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

OMB NO. 0938-0463

Expires: 12/31/2021

			Exp11 03. 12/01/2021
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315477	From 01/01/2023	Worksheet S Parts I, II & III Date/Time Prepared: 5/15/2024 12:23 pm

				0/10	0/2024 12	.: 23 piii
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically prepared cost rep	ort		Date: 5/15/2024	Time: 1	12: 23 pm
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	st report	į.
	3.01 [ ] No Medicare Utilization. Enter "	Y" for yes or	leave blank for no.			
Contractor	4.[ 1 ]Cost Report Status	6. Contractor	No.			
use only	(1) As Submitted	7.[ N ] First Cost Report for this Provider CCN				
	(2) Settled without audit	8.[ N ] Last	Cost Report for this F	Provider CCN		
	(3) Settled with audit	9. NPR Date:	·			
	(4) Reopened	10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened			ned	
	(5) Amended		Vendor Code	4		
	5. Date Received:	12. [ F ] Medi	care Utilization. Ente	 r "F" for full, "L" fo	or low, d	or "N"
			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 WAYNE (315477) 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	-94, 415	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	-94, 415	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 WAYNE In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315477 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/15/2024 12: 23 pm 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 493 BLACK OAK RIDGE ROAD PO Box: 1.00 2.00 City: WAYNE State: NJ Zi p Code: 07470 2.00 3.00 County: PASSAIC CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF CARE ONE AT WAYNE 315477 08/15/2002 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) 01/01/2023 12/31/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 23.00 Sum of line 20 through 22 d 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 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 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF Ν 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 38.00 38.00 Υ 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00 33.037

Heal th	Financial Systems	CARE ONE AT WA	YNE	In Lie	u of Form CMS-2	2540-10
SKI LLE	KILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315477   Period:			Worksheet S-2		
COMPLE	MPLEX INDENTIFICATION DATA From 01/01/2023			Part I		
				To 12/31/2023		
					5/15/2024 12:	23 pm_
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative a	nd 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.		-			
43.00	Are there any home office costs as def	ined 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	home office on the	lines	
	bel ow.	_				
45.00	Name: HEALTHBRI DGE	Contractor's Name: NOVITA	S SOLUTIONS Contrac	ctor's Number: 1200	1	45. 00
46.00	Street: 173 BRIDGE PLAZA NORTH	PO Box:				46. 00
47.00	City: FORT LEE	State: NJ	Zi p Coo	de: 0702	4	47. 00

Heal th	Financial Systems	CARE ONE AT WA	YNE		In Lie	eu of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	1	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre	epared:
					Y/N	5/15/2024 12: Date	23 pili
	General Instruction: For all column 1 responses some sponses the format will be (mm/dd/yyyy)  Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fo	r Yes or "N" f	1.00 For No. For all	2.00 the date	
1.00	Provider Organization and Operation Has the provider changed ownership immediate reporting period? If column 1 is "Y", enterinstructions)				N		1.00
				Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			N	2.00	0.00	2.00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offic d to the provider o I, or members of the	es, drug r its e board	Y			3.00
				Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports		5			0.00	
4. 00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" te copy or enter da	for te	Y	A		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2	ls the	provider the	N	N	6. 00
7. 00 8. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained duri	ng the cost reporti		for Nursing	N N		7. 00 8. 00
	School and/or Allied Health Program? (Y/N) s	ee instructions.				Y/N 1.00	
9. 00 10. 00	Bad Debts  Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				reporting	Y N	9. 00 10. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wa	ived? If "	Y", see instru	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	iod? If "Y			N	12. 00
		Descriptio	n	Y/N	rt A Date	Part B Y/N	
	PS&R Data	0		1. 00	2. 00	3. 00	
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			Y	03/19/2024	Y	13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N		N	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			N		N	17. 00
	Describe the other adjustments:						

Health Financial Systems CARE ONI			AYNE	In Lie	2540-10	
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		RE	Provi der No.: 315477	Peri od: From 01/01/2023 To 12/31/2023		
				10 12/31/2023	5/15/2024 12:	23 pm
			1. 00	2.	00	
C	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position	CHA	RLES	REED		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
r	respecti vel y.					
20. 00 E	Enter the employer/company name of the cost report	EXE	CUCARE ASSOCIATES			20. 00
ļŗ	oreparer.					
	Enter the telephone number and email address of the cost	(609	9) 738-3200	CRWASSC@NETSCAL	PE. NET	21. 00
r	report preparer in columns 1 and 2, respectively.					

Health Financial Systems CARE ONE A SKILLED NURSING FACILITY HEALTH CARE CARE ONE AT WAYNE Provi der No.: 315477

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE

				10 12/31/2023	Date/lime Prepared: 5/15/2024 12:23 pm
		Part B			6, 10, 2021 12, 20 pm
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	03/19/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14.00
11.00	for total and the provider's records for				11.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
	made to PS&R data for additional claims that have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16.00	If line 13 or 14 is "Y", then were				16. 00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00					17. 00
	adjustments made to PS&R data for Other?				
18 00	Describe the other adjustments: Was the cost report prepared only using the				18. 00
10.00	provider's records? If "Y" see Instructions.				16.00
			3. 00		
	Cost Report Preparer Contact Information		I		
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 respectively.	, 2, and 3,			
20 00	Enter the employer/company name of the cost r	enort			20. 00
20.00	preparer.	opor t			25.00
21. 00	Enter the telephone number and email address	of the cost			21. 00
	report preparer in columns 1 and 2, respectiv				

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

Health Financial Systems CARE ONE A SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315477 COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/15/2024 12: 23 pm

					7 12/31/2023	5/15/2024 12: 2	
				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	73		0	12, 544	0	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	I CF/II D	0	0	0	0	0 0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	59	21, 535		0	١	4. 00 5. 00
6.00	SNF-Based CMHC	37	21, 555				6. 00
7. 00	HOSPI CE	0	0	0	0	o	7. 00
8. 00	Total (Sum of lines 1-7)	132	48, 180		12, 544	o o	8. 00
	,	Inpatient [			Di scharges		
		211		<del>-</del>		<del>-</del> 1.11 V/1.V/	
	Component	Other	Total 7. 00	Title V	7itle XVIII 9.00	Title XIX	
1. 00	SKILLED NURSING FACILITY	6. 00	7. 00 24, 254	8. 00	9.00	10.00	1. 00
2.00	NURSING FACILITY	11, 710	24, 234	0	524		2. 00
3.00	ICF/IID	0	0			اه	3. 00
4.00	HOME HEALTH AGENCY COST	0	Ö				4. 00
5.00	Other Long Term Care	2, 718	2, 718				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)	14, 428		0	524	0	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	514	1, 038		23. 94	l	1. 00
2.00	NURSING FACILITY	0	0	0. 00		0.00	2.00
3.00	I CF/IID   HOME HEALTH AGENCY COST	O	0			0.00	3.00
4. 00 5. 00	Other Long Term Care	7	7				4. 00 5. 00
6.00	SNF-Based CMHC	/	·				6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	521	1, 045			l I	8. 00
		Average Length		Admi s	si ons		
	C	of Stay	T: +1 - \/	T: ±1 - W// 1 1	T: ±1 - VIV	0+1	
	Component	Total 16. 00	Title V 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
1.00	SKILLED NURSING FACILITY	23. 37	17.00		19.00	462	1. 00
2.00	NURSING FACILITY	0.00		001	0	0	2. 00
3.00	ICF/IID	0. 00			0	l ol	3. 00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	388. 29				10	5.00
6.00	SNF-Based CMHC						6.00
7. 00	HOSPICE	0. 00	0	0	0		7. 00
8. 00	Total (Sum of lines 1-7)	25. 81 Admi ssi ons	Full Time	584 Faui val ent	0	472	8. 00
	Component	Total	Employees on	Nonpai d			
		21.00	Payrol I 22. 00	Workers 23.00			
1.00	SKILLED NURSING FACILITY	1, 046					1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3. 00	ICF/IID	0					3. 00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	10					5.00
6.00	SNF-Based CMHC		0.00				6. 00
7.00	HOSPI CE	0					7. 00
8. 00	Total (Sum of lines 1-7)	1, 056	112. 27	0.00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT WAYNE

Provi der No.: 315477

				T	o 12/31/2023	Date/Time Prep 5/15/2024 12:	
	·	Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
		Ropor tou	Worksheet A-6		Salary in col.	col. 4)	
					3	.,	
		1.00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	7, 428, 376	0	7, 428, 376	233, 514. 00	31. 81	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)	7, 428, 376	0	7, 428, 376	233, 514. 00	31. 81	6. 00
7.00	Other Long Term Care	0	179, 618	179, 618	6, 598. 00	27. 22	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	179, 618	179, 618	6, 598. 00	27. 22	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	7, 428, 376	-179, 618	7, 248, 758	226, 916. 00	31. 94	13.00
	12)						
	OTHER WAGES & RELATED COSTS		1				
14. 00	Contract Labor: Patient Related & Mgmt	20, 818	0	20, 818			
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		
16. 00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	1, 145, 694	0	1, 145, 694			17. 00
18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	27, 703	0	27, 703			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, 117, 991	0	1, 117, 991			22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE ONE AT WAYNE

| In Lieu of Form CMS-2540-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315477

				T	o 12/31/2023		
		Amount	Reclass. of	Adj usted	Pai d Hours	5/15/2024 12: Average Hourly	
		Reported		Sal ari es (col.		Wage (col. 3 ÷	
		Reported	Worksheet A-6		Salary in col.		
			lior Rondot 71 o		3	00.1.1)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES			•	<u> </u>		
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	627, 318	0	627, 318	14, 979. 00	41. 88	2. 00
3.00	Plant Operation, Maintenance & Repairs	43, 975	0	43, 975	2, 503. 00	17. 57	3. 00
4.00	Laundry & Linen Service	25, 739	0	25, 739	2, 062. 00	12. 48	4. 00
5.00	Housekeepi ng	348, 735	0	348, 735	20, 821. 00	16. 75	5. 00
6.00	Di etary	505, 987	0	505, 987	21, 427. 00	23. 61	6. 00
7.00	Nursing Administration	517, 969	0	517, 969	12, 106. 00	42. 79	7. 00
8.00	Central Services and Supply	30, 472	0	30, 472	1, 924. 00	15. 84	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	47, 533	0	47, 533	1, 975. 00	24. 07	10.00
11. 00	Soci al Servi ce	154, 199	0	154, 199	4, 020. 00	38. 36	11. 00
12.00	Nursing and Allied Health Ed. Act.						12. 00
13.00	Other General Service	202, 643	0	202, 643	10, 470. 00	19. 35	13. 00
14.00	Total (sum lines 1 thru 13)	2, 504, 570	0	2, 504, 570	92, 287. 00	27. 14	14. 00

Health Financial Systems	CARE ONE AT WAYNE	CARE ONE AT WAYNE In Lie		
SNF WAGE RELATED COSTS	Provi der No.: 315477	From 01/01/2023	Worksheet S-3 Part IV Date/Time Prep 5/15/2024 12:2	
	,		Amount	

	To 12/31/2023	Date/Time Prep 5/15/2024 12:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	33, 732	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
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	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	456, 732	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1, 316	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	115, 944	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	457, 102	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	77, 711	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	3, 157	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 145, 694	24.00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COST	0	25.00

YNE In Lieu of Form CMS-2540-10
Provider No.: 315477 | Period: | Worksheet S-3 | From 01/01/2023 | Part V

					rom 01/01/2023 o 12/31/2023	Part V   Date/Time Pre	pared:
						5/15/2024 12:	
	Occupational Category	Amount	Fri nge	Adj usted		Average Hourly	
		Reported	Benefits	Salaries (col.		Wage (col. 3 ÷	
				1 + col. 2)	Salary in col.	col. 4)	
					3		
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	958, 428	117, 538				1. 00
2.00	Licensed Practical Nurses (LPNs)	913, 196	111, 991	1, 025, 187	·		2. 00
3.00	Certified Nursing Assistant/Nursing	1, 374, 817	168, 602	1, 543, 419	49, 911. 00	30. 92	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 246, 441	398, 131	3, 644, 572			4. 00
5.00	Physical Therapists	824, 005	101, 053	925, 058			5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
7.00	Physical Therapy Aides	0	0	0	0.00		7. 00
8.00	Occupational Therapists	632, 271	77, 539	709, 810	·		8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0.00		10.00
11. 00	Speech Therapists	109, 057	13, 374	122, 431			11.00
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)	8, 213		8, 213			14.00
15. 00	Licensed Practical Nurses (LPNs)	0		0	0.00	0. 00	15.00
16. 00	Certified Nursing Assistant/Nursing	1, 876		1, 876	52.00	36. 08	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	10, 089		10, 089			17. 00
18. 00	Physi cal 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	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22. 00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	0		0	0.00	0.00	24.00
25.00	Respi ratory Therapi sts	10, 729		10, 729	215. 00	49. 90	25.00
26. 00	Other Medical Staff	O		0	0. 00	0.00	26. 00

Peri od: Worksheet S-7
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/15/2024 12:23 pm

10 127	5/15/2024 12: 23	
	oup Days	
	00 2.00	
	UX	1.00
	UL VX	2. 00 3. 00
	VL	4. 00
	HX	5. 00
	HL	6. 00
	MX	7. 00
8. 00 RN	ML	8.00
	LX	9. 00
		10.00
		11.00
		12. 00 13. 00
		14. 00
		15. 00
		16. 00
		17. 00
		18. 00
		19. 00
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		21. 00 22. 00
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		29. 00
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		44. 00
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		48. 00
		49.00
		50. 00 51. 00
		52. 00
		53. 00
54. 00 SE	E2 !	54.00
		55. 00
56. 00 SS	SC	56. 00
		57. 00 58. 00
		58. 00 59. 00
		60. 00
		61. 00
62.00	A1	62. 00
63. 00 BB	B2	63. 00
		64. 00
		65. 00
		66. 00 67. 00
		67. 00 68. 00
		69. 00
		70. 00
		71. 00
		72. 00
73. 00 PE	B2	73. 00
	B1	74. 00
75. 00 PA	A2	75. 00

Health Financial Systems CARI	ONE AT WAYNE		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315477	Peri od:	Worksheet S-	7
			From 01/01/2023 To 12/31/2023	Date/Time Pr 5/15/2024 12	
			Group	Days	
			1. 00	2. 00	
76. 00			PA1		76. 00
99. 00			AAA		99. 00
100. 00 TOTAL					100. 00
		Expenses	Percentage	Y/N	
		1.00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column column 2 the percentage of total expenses for each caline 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each (See instructions)	increase to be used 1 the amount of the tegory to total SNF "N" for no if the	d for direct perpense for expense for expense from spending refle	oatient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, col	umn 3)				101. 00 102. 00 103. 00 104. 00 105. 00 106. 00

