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 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315509 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/2/2024 10:06 am PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 5/2/2024 Time: 10:06 am use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. (1) As Submitted use only 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this 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 (5) Amended

11. Contractor Vendor Code

for no utilization.

12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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 ROOSEVELT CARE CENTER AT OLD BRIDGE (315509) 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	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	E۱	an Gold	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	Evan Gold			2
3	Signatory Title	ADMI NI STRATOR			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	-28, 192	1, 016	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	I CF/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 FOHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-28, 192	1, 016	0	100.00
Tho ob	and amounts represent "due to" or "due from" the applicable	program for th	o alamont of t	ha above comple	v indicated	

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

Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315509 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Street: 1133 MARLBORO ROAD 1.00 PO Box: 1.00 2.00 City: OLD BRDIGE State: NJ Zi p Code: 08857 2.00 3.00 County: MI DDLESEX CBSA Code: 35154 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF ROOSEVELT CARE CENTER 315509 03/01/2012 N Р Ν 4.00 AT OLD BRIDGE 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 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. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 47 295 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 47, 295 23.00 23.00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0

Heal th	Financial Systems	ROOSEVELT CARE CENTER A	T OLD BRIDGE	In Lie	u of Form CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31	5509 Peri od:	Worksheet S-2	
COMPLE	COMPLEX INDENTIFICATION DATA From 01/01/2023 F					
				To 12/31/2023	Date/Time Prep	
					5/2/2024 10:0	6 am
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrati	ve and 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	ned in CMS Pub. 15-1, Cha	pter 10?		N	43. 00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and add	Iress of the home		44.00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	and address of	the home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Co	ntractor's Number:		45. 00
46. 00	Street:	PO Box:				46. 00
47.00	Ci tv:	State:	Zi	p Code:		47. 00
	1	10.00	·	I		

Heal th	Financial Systems ROOS	EVELT CARE CENTER	AT OLD BRID	GE	In Li∈	eu of Form CMS-	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE			No.: 315509	Period: From 01/01/2023 To 12/31/2023		epared:
					Y/N	Date	
	General Instruction: For all column 1 respons	cos ontor in column	1 "V" for	r Vos or "N"	1.00	2. 00	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in corum	1 1, 1 10	Tes of N	TOT NO. TOT ATT	the date	
1 00	Provider Organization and Operation		-11	46	N.	I	1 00
1. 00	Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N	Date	V/I	
0.00	I		0.16	1.00	2. 00	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.	of termination and	in column	N			2.00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or to relationships? (see instructions)	., chain home officed to the provider of the provider of the control of the contr	ces, drug or its ne board	Y			3.00
				Y/N	Туре	Date	
	Eigensiel Bets au 1 B			1. 00	2. 00	3. 00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepare	arod by a Cortific	d Dublic	Y	A		4.00
4.00	Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If	' for Audited, "C" te copy or enter da	for ate	ľ	A		4.00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If a reconciliation.	revenues different	t from	N			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6.00	Approved Educational Activities Column 1: Were costs claimed for Nursing Schollegal operator of the program? (Y/N)	ool? (Y/N) Column 2	2: Is the	provi der the	N	N	6. 00
7. 00 8. 00	00 Were costs claimed for Allied Health Programs? (Y/N) see instructions.						7. 00 8. 00
	Toolises and or mirror hearth frequency (1711) se	20 111011 4011 01101				Y/N	
	T					1. 00	
9. 00	Bad Debts Is the provider seeking reimbursement for bad	d dobte2 (V/N) coo	instructio	nc		Y	9. 00
10. 00	If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.				t reporting	N N	10.00
11. 00	Bed Complement					N	11. 00
12.00	Have total beds available changed from prior	cost reporting per	riod? If "Y			N	12. 00
		Descripti	on	Pa Y/N	rt A Date	Part B Y/N	
		0	OH	1. 00	2. 00	3. 00	
	PS&R Data						
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			Y	03/15/2024	Y	13. 00
14. 00	4. (see Instructions.) 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			N		N	14. 00
15. 00	4. 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",			N		N	15. 00
16. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report			N		N	16. 00
17. 00	adjustments made to PS&R data for Other?			N		N	17. 00
18. 00	Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions.			N		N	18. 00

Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10							2540-10	
SKI LLEI	NURSING FACILITY AND SKILLED NURSING FACIL	TY HEALTH CARE	Pro	vi der No.: 315509	Peri		Worksheet S-2	
COMPLEX REIMBURSEMENT QUESTIONNAIRE					From	m 01/01/2023 12/31/2023	Part II Date/Time Pre	nared:
							5/2/2024 10:0	6 am
				1. 00		2. (00	
	Cost Report Preparer Contact Information							
19. 00	Enter the first name, last name and the titl	e/position	SLAVKA		PA	RTI LOVA		19. 00
	held by the cost report preparer in columns	1, 2, and 3,						
	respecti vel y.							
20. 00	Enter the employer/company name of the cost	report	HEALTH CA	ARE RESOURCES				20. 00
	preparer.							
21. 00	Enter the telephone number and email address	s of the cost	609-987-1	1440	SL	AVKA. PARTI LOV	'A@HCRNJ. NET	21.00
	report preparer in columns 1 and 2, respecti	vel y.						

| Peri od: | Worksheet S-2 | From 01/01/2023 | Part II | Date/Time Prepared: | 5/2/2024 10:06 am Health Financial Systems ROOSEVELT CARE CENT SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE ROOSEVELT CARE CENTER AT OLD BRIDGE Provi der No.: 315509 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				5/2/2024 10:	06 am
		Part B			
		Date			
		4. 00			
	PS&R Data				
13.00		03/15/2024			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
	4. (see Instructions.)				
14.00	Was the cost report prepared using the PS&R				14. 00
	for total and the provider's records for				
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00					15. 00
	made to PS&R data for additional claims that				
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
16. 00	see Instructions. If line 13 or 14 is "Y", then were				16. 00
10.00	adjustments made to PS&R data for				16.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00					17. 00
17.00	adjustments made to PS&R data for Other?				17.00
	Describe the other adjustments:				
18.00	Was the cost report prepared only using the				18. 00
	provider's records? If "Y" see Instructions.				
			3. 00		
	Cost Report Preparer Contact Information				
19.00			PREPARER		19. 00
	held by the cost report preparer in columns 1	I, 2, and 3,			
	respecti vel y.				
20. 00	Enter the employer/company name of the cost r	report			20. 00
	preparer.				1
21. 00	Enter the telephone number and email address				21. 00
	report preparer in columns 1 and 2, respective	/el y.	l		1

Health Financial Systems ROOSEVELT CARE CENT COMPLEX STATISTICAL DATA

Provi der No.: 315509

				10	J 12/31/2023	5/2/2024 10:00	
				I npa	atient Days/Vis	i 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 2. 00 3. 00 4. 00 5. 00 6. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	180 0 0	65, 700 0 0	0	8, 191 0	43, 138 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	180	65, 700	0	8, 191	43, 138	8. 00
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
4.00	OVALLED ANDROLMO FACILITY	6.00	7. 00	8. 00	9. 00	10.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	9, 359 0 0 0 0	60, 688 0 0 0 0	0	247	8 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	9, 359 Di sch	60, 688 arges	Aver	247 age Length of	8 Stay	8. 00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1.00	SKILLED NURSING FACILITY	11.00	12. 00 519	13. 00	14. 00 33. 16	15. 00 5, 392. 25	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	0 0	0	0.00	0. 00	0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00	Total (Sum of lines 1-7)	264	519			5, 392. 25	8. 00
		Average Length of Stay		Admi s	sions		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1.00	TOWALLED MURDING FACILITY	16.00	17. 00	18. 00	19. 00	20.00	1.00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	116. 93 0. 00	0	322	2	196 0	1. 00 2. 00
3.00	ICF/IID	0.00	J		0	0	3. 00
4.00	HOME HEALTH AGENCY COST						4.00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0. 00				0	5. 00 6. 00
7. 00	HOSPI CE	0. 00	0	0	o	o	7. 00
8.00	Total (Sum of lines 1-7)	116. 93 Admi ssi ons	0 Full Time	322 Equi val ent	2	196	8. 00
	Companent	Total	Employees on	Nonpai d			
	Component	21.00	Payrol I 22. 00	Workers 23.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	520 0 0 0 0 0 520	124. 30 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 124. 30	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provider No.: 315509

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared:

