroll taxes payable	4, 865	0	0	0	37.0
38. 00	Notes & Loans payable (Short term)	0	0	0	0	
39. 00	Deferred income	0	0	0	0	
40.00	Accel erated payments	0		0	0	40.0
41. 00 42. 00	Due to other funds Other current liabilities	1, 921, 461	0	0	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4, 523, 719		o	0	
.0.00	LONG TERM LIABILITIES	1,020,717	<u> </u>			1
44. 00	Mortgage payable	21, 645, 332	0	0	0	44.0
45. 00	Notes payable	0	0	0	0	45.0
46. 00	Unsecured Loans	0	0	0	0	
47. 00	Loans from owners:	0	0	0	0	
48. 00	Other long term liabilities	-44, 445, 437	0	0	0	
49. 00 50. 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-22, 800, 105	0	0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	-18, 276, 386		0	0	
	CAPI TAL ACCOUNTS	10,2,0,000	<u> </u>	<u>9</u> 1		1
52. 00	General fund balance	31, 092, 008				52.0
53. 00	Specific purpose fund		0			53.0
54. 00	Donor created - endowment fund balance - restricted			0		54. (
55.00	Donor created - endowment fund balance - unrestricted			O		55. (
56.00	Governing body created - endowment fund balance			0	^	56. (
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
JO. UU	replacement, and expansion				U	30.0
	TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	31, 092, 008	0	0	0	59. 0
59. 00	TIVIAL FUND DALANCES (Suil OF FITTES 52 till u 56)	31,072,000				
59. 00 60. 00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	12, 815, 622	l	o	0	

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

STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315502 | Peri od: From 01/01/2023

Worksheet G-1

14.00

15.00

16.00

17.00

18.00

19.00

12/31/2023 Date/Time Prepared: 5/10/2024 11:49 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 31, 630, 501 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -287, 409 2.00 3.00 Total (sum of line 1 and line 2) 31, 343, 092 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0000 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 31, 343, 092 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 251, 084 0 13.00 14.00 0 0 0 14.00 0 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 251, 084 18.00 Fund balance at end of period per balance 19.00 31, 092, 008 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 0 0 Subtotal (line 3 plus line 10) 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00

0

0

0

0

0

14.00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 13 - 17)

sheet (Line 11 - line 18)

Fund balance at end of period per balance

Heal th	Financial Systems	CARE ONE AT TEA	NECK			In Lie	u of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315502	Peri Fron To	n 01/01/2023	Worksheet G-2 Parts I-II Date/Time Pre 5/10/2024 11:	pared:
	Cost Center Description			Inpati ent	(Outpati ent	Total	
				1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			16, 364, 59	90		16, 364, 590	1.00
2.00	NURSING FACILITY				0		0	2. 00
3 00	ICE/IID				Λ		0	3 00

				3/ 10/ 2024 11.	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	16, 364, 590		16, 364, 590	1. 00
2.00	NURSING FACILITY	0		0	2. 00
3.00	ICF/IID	0		0	3. 00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	16, 364, 590		16, 364, 590	5. 00
	All Other Care Services	.,			
6.00	ANCI LLARY SERVI CES	11, 179, 636	0	11, 179, 636	6.00
7.00	CLINIC	, , , , , , , , , , , , , , , , , , , ,	0	0	7. 00
8.00	HOME HEALTH AGENCY COST		0	o	8. 00
9.00	AMBULANCE		0	o	9. 00
10.00	RURAL HEALTH CLINIC		0	0	10.00
			0	Ö	
	CMHC		0	Ö	
	HOSPI CE	0	0	0	
	OTHER (SPECIFY)	0	0	0	13.00
14. 00		27, 544, 226	0	27, 544, 226	
00	Worksheet G-3, Line 1)	27,011,220	ŭ	27,011,220	
	Cost Center Description				
			1. 00	2. 00	
	PART II - OPERATING EXPENSES				
	PART II - UPERATING EAPENSES				
1. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			20, 865, 747	1. 00
1. 00 2. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		0	20, 865, 747	1. 00
			0	20, 865, 747	
2. 00 3. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		0 0	20, 865, 747	2. 00 3. 00
2.00 3.00 4.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		0 0 0	20, 865, 747	2. 00
2.00 3.00 4.00 5.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		0 0 0 0	20, 865, 747	2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		0 0 0 0 0	20, 865, 747	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify)		0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify) Total Additions (Sum of lines 2 - 7)		0 0 0 0 0 0	20, 865, 747	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify)		0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify) Total Additions (Sum of lines 2 - 7)		0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify) Total Additions (Sum of lines 2 - 7)		0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify) Total Additions (Sum of lines 2 - 7)		0 0 0 0 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify) Total Additions (Sum of lines 2 - 7) Deduct (Specify)		0 0 0 0 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100) Add (Specify) Total Additions (Sum of lines 2 - 7)		0 0 0 0 0 0 0	0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00

					6.5	
		ARE ONE AT TEANECK	045500		u of Form CMS-2	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 3	315502	Peri od: From 01/01/2023	Worksheet G-3	
					Date/Time Pre	
					5/10/2024 11:	49 am
					1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)					1.00
2.00	Less: contractual allowances and discounts on patients accounts					2. 00
3.00	Net patient revenues (Line 1 minus line 2)					3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)					4.00
5.00	0 Net income from service to patients (Line 3 minus 4)				-309, 110	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments					7. 00
8.00	Revenues from communications (Telephone and Internet service)					8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11. 00
12.00	Parking lot receipts				0	12. 00
	,					

0 13.00

14.00

15.00

16.00

17.00

21.00

23.00

24.00

24.01

24.02

24.03

24.50

25.00

26.00

27.01

0 18.00

0 19.00

0 20.00

0 22.00

0

70

0

0 27.00

0 28.00

0 29.00

0 30.00

-287, 409 31.00

3, 023

6, 317

8, 266

21, 701

-287, 409

13.00 Revenue from Laundry and Linen service

Rental of vending machines

Governmental appropriations

RESIDENT PERSONAL ITEMS

COVI D-19 PHE Funding

26.00 Total (Line 5 plus line 25)

BARBER & BEAUTY

OTHER REVENUE

OTHER INCOME

Rental of skilled nursing space

Revenue from rental of living quarters

Total other income (Sum of lines 6 - 24)

Total other expenses (Sum of lines 27 - 29)

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

Revenue from meals sold to employees and guests

Revenue from sale of drugs to other than patients

Revenue from sale of medical records and abstracts

Tuition (fees, sale of textbooks, uniforms, etc.)

Revenue from gifts, flower, coffee shops, canteen

Revenue from sale of medical and surgical supplies to other than patients

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

24. 01

24.02

24.03

24.50

25.00

27.00

27.01

28.00

29.00