Heal th	Financial Systems	CARE ONE AT	WAYNE		In Lie	u of Form CMS-	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od: From 01/01/2023	Worksheet A	
					To 12/31/2023		
	Cost Center Description	Sal ari es	Other	Total (col 1	1 Reclassi fi cati	5/15/2024 12: Reclassi fi ed	23 pm
	oost contor bescription	Sur ur res	Other	+ col . 2)	ons	Trial Balance	
					Increase/Decre	,	
					ase (Fr Wkst A-6)	col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		4 140 4/1	1 110 1/	1 0	4 140 4/1	1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		4, 140, 461 68, 888			4, 140, 461 47, 965	1. 00 2. 00
3.00	00300 EMPLOYEE BENEFITS	O	910, 986			910, 986	
4.00	00400 ADMINISTRATIVE & GENERAL	627, 318	1, 941, 164			2, 568, 482	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	43, 975	503, 321			547, 296	
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	25, 739 348, 735	41, 778 41, 354			67, 517 390, 089	
8. 00	00800 DI ETARY	505, 987	299, 628			805, 615	
9.00	00900 NURSING ADMINISTRATION	517, 969	25, 007			542, 976	1
10.00	01000 CENTRAL SERVICES & SUPPLY	30, 472	208, 726			224, 301	1
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	47, 533	15, 349	15, 34 47, 53		15, 349 47, 533	
13. 00	01300 SOCIAL SERVICE	154, 199	0	154, 19		154, 199	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1	ó	0	14. 00
15. 00	01500 ACTI VI TES	202, 643	10, 709	213, 35	2 0	213, 352	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.046.444	(4.50/	2 200 00	7 470 (40	0 400 440	00.00
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 246, 441	61, 596	3, 308, 03	7 -179, 618	3, 128, 419 0	1
32. 00	03200   CF/IID		0		0 0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	O	0		0 179, 618	179, 618	
	ANCILLARY SERVICE COST CENTERS						
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	64, 728	1		64, 728	
41.00	04200 I NTRAVENOUS THERAPY		102, 476 410, 701			102, 476 410, 701	
43. 00	04300 OXYGEN (INHALATION) THERAPY	o	0	1	0 0	0	1
44.00	04400 PHYSI CAL THERAPY	936, 037	18, 924			954, 961	
45. 00	04500 OCCUPATI ONAL THERAPY	632, 271	0	632, 27		632, 271	
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	109, 057	0	109, 05	0	109, 057 0	1
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 14, 897	14, 897	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	714, 473	714, 47		714, 473	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	
51. 00 52. 00	05100   SUPPORT SURFACES   05200   COMPLEX MEDI CAL EQUI PMENT	0	0		0 20, 923	20, 923 0	1
52. 00	05201 OTHER ANCILLARY SERVICES COST		0		0 0	0	1
	05202 MEDI CAL SERVI CES	O	0		0 0	_	1
	OUTPATIENT SERVICE COST CENTERS						
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0	0	
	06200 FQHC		Ü		0	0	62.00
	06300 DI ALYSI S	O	0		0 0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	I I	0	0	(4.70	0		70.00
71.00	07100   AMBULANCE	0	64, 737	64, 73	0 0	64, 737	71. 00 73. 00
	07400 OTHER REIMBURSEMENT		0		0 0		
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80.00
81. 00 82. 00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF		0		0	0	
83. 00			0		0 0	0	1
84. 00	08400 OTHER SPECIAL PURPOSE COST I	o	0		0 0	Ō	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0		0 0	0	
89. 00		7, 428, 376	9, 645, 006	17, 073, 38	2 0	17, 073, 382	89. 00
90. 00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	11, 658	11, 65	8 0	11, 658	90.00
	09100 BARBER AND BEAUTY SHOP		9, 184			'	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	1	0 0	0	92. 00
	09300 NONPALD WORKERS	0	0		0	0	
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST	0	0		0	0	
100.00		7, 428, 376	9, 665, 848	17, 094, 22	4 0	_	
. 50. 50	1.5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, 500, 040	, 0, 1, 22	.,	1, 0, 1, 224	1.00.00

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

 
 Heal th Financial
 Systems
 CARE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315477 | Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Pr

				To 12/31/2023 Date/Time Pro 5/15/2024 12:	
	Cost Center Description	Adjustments to			23 piii
			For Allocation		
		Wkst A-8)	(col. 5 +- col. 6)		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-66, 544			1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	C	1		2. 00 3. 00
4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	-675, 857	1	i de la companya del companya de la companya de la companya del companya de la co	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	075,057		l e e e e e e e e e e e e e e e e e e e	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	C	67, 517		6. 00
7.00	00700 HOUSEKEEPI NG	C	390, 089		7. 00
8. 00	00800 DI ETARY	C	805, 615	l e e e e e e e e e e e e e e e e e e e	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	-2, 361		l e e e e e e e e e e e e e e e e e e e	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	-1, 228	224, 301 14, 121		10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	-1, 220			12.00
13. 00	01300 SOCI AL SERVI CE				13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	C	0		14. 00
15. 00	01500 ACTI VI TES	C	213, 352	2	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	25 170	2 102 240	N.	1 20 00
30.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	-25, 170			30. 00 31. 00
32. 00	03200   CF/IID		1		32.00
	03300 OTHER LONG TERM CARE		<b> </b>		33. 00
	ANCILLARY SERVICE COST CENTERS				
40. 00	04000 RADI OLOGY	C			40. 00
41. 00	04100 LABORATORY	00.05	1 .02, ., 0		41. 00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	-32, 856	1		42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		1		44. 00
	04500 OCCUPATI ONAL THERAPY			l e e e e e e e e e e e e e e e e e e e	45. 00
46.00	04600 SPEECH PATHOLOGY	C			46. 00
47. 00	04700 ELECTROCARDI OLOGY	C	1		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	1,		48. 00
	O4900   DRUGS CHARGED TO PATIENTS   O5000   DENTAL CARE - TITLE XIX ONLY	-57, 157	657, 316	1	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		1		51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT			l e e e e e e e e e e e e e e e e e e e	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	C	0		52. 01
52. 02	05202 MEDI CAL SERVI CES	C	0	0	52. 02
60. 00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC		) 0	\ \	60.00
61. 00	06100 RURAL HEALTH CLINIC		<b> </b>		61. 00
62. 00	06200 FQHC				62. 00
63.00	06300 DI ALYSI S	C	0		63. 00
	OTHER REIMBURSABLE COST CENTERS		_		4
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	C	-		70.00
	07300 CMHC			l e e e e e e e e e e e e e e e e e e e	71. 00 73. 00
74. 00	07400 OTHER REI MBURSEMENT			l e e e e e e e e e e e e e e e e e e e	74.00
	SPECIAL PURPOSE COST CENTERS				
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	C	1	l e e e e e e e e e e e e e e e e e e e	80. 00
81. 00	08100   I NTEREST EXPENSE	C	1	1	81. 00
	i i		0	1	82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	C	1		83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II		1		84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	-861, 173	16, 212, 209		89. 00
	NONREI MBURSABLE COST CENTERS				4
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		11, 658		90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		9, 184	l e e e e e e e e e e e e e e e e e e e	91. 00 92. 00
	09300 NONPALD WORKERS			1	93. 00
	09400 PATIENTS LAUNDRY		1		94. 00
	09500 OTHER NONREIMBURSABLE COST	C	1		95. 00
100.00	TOTAL	-861, 173	16, 233, 051		100. 00

Health Financial Systems	CARE ONE AT WAYNE			In Lieu	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Pro	ovider N		eri od:	Worksheet A-6	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
					5/15/2024 12:	23 pm_
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3.00	4. 00	5. 00	
(1) A - RECLASS MED SUPP						
1.00	MEDICAL SUPPLIES CHARGI	ED TO	48. 00	0	14, 897	1. 00
(1) C - RECLASS SUPP SURFACE				<u> </u>		
2.00	SUPPORT SURFACES		51.00	0	20, 923	2.00
(1) E - RECLASS ALF RNS						
3.00	OTHER LONG TERM CARE		33.00	25, 245	0	3.00
4. 00	OTHER LONG TERM CARE		33.00	18, 004	0	4.00
5. 00	OTHER LONG TERM CARE		33.00	136, 369	0	5.00
TOTALS						
100. 00	Total Reclassifications	ıs (Sum		179, 618	35, 820	100.00
	of columns 4 and 5 mus	t				
	equal sum of columns 8	and				
	9)					

<sup>(1)</sup> 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	CA	RE ONE AT WAYNE		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2023	Worksheet A-6	
			Т	To 12/31/2023	Date/Time Pre 5/15/2024 12:	pared: 23 pm
		Decreases				
		Cost Center	Li ne #	Sal ary	Non Salary	
		6. 00	7. 00	8. 00	9. 00	
(1) A - RECLASS MED	SUPP					
1. 00	CENTRAL	SERVICES & SUPPLY	10.00	0	14, 897	1. 00
(1) C - RECLASS SUP	SURFACE					
2.00	CAP REL EQUI PME	_ COSTS - MOVABLE ENT	2.00	0	20, 923	2. 00
(1) E - RECLASS ALF	RNS					
3. 00	SKI LLEI	NURSING FACILITY	30.00	25, 245	0	3. 00
4. 00	SKI LLEI	NURSING FACILITY	30.00	18, 004	0	4. 00
5. 00	SKI LLEI	NURSING FACILITY	30.00	136, 369	0	5. 00
TOTALS						
100. 00				179, 618	35, 820	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 WAYNE

					To 12/31/2023	Date/Time Prep 5/15/2024 12:2	oared: 23 pm_
				Acqui si ti on	s		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	0	0		0	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	0	0		0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	0	0		0	0	7. 00
8.00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	0	0		0 0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	ANALYCIC OF CHANCEC IN CARLTAL ACCET DALANCE	6.00	7. 00				
1. 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		0				1. 00
2.00		0	0				2. 00
	Land Improvements	0	0				3. 00
3. 00 4. 00	Buildings and Fixtures	0	0				4. 00
	Building Improvements	0	0				4. 00 5. 00
5. 00 6. 00	Fixed Equipment	0	0				6. 00
	Movable Equipment	0	0				
7. 00 8. 00	Subtotal (sum of lines 1-6)		0				7. 00
9. 00	Reconciling Items		0				8. 00 9. 00
9.00	Total (line 7 minus line 8)	ı U	U	l		ļ	9.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der No.: 315477 Peri od: Worksheet A-8 Period: | WULKSHEEL A-0 | From 01/01/2023 | Date/Time Prepared: | 5/15/2024 | 12:23 pm

				10 12/31/2023	5/15/2024 12:	
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
					Ĵ	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1. 00	2. 00	3. 00	4. 00	
1.00	Investment income on restricted funds	В	-2, 095	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)		_	FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		(	)	0.00	2. 00
0.00	8)				0.00	0.00
3.00	Refunds and rebates of expenses (chapter 8)		(		0.00	3. 00
4. 00	Rental of provider space by suppliers		(	7	0.00	4. 00
5.00	(chapter 8)		(		0.00	5. 00
5.00	Tel ephone services (pay stations excluded) (chapter 21)			1	0.00	3.00
6. 00	Television and radio service (chapter 21)		(		0.00	6. 00
7. 00	Parking lot (chapter 21)		(		0.00	
8. 00	Remuneration applicable to provider-based	A-8-2			0.00	8. 00
0.00	physician adjustment	A-0-2		1		0.00
9. 00	Home office cost (chapter 21)		(		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)				0.00	
11. 00	Nonallowable costs related to certain			1	0.00	
11.00	Capital expenditures (chapter 24)				0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	-431, 884	1		12. 00
	related organizations (chapter 10)		,			
13.00	Laundry and Linen service	•	(		0.00	13. 00
14.00	Revenue - Employee meals	В	C	DI ETARY	8. 00	
15.00	Cost of meals - Guests	В	(	DI ETARY	8.00	15. 00
16.00	Sale of medical supplies to other than		(		0.00	16. 00
	patients					
17.00	Sale of drugs to other than patients		(		0.00	17. 00
18.00	Sale of medical records and abstracts		(		0.00	18. 00
19. 00	Vending machines		(	D	0.00	19. 00
20.00	Income from imposition of interest, finance		(		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		(	)	0.00	21. 00
	and borrowings to repay Medicare					
00.00	overpayments			NET LIZATION DEVILENCE CALE	00.00	00.00
22. 00	Utilization reviewphysicians' compensation		(	DUTILIZATION REVIEW - SNF	82.00	22. 00
22.00	(chapter 21)		,	CAD DEL COSTS DIDOS 8	1 00	22.00
23. 00	Depreciationbuildings and fixtures		(	CAP REL COSTS - BLDGS & FLXTURES	1.00	23. 00
24. 00	  Depreciationmovable equipment		(	CAP REL COSTS - MOVABLE	2 00	24. 00
24.00	Depreciationmovabre equipment			EQUI PMENT	2.00	24.00
25. 00	RESIDENT REPLACEMENT ITEMS	A	7 200	DADMINISTRATIVE & GENERAL	4.00	25. 00
25. 00	REFERAL FEES	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	MARKETI NG EXPENSE	A		BADMINISTRATIVE & GENERAL	4. 00	
25. 03	MARKETING CORP EXPENSE	A		DADMINISTRATIVE & GENERAL	4. 00	
	MARKETING - MEALS	A		ADMINISTRATIVE & GENERAL		25. 04
25. 05	SHOWS & CONFERENCES	A		BADMINISTRATIVE & GENERAL		25. 05
25.06	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL	4.00	•
25. 07	BAD DEBT EXPENSE	A	-308, 687	ADMINISTRATIVE & GENERAL	4.00	25. 07
25. 08	BAD DEBT EXPENSE - MEDICARE	A	-44, 509	ADMINISTRATIVE & GENERAL	4.00	25. 08
25. 09	BAD DEBT EXPENSE - OTHER	A	-164	ADMINISTRATIVE & GENERAL	4.00	25. 09
25. 10	OTHER MEDICAL SERVICES EXPENSE	A	-25, 170	SKILLED NURSING FACILITY	30.00	25. 10
25. 11	MAINTENANCE FEE INCOME	В	-1, 900	CAP REL COSTS - BLDGS &	1.00	25. 11
				FI XTURES		
25. 12	OTHER REVENUE	В		BADMINISTRATIVE & GENERAL	1	25. 12
25. 13	OTHER INCOME	В		ADMINISTRATIVE & GENERAL	4.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-861, 173	3		100. 00
	to Worksheet A, col. 6, line 100)	1		I		l
(1) De	scription - all chapter references in this co	Lumn nertain to	CMS Pub 15_1	1		

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

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

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

B. Amount Received - if cost cannot be determined.

CARE ONE AT WAYNE

Health Financial Systems CARE ONE AT STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315477 OFFICE COSTS

OFFICE	0313			Ť	o 12/31/2023 Date/Time Pre 5/15/2024 12:	
	·	Li ne No.	Cost (	Center	Expense Items	
		1.00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00			CAP REL COSTS FIXTURES	- BLDGS &	RENT - RELATED PARTY	1. 00
2.00		4. 00	ADMI NI STRATI VE	& GENERAL	MANAGEMENT FEES	2.00
3.00		9. 00	NURSING ADMINI	STRATI ON	PHARMACY CONSULTANT	3. 00
4.00			CENTRAL SERVIC	ES & SUPPLY	WOUND CARE EXPENSE	4. 00
5. 00		11. 00	PHARMACY		DRUGS-NON-PRESCRI PTI ON, NON-LEGEND	5. 00
6.00			PHARMACY		PHARMACY SUPPLIES	6. 00
7.00			INTRAVENOUS TH		IV EXPENSE	7. 00
8. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	8. 00
9. 00		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	9. 00
9. 01		49. 00	DRUGS CHARGED	TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE A	9. 01
9. 02		0. 00				9. 02
9. 03		0. 00				9. 03
10.00	TOTALS (sum of lines 1-9). Transfer column					10. 00
	6, line 100 to Worksheet A-8, column 3, line 12.					
	12.	Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col. 5)		
			5	ĺ		
		4.00	5. 00	6.00		
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALMED HOME OFFICE COSTS:	RED AS A RESULT			D ORGANIZATIONS OR	
1.00		3, 750, 123				1.00
2.00		616, 208				2. 00
3.00		27, 146				3. 00
4.00		74, 726				4. 00
5.00		13, 609				5. 00
6.00		512		-45		6.00
7.00		377, 845				7. 00
8.00		23, 667				8. 00
9. 00 9. 01		267, 541	290, 805			9. 00 9. 01
9.01		366, 108	397, 943	-31, 835		9.01
9. 02 9. 03						9. 02
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line	5, 517, 485	5, 949, 369	-431, 884		10.00
	12.					