Amount Reported Reported Salaries Col. Co					Т	o 12/31/2023	Date/Time Prep 5/2/2024 10:00	
Reported Reported Salaries From Salaries (col. 2) Salary in col. Wage (col. 3 s col. 4)			Amount	Reclass. of	Adj usted	Paid Hours		
PART II - DIRECT SALARIES SAL			Reported	Salaries from	Salaries (col.			
PART II - DIRECT SALARIES SALARIES SALARIES SALARIES 1.00 Total salaries (See Instructions) 6,942,253 0 6,942,253 258,967.00 26.81 1.00 2.00 Physician salaries-Part A 0 0 0 0 0 0.00 0.00 2.00 2.00 2.00 Physician salaries-Part B 0 0 0 0 0 0.00 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0 0 0 0.00 0.00 5.00 5.00 Sum of lines 2 through 4 0 0 0 0 0 0 0.00 0.00 5.00 8.00 Physician graph of the salaries of t			· ·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
PART II - DIRECT SALARIES SALARIES SALARIES SALARIES 1.00 Total salaries (See Instructions) 6,942,253 0 6,942,253 258,967.00 26.81 1.00 2.00 Physician salaries-Part A 0 0 0 0 0 0.00 0.00 2.00 2.00 2.00 Physician salaries-Part B 0 0 0 0 0 0.00 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0 0 0 0.00 0.00 5.00 5.00 Sum of lines 2 through 4 0 0 0 0 0 0 0.00 0.00 5.00 8.00 Physician graph of the salaries of t					·	3		
SALARIES Total salaries (See Instructions) 6,942,253 0 6,942,253 258,967.00 26.81 1.00 2.00 Physician salaries-Part A 0 0 0 0 0 0.00 0.00 2.00 3.00 Physician salaries-Part B 0 0 0 0 0 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0 0 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0 0 0.00 0.00 5.00 5.00 Sum of lines 2 through 4 0 0 0 0 0 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 6,942,253 0 6,942,253 258,967.00 26.81 6.00 7.00 0 0 0 0 0 0 0 0 0			1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 Total salaries (See Instructions) 6, 942, 253 0 6, 942, 253 258, 967. 00 26. 81 1.00 2.00 Physician salaries-Part A 0 0 0 0 0.00 0.00 2.00 4.00 Home office personnel 0 0 0 0 0 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0 0.00 0.00 0.00 5.00 7.00 Other Long Term Care 0 0 0 0 0 0.00 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 0.00 7.00 9.00 CMHC 0 0 0 0 0.00 0.00 0.00 7.00 11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 0.00 11.00 11.00 Other excluded salary (Sum of lines 7 0 0 0 0.00 0.00 0.00 12.00 12.00 Subtotal Excluded Salaries (line 6 minus line 6, 942, 253 0 6, 942, 253 258, 967. 00 0 0 0.00 0.00 12. 00 13.00 Total Adjusted Salaries & wage related costs of (See Part IV) 0 0 Wage-related costs of (See Part IV) 0 0 Wage-related costs of (See Part IV) 0 Physician Part B - WRC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
2.00 Physician salaries-Part A								
3.00	1.00	Total salaries (See Instructions)	6, 942, 253	0	6, 942, 253	258, 967. 00	26. 81	1. 00
4.00 Home office personnel 0 0 0 0 0.00 0.00 0.00 5.00 5.00 Sum of lines 2 through 4 0 0 0 0 0.00 0.00 0.00 5.00 5.00 7.00 Other Long Term Care 0 0 0 0.00 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 8.00 10.00 HOSPICE 0 0 0 0 0.00 0.00 0.00 10.00 11.00 HOSPICE 0 0 0 0 0 0.00 0.00 10.00 11.00 11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00 11.00 Other excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 0.00 12.00 11.00 12.00 Subtotal Excluded salaries (line 6 minus line 6,942,253 0 6,942,253 258,967.00 26.81 13.00 15.00 Contract Labor: Patient Related & Mgmt 15,144,495 0 15,144,495 156,629.00 96.69 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0 0.00 0.00 15.00 15.00 Home office salaries & wage related costs 0 0 0 0 0 0.00 0.00 16.00 18.00 19.00 Wage-related costs core (See Part IV) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
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) 6,942,253 0 6,942,253 258,967.00 26.81 6.00 8.00 HOME LEALTH AGENCY COST 0 0 0 0.00<	3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
6. 00 Revised wages (line 1 minus line 5) 6, 942, 253 0 6, 942, 253 258, 967. 00 26. 81 6. 00 7. 00 0 ther Long Term Care 0 0 0 0 0 0 0. 00 0. 00 7. 00 8. 00 9. 00 0 0. 00 0. 00 0. 00 0. 00 9. 00 0.	4.00	Home office personnel	0	0	0	0.00	0.00	4.00
7. 00 Other Long Term Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 10.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0 0 0.00 0.00 10.00 11.00	6.00	Revised wages (line 1 minus line 5)	6, 942, 253	0	6, 942, 253	258, 967. 00	26. 81	6.00