			_	5/15/2024 12:	23 pm
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/O	R 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	A	CARE ONE	100.00	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 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	
4.00	5. 00	6.00	1

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		493 BLACK OAK RIDGE ROAD	100.00	REALTY	1. 00
2.00		HEALTHBRIDGE MANAGEMENT	100.00	HOME OFFICE	2.00
3.00		PARTNERS PHARMACY	64. 87	PHARMACY	3. 00
4.00		TOTAL CARE LLC	100.00	WOUND CARE	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.: 315477

					To	12/31/2023	Date/Time Prep 5/15/2024 12:	
				CAPI TAL REL	ATED COSTS		37 137 2024 12	23 piii
		Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	FI XTURES	EQUI PMENT	BENEFITS	Subtotal	
			Allocation					
			(from Wkst A col. 7)					
			0	1. 00	2. 00	3. 00	3A	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS - BLDGS & FIXTURES	4, 073, 917	4, 073, 917				1. 00
2. 00	1	CAP REL COSTS - BLDGS & FIXTURES  CAP REL COSTS - MOVABLE EQUIPMENT	4, 073, 917	4,073,917	47, 965			2. 00
3.00	00300	EMPLOYEE BENEFITS	910, 986	0	0	910, 986		3. 00
4.00		ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	1, 892, 625	107, 585		76, 932 5, 393	2, 078, 409	4. 00 5. 00
5. 00 6. 00		LAUNDRY & LINEN SERVICE	547, 296 67, 517	132, 121 0		3, 157	686, 366 70, 674	6. 00
7.00	00700	HOUSEKEEPI NG	390, 089	39, 694		42, 767	473, 017	7. 00
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON	805, 615 540, 615	90, 083 16, 987		62, 052 63, 522	958, 811 621, 324	8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	224, 301	66, 061		3, 737	294, 877	10. 00
11. 00		PHARMACY	14, 121	3, 832		0	17, 998	11.00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	47, 533 154, 199	3, 089 28, 083		5, 829 18, 910	56, 487 201, 523	12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	20, 003		0	0	14. 00
15. 00		ACTI VI TES	213, 352	0	0	24, 851	238, 203	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	3, 103, 249	2, 236, 055	26, 326	398, 131	5, 763, 761	30. 00
31. 00		NURSING FACILITY	0, 100, 217	0		0,0,101	0, 700, 701	31. 00
32.00		ICF/IID	0	0	0	O	0	32.00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	179, 618	1, 211, 685	14, 266	0	1, 405, 569	33. 00
40.00		RADI OLOGY	64, 728	0	0	0	64, 728	40. 00
41. 00		LABORATORY	102, 476	0		0	102, 476	41.00
42. 00 43. 00		INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	377, 845	0	0	0	377, 845 0	42. 00 43. 00
44. 00		PHYSI CAL THERAPY	954, 961	88, 253	1, 039	114, 792	1, 159, 045	
45. 00	1	OCCUPATIONAL THERAPY	632, 271	36, 548		77, 539	746, 788	45. 00
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	109, 057	5, 262 0	1	13, 374 0	127, 755 0	46. 00 47. 00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 897	0		ō	14, 897	48. 00
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	657, 316	0	0	0	657, 316 0	49. 00 50. 00
51. 00		SUPPORT SURFACES	20, 923	0	0	o	20, 923	
52. 00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	· -	o	0	52.00
52. 01 52. 02		OTHER ANCILLARY SERVICES COST MEDICAL SERVICES	0	0		0	0	52. 01 52. 02
32. 02		TIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	0	32.02
60.00		CLINIC	0	0		0	0	60.00
61. 00 62. 00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61. 00 62. 00
63.00	06300	DIALYSIS	0	0	0	o	0	
70.00		REI MBURSABLE COST CENTERS				ما	0	70.00
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	64, 737	0	0	ol	0 64, 737	70. 00 71. 00
73. 00	07300	СМНС	0	0		o	0	73. 00
74. 00		OTHER REIMBURSEMENT AL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	1	INTEREST EXPENSE						81. 00
82. 00 83. 00		UTILIZATION REVIEW - SNF HOSPICE		0	0		0	82. 00 83. 00
84. 00	1	OTHER SPECIAL PURPOSE COST I		0	0	o	0	84. 00
84. 01		OTHER SPECIAL PURPOSE COST II	0	0	0	О	0	84. 01
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)  IMBURSABLE COST CENTERS	16, 212, 209	4, 065, 338	47, 864	910, 986	16, 203, 529	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	11, 658	0	0	0	11, 658	90. 00
91. 00		BARBER AND BEAUTY SHOP	9, 184	8, 579	101	o	17, 864	91. 00
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0	0	0	0	0	92. 00 93. 00
94.00	09400	PATIENTS LAUNDRY		0		ő	0	94. 00
95.00	09500	OTHER NONREIMBURSABLE COST	0	0	0	O	0	95. 00
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers		0		0  0	0	98. 00 99. 00
100.00		TOTAL	16, 233, 051	4, 073, 917	47, 965	910, 986	16, 233, 051	

Provi der No.: 315477

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

					o 12/31/2023		
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/15/2024 12: DI ETARY	23 piii
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	4 00	7.00	9 00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 078, 409					4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	100, 783	787, 149	•			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	10, 377	0 140	01,001			6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	69, 456	8, 149	•	,	1 101 145	7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	140, 788 91, 233	18, 494 3, 487	1		1, 131, 165 0	9. 00
10. 00		43, 299	13, 562	1	9, 586	0	10.00
11. 00	• • • • • • • • • • • • • • • • • • •	2, 643	787	1	556	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	8, 294	634	·	448	0	12. 00
13. 00		29, 591	5, 765	5 C	4, 075	0	13. 00
14. 00		0	0	0	0	0	14. 00
15. 00		34, 977	0	) <u> </u>	0	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   SKILLED NURSING FACILITY	044 224	459, 055	72 002	224 474	1, 017, 176	30. 00
31. 00		846, 326	439, 033			1,017,170	31.00
32. 00			0		Ö	0	32. 00
33. 00		206, 388	248, 754	8, 168	175, 828	113, 989	33. 00
	ANCILLARY SERVICE COST CENTERS			•	<u> </u>	•	
40.00	04000 RADI OLOGY	9, 504	0	) C	0	0	40. 00
41. 00		15, 047	0	0	-	0	41. 00
42. 00	• • • • • • • • • • • • • • • • • • •	55, 481	0		0	0	42.00
43. 00		170 100	10 110		12, 806	0	43.00
44. 00 45. 00	• • • • • • • • • • • • • • • • • • •	170, 190 109, 655	18, 118 7, 503	1	5, 303	0	44. 00 45. 00
46. 00	• • • • • • • • • • • • • • • • • • •	18, 759	1, 080	•	764	0	46. 00
47. 00	•	0	0,000	1	0	0	47. 00
48. 00	•	2, 187	0	o c	o	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	96, 518	0	) c	o	0	49. 00
50.00		0	0	0	0	0	50.00
51. 00		3, 072	0	0	0	0	51.00
52. 00 52. 01		0	0			0	52. 00 52. 01
52. 01	• • • • • • • • • • • • • • • • • • •	0	0			0	52. 01
52. 02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,, ,	'I		32.02
60.00		0	0	) C	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	) c	o	0	61. 00
62. 00							62. 00
63. 00		0	0	) <u> </u>	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST		0	) C	ا	0	70.00
70. 00 71. 00		9, 506	0		_	0	70. 00 71. 00
	07300 CMHC	0	0		Ö	0	73. 00
74. 00		0	0	Ö	o	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00							80. 00
81. 00							81. 00
82. 00			0			0	82.00
83. 00 84. 00	• • • • • • • • • • • • • • • • • • •		0			0	83. 00 84. 00
84. 01			0			0	84. 01
89. 00		2, 074, 074	785, 388	81, 051	549, 377	1, 131, 165	89. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , ,					
90. 00		1, 712	0	) C		0	90. 00
91. 00		2, 623	1, 761	C	1, 245	0	91. 00
92.00		0	0	O C	0	0	92.00
93. 00 94. 00		0	0			0	93. 00 94. 00
94. 00 95. 00			0			0	95.00
98. 00			0			0	98. 00
99. 00			0	) 0	o	0	99. 00
100.0		2, 078, 409	787, 149	81, 051	550, 622	1, 131, 165	100. 00

Provi der No.: 315477

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

CENERAL SERVICE COST CENTERS				Ic	12/31/2023	5/15/2024 12:	
Seneral Service Cost Centers   9.00   10.00   11.00   12.00   13.00	Cost Center Description		SERVICES &	PHARMACY	RECORDS &		
0.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00		9. 00		11. 00		13.00	
2.00							
7.00   00700  MUSESTREFING     7.10   8.00   0.00	2. 00	MENT					2. 00 3. 00 4. 00 5. 00
11.00   01100   PHARMACY   0   0   21,984   11.00   13.00   13.00   01300   SOCIAL SERVICE   0   0   0   0   0   0   0   0   0	7. 00 00700 HOUSEKEEPING 8. 00 00800 DIETARY 9. 00 00900 NURSING ADMINISTRATION		361 324				7. 00 8. 00 9. 00
14. 0.0   01-400   NURSING AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   0   0   0	11. 00   01100   PHARMACY 12. 00   01200   MEDICAL RECORDS & LIBRARY	0 0	0 0	21, 984 0 0	65, 863 0	240. 954	11. 00 12. 00
31. 00   03100   NURSING FACILITY	14.00   01400   NURSING AND ALLIED HEALTH EDU 15.00   01500   ACTIVITES	0	0	0	0	0	14. 00
MICH LLARY SERVICE COST CENTERS	31.00   03100   NURSING FACILITY 32.00   03200   CF/IID	0	0 0	0	0 0	0	31. 00 32. 00
40.00   04000   0400   0400   050   0   0   0   0   0   0   0   0		72, 405	36, 411	2, 215	6, 637	24, 281	33. 00
42.00   04200   INTRAVENOUS THERAPY   0   0   0   0   0   0   24.00     43.00   04300   0XYGEN (INMALATI ON) THERAPY   0   0   0   0   0   0   0   34.00     44.00   04400   PHYSICAL THERAPY   0   0   0   0   0   0   0   45.00     45.00   04500   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0     45.00   04500   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0     46.00   04600   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0     48.00   04900   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0     49.00   04900   DRIVICS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0     50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0   0     50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0     50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0     50.00   05000   COMPLEX MEDI CAL EQUIPMENT   0   0   0   0   0   0   0   0     50.00   05000   COMPLEX MEDI CAL EQUIPMENT   0   0   0   0   0   0   0   0     50.00   05000   COMPLEX MEDI CAL EQUIPMENT   0   0   0   0   0   0   0   0     50.00   05000   COMPLEX MEDI CAL EQUIPMENT   0   0   0   0   0   0   0   0     50.00   05000   COLL NIC   C	40. 00 04000 RADI OLOGY	0	0	0	0		40. 00
43. 00   04300 DAYSCEN (INNALATION) THERAPY		0	0	0	0	_	
44. 00   04400   PHYSICAL THERAPY   0   0   0   0   0   0   44. 00   04500   04600   020   020   020   020   020   03   04. 00	1 1		0	0	0		
44.00   04600   SPECH PATHOLOGY   0   0   0   0   0   0   0   0   0	44. 00 04400 PHYSI CAL THERAPY	0	0	0	0		
47. 00   04700   ELECTROCARDI OLOCY   0   0   0   0   0   0   0   0   0		0	0	0	0		
48.0 0   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   48.00   0   0   0   0   0   0   0   0   0		0	0	0	0	_	
49.00   04900   DRUCS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0		ATLENTS 0	0	0	0	_	
51.00		0	o	Ö	Ö	_	
52. 00   05200   COMPLEX MEDI CAL EQUI PMENT   0   0   0   0   0   52. 00		0	0	0	0	_	
52. 01   05.201   OTHER ANCILLARY SERVICES COST   0   0   0   0   0   52. 01		0	0	0	0		
52. 02   05.202   MEDI CAL SERVICES   0   0   0   0   0   0   52. 02	l l		0	0	0		
60.00	1 1	1	O	Ö	0		
61. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   62. 00   62. 00   63. 00   06200   FOHC   0   0   0   0   0   0   0   0   0							
62. 00   06200   FOHC   0   0   0   0   0   0   0   0   63.00   63.00   06300   DI ALYSI S   0   0   0   0   0   0   0   0   63.00    OTHER REI MBURSABLE COST CENTERS  70. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   71.00    71. 00   07100   AMBULANCE   0   0   0   0   0   0   0   71.00    73. 00   07300   CMHC   0   0   0   0   0   0   0   0    74. 00   07400   OTHER REI MBURSEMENT   0   0   0   0   0   0   0    80. 00   08000   MALPRACTI CE PREMI UMS & PAI D LOSSES    80. 00   08000   MALPRACTI CE PREMI UMS & PAI D LOSSES    81. 00   08300   HOSPI CE   0   0   0   0   0   0    82. 00   08300   HOSPI CE   SEVENSE    83. 00   08300   HOSPI CE   0   0   0   0   0   0    84. 01   08401   OTHER SPECI AL PURPOSE COST I   0   0   0   0   0    84. 01   08401   OTHER SPECI AL PURPOSE COST I   0   0   0   0   0    89. 00   SUBTOTALS (sum of lines 1-84)   718,509   361,324   21,984   65,863   240,954    NONREI MBURSABLE COST CENTERS    90. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0    91. 00   09100   PHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0    92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0    93. 00   09400   OTHER REI MBURSABLE COST   0   0   0   0    94. 00   09400   OTHER REI MBURSABLE COST   0   0   0   0    95. 00   09500   OTHER REI MBURSABLE COST   0   0   0   0    96. 00   09500   OTHER REI MBURSABLE COST   0   0   0    97. 00   09500   OTHER REI MBURSABLE COST   0   0   0    98. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   Norgati ve Cost Centers   0   0   0   0    99. 00   0   0   0   0   0   0    99. 00   0   0   0   0   0    99. 00   0   0   0   0   0    99. 00   0   0   0   0		1	0		0		
63.00	l l	0	U	U	U	0	
70.00	l l	О	0	0	0	0	
71.00				_1	-1		
73.00		0	0	0	0		
SPECIAL PURPOSE COST CENTERS   S0. 00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   S1. 00   08100   INTEREST EXPENSE   S2. 00   08200   UTILIZATION REVIEW - SNF   S2. 00   08300   HOSPICE   O O O O O O O O O O O O O O O O O O		0	0	0	0		
80. 00	1 11 11 11 11 11 11 11 11 11 11 11 11 1	0	0	0	0	0	74. 00
81. 00		00050					00.00
82.00		USSES					
84. 00   08400   OTHER SPECIAL PURPOSE COST         0   0   0   0   0   0   0   84. 00   84. 01   89. 00     SUBTOTALS (sum of lines 1-84)   718,509   361,324   21,984   65,863   240,954   89. 00   NONREI MBURSABLE COST CENTERS	l l						
84. 01	83. 00 08300 HOSPI CE	0	0	0	0	0	
89. 00 SUBTOTALS (SUM OF LI NES 1-84) 718,509 361,324 21,984 65,863 240,954 89. 00 NONREI MBURSABLE COST CENTERS  90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 90. 00 91. 00 91. 00 0 0 0 0 0 0 0 91. 00 92. 00 92. 00 92.00 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 0 92. 00 93. 00 NONPAI D WORKERS 0 0 0 0 0 0 0 0 93. 00 93. 00 93.00 NONPAI D WORKERS 0 0 0 0 0 0 0 0 93. 00 95.00 0THER NONREI MBURSABLE COST 0 0 0 0 0 0 95. 00 98. 00 Cross Foot Adjustments 0 0 0 0 0 0 99. 00 99. 00 Negative Cost Centers 0 0 0 0 0 0 0 99. 00			0	0	0		
NONREI MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   90.00     91.00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   0   91.00     92.00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0   0   92.00     93.00   09300   NONPAI D WORKERS   0   0   0   0   0   0   93.00     94.00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   94.00     95.00   09500   OTHER NONREI MBURSABLE COST   0   0   0   0   95.00     98.00   Cross Foot Adjustments   0   0   0   0   99.00     99.00   Negati ve Cost Centers   0   0   0   0   0   99.00		_	361 324	0 21 984	65 863		
91. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   91. 00   92. 00   92. 00   93. 00   93. 00   93. 00   93. 00   93. 00   94. 00   94. 00   94. 00   95. 00   0   0   0   0   0   0   95. 00   98. 00   0   0   0   0   0   0   0   98. 00   99. 00   0   0   0   0   0   0   0   0   0		7 10, 307	301, 324	21, 704	03, 003	240, 734	07.00
92. 00         09200         PHYSI CIANS PRI VATE OFFICES         0         0         0         0         92. 00           93. 00         09300         NONPAI D WORKERS         0         0         0         0         0         93. 00           94. 00         09400         PATI ENTS LAUNDRY         0         0         0         0         0         94. 00           95. 00         09500         OTHER NONREI MBURSABLE COST         0         0         0         0         95. 00           98. 00         Cross Foot Adj ustments         0         0         0         0         0         99. 00           99. 00         Negati ve Cost Centers         0         0         0         0         0         0         99. 00		l l	0	0	0		
93. 00   09300   NONPAI D WORKERS   0   0   0   0   93. 00   94. 00   94. 00   95. 00   09500   OTHER NONREI MBURSABLE COST   0   0   0   0   0   95. 00   99. 00   Negative Cost Centers   0   0   0   0   0   0   99. 00   0   0   0   0   0   0   0   0   0	l l	0	0	0	0		
94. 00   09400   PATIENTS LAUNDRY   0   0   0   0   94. 00   095.00   095.00   07HER NONREIMBURSABLE COST   0   0   0   0   95. 00   095.0	l l			0	O O		
98.00   Cross Foot Adjustments			0	0	ő		
99.00   Negative Cost Centers   0   0   0   99.00	l	-	0	0	o	0	
		-	0			0	
	, i		361, 324	21, 984	65, 863		

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provi der No.: 315477

					To 12/31/2023	Date/Time Pre 5/15/2024 12:	
			OTHER GENERAL			37 137 2024 12.	23 piii
			SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Stepdown Adjustments	Total	
		EDUCATION			Auj us tillerits		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY						12. 00
13.00	01300 SOCIAL SERVICE						13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITES	0	l .				14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		273, 100	71			15.00
30.00	03000 SKILLED NURSING FACILITY	0	245, 651	9, 996, 01	1 0	9, 996, 011	30.00
31. 00	03100 NURSING FACILITY	0	l	O .	0 0		31. 00
32. 00	03200 I CF/IID	0	ł .	2 220 17	0		32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	27, 529	2, 328, 17	4  0	2, 328, 174	33. 00
40. 00	04000 RADI OLOGY			74, 23	2 0	74, 232	40. 00
41. 00	04100 LABORATORY	0	) (	117, 52		117, 523	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	1	433, 32		,	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	1	1, 360, 15	0 0	0 1, 360, 159	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	1 0		869, 24		869, 249	45. 00
46. 00	04600 SPEECH PATHOLOGY	0		148, 35		148, 358	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	(	O .	0 0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		17, 08		17, 084	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY			753, 83	0 0	753, 834 0	49. 00 50. 00
51.00	05100 SUPPORT SURFACES			23, 99	5 0	23, 995	1
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	) (	)	0 0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	<b>   </b>		0 0		52. 01
52. 02	O5202   MEDI CAL SERVI CES   OUTPATI ENT SERVI CE COST CENTERS	0	)  (	0	0 0	0	52. 02
60. 00	06000 CLINIC	0			0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	•		0 0		61. 00
62.00	06200 FQHC	_				_	62.00
63. 00	06300 DI ALYSI S OTHER REI MBURSABLE COST CENTERS	0	)  (	0	0 0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0			0 0	0	70. 00
71. 00	07100 AMBULANCE	0	) (	74, 24	3 0	74, 243	71. 00
73. 00	07300 CMHC	0			0	0	73. 00
74.00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	)  (	)	0 0	0	74. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECIAL PURPOSE COST I	0			0	0	83. 00 84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II				0 0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	273, 180	16, 196, 18	8 0	16, 196, 188	89. 00
00.05	NONREI MBURSABLE COST CENTERS	-		J		10.0==	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	l .	13, 37 23, 49		13, 370 23, 493	90. 00 91. 00
92. 00	09200 PHYSI CLANS PRI VATE OFFICES			23, 49	0 0	23, 443	92.00
93. 00	09300 NONPAI D WORKERS		ol d		o o	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	) (		0 0	0	94. 00
95. 00	09500 OTHER NONREI MBURSABLE COST	0			0	0	95.00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers					0	98. 00 99. 00
100.00	1 1 0		273, 180	16, 233, 05	1 0	16, 233, 051	•
		1			,		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315477

					10	12/31/2023	Date/IIme Pre 5/15/2024 12:	
				CAPITAL REL	ATED COSTS			
		Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		cost center bescription	Assigned New	FIXTURES	EQUI PMENT	Subtotal	BENEFI TS	
			Capi tal					
			Related Costs	1.00	2. 00	2A	3. 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	2/1	3.00	
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT					0	2.00
3. 00 4. 00		EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	0	0 107, 585	0 1, 267	0 108, 852	0	3. 00 4. 00
5. 00		PLANT OPERATION, MAINT. & REPAIRS	0	132, 121	1, 556	133, 677	0	5. 00
6.00	00600	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7.00	1	HOUSEKEEPI NG	0	39, 694	467	40, 161	0	7. 00
8. 00 9. 00	1	DI ETARY NURSI NG ADMI NI STRATI ON	0	90, 083 16, 987	1, 061 200	91, 144 17, 187	0	8. 00 9. 00
10. 00		CENTRAL SERVICES & SUPPLY	0	66, 061	778	66, 839	0	10.00
11. 00	1	PHARMACY	0	3, 832	45	3, 877	0	11. 00
12.00		MEDICAL RECORDS & LIBRARY	0	3, 089		3, 125	0	12.00
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0	28, 083 0		28, 414 0	0	13. 00 14. 00
15. 00	1	ACTI VI TES	0	Ö		o	0	15. 00
		ENT ROUTINE SERVICE COST CENTERS						
30.00		SKILLED NURSING FACILITY	0	2, 236, 055		2, 262, 381	0	30.00
31. 00 32. 00		NURSING FACILITY	0	0	0	0	0	31. 00 32. 00
33. 00		OTHER LONG TERM CARE	Ö	1, 211, 685	14, 266	1, 225, 951	0	33. 00
	ANCI L	LARY SERVICE COST CENTERS						
40.00		RADI OLOGY	0	0	-	0	0	40.00
41. 00 42. 00		LABORATORY INTRAVENOUS THERAPY	0	0	0	0	0	41. 00 42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	ő	o	0	43. 00
44. 00	1	PHYSI CAL THERAPY	0	88, 253		89, 292	0	44. 00
45. 00		OCCUPATIONAL THERAPY	0	36, 548		36, 978	0	45. 00
46. 00 47. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	5, 262 0	62	5, 324 0	0	46. 00 47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ő	o	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0	О	0	0	49. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 52. 00		SUPPORT SURFACES COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	51. 00 52. 00
52. 01		OTHER ANCILLARY SERVICES COST	0	0	ő	o	0	52. 01
52. 02		MEDICAL SERVICES	0	0	0	0	0	52. 02
(0.00		TIENT SERVICE COST CENTERS	0	0		٥	0	40.00
60. 00 61. 00		CLINIC RURAL HEALTH CLINIC	0	0		0	0	60. 00 61. 00
62. 00	06200			J			Ü	62. 00
63. 00		DI ALYSI S	0	0	0	o	0	63. 00
70.00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71.00		AMBULANCE		0		ol O	0	70.00
73. 00	07300	CMHC	0	0	O	0	0	73. 00
74. 00		OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
80. 00		AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES	T					80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00	08200	UTILIZATION REVIEW - SNF						82. 00
83.00		HOSPI CE	0	0	0	0	0	83. 00
84. 00 84. 01		OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 00 84. 01
89. 00	00401	SUBTOTALS (sum of lines 1-84)	0	4, 065, 338	47, 864	4, 113, 202	0	89. 00
		IMBURSABLE COST CENTERS						
90.00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00 92. 00	1	BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES		8, 579 0	101	8, 680 0	0	91. 00 92. 00
93. 00	1	NONPALD WORKERS		0	O	o	0	93. 00
94.00	09400	PATIENTS LAUNDRY	0	0	0	О	0	94. 00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00 98. 00
98.00		Cross Foot Adjustments Negative Cost Centers		O	n	0	0	
100.00		TOTAL	o	4, 073, 917	47, 965	4, 121, 882		100. 00

Provider No.: 315477

				T	o 12/31/2023	Date/Time Pre 5/15/2024 12:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	23 piii
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	/ 00	7.00	0.00	
	CENEDAL CEDVICE COCT CENTEDS	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS  O0100 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	108, 852					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	5, 278	138, 955				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	543	0	543			6. 00
7.00	00700 HOUSEKEEPI NG	3, 638	1, 439	1	,		7. 00
8.00	00800 DI ETARY	7, 373	3, 265	i	1, 074	102, 856	8. 00
9.00	00900 NURSING ADMINISTRATION	4, 778	616	0	203	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	2, 268 138	2, 394 139		788 46	0	10. 00 11. 00
12. 00	• • • • • • • • • • • • • • • • • • •	434	112	1	37	0	12.00
13. 00		1, 550	1, 018	1	335	0	13. 00
14. 00	• • • • • • • • • • • • • • • • • • •	0	0	I	l	0	14. 00
15.00		1, 832	0	0	0	0	15. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00		44, 325	81, 034	488		92, 491	30. 00
31.00		0	0	0	0	0	31.00
32. 00		10,000	42.012	0	14 44	10.245	32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	10, 809	43, 913	55	14, 446	10, 365	33. 00
40. 00		498	0	0	0	0	40. 00
41. 00	• • • • • • • • • • • • • • • • • • •	788	0	0	-	0	41. 00
42. 00		2, 906	0	Ö	ő	0	42. 00
43.00	• • • • • • • • • • • • • • • • • • •	0	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	8, 913	3, 198	0	1, 052	0	44. 00
45.00		5, 743	1, 325		436	0	45. 00
46. 00	•	982	191		63	0	46. 00
47. 00	•	0	0	0	0	0	47. 00
48. 00 49. 00	•	115 5, 055	0	0	0	0	48. 00 49. 00
50.00	· •	5,055	0		0	0	50.00
51.00	•	161	0	0	0	0	51.00
52. 00	l l	0	0	ő	o	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			1			
60.00		0	0	_	· ·	0	60.00
61.00	• • • • • • • • • • • • • • • • • • •	0	0	0	0	0	61.00
62. 00 63. 00	• • • • • • • • • • • • • • • • • • •	0	0		0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	١		0	<u> </u>	0	03.00
70.00		0	0	0	0	0	70. 00
	07100 AMBULANCE	498	0	0	0	0	71. 00
73.00	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	0	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS			1			
80.00							80.00
81. 00 82. 00	• • • • • • • • • • • • • • • • • • •						81. 00 82. 00
83. 00			0		0	0	83. 00
84. 00			0	0	0	0	84. 00
84. 01		o	0	ő	o	0	84. 01
89. 00		108, 625	138, 644	543	45, 136	102, 856	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00		90	0	0	_	0	90. 00
91. 00		137	311	0	102	0	91.00
92.00		0	0	] 0	0	0	92.00
93. 00 94. 00		0	0	0		0	93. 00 94. 00
94. 00 95. 00			0	0		0	95.00
98. 00			0	1 0		0	98.00
99. 00		0	0	Ö	Ö	0	99. 00
100.00		108, 852	138, 955	543	45, 238	102, 856	

Provi der No.: 315477

				10	J 12/31/2023	5/15/2024 12:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
		0.00	SUPPLY	11 00	LI BRARY	12.00	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	22, 784					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	72, 289				10.00
11. 00	01100 PHARMACY	o	0	4, 200		•	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	o	0	0	3, 708		12. 00
13. 00	01300 SOCIAL SERVICE	0	0	0	0	31, 317	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	o	o	0	0	0	14. 00
15.00	01500 ACTI VI TES	o	o	0	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	20, 488	65, 004	3, 777	3, 334	28, 161	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	2, 296	7, 285	423	374	3, 156	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	04000 RADI OLOGY	0	0	0	0	_	40. 00
41. 00	04100 LABORATORY	0	0	0	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45. 00	04500 OCCUPATIONAL 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 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00 50. 00	05000 DENTAL CARE - TITLE XIX ONLY		0	0	0	0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		0	0	0	0	51.00
52. 00	05200 COMPLEX MEDICAL EQUIPMENT		0	0	0	ő	52. 00
52. 01	05201 OTHER ANCI LLARY SERVICES COST	0	0	0	0	Ö	52. 01
52. 02	05202 MEDI CAL SERVI CES	o	0	0	0	0	52. 02
	OUTPATIENT SERVICE COST CENTERS	, -,	-	-			
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
63. 00	06300  DI ALYSI S	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS		_1	_			
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0	0	0	0	71.00
	07400 OTHER REI MBURSEMENT		0	0	0	0 0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	l ol		U		0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100   INTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	o	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	84. 00
84. 01	08401 OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	22, 784	72, 289	4, 200	3, 708	31, 317	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	_	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	_	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93. 00	09300 NONPAI D WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY		0	0	0	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments	0	0	0	_	_	98. 00
99.00	Negative Cost Centers   TOTAL	22 784	72 200	4 300	0 3, 708	0 31, 317	99.00
100.00	)   IOTAL	22, 784	72, 289	4, 200	3, 708	31,317	1100.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315477