9.00 CMHC 10.00 HOSPICE 0 0 0 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (line 6 minus line 6,942,253 0 6,942,253 258,967.00 26.81 13.00 12.00 THER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 15,144,495 0 15,144,495 156,629.00 96.69 15.00 Contract Labor: Physician services-Part A 0 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 4,547,213 0 4,547,213 0 17.00 18.00 Wage-related costs other (See Part IV) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
10.00 HOSPICE 0 0 0 0 0 0.00 0.00 10.00 11.00 11.00 Other excluded areas 0 0 0 0 0 0 0.00 0.00 11.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 6, 942, 253 0 6, 942, 253 258, 967.00 26.81 13.00 OTHER WAGES & RELATED COSTS	8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
11. 00 Other excluded areas 0 0 0 0 0 0.00 0.00 11. 00 12. 00 12. 00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0 0. 00 0. 00 12. 00 12. 00 13. 00 Total Adjusted Salaries (line 6 minus line 12) 0 6, 942, 253 258, 967. 00 26. 81 13. 00 120 0 15. 00 Other excluded salary (Sum of lines 7 0 0 0 6, 942, 253 258, 967. 00 26. 81 13. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00	CMHC	0	0	0	0.00	0.00	9. 00
12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0 0.00 0.00 12.00 through 11) 13.00 Total Adjusted Salaries (Line 6 minus Line 6,942,253 0 6,942,253 258,967.00 26.81 13.00 0THER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 15,144,495 0 15,144,495 156,629.00 96.69 14.00 0 0 0 0 0 0 0 0 0 0 15.00 16.00 Home office salaries & wage related costs 0 0 0 0 0 0 0 0 0 0 0 16.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 4,547,213 0 4,547,213 0 17.00 18.00 Wage related costs (excluded units) 0 0 0 0 0 0 0 0 0 19.00 19.00 19.00 Physician Part A - WRC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
through 11) Total Adjusted Salaries (line 6 minus line 6,942,253 0 6,942,253 258,967.00 26.81 13.00 OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 15,144,495 0 15,144,495 156,629.00 96.69 14.00 0 0 0 0 0 0 0 0 0 0 15.00 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
13.00 Total Adjusted Salaries (line 6 minus line 6,942,253 0 6,942,253 258,967.00 26.81 13.00	12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
12 OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 15,144,495 0 15,144,495 156,629.00 96.69 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0 0.00 0.00 16.00 MAGE-RELATED COSTS		through 11)						
OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 15,144,495 0 15,144,495 156,629.00 96.69 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS Wage-related costs core (See Part IV) 4,547,213 0 4,547,213 17.00 18.00 18.00 Wage-related costs other (See Part IV) 0 0 0 0 18.00 19.00 Wage related costs (excluded units) 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 4,547,213 22.00 22.00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22.00	13.00	Total Adjusted Salaries (line 6 minus line	6, 942, 253	0	6, 942, 253	258, 967. 00	26. 81	13.00
14.00 Contract Labor: Patient Related & Mgmt								
15.00 Contract Labor: Physician services-Part A 0 0 0 0 0 0 0 0 15.00								
16.00 Home office salaries & wage related costs 0 0 0 0 0 0 0 0 0	14.00	9	15, 144, 495	0	15, 144, 495			
WAGE-RELATED COSTS 17. 00 Wage-related costs core (See Part IV) 4,547,213 0 4,547,213 17. 00 18. 00 Wage-related costs other (See Part IV) 0 0 0 18. 00 19. 00 Wage related costs (excluded units) 0 0 0 19. 00 20. 00 Physician Part A - WRC 0 0 0 20. 00 21. 00 Physician Part B - WRC 0 0 0 21. 00 22. 00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22. 00			0	0	0			
17.00 Wage-related costs core (See Part IV)	16.00		0	0	0	0.00	0.00	16. 00
18.00 Wage-related costs other (See Part IV) 0 0 0 18.00 19.00 Wage related costs (excluded units) 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 0 21.00 Physician Part B - WRC 0 0 0 0 22.00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22.00								
19.00 Wage related costs (excluded units) 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22.00			4, 547, 213	0	4, 547, 213			
20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 0 22.00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22.00	18. 00	Wage-related costs other (See Part IV)	0	0	0			18. 00
21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22.00	19.00		0	0	0			
22.00 Total Adjusted Wage Related cost (see 4,547,213 0 4,547,213 22.00	20.00	Physician Part A - WRC	0	0	0			
	21. 00	Physician Part B - WRC	0	0	0			21. 00
instructions)	22. 00		4, 547, 213	0	4, 547, 213			22. 00
		instructions)						