					To 12/31/2023	Date/Time Pre 5/15/2024 12:	
			OTHER GENERAL			37 137 2024 12.	23 piii
			SERVI CE				
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TES	Subtotal	Post Step-Down Adjustments	Total	
		EDUCATION			Aujustillerits		
		14. 00	15.00	16.00	17. 00	18.00	
	GENERAL SERVICE COST CENTERS	T	T			T	
1. 00 2. 00	OO100   CAP REL COSTS - BLDGS & FIXTURES   OO200   CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION						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 14. 00	01300   SOCIAL SERVICE   01400   NURSING AND ALLIED HEALTH EDUCATION	0					13. 00 14. 00
	01500 ACTIVITES		1, 832				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		.,				
30.00	03000 SKILLED NURSING FACILITY	0	.,	1		, , , , , , , , , , , , , , , , , , , ,	1
31. 00	03100 NURSING FACILITY	0	0		0		31.00
32. 00 33. 00	03200   CF/IID 03300 OTHER LONG TERM CARE	0	0 185	•	0 8 0		32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS		100	1, 317, 23	0  0	1, 317, 230	] 33.00
40.00	04000 RADI OLOGY	0	0	49	8 0	498	40. 00
41. 00	04100 LABORATORY	0	0	1			1
42. 00 43. 00	04200   INTRAVENOUS THERAPY   04300   OXYGEN (INHALATION) THERAPY	0	0	2, 90	6 0 0 0	2, 906 0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0		102, 45		-	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	Ö	44, 48			1
46.00	04600 SPEECH PATHOLOGY	0	0	6, 56	0 0	6, 560	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	•	0		47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	) 11 5, 05			1
50. 00	05000 DENTAL CARE - TITLE XIX ONLY				0 0	3,033	50.00
51. 00	05100 SUPPORT SURFACES	0	Ö	16		161	51.00
52.00	05200 COMPLEX MEDICAL EQUIPMENT	0	0		0	0	52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	0	1	0		52. 01
52. 02	05202 MEDICAL SERVICES   OUTPATIENT SERVICE COST CENTERS	0	0	η	0 0	0	52. 02
60. 00	06000 CLINIC	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FOHC						62.00
63. 00	06300 DIALYSIS OTHER REIMBURSABLE COST CENTERS	0	0	ν	0 0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70. 00
	07100 AMBULANCE	0	0	49	8 0	498	
	07300 CMHC	0	0		0	l .	
74. 00	07400 OTHER REIMBURSEMENT SPECIAL PURPOSE COST CENTERS	0	0	)[	0 0	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 HOSPI CE	0	0		0	0	1
84. 00 84. 01	08400 OTHER SPECIAL PURPOSE COST   08401 OTHER SPECIAL PURPOSE COST	0	0		0 0	0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 832	4, 112, 56			ı
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	•			1
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES			9, 23	0 0 0	9, 230 0	1
93.00	09300 NONPALD WORKERS	0	0	1		0	1
94.00	09400 PATIENTS LAUNDRY	0	0	1	o o	Ö	
95. 00	09500 OTHER NONREIMBURSABLE COST	0	0		0 0	0	95. 00
98. 00 99. 00	Cross Foot Adjustments	0	0		0	0	98. 00 99. 00
99. 00 100. 00	Negative Cost Centers   TOTAL	0	1, 832	4, 121, 88	0 2 0		
	1 - 1	1	., 302	., .2., 00		., .2., 502	,

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315477

				Τ̈́	o 12/31/2023	Date/Time Pre 5/15/2024 12:	
		CAPITAL REL	ATED COSTS			37 137 2024 12.	23 piii
	Cost Conton Decement on	DI DCC 0	MOVADLE	EMDL OVEE	Dogganailiation	ADMINI CTDATIVE	
	Cost Center Description	BLDGS & FLXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)	
		4.00	2.22	SALARI ES)	4.0	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4A	4. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	71, 228					1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		71, 228				2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0	7, 428, 376 627, 318		14 154 740	3. 00 4. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 881 2, 310	1, 881 2, 310	43, 975		14, 154, 642 686, 366	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	0	25, 739		70, 674	6. 00
7.00	00700 HOUSEKEEPI NG	694	694	348, 735		473, 017	7. 00
8. 00 9. 00	00800 DI ETARY	1, 575		505, 987		958, 811	8.00
9. 00 10. 00	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	297 1, 155	297 1, 155	517, 969 30, 472		621, 324 294, 877	9. 00 10. 00
	01100 PHARMACY	67	67	00, 172		17, 998	11. 00
	01200 MEDICAL RECORDS & LIBRARY	54	54	47, 533		56, 487	12. 00
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	491	491 0	154, 199	0	201, 523	13. 00 14. 00
	01500 ACTIVITES	0		202, 643	1	0 238, 203	
	INPATIENT ROUTINE SERVICE COST CENTERS		-1				
	03000 SKILLED NURSING FACILITY	39, 095	l ' l	3, 246, 441			30.00
	03100   NURSING FACILITY   03200   ICF/IID	0	0	C	0	•	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	21, 185	۱ ۱	C	0	•	33. 00
	ANCILLARY SERVICE COST CENTERS		,			, , , , , , , , , , , , , , , , , , , ,	
	04000 RADI OLOGY	0	0	C	-	,	
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	C	0	102, 476 377, 845	41. 00 42. 00
	04300 OXYGEN (INHALATION) THERAPY	0		C	o o	0	43. 00
	04400 PHYSI CAL THERAPY	1, 543	1, 543	936, 037	0	1, 159, 045	
45. 00	04500 OCCUPATI ONAL THERAPY	639	l	632, 271		746, 788	
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	92	92	109, 057	0	127, 755 0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		C	o o	14, 897	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	o	C	0	657, 316	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	0	0	50.00
51. 00 52. 00	05100   SUPPORT SURFACES   05200   COMPLEX   MEDI CAL   EQUI PMENT	0		C	0	20, 923	51. 00 52. 00
52. 01	05201 OTHER ANCILLARY SERVICES COST	0	o	C	o o	ő	52. 01
52. 02	05202 MEDI CAL SERVI CES	0	O	C	0	0	52. 02
(0.00	OUTPATIENT SERVICE COST CENTERS	0	ol	C	0	1 0	40.00
60. 00 61. 00	06000   CLI NI C   06100   RURAL   HEALTH   CLI NI C	0		C	0	0	60. 00 61. 00
62. 00	06200 FQHC			_			62. 00
63. 00	06300 DI ALYSI S	0	0	C	0	0	63. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	1			) 0	0	70. 00
	07100 AMBULANCE	0		C	o o	64, 737	
73. 00	07300 CMHC	0	o	C	0	0	73. 00
74. 00	07400 OTHER REIMBURSEMENT	0	0	C	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS  08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100   NTEREST EXPENSE						81. 00
	08200 UTILIZATION REVIEW - SNF						82. 00
	08300 HOSPI CE	0	0	C	0	0	83. 00
	08400 OTHER SPECIAL PURPOSE COST I 08401 OTHER SPECIAL PURPOSE COST II	0		(	0	0	84. 00 84. 01
89. 00	SUBTOTALS (sum of lines 1-84)	71, 078	71, 078	7, 428, 376	-2, 078, 409	14, 125, 120	89. 00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 150	1	C	0	11, 658	
	09200 PHYSICIANS PRIVATE OFFICES	150	130	(	0	17, 864 0	91. 00 92. 00
93. 00	09300 NONPAID WORKERS	0	Ö	C	Ö	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	C	0	0	94.00
95. 00 98. 00	O9500 OTHER NONREIMBURSABLE COST   Cross Foot Adjustments	0	0	C	0	0	95. 00 98. 00
98. 00 99. 00	Negative Cost Centers	-					98.00
102.00	Cost to be allocated (per Wkst. B,	4, 073, 917	47, 965	910, 986		2, 078, 409	
102.00	Part I)	E7 105440	0 472404	0 100/0/		0.14(00)	102 00
103. 00 104. 00	1	57. 195443	0. 673401	0. 12263 <i>6</i>		0. 146836 108, 852	
.51.50	Part II)				1	100,002	

Health Financial Systems	CARE ONE AT WAYNE			In Lieu of Form CMS-2540-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/15/2024 12:		
	CAPITAL REI	LATED COSTS					
Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
	FI XTURES	EQUI PMENT	BENEFITS		& GENERAL		
	(SQUARE FEET)	(SQUARE FEET)	(GROSS		(ACCUM COST)		
			SALARI ES)				
	1.00	2.00	3.00	4A	4. 00		
105.00 Unit cost multiplier (Wkst. B, Part			0. 00000	D	0. 007690	105. 00	

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315477 | Peri od: From 01/01/2023

d: Worksheet B-1 01/01/2023 12/31/2023 Date/Time Prepared:

5/15/2024 12:23 pm Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, LINEN SERVICE MAINT. & (PATIENT DAYS) (PATIENT DAYS) REPAIRS (SQUARE FEET) 9. 00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 67,037 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 26, 972 7.00 00700 HOUSEKEEPI NG 694 66, 343 7.00 8.00 00800 DI ETARY 1,575 1,575 80, 916 8.00 26, 972 00900 NURSING ADMINISTRATION 9 00 297 297 9 00 1, 155 10.00 01000 CENTRAL SERVICES & SUPPLY 1, 155 0 0 10.00 11.00 01100 PHARMACY 67 67 0 11.00 01200 MEDICAL RECORDS & LIBRARY 54 54 0 12.00 0 12.00 01300 SOCIAL SERVICE 0 13 00 13 00 491 491 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C 0 0 14.00 01500 ACTI VI TES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 39,095 24, 254 39, 095 72, 762 24, 254 30.00 03100 NURSING FACILITY 31.00 31.00 0 32.00 03200 | CF/IID 32.00 03300 OTHER LONG TERM CARE 21, 185 2,718 8, 154 2, 718 33.00 21, 185 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40.00 0 C 0 0 41.00 04100 LABORATORY 0 0 0 0 41.00 04200 INTRAVENOUS THERAPY 0 42 00 42 00 0 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 43.00 0 04400 PHYSI CAL THERAPY 44.00 1.543 1.543 0 0 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 639 639 45.00 0 04600 SPEECH PATHOLOGY 46.00 92 92 0 46.00 04700 ELECTROCARDI OLOGY 0 0 47.00 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 0 49.00 49.00 0 0 50.00 0 Λ 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 52.00 0 0 52.00 05201 OTHER ANCILLARY SERVICES COST 0 0 52.01 0 52.01 C 0 52.02 05202 MEDICAL SERVICES 0 52.02 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 06100 RURAL HEALTH CLINIC 0 C 0 61.00 0 Λ 61.00 62.00 06200 FQHC 62.00 63.00 06300 DI ALYSI S 0 0 O 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 71.00 0 o 73.00 07300 CMHC C 0 73.00 0 07400 OTHER REIMBURSEMENT 74.00 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 C 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 84.00 0 0 84 01 08401 OTHER SPECIAL PURPOSE COST LL 84 01 0 SUBTOTALS (sum of lines 1-84) 89.00 66,887 26, 972 66, 193 80, 916 26, 972 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 0 09100 BARBER AND BEAUTY SHOP 91 00 150 150 0 91 00 Ω 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 C 0 0 92.00 09300 NONPALD WORKERS 0 0 0 93.00 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 0 09500 OTHER NONREIMBURSABLE COST 95.00 0 0 0 95.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 787.149 81, 051 550, 622 718, 509 102. 00 102.00 1, 131, 165 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 11. 742008 3.005005 8. 299625 13.979497 26. 639070 103. 00 104.00 Cost to be allocated (per Wkst. B, 138.955 543 45, 238 102, 856 22, 784 104. 00 Part II) 105 00 Unit cost multiplier (Wkst. B, Part 2 072811 0.020132 0 681881 1 271145 0. 844728 105. 00 111)

Provi der No.: 315477

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

				1	o 12/31/2023	Date/Time Pre 5/15/2024 12:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	
		SERVICES &	(PATIENT DAYS)		(DATIENT DAVE)	ALLI ED HEALTH	
		SUPPLY (PATIENT DAYS)		LIBRARY (PATIENT DAYS)	(PATIENT DAYS)	EDUCATION (ASSIGNED	
		(171112111 27110)		(.,)		TIME)	
		10.00	11. 00	12.00	13.00	14. 00	
1 00	GENERAL SERVICE COST CENTERS	T	ı	T			1 00
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	26, 972	1				10.00
11. 00 12. 00	01100 PHARMACY	0	26, 972		,		11. 00 12. 00
13. 00	01200   MEDICAL RECORDS & LIBRARY   01300   SOCIAL SERVICE			26, 972			13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION				20, 772	0	1
15. 00	01500 ACTIVITES				o o	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	-	-		-,		1
30.00	03000 SKILLED NURSING FACILITY	24, 254	24, 254	24, 254	24, 254	0	30.00
31. 00	03100 NURSING FACILITY	0	0	) c	0	0	
32. 00	03200   CF/IID	0	0	0	0	0	1
33. 00	03300 OTHER LONG TERM CARE	2, 718	2, 718	2, 718	2, 718	0	33.00
40.00	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY		J	J		0	40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0				0	
42. 00	04200 I NTRAVENOUS THERAPY					0	
43. 00	04300 OXYGEN (INHALATION) THERAPY				o o	0	
44. 00	04400 PHYSI CAL THERAPY	0	o		o	0	
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	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0				0	
51. 00 52. 00	05100   SUPPORT SURFACES   05200   COMPLEX MEDICAL EQUIPMENT					0	
52. 00	05201 OTHER ANCILLARY SERVICES COST					0	
52. 02	05202 MEDI CAL SERVI CES				ol ol	0	1
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	)	C	0	0	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	0	) <u> </u>	) <u> </u>	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS  07000 HOME HEALTH AGENCY COST					0	70.00
70.00	07100 AMBULANCE	0			0	0	
73. 00	07300 CMHC					0	
74. 00	07400 OTHER REIMBURSEMENT				ol ol	0	
	SPECIAL PURPOSE COST CENTERS	_			-1	-	1
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	
84. 00	08400 OTHER SPECIAL PURPOSE COST I	0			0	0	
84. 01 89. 00	08401 OTHER SPECIAL PURPOSE COST II	26, 972	26, 972	26, 972	26, 972	0	
69.00	SUBTOTALS (sum of lines 1-84)   NONREIMBURSABLE COST CENTERS	20, 972	20, 972	20, 972	20, 912	0	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	T 0		) (	ol	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0		o  c	ol ől	0	
92. 00	09200 PHYSICIANS PRIVATE OFFICES		0	)	ol	0	
93.00	09300 NONPALD WORKERS	0	0	) c	0	0	93.00
94. 00	09400 PATIENTS LAUNDRY	0	0	) C	o	0	
95.00	09500 OTHER NONREIMBURSABLE COST	0	0	) c	이	0	
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers	2/1 224	21 004	/E 0/3	340 054	_	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	361, 324	21, 984	65, 863	240, 954	0	102. 00
103.00	1 1 1	13. 396263	0. 815067	2. 441903	8. 933487	0. 000000	103.00
104.00		72, 289	1	1			104. 00
30	Part II)	]		]			
105.00	Unit cost multiplier (Wkst. B, Part	2. 680150	0. 155717	0. 137476	1. 161093	0. 000000	105.00
		l	I	I			I

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315477

				5/15/2024 1	
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TES		
			(PATIENT DAYS)		
	CENED	AL SERVICE COST CENTERS	15. 00		
1. 00		CAP REL COSTS - BLDGS & FLXTURES			1.00
2. 00		CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	1	EMPLOYEE BENEFITS			3. 00
4.00	00400	ADMINISTRATIVE & GENERAL			4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00		LAUNDRY & LINEN SERVICE			6. 00
7.00		HOUSEKEEPI NG			7. 00
8.00	1	DI ETARY			8. 00
9.00		NURSING ADMINISTRATION			9.00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY			10.00
12. 00	1	MEDICAL RECORDS & LIBRARY			12. 00
13. 00	1	SOCIAL SERVICE			13. 00
14.00	1	NURSING AND ALLIED HEALTH EDUCATION			14. 00
15.00	01500	ACTI VI TES	26, 972		15. 00
		ENT ROUTINE SERVICE COST CENTERS			
30. 00		SKILLED NURSING FACILITY	24, 254		30. 00
31.00		NURSING FACILITY	0		31.00
32. 00		ICF/IID	0		32. 00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	2, 718		33. 00
40. 00		RADI OLOGY	0		40.00
41. 00	1	LABORATORY			41. 00
42. 00		I NTRAVENOUS THERAPY			42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	O		43. 00
44.00	04400	PHYSI CAL THERAPY	0		44. 00
45. 00		OCCUPATI ONAL THERAPY	0		45. 00
46. 00	1	SPEECH PATHOLOGY	0		46. 00
47. 00	1	ELECTROCARDI OLOGY	0		47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49. 00 50. 00	1	DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0		49. 00 50. 00
51. 00	1	SUPPORT SURFACES			51.00
52. 00	1	COMPLEX MEDICAL EQUIPMENT			52. 00
52. 01	1	OTHER ANCILLARY SERVICES COST			52. 01
52. 02	1	MEDICAL SERVICES	O		52. 02
	OUTPA	TIENT SERVICE COST CENTERS			
60. 00	1	CLINIC	0		60. 00
61.00	1	RURAL HEALTH CLINIC	0		61. 00
62. 00	06200	•			62.00
63. 00		DIALYSIS   REIMBURSABLE COST CENTERS	0		63. 00
70. 00		HOME HEALTH AGENCY COST	O		70.00
		AMBULANCE			71.00
	07300	1	l o		73. 00
		OTHER REIMBURSEMENT	0		74. 00
	SPECI	AL PURPOSE COST CENTERS			
80.00		MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
81.00		I NTEREST EXPENSE			81.00
82.00	1	UTILIZATION REVIEW - SNF			82. 00
83. 00 84. 00		HOSPICE OTHER SPECIAL PURPOSE COST I	0		83. 00 84. 00
84. 00		OTHER SPECIAL PURPOSE COST I			84. 00
89. 00	00401	SUBTOTALS (sum of lines 1-84)	26, 972		89. 00
57.00	NONRF	IMBURSABLE COST CENTERS	20, ,,2		7.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91. 00	09100	BARBER AND BEAUTY SHOP	O		91. 00
92. 00		PHYSICIANS PRIVATE OFFICES	0		92. 00
93.00		NONPALD WORKERS	0		93. 00
94.00		PATIENTS LAUNDRY	0		94.00
95. 00 98. 00	09500	OTHER NONREIMBURSABLE COST	0		95. 00 98. 00
98. 00 99. 00	-	Cross Foot Adjustments Negative Cost Centers			98.00
102.00		Cost to be allocated (per Wkst. B,	273, 180		102.00
102.00		Part I)	275, 100		1.02.00
103.00		Unit cost multiplier (Wkst. B, Part I)	10. 128281		103. 00
104.00	1	Cost to be allocated (per Wkst. B,	1, 832		104. 00
		Part II)			
105.00	1	Unit cost multiplier (Wkst. B, Part	0. 067922		105. 00
	ļ	[11]	I I		I

Health Financial Systems	CARE ONE AT WAYNE		In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR	ANCILLARY AND OUTPATIENT COST CENTERS Provider No.: 315477	Peri od:	Worksheet C

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/15/2024 12: 23 pm Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 col . 18 3. 00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 74, 232 161, 820 0. 458732 40.00 04100 LABORATORY 117, 523 256, 190 0.458734 41.00 41.00 433, 326 0. 422035 42.00 04200 I NTRAVENOUS THERAPY 1, 026, 753 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 1, 360, 159 3, 698, 189 0.367791 44.00 04500 OCCUPATIONAL THERAPY 45.00 869, 249 3, 068, 348 0. 283295 45.00 04600 SPEECH PATHOLOGY 46.00 148, 358 440, 325 0. 336928 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 17, 084 37, 242 0. 458729 48.00 04900 DRUGS CHARGED TO PATIENTS 0. 422037 49.00 49.00 753, 834 1, 786, 182 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 50.00 51.00 05100 SUPPORT SURFACES 23, 995 52, 307 0.458734 51.00 52.00 05200 COMPLEX MEDICAL EQUIPMENT 0.000000 52.00 52. 01 05201 OTHER ANCILLARY SERVICES COST 0.000000 0 52.01 0 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

74, 243

3, 872, 003

161, 842

10, 689, 198

0. 458738 71. 00

100. 00

71. 00 07100 AMBULANCE

Total

100.00

Health Financial Systems	CARE ONE A				eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/15/2024 12:	epared: 23 pm
		Title	XVIII (1)	Skilled Nursing Facility	PPS	
		Health Care Pr	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 OUTPAT	TENT COST		•			
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	0. 458732	34, 559		0 15, 853	0	40. 00
41. 00   04100   LABORATORY	0. 458734	72, 171		0 33, 107	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 422035	74, 732		0 31, 540	l .	
43. 00   04300   0XYGEN (INHALATION) THERAPY	0. 000000	0		0	0	
44. 00   04400   PHYSI CAL THERAPY	0. 367791	1, 833, 067		0 674, 186	l	
45. 00   04500   OCCUPATI ONAL THERAPY	0. 283295	1, 539, 633		0 436, 170	0	
46. 00 04600 SPEECH PATHOLOGY	0. 336928	216, 108		0 72, 813	0	
47. 00   04700   ELECTROCARDI OLOGY	0. 000000	0		0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 458729	37, 242		0 17, 084		
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 422037	230, 194		0 97, 150	0	1
50.00 O5000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00   05100   SUPPORT SURFACES	0. 458734	52, 307		0 23, 995	l	
52. 00 05200 COMPLEX MEDICAL EQUIPMENT	0. 000000	0		0	0	
52. 01 05201 OTHER ANCILLARY SERVICES COST	0. 000000	0		0	0	
52. 02 05202 MEDI CAL SERVI CES	0. 000000	0		0 0	0	52. 02
OUTPATIENT SERVICE COST CENTERS						_
60. 00   06000   CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00   06200   FQHC						62. 00
63. 00   06300   DI ALYSI S	0. 000000	0		0 0	0	
71. 00 07100 AMBULANCE (2)	0. 458738			0	0	
100.00   Total (Sum of lines 40 - 71)		4, 090, 013		0 1, 401, 898	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	V					

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

From 01/01/2023 To 12/31/2023 Date/5/15/ Title XVIII Skilled Nursing Facility  Cost Center Description	sheet D s II-III 'Time Prep '2024 12:2 PPS	pared: 23 pm
Cost Center Description Facility		
1	. 00	
	. 00	
FART II - AFFORTIONWENT OF VACCINE COST		
1.00 Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	0. 422037	1. 00
2.00 Program vaccine charges (From your records, or the PS&R)	0. 422037	2. 00
3.00   Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet	0	3. 00
E, Part I, line 18)	_	
Cost Center Description Total Cost Nursing & Ratio of Program Part A	Nursi ng	
	llied	
	h Costs	
	Pass	
	gh (Col.	
(Col. 2 / Col. 3 x (	Col . 4)	
	. 00	
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH		
ANCI LLARY SERVI CE COST CENTERS		
40. 00   04000   RADI OLOGY   74, 232   0   0. 000000   15, 853	0	40.00
41. 00   04100   LABORATORY   117, 523   0   0. 000000   33, 107	0	41.00
42. 00   04200   I NTRAVENOUS THERAPY 433, 326 0 0. 000000 31, 540	0	42.00
43. 00   04300   0XYGEN (I NHALATI ON) THERAPY   0   0. 000000   0	0	43.00
44. 00   04400   PHYSI CAL THERAPY	0	44.00
45. 00   04500   0CCUPATI ONAL THERAPY   869, 249   0   0. 000000   436, 170	0	45.00
46. 00   04600   SPEECH PATHOLOGY   148, 358   0   0. 000000   72, 813	0	46. 00 47. 00
47. 00   04700   ELECTROCARDI OLOGY	0	47.00
49. 00   04900   DRUGS CHARGED TO PATIENTS   17, 064   0 0. 000000   17, 064   49. 00   0. 000000   97, 150	0	49. 00
50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0. 000000   0   0   0   0   0   0	0	50.00
51. 00   05100   SUPPORT SURFACES   23, 995   0 0.000000   23, 995	0	51. 00
52. 00   05200  COMPLEX MEDI CAL EQUI PMENT   0   0   0.000000   0	0	52. 00
52. 01   05201  0THER ANCI LLARY SERVICES COST	Ö	52. 01
52. 02   05202   MEDI CAL SERVI CES   0   0   0. 000000   0	0	52. 02
100.00 Total (Sum of Lines 40 - 52) 3,797,760 0 1,401,898	0	100. 00

eal th	Financial Systems CARE ONE AT N	VAYNE	In Lie	eu of Form CMS-2	2540-1
COMPUT	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315477	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title XVIII	Skilled Nursing Facility		23 piii
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	INPATIENT DAYS				1
. 00	Inpatient days including private room days			24, 254	1 1. C
00	Private room days			0	2.0
00	Inpatient days including private room days applicable to the F	Program		12, 544	3.0
. 00	Medically necessary private room days applicable to the Progra	nm		0	4.0
. 00	Total general inpatient routine service cost			9, 996, 011	5.0
00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			16, 382, 393	6.0
00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 c	livided by Line 6)		0. 610168	1
00	Enter private room charges from your records	in vided by Title 0)		0.010100	8.0
. 00	Average private room per diem charge (Private room charges lir	ne 8 divided by private	room days. line	0.00	
	2)		, , , , , , , , , , , , , , , , , , ,		
0. 00	Enter semi-private room charges from your records			0	10.0
1. 00	Average semi-private room per diem charge (Semi-private room semi-private room days)	charges line 10, divide	ed by	0.00	11.0
2. 00	Average per diem private room charge differential (Line 9 minu			l	12. 0
3. 00	Average per diem private room cost differential (Line 7 times			0.00	
4.00	Private room cost differential adjustment (Line 2 times line 1 General inpatient routine service cost net of private room cost		minus lino 14)	9, 996, 011	14. C
3.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Line 5	III TIUS TTTIE 14)	7, 770, 011	15.0
6. 00	Adjusted general inpatient service cost per diem (Line 15 div	rided by line 1)		412. 14	16. C
7. 00	Program routine service cost (Line 3 times line 16)	•		5, 169, 884	
8. 00	Medically necessary private room cost applicable to program (			0	
9. 00	Total program general inpatient routine service cost (Line 17			5, 169, 884	
0. 00	Capital related cost allocated to inpatient routine service colline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	2, 629, 786	20.0
1. 00	Per diem capital related costs (Line 20 divided by line 1)			108. 43	21.0
2. 00	Program capital related cost (Line 3 times line 21)			1, 360, 146	
3. 00	Inpatient routine service cost (Line 19 minus line 22)			3, 809, 738	
1. 00	Aggregate charges to beneficiaries for excess costs (From pro			0	24.0
5. 00	Total program routine service costs for comparison to the cost	: limitation (Line 23 mi	nus line 24)	3, 809, 738	
5. 00	Enter the per diem limitation (1)		2() (1)		26.0
7. 00 3. 00	Inpatient routine service cost limitation (Line 3 times the per Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)				27. C
1) Li	nes 26 and 27 are not applicable for title XVIII, but may be us	sed for title V and or t	itle XIX	I	1
	The 20 and 27 and not approcable for the Avitt, but may be us				
				1. 00	
				1.00	

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	24, 254	1.00
2.00	Program inpatient days (see instructions)	12, 544	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. 517193	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00
	1 -2	- 1	,

		RE ONE AT WAY			u of Form CMS-	
COMPUT	ATION OF INPATIENT ROUTINE COSTS		Provider No.: 315477	Peri od: From 01/01/2023 To 12/31/2023		pared:
			Title XIX	Skilled Nursing Facility		20 piii
					1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				1.00	
	I NPATI ENT DAYS					
1.00	Inpatient days including private room days				24, 254	1. 00
2.00	Private room days				0	
3.00	Inpatient days including private room days applicabl		gram		0	
4.00	Medically necessary private room days applicable to	the Program			0	
5. 00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				9, 996, 011	5.00
6. 00	General inpatient routine service charges				16, 382, 393	6.00
7. 00	General inpatient routine service cost/charge ratio	(Line 5 div	ided by line 6)		0, 610168	
8.00	Enter private room charges from your records	(=:::::			0	
9. 00	Average private room per diem charge (Private room charges line 8 divided by private room days, line   2)				0.00	9. 00
10.00						10.00
11. 00	Average semi-private room per diem charge (Semi-pri semi-private room days)	vate room ch	arges line 10, divide	d by	0. 00	11. 00
12.00	Average per diem private room charge differential (L	ine 9 minus	line 11)		0.00	12. 00
13.00	Average per diem private room cost differential (Lin	ne 7 times li	ne 12)		0.00	13.00
	Private room cost differential adjustment (Line 2 ti	,			0	
15. 00	General inpatient routine service cost net of privat PROGRAM INPATIENT ROUTINE SERVICE COSTS	te room cost	differential (Line 5	minus line 14)	9, 996, 011	15. 00
16. 00	Adjusted general inpatient service cost per diem (Li	ne 15 divid	ed by line 1)		412. 14	16. 00
17.00	Program routine service cost (Line 3 times line 16)	)	,		0	17. 00
	Medically necessary private room cost applicable to				0	18.00
19. 00	Total program general inpatient routine service cost	t (Line 17 p	lus line 18)		0	19. 00
20. 00	Capital related cost allocated to inpatient routine line 30 for SNF; line 31 for NF, or line 32 for ICF/		s (From Wkst. B, Par	t II column 18,	2, 629, 786	20.00
21.00	Per diem capital related costs (Line 20 divided by	,			108. 43	
	Program capital related cost (Line 3 times line 21)				0	
	Inpatient routine service cost (Line 19 minus line	,			0	
24. 00				1. 0.1)	0	
	Total program routine service costs for comparison t	to the cost I	imitation (Line 23 mi	nus line 24)	0 0.00	
	Enter the per diem limitation (1)					

		1.00	
<u> </u>	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	24, 254	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 WA	YNE	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	TITLE XVIII	Provi der No.: 315477	From 01/01/2023	Worksheet E Part I Date/Time Prepared: 5/15/2024 12: 23 pm
		Title XVIII	Skilled Nursing	PPS

-		Title XVIII	Skilled Nursing	PPS	23 μιιι
			Facility		
	DART A LABOATIENT CERVICE DEC DROVIDER COMPUTATION OF RELABURE	EMENT		1. 00	
1 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENI		11 2/4 01/	1 00
1.00	Inpatient PPS amount (See Instructions)	, manta)		11, 264, 916 0	
2.00	Nursing and Allied Health Education Activities (pass through pa Subtotal ( Sum of lines 1 and 2)	ymerits)		-	
3. 00 4. 00	Primary payor amounts			11, 264, 916 0	3. 00 4. 00
5.00	Coi nsurance			1, 068, 400	
6.00	Allowable bad debts (From your records)			1, 088, 400	
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		120, 804	
8.00	Adjusted reimbursable bad debts. (See instructions)	Ctrons)		78, 523	
9. 00	Recovery of bad debts - for statistical records only			76, 523	
10.00	Utilization review			0	1
11. 00	Subtotal (See instructions)			10, 275, 039	
	Interim payments (See instructions)			10, 273, 039	
13. 00	Tentative adjustment			10, 103, 433	1
	1			0	1
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration for non-claims based amounts (see instructions)			1, 570	
	Sequestration amount (see instructions)			203, 931	
	Balance due provider/program (see Instructions)			-94, 415	
	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2.	section 115.2)	0	
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER				1
17. 00	Ancillary services Part B			0	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19.00	Total reasonable costs (Sum of lines 17 and 18)			0	19.00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22.00	Primary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
	Allowable bad debts (From your records)			0	24.00
	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
	Adjusted reimbursable bad debts (see instructions)			0	24. 02
	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	
	Interim payments (See instructions)			0	
27. 00	Tentati ve adj ustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	
28. 50	, , , ,			0	
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
	Sequestration amount (see instructions)			0	
	Balance due provider/program (see instructions)			0	
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315477 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared to 12/31/2023 | Provider No.: 315477 | Period: From 01/01/2023 | Date/Time Prepared to 12/31/2023 | Date/Time Prepared t