In Lieu of Form CMS-2540-10

| Period: | Worksheet S-3 | From 01/01/2023 | Part III |
| To | 12/31/2023 | Date/Time Prepared: | 5/2/2024 | 10:06 am | Health Financial Systems
SNF WAGE INDEX INFORMATION Provider No.: 315509

						5/2/2024 10:0	<u>6 am</u>
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries fro	m Salaries (col	. Related to	Wage (col. 3 ÷	
			Worksheet A-	6 1 ± col. 2)	Salary in col.	col. 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0		0	0.00	0.00	1. 00
2.00	Administrative & General	812, 982		0 812, 98	23, 709. 00	34. 29	2. 00
3.00	Plant Operation, Maintenance & Repairs	163, 907		0 163, 90	7 10, 693. 00	15. 33	3. 00
4.00	Laundry & Li nen Servi ce	0		0	0.00	0.00	4. 00
5.00	Housekeepi ng	259, 302		0 259, 30	2 13, 806. 00	18. 78	5. 00
6.00	Di etary	624, 817		0 624, 81	7 34, 832. 00	17. 94	6. 00
7.00	Nursing Administration	1, 321, 851		0 1, 321, 85	1 34, 661. 00	38. 14	7. 00
8.00	Central Services and Supply	0		0	0.00	0.00	8. 00
9.00	Pharmacy	0		0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0		0	0.00	0.00	10.00
11.00	Soci al Servi ce	135, 684		0 135, 68	4 3, 637. 00	37. 31	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	368, 126		0 368, 12	6 16, 741. 00	21. 99	13. 00
14.00	Total (sum lines 1 thru 13)	3, 686, 669		0 3, 686, 66	9 138, 079. 00	26. 70	14. 00

Health Financial Systems	ROOSEVELT CARE CENTER AT OLD BRIDGE	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No. : 315509	Period: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:

PART I V - WAGE RELATED COSTS 1.00 1.0		To 12/31/2023	Date/Time Prep 5/2/2024 10:00	
PART IV - WAGE RELATED COSTS			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Reported	
Part A - Core List RETIREMENT COST 1.00 401K Employer Contribution 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0.2.00 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 965,719 3.00 0.00 1.00 7.00			1.00	
RETIREMENT COST A01K Employer Contributions 0 1.00 2.00				
1.00				
2. 00				
3.00 Qualified and Non-Qualified Pensi on Plan Cost 965,719 3.00 Prior Year Pensi on Service Cost 0 4.00 Administration fees 0 5.00 4.00 Administration in Service Cost 0 7.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 7.00 Health Insurance (Purchased or Self Funded) 2,066,602 8.00 9.00 Prescription Drug Plan 774,273 9.00 9.00 Prescription Drug Plan 774,273 9.00 9.00 Prescription Drug Plan 774,273 9.00 11.00 1	1.00		0	
Prior Year Pension Service Cost 0	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	3.00	Qualified and Non-Qualified Pension Plan Cost	965, 719	3. 00
5.00 401K/TSA Plan Administration fees 0 6.00 1.	4.00		0	4. 00
Column C		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST	5.00		0	5. 00
HEALTH AND INSURANCE COST 8. 00 Heal th Insurance (Purchased or Self Funded) 2,066,602 8. 00 1. 00	6.00		0	
Real th Insurance (Purchased or Self Funded) 2,066,602 8.00 9.00 Prescription Drug Plan 774,273 9.00 10.00 Dental, Hearing and Vision Plan 77,122 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 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 10.5ability Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 113,790 15.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 16.00 16	7.00		0	7. 00
Prescription Drug Plan 774, 273 9.00 10.00 Dental, Hearing and Vision Plan 77, 122 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 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 113,790 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 18.00 18.00 Modicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 0 19.00 10.00 State or Federal Unemployment Taxes 0 20.00 10.00 Day Care Cost and Allowances 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 3,750 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23)		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 77,122 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 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 113,790 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 545,957 17.00 17.00 FICA-Employers Portion Only 545,957 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 3,750 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported Reported 1.00 Part B - Other than Core Related Cost	8.00	Health Insurance (Purchased or Self Funded)	2, 066, 602	8. 00
11.00	9.00	Prescription Drug Plan	774, 273	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	77, 122	10.00
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 113,790 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion) 16.00 TAXES 17.00 FI CA-Employers Portion Only 545,957 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 0 19.00 20.00 State or Federal Unemployment Taxes 0 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 3,750 33.00 24.00 Total Wage Related cost (Sum of Lines 1 - 23) 4,547,213 24.00 Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
15.00 Workers' Compensation Insurance 113,790 15.00	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion TAXES TAX	15.00	Workers' Compensation Insurance	113, 790	15. 00
TAXES 17. 00 FI CA-Empl oyers Portion Onl y 545, 957 17. 00 18. 00 Medi care Taxes - Empl oyers Portion Onl y 0 18. 00 19. 00 Unempl oyment I nsurance 0 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation 0 22. 00 22. 00 23. 00 Tuition Reimbursement 3, 750 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 4, 547, 213 24. 00 Amount Reported 1. 00 Part B - Other than Core Related Cost 17. 00 17. 00 18. 00 19.	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 0				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 0 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 3,750 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 4,547,213 24.00 Amount Reported 1.00 -		·		
19.00 Unemployment Insurance 0 19.00			545, 957	17. 00
20.00 State or Federal Unemployment Taxes			0	18. 00
OTHER 21.00 Executive Deferred Compensation 0 21.00			0	
21.00 Executive Deferred Compensation 0 21.00	20.00		0	20. 00
22.00 Day Care Cost and Allowances 0 22.00				
23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost			0	21. 00
24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost			0	
Amount Reported 1.00 Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost	24. 00	Total Wage Related cost (Sum of lines 1 - 23)	4, 547, 213	24. 00
Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost				
			1. 00	
25.00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25.00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No.: 315509

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part V | To 12/31/2023 | Date/Time Prepared: | Construction | Prepared: | Construc

				1	0 12/31/2023	5/2/2024 10:00	
	Occupational Category	Amount	Fri nge	Adj usted	Paid Hours	Average Hourly	
	·	Reported	Benefits	Salaries (col.	Related to	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	054 000	4/0 700	100 500			
1.00	Registered Nurses (RNs)	251, 828	168, 700	•			1.00
2.00	Licensed Practical Nurses (LPNs)	1, 301, 007	871, 545				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 566, 149	1, 049, 163	2, 615, 312	75, 564. 00	34. 61	3. 00
4. 00	Assistants/Aides Total Nursing (sum of lines 1 through 3)	3, 118, 984	2, 089, 408	5, 208, 392	120, 889. 00	43.08	4. 00
5.00	Physical Therapists	3, 110, 904	2,009,400	0, 200, 392	0.00		5. 00
6.00	Physical Therapy Assistants		0		0.00		
7. 00	Physical Therapy Assistants Physical Therapy Aides		0		0.00		
8. 00	Occupational Therapists		0		0.00		
9. 00	Occupational Therapy Assistants		0		0.00		
10.00	Occupational Therapy Aides		0		0.00		
11. 00	Speech Therapists		0		0.00		
12. 00	Respi ratory Therapi sts		0				
13. 00	Other Medical Staff		0	1			
13.00	Contract Labor	<u> </u>		, 0	0.00	0.00	13.00
	Nursing Occupations						
14.00	Registered Nurses (RNs)	1, 680, 553		1, 680, 553	25, 128. 00	66.88	14. 00
15.00	Licensed Practical Nurses (LPNs)	2, 069, 265		2, 069, 265		59. 24	15. 00
16.00	Certified Nursing Assistant/Nursing	3, 181, 997		3, 181, 997	80, 338. 00	39. 61	16. 00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	6, 931, 815		6, 931, 815	140, 398. 00	49. 37	17.00
18. 00	Physi cal Therapists	370, 318		370, 318	4, 634. 00	79. 91	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	178, 918		178, 918	2, 239. 00	79. 91	20.00
21. 00	Occupational Therapists	309, 091		309, 091	4, 770. 00	64. 80	21.00
22.00	Occupational Therapy Assistants	O		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	188, 158		188, 158	2, 904. 00	64. 79	23.00
24.00	Speech Therapists	137, 889		137, 889	1, 684. 00	81. 88	24.00
25.00	Respi ratory Therapi sts	0		0	0.00	0.00	25. 00
26. 00	Other Medical Staff	O		0	0.00	0.00	26. 00