To 12/31/2023 Date/Time Prepared: 5/15/2024 12:23 pm

Title XVIII Skilled Nursing PPS

		IITI	e XVIII S	Facility	PPS	
		Innation	t Part A		rt B	
		rnpatren		Tai		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		9, 992, 585		0	
2.00	Interim payments payable on individual bills, either		147, 868		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	enter zero					2 00
3. 00	List separately each retroactive lump sum adjustment 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	06/06/2023	23, 500		0	3. 01
3. 02	THE TO THOMBEN	007 007 2020	0		o o	
3. 03			Ö		Ö	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		23, 500		0	3. 99
	- 3.98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 163, 953		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
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	
5. 52			0		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
. 01	the cost report. (1)		_			/ 01
6. 01	PROGRAM TO PROVIDER		04 445		0	
6. 02	PROVIDER TO PROGRAM		94, 415 10, 069, 538		0	
7. 00	Total Medicare program liability (see instructions)		10, 069, 538 Contract		Contractor	7. 00
			COILLIAC	I Ivallie	Number	
			1.	00	2. 00	
8, 00	Name of Contractor		1.		2.00	8. 00
	1: 0 5 1/ 1				'	

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

4.00 Accounts receivable	Heal th	Financial Systems	CARE ONE A	AT WAYNE		In Lie	u of Form CMS-	2540-10
Control   Fund   Control   Control				Provi der			Worksheet G	
Control Fund   Specific   Endowment Fund   Plant Fund		ype accounting records, complete the "General Fund	" column				Date/Time Pre	epared:
Secret   S	OIII y)						5/15/2024 12:	23 pm
Appendix   Appendix				General Fund			PLANT FUNG	
				1. 00	<del>                                     </del>		4. 00	
1.00								
Description	1 00			442 E0E			0	1 00
3.00   Notices receivable				002, 595	1	۳ <sub>ا</sub> ۳ <sub>ا</sub>		
0   0   0   0   0   0   0   0   0   0				Ö		-1		
Less: all oweners for uncollectible notes and accounts	4.00	Accounts receivable		2, 644, 376		o o		
Tock   Value   Control				0		-1		
Inventory	6.00		unts	-305, 936		이	0	6.00
8.00   Peppal d expenses	7 00	1		0		اه	0	7 00
10.00   Diver from other funds		1		18, 348		o o		
11.00   DITAL CURRENT ASSETS (Sum of Fines 1 - 10)   3,166,449   0   0   0   11.00				147, 066		0 0		
FIXED ASSETS				0				
12.00   Land   Improvements	11.00	· · · · · · · · · · · · · · · · · · ·		3, 166, 449		0  0	0	11.00
13.00   Land improvements	12. 00			0	ı	ol ol	0	12.00
15.00   Bail dings				0		o o	0	
16.00   Less Accumulated depreciation		·		0		0 0		
17.00   Leasehol d Improvements				0		0		
18.00   Less: Accumulated Amortization   0   0   0   0   18.00   19.00   Fixed equipment   0   0   0   0   0   19.00   19.00   Elses: Accumulated depreciation   0   0   0   0   0   0   21.00   0   0   0   0   0   0   0   0   21.00   0   0   0   0   0   0   0   0   0		•		0		-1		1
19,00   Fixed equipment		·		0		-1		
21.00   Automobil es and trucks				0		-1		1
22.00   Less: Accumulated depreciation   0   0   0   0   22.00	20.00	Less: Accumulated depreciation		0	)	o o	0	20.00
23.00				0	)	이		
24.00   Less: Accumulated depreciation		·		0		۳ <sub>ا</sub> ۳ <sub>ا</sub>		
25.00 MInor equipment - Depreciable 0 0 0 0 0.25.00 27.00 Other fixed assets 5.401 0 0 0 0.26.00 27.00 Other fixed assets 5.401 0 0 0 0.27.00 28.00 THER ASSETS (Sum of lines 12 - 27) 5.491 0 0 0 0.27.00 29.00 THER ASSETS (Sum of lines 12 - 27) 5.491 0 0 0 0 0.27.00 30.00 Deposits on leases 0 0 0 0 0 0 0 0 0.30.00 31.00 Due from owners/officers 0 0 0 0 0 0 0 0 0.30.00 31.00 Due from owners/officers 0 0 0 0 0 0 0 0 0 0.30.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 32.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL BSSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL ASSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL BSSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL BSSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 33.00 31.00 TOTAL BSSETS (Sum of lines 29 - 32) 588.550 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 3		0				1
26.00 MI nor equipment nondepreciable 0 0 0 0 0 26.00 28.00 TOTAL FIXED ASSETS (Sum of Lines 12 - 27) 5, 491 0 0 0 0 27.00 28.00 TOTAL FIXED ASSETS (Sum of Lines 12 - 27) 5, 491 0 0 0 0 0 0 0 28.00 29.00 TOTAL FIXED ASSETS (Sum of Lines 12 - 27)  29.00 Linvestments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•		0				1
28. 00   TOTAL FIXED ASSETS (Sum of lines 12 - 27)   5, 491   0   0   0   28. 00				0	1	-1		1
OTHER ASSETS	27. 00			5, 491		o o		
29.00   Investments	28. 00			5, 491		0 0	0	28. 00
30.00   Deposits on leases	20 00			0			0	20 00
31.00   Due from owners/officers   0   0   0   31.00     22.00   Other assets   588,550   0   0   0   32.00     33.00   TOTAL OTHER ASSETS (Sum of lines 11, 28, and 33)   3,760,490   0   0   0   33.00     10TAL ASSETS (Sum of lines 11, 28, and 33)   3,760,490   0   0   0   0     Liabilities and fund Balances		•		0	1			
33.00   TOTAL OTHER ASSETS (Sum of lines 29 - 32)   588,550   0   0   0   33.00     TOTAL ASSETS (Sum of lines 11, 28, and 33)   3,760,490   0   0   0   0     Liabilities and Fund Balances		1 '		0		o o		
TOTAL ASSETS (Sum of lines 11, 28, and 33)   3,760,490   0   0   0   34,00					l .	0 0		
Liabilities and Fund Balances  CURRENT LIABILITIES  35.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  36.00  37.00  38.00  38.00  Notes & loans payable (Short term)  0 0 0 0 0 0 0 0 38.00  39.00  Deferred income 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1			
CURRENT LIABILITIES	34.00			3, 760, 490	1	0  0	0	34.00
35.00   Accounts payable     1,774,574   0   0   0   35.00   36.00   Salaries, wages, and fees payable   -222,418   0   0   0   36.00   37.00   Payroll taxes payable   -121,418   0   0   0   37.00   38.00   Notes & loans payable (Short term)   0   0   0   0   0   38.00   Notes & loans payable (Short term)   0   0   0   0   0   38.00   Notes & loans payable (Short term)   0   0   0   0   0   38.00   Notes & loans payable (Short term)   0   0   0   0   0   0   0   0   0								1
37.00   Payroll taxes payable   -121,418   0   0   0   37.00   38.00   Notes & loans payable (Short term)   0   0   0   0   38.00   0   0   0   0   0   0   0   0   0	35.00			1, 774, 574		0 0	0	35. 00
38. 00 Notes & Ioans payable (Short term)				-222, 418		0 0		
39.00   Deferred income				-121, 418		0 0		1
40.00   Accelerated payments   0   134, 181   0   0   0   0   41.00				0				1
41.00   Due to other funds				0		9	0	
43.00   TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)   3,477,798   0   0   0   0   43.00				134, 181		o o	0	1
LONG TERM LIABILITIES	42.00	Other current liabilities		1, 912, 879		0 0	0	42. 00
44. 00       Mortgage payable       0       0       0       44. 00         45. 00       Notes payable       0       0       0       0       45. 00         46. 00       Unsecured Loans       0       0       0       0       0       0       45. 00         47. 00       Loans from owners:       0       0       0       0       0       0       46. 00         48. 00       Other Long term Liabilities       -43, 968, 106       0       0       0       0       48. 00         49. 00       OTHER (SPECIFY)       0       0       0       0       49. 00         50. 00       TOTAL LIABILITIES (Sum of Lines 44 - 49       -43, 968, 106       0       0       0       50. 00         51. 00       TOTAL LIABILITIES (Sum of Lines 43 and 50)       -40, 490, 308       0       0       0       50. 00         52. 00       General fund balance       44, 250, 798       0       0       51. 00         53. 00       Specific purpose fund       0       53. 00         54. 00       Donor created - endowment fund balance - restricted       0       55. 00         55. 00       Governing body created - endowment fund balance - restricted       0       56. 00 <td>43. 00</td> <td>,</td> <td></td> <td>3, 477, 798</td> <td></td> <td>0 0</td> <td>0</td> <td>43. 00</td>	43. 00	,		3, 477, 798		0 0	0	43. 00
45.00 Notes payable 0 0 0 0 0 0 45.00 46.00 Unsecured loans 0 0 0 0 0 0 46.00 47.00 Loans from owners: 0 0 0 0 0 0 46.00 48.00 Other long term liabilities -43, 968, 106 0 0 0 0 0 48.00 49.00 OTHER (SPECIFY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44.00			^				14 00
46.00 Unsecured Loans  46.00 Unsecured Loans  47.00 Loans from owners:  48.00 Other long term liabilities  49.00 OTHER (SPECIFY)  50.00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49		1 3 3 1 3		0				1
48.00 Other long term liabilities				Ö	1	-1		1
49.00 OTHER (SPECIFY)  0 0 0 0 49.00  50.00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 -43,968,106 0 0 0 50.00  51.00 TOTAL LIABILITIES (Sum of lines 43 and 50) -40,490,308 0 0 0 51.00  CAPITAL ACCOUNTS  52.00 General fund balance  52.00 Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58)  60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3,760,490 0 0 0 60.00	47.00	Loans from owners:		0		o o	0	47. 00
50. 00 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49				-43, 968, 106	1			
51.00 TOTAL LIABILITIES (Sum of lines 43 and 50)				0		-1		
CAPITAL ACCOUNTS  52. 00 General fund balance  52. 00 Specific purpose fund  53. 00 Donor created - endowment fund balance - restricted  55. 00 Donor created - endowment fund balance - unrestricted  56. 00 Governing body created - endowment fund balance  57. 00 Plant fund balance - invested in plant  58. 00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59. 00 TOTAL FUND BALANCES (Sum of lines 52 thru 58)  60. 00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3, 760, 490  60. 00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490  60. 00 TOTAL SUND BALANCES (SUM of lines 51 and 3, 760, 490					1			
52.00   General fund balance   44,250,798   52.00   53.00   53.00   54.00   Donor created - endowment fund balance - restricted   55.00   Donor created - endowment fund balance - unrestricted   6.00   Governing body created - endowment fund balance   55.00   Plant fund balance - invested in plant   0   57.00   Plant fund balance - reserve for plant improvement, replacement, and expansion   59.00   TOTAL FUND BALANCES (Sum of lines 52 thru 58)   44,250,798   0   0   0   59.00   60.00   TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and   3,760,490   0   0   60.00	31.00	,		-40, 490, 300		<u> </u>	0	31.00
53.00 Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58)  60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and  44,250,798  0 0 0 59.00	52. 00			44, 250, 798				52. 00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Flant fund balance - invested in plant Flant fund balance - reserve for plant improvement, replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and  55.00 56.00 56.00 56.00 57.00 58.00 59.00 60.00 59.00 60.00		1				0		53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) 60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3,760,490  56.00 56.00 57.00 58.00 58.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1				0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) 60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3,760,490 0 57.00 0 58.00 0 0 59.00			cted			0		1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58)  60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3,760,490 0 0 0 60.00		, ,				١	Λ	
replacement, and expansion 59.00 TOTAL FUND BALANCES (Sum of lines 52 thru 58) 60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3,760,490 0 0 0 60.00		•	t,					
60.00 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 3,760,490 0 0 0 60.00		repl acement, and expansion						
					1	이		1
	60.00		51 and	3, 760, 490	1	이 이	0	60.00
		1/	'		1	1		1

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

Provi der No.: 315477

					10 12/31/2023	5/15/2024 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	ZO PIII
		1. 00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		43, 335, 172		С		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		915, 633				2. 00
3.00	Total (sum of line 1 and line 2)		44, 250, 805		C		3. 00
4.00	Additions (credit adjustments)					_	4. 00
5.00		0			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	7. 00 8. 00
8. 00 9. 00		0			0	0	9.00
10.00	Total additions (sum of line 5 - 9)	0	0			٦	10.00
11. 00	Subtotal (line 3 plus line 10)		44, 250, 805				11. 00
12. 00	Deductions (debit adjustments)		44, 230, 003			1	12.00
13. 00	ROUNDI NG	7			0	0	13.00
14. 00	THE STATE OF THE S	Ó			o	0	14. 00
15. 00		O			0	0	15. 00
16.00		0			0	0	16. 00
17.00		O			0	0	17. 00
18.00	Total deductions (sum of lines 13 - 17)		7		C		18. 00
19. 00	Fund balance at end of period per balance		44, 250, 798		C		19. 00
	sheet (Line 11 - line 18)						
		Endowment Fund	PI ant	Funa			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	6.00	7.00	8. 00	0		1. 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)		7. 00	8. 00	0		1. 00 2. 00
			7.00	8.00	0		
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 31)	0	7. 00	8. 00			2. 00 3. 00 4. 00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0	7.00	8.00			2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0	7. 00 0 0	8.00			2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0	7. 00 0 0	8. 00			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	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)	0	7. 00 0 0 0	8. 00			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	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0	7.00 0 0 0 0	8. 00	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	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9)	0	7.00 0 0 0 0	8. 00	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	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	7.00 0 0 0 0	8. 00	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	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	7.00 0 0 0 0	8.00	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	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0	7.00 0 0 0 0	8. 00	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 13.00 14.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	7.00 0 0 0 0	8. 00	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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	7.00 0 0 0 0 0	8. 00	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 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	7.00 0 0 0 0 0	8. 00	0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	0 0	7.00 0 0 0 0 0	8. 00	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 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	7.00 0 0 0 0 0	8. 00	0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)  Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING  Total deductions (sum of lines 13 - 17)	0 0 0	7.00 0 0 0 0 0 0	8.00	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 15. 00 16. 00 17. 00 18. 00

Health Financial Systems	CARE ONE AT WAYNE	In Lieu of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315477 P	Period: Worksheet G-2

Heal th	Financial Systems	CARE ONE AT WA	YNE		In Lie	eu of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315477	Peri od:	Worksheet G-2	
					From 01/01/2023	Parts I-II	
					To 12/31/2023		
						5/15/2024 12:	23 pm
	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, 382, 39	93	16, 382, 393	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 Li	ines 1 - 4)		16, 382, 39	93	16, 382, 393	5. 00
	All Other Care Services						
6.00	ANCILLARY SERVICES			10, 689, 19	98 0	10, 689, 198	6. 00
7.00	CLINIC				0	0	7. 00
8.00	HOME HEALTH AGENCY COST				0	0	8. 00
9.00	AMBULANCE				0	0	9. 00
10.00	RURAL HEALTH CLINIC				0	0	
10. 10	FQHC				0	0	10. 10
11. 00	CMHC				0	0	11. 00
	HOSPI CE					o o	
	OTHER (SPECIFY)					o o	13. 00
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Tr	ransfer column 3	to	27, 071, 59	91 0	27, 071, 591	
14.00	Worksheet G-3, Line 1)	ansier corumn s	10	27,071,3	71	27,071,371	14.00
	Cost Center Description						
	Cost Center Description				1. 00	2. 00	
	PART II - OPERATING EXPENSES				1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Lir	ne 100)				17, 094, 224	1. 00
2.00	Add (Specify)	16 100)			0	17,074,224	2. 00
3.00	Add (Specify)				0		3. 00
4.00					0		4. 00
5.00					0		5. 00
					0		
6.00					0		6. 00
7.00	T				0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				_	0	8. 00
9.00	Deduct (Specify)				0		9. 00
10.00					0		10. 00
11. 00					0		11. 00
12.00					0		12.00
13.00					0		13. 00
	Total Deductions (Sum of lines 9 - 13)					0	14. 00
15.00	Total Operating Expenses (Sum of lines 1 and 8,	minus line 14)				17, 094, 224	15. 00
					•	•	

Health Financial Systems	CARE ONE AT WA	AYNE	In Lie	eu of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING	EXPENSES	Provi der No.: 315477	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Prep 5/15/2024 12:3	
				1. 00	
1.00 Total patient revenues (From Wkst. G	-2, Part I, col. 3, line 1	4)		27, 071, 591	1. 00
2.00 Less: contractual allowances and dis	counts on patients accounts	3		9, 083, 817	2. 00
2 00   Not noticed assume (1) as 1 minus 1	2)			1 7 007 774	2 00

S/15/2024 12: 23 pm		10 12/31/2023		
Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			5/15/2024 12: 2	23 piii
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   9,083,817   2.00     Net patient revenues (Line 1 minus line 2)   17,987,774   3.00     Action   Less: total operating expenses (From Worksheet G-2, Part II, Iine 15)   17,094,224   4.00     Net income from service to patients (Line 3 minus 4)   893,550     Other income:	1 00	Total nations revenues (From West C 2 Part L col 2 Line 14)		1 00
17, 987, 774   3.00   Less: total operating expenses (From Worksheet G-2, Part II, Iine 15)   17, 987, 774   4.00   17, 987, 774   4.00   17, 987, 774   4.00   17, 987, 774   4.00   17, 987, 774   4.00   17, 987, 774   4.00   17, 987, 774   4.00   17, 987, 775   5.00   17, 908, 224   4.00   17, 987, 774   5.00   17, 908, 224   17, 908, 224   17,				
Less: total operating expenses (From Worksheat G-2, Part II, line 15)   17, 094, 224   4.00     Net income from service to patients (Line 3 minus 4)   00     Other incomes   00     Other income   00     Other expenses   00     Other expenses   00     Other income   00     Other expenses   00     Other   00     Other income   00     Other				
Section   Net income from service to patients (Line 3 minus 4)   Section				
Other Income:				
6. 00       Contributions, donations, bequests, etc       0       6.00         7. 00       Income from Investments       2,095       7.00         8. 00       Revenues from communications (Telephone and Internet service)       0       8.00         9. 00       Revenue from television and radio service       0       9.00         10. 00       Purchase discounts       0       10.00         11. 00       Rebates and refunds of expenses       0       11.00         12. 00       Parking lot receipts       0       13.00         13. 00       Revenue from laundry and linen service       0       13.00         14. 00       Revenue from laundry and linen service       0       14.00         15. 00       Revenue from meals sold to employees and guests       0       14.00         16. 00       Revenue from meal sold to employees and guests       0       14.00         17. 00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         18. 00       Revenue from sale of drugs to other than patients       0       17.00         19. 00       Revenue from sale of drugs to other than patients       0       17.00         19. 00       Revenue from gifts, flower, coffee shops, canteen       0       19.00	5.00		893, 550	5.00
7. 00       Income from investments       2,095       7.00         8. 00       Revenues from communications ( Telephone and Internet service)       0       8.00         9. 00       Revenue from television and radio service       0       9.00         10. 00       Purchase discounts       0       10.00         11. 00       Rebates and refunds of expenses       0       11.00         12. 00       Parking lot receipts       0       12.00         13. 00       Revenue from laundry and linen service       0       13.00         14. 00       Revenue from meals sold to employees and guests       0       14.00         15. 00       Revenue from meals sold to employees and guests       0       15.00         16. 00       Revenue from rental of living quarters       0       15.00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         17. 00       Revenue from sale of medical records and abstracts       0       16.00         18. 00       Revenue from gale of medical records and abstracts       0       18.00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20. 00       Revenue from gifts, flower, coffee shops, canteen       0	4 00		0	/ 00
8.00       Revenues from communications (Telephone and Internet service)       0       8.00         9.00       Revenue from television and radio service       0       9.00         11.00       Purchase discounts       0       10.00         12.00       Parking lot receipts       0       11.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from eals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       18.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of skilled nursing space       0       22.00         23.00       Governmental appropriations       0       23.00				
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of vending machines       0       21.00         23.00       Governmental appropriations       0       23.00         24.01       Mal				
10. 00       Purchase discounts       0       10. 00         11. 00       Rebates and refunds of expenses       0       11. 00         12. 00       Parkin gl of treceipts       0       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from rental of living quarters       0       15. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of medical records and abstracts       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       17. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flower, coffee shops, canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of vending machines       0       22. 00         23. 00       Governmental appropriations       0       22. 00         24. 00       BARBER AND BEAUTY       5,550       24. 00         24. 03 <td></td> <td></td> <td>- 1</td> <td></td>			- 1	
11. 00       Rebates and refunds of expenses       0       11. 00         12. 00       Parking lot recei pts       0       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from laundry and linen service       0       14. 00         15. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from sele of medical and surgical supplies to other than patients       0       16. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tui tion (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flower, coffee shops, canteen       0       20. 00         21. 00       Revalu of vending machines       0       21. 00         22. 00       Rental of skilled nursing space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 01       Mal NT FEE INCOME       1, 900				
12. 00       Parking lot receipts       0       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       0       14. 00         15. 00       Revenue from rental of living quarters       0       15. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       16. 00         17. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flower, coffee shops, canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of skilled nursing space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 01       MAINT FEE INCOME       1, 900       24. 01         24. 02       OTHER REV       6, 523       24. 02         20. 00       Total other income (Sum of lines 6 - 24)       22. 083       25. 00         25. 00       Total (Line 5 plus line 25)       915, 633       26. 00         27. 00				
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meal's sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of skilled nursing space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       BARBER AND BEAUTY       5,550       24.00         24.01       MAINT FEE INCOME       6,015       24.02         24.02       OTHER INCOME       6,015       24.02         25.00       Total other income (Sum of lines 6 - 24)       22,083       25.00         26.00       Tot			1	
14.00   Revenue from meals sold to employees and guests   0   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00     17.00   Revenue from sale of drugs to other than patients   0   17.00     18.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   0   19.00     20.00   Revenue from gifts, flower, coffee shops, canteen   0   20.00     21.00   Rental of vending machines   0   21.00     22.00   Rental of skilled nursing space   0   22.00     23.00   Governmental appropriations   0   23.00     24.00   BARBER AND BEAUTY   5,550   24.00     24.01   MAINT FEE INCOME   1,900   24.01     24.02   OTHER REV   6,523   24.02     24.03   OTHER INCOME   6,015   24.03     25.00   Total other income (Sum of lines 6 - 24)   22,083   25.00     25.00   Total (Line 5 plus line 25)   915,633   26.00     27.00   29.00   0   0   0     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 27 - 29)   0   30.00     30.00   Total other expenses (Sum of lines 40.00   10.00   10.00   10.00			- 1	
15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00     17.00   Revenue from sale of drugs to other than patients   0   17.00     18.00   Revenue from sale of drugs to other than patients   0   17.00     18.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00     19.00   19.00     19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.00     19.00   19.00   19.0			- 1	
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of skilled nursing space       0       22.00         23.00       Governmental appropriations       0       23.00         24.01       MAINT FEE INCOME       1, 900       24.01         24.02       OTHER REV       6, 523       24.02         24.50       OVI D-19 PHE Funding       6, 015       24.50         25.00       Total other income (Sum of lines 6 - 24)       22, 083       25.00         27.00       Other expenses (specify)       0       27.00         29.00       0       0       0       0       29.00         30.00       Total other expenses (Sum of lines 27 - 29)       0       30.00       0       0       0       0			- 1	
17. 00       Revenue from sale of drugs to other than patients       0       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tui ti on (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flower, coffee shops, canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of skilled nursing space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       BARBER AND BEAUTY       5, 550       24. 00         24. 01       MAINT FEE INCOME       5, 550       24. 00         24. 02       OTHER REV       6, 523       24. 02         24. 03       OTHER INCOME       6, 015       24. 03         24. 50       COVI D-19 PHE Funding       0       24. 03         25. 00       Total other income (Sum of lines 6 - 24)       915, 633       26. 00         27. 00       Other expenses (specify)       0       27. 00         28. 00       0       29. 00       0       29. 00         30. 00       Total other expenses (Sum of lines 27 - 29)       0       30. 0			· - 1	
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuit ion (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machi nes       0       21.00         22.00       Rental of skilled nursing space       0       22.00         23.00       Governmental appropriations       0       23.00         24.01       BARBER AND BEAUTY       5,550       24.00         24.01       MAINT FEE INCOME       1,900       24.01         24.02       OTHER REV       6,523       24.02         24.03       OTHER INCOME       6,015       24.03         24.50       COVI D-19 PHE Funding       0       24.50         25.00       Total other income (Sum of lines 6 - 24)       22,083       25.00         26.00       Total (Line 5 plus line 25)       915,633       26.00         27.00       28.00         29.00       0       29.00         30.00       Total other expenses (Sum of lines 27 - 29)       0       30.00				
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of skilled nursing space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       BARBER AND BEAUTY       5,550       24.00         24.01       MAINT FEE INCOME       1,900       24.01         24.02       OTHER REV       6,523       24.02         24.03       OTHER INCOME       6,523       24.02         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (Sum of lines 6 - 24)       22,083       25.00         26.00       Total (Line 5 plus line 25)       915,633       26.00         27.00       0       28.00         29.00       0       29.00         30.00       Total other expenses (Sum of lines 27 - 29)       0       30.00				
20.00       Revenue from gifts, flower, coffee shops, canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of skilled nursing space       0       22.00         23.00       Governmental appropriations       0       23.00         24.01       BARBER AND BEAUTY       5,550       24.00         24.01       MAINT FEE INCOME       1,900       24.00         24.02       OTHER REV       6,523       24.02         24.03       OTHER INCOME       6,015       24.03         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (Sum of lines 6 - 24)       22,083       25.00         26.00       Total (Line 5 plus line 25)       915,633       26.00         27.00       Other expenses (specify)       0       27.00         28.00       0       0       29.00         30.00       Total other expenses (Sum of lines 27 - 29)       0       30.00			l .	
21.00 Rental of vending machines  22.00 Rental of skilled nursing space  30 Governmental appropriations  30 BARBER AND BEAUTY  4.00 MAINT FEE INCOME  44.01 MAINT FEE INCOME  44.02 OTHER REV  5,550 24.00  24.03 OTHER INCOME  45.00 Total other income (Sum of lines 6 - 24)  70 Total (Line 5 plus line 25)  70 Other expenses (specify)  80 Other expenses (Sum of lines 27 - 29)  80 Other expenses (Sum of lines 27 - 29)  80 Other expenses (Sum of lines 27 - 29)				
22.00 Rental of skilled nursing space 3.00 Governmental appropriations 4.00 BARBER AND BEAUTY 5,550 24.00 24.01 MAINT FEE INCOME 1,900 24.01 24.02 OTHER REV 24.03 OTHER INCOME 6,523 24.02 24.03 OTHER INCOME 6,015 24.03 24.50 COVID-19 PHE Funding 7 O 24.50 25.00 Total other income (Sum of lines 6 - 24) 27.00 Other expenses (specify) 28.00 Other expenses (Sum of lines 27 - 29) 30.00 Total other expenses (Sum of lines 27 - 29)			- 1	
23. 00 Governmental appropriations 24. 00 BARBER AND BEAUTY 5, 550 24. 00 24. 01 MAINT FEE INCOME 1, 900 24. 01 24. 02 OTHER REV 6, 523 24. 02 24. 03 OTHER INCOME 6, 015 24. 03 24. 50 COVID-19 PHE Funding 7 Total other income (Sum of lines 6 - 24) 7 Total (Line 5 plus line 25) 7 Total (Line 5 plus line 25) 7 Other expenses (specify) 8 8. 00 9 9. 00 9 00 9 00 9 1 Total other expenses (Sum of lines 27 - 29)			- 1	
24. 00 BARBER AND BEAUTY 24. 01 MAINT FEE INCOME 1, 900 24. 01 24. 02 OTHER REV 6, 523 24. 02 24. 03 OTHER INCOME 6, 015 24. 03 24. 50 COVID-19 PHE Funding 7 Total other income (Sum of lines 6 - 24) 7 Total (Line 5 plus line 25) 7 Total (Line 5 plus line 25) 9 Other expenses (specify) 9 O 27. 00 28. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29) 9 O 30. 00 Total other expenses (Sum of lines 27 - 29)			- 1	
24. 01 MAINT FEE INCOME 24. 02 OTHER REV 6, 523 24. 02 24. 03 OTHER INCOME 6, 015 24. 03 24. 50 COVID-19 PHE Funding 7 O 24. 50 7 Otal other income (Sum of lines 6 - 24) 7 Otal (Line 5 plus line 25) 7 Other expenses (specify) 8. 00 9.				
24. 02 OTHER REV 24. 03 OTHER INCOME 24. 03 OTHER INCOME 24. 50 COVID-19 PHE Funding 25. 00 Total other income (Sum of lines 6 - 24) 26. 00 Total (Line 5 plus line 25) 27. 00 Other expenses (specify) 28. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29) 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29)				
24. 03 OTHER INCOME 24. 05 COVID-19 PHE Funding 25. 00 Total other income (Sum of lines 6 - 24) 26. 00 Total (Line 5 plus line 25) 27. 00 Other expenses (specify) 28. 00 29. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29) 26. 01 Other expenses (Sum of lines 27 - 29) 27. 02 Other expenses (Sum of lines 27 - 29) 28. 00 Other expenses (Sum of lines 27 - 29) 30. 00 Total other expenses (Sum of lines 27 - 29)				
24. 50 COVID-19 PHE Funding 25. 00 Total other income (Sum of lines 6 - 24) 26. 00 Total (Line 5 plus line 25) 27. 00 Other expenses (specify) 28. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29) 29. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
25. 00 Total other income (Sum of lines 6 - 24) 26. 00 Total (Line 5 plus line 25) 27. 00 Other expenses (specify) 28. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29) 28. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29)			6, 015	
26.00 Total (Line 5 plus line 25) 27.00 Other expenses (specify) 28.00 29.00 30.00 Total other expenses (Sum of lines 27 - 29)  915, 633	24. 50		1	
27. 00 Other expenses (specify) 28. 00 29. 00 30. 00 Total other expenses (Sum of lines 27 - 29)  0 27. 00 0 28. 00 0 29. 00 0 30. 00				
28.00 29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 28.00 0 29.00 0 30.00	26. 00	Total (Line 5 plus line 25)	915, 633	26.00
29.00 30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00		Other expenses (specify)	0	
30.00 Total other expenses (Sum of lines 27 - 29) 0 30.00	28.00		0	28.00
	29. 00		0	29.00
31.00   Net income (or loss) for the period (Line 26 minus line 30) 915,633   31.00	30.00	Total other expenses (Sum of lines 27 - 29)		
	31.00	Net income (or loss) for the period (Line 26 minus line 30)	915, 633	31.00