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider No.: 315509

	10	5 12/31/2023	Date/lime Pre 5/2/2024 10:0	
	'	Group	Days	
4.00		1. 00	2. 00	4 00
1. 00 2. 00		RUX RUL		1. 00 2. 00
3.00		RVX		3. 00
4. 00		RVL		4. 00
5. 00		RHX		5. 00
6.00		RHL		6.00
7. 00 8. 00		RMX RML		7. 00 8. 00
9.00		RLX		9. 00
10.00		RUC		10.00
11. 00		RUB		11. 00
12.00		RUA		12.00
13. 00 14. 00		RVC RVB		13. 00 14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18.00		RHA		18.00
19. 00 20. 00		RMC RMB		19. 00 20. 00
21. 00		RMA		21. 00
22. 00		RLB		22. 00
23. 00		RLA		23. 00
24.00		ES3		24. 00
25. 00 26. 00		ES2 ES1		25. 00 26. 00
27. 00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30.00		HD1		30.00
31. 00 32. 00		HC2 HC1		31. 00 32. 00
33. 00		HB2		33. 00
34. 00		HB1		34. 00
35. 00		LE2		35. 00
36. 00 37. 00		LE1 LD2		36. 00 37. 00
38.00		LD2 LD1		38.00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41.00		LB2		41.00
42. 00 43. 00		LB1 CE2		42. 00 43. 00
44. 00		CE1		44. 00
45. 00		CD2		45. 00
46.00		CD1		46. 00
47. 00 48. 00		CC2 CC1		47. 00 48. 00
49.00		CB2		49. 00
50.00		CB1		50.00
51. 00		CA2		51.00
52.00		CA1		52.00
53. 00 54. 00		SE3 SE2		53. 00 54. 00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57. 00
58. 00 59. 00		SSA I B2		58. 00 59. 00
60.00		1 B2 1 B1		60.00
61. 00		I A2	•	61. 00
62. 00		I A1		62. 00
63.00		BB2		63. 00
64. 00 65. 00		BB1 BA2		64. 00 65. 00
66. 00		BA2 BA1		66.00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69.00		PD2		69. 00
70. 00 71. 00		PD1 PC2		70. 00 71. 00
71.00		PC1		71.00
73. 00		PB2		73. 00
74. 00		PB1		74. 00
75. 00		PA2		75. 00

Health Financial Systems ROOSEVELT CARE CE	NTER AT OLD BRII	OGE	In Lie	eu of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-	7
			From 01/01/2023 To 12/31/2023		
			Group	Days	
			1. 00	2. 00	
76. 00			PA1		76. 00
99. 00			AAA		99. 00
100. 00 TOTAL					100. 00
		Expenses	Percentage	Y/N	
		1. 00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No. payments beginning 10/01/2003. Congress expected this increxpenses. For lines 101 through 106: Enter in column 1 the column 2 the percentage of total expenses for each categor line 1, column 3. Indicate in column 3 "Y" for yes or "N" with direct patient care and related expenses for each cat (See instructions)	rease to be used e amount of the ry to total SNF for no if the s	l for direct p expense for e revenue from pending refle	atient care and ach category. Er Worksheet G-2, F cts 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, column 3	3)				101. 00 102. 00 103. 00 104. 00 105. 00 106. 00

Heal th	Financial Systems ROOS	SEVELT CARE CENTER	R AT OLD BRID	OGE	In Lie	u of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF			No.: 315509 I	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
					10 12/31/2023	5/2/2024 10:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre		
					ase (Fr Wkst	col. 4)	
		1.00	2.00	2.00	A-6)	Г 00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES		193, 773	193, 77	3 0	193, 773	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		173, 773		0	0	2.00
3.00	00300 EMPLOYEE BENEFITS	0	4, 650, 462		-	4, 650, 462	3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	812, 982	2, 730, 476			3, 543, 458	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	163, 907	940, 794			1, 104, 701	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	334, 030			334, 030	6. 00
7.00	00700 HOUSEKEEPI NG	259, 302	1, 708, 801	1, 968, 10	3 0	1, 968, 103	7. 00
8.00	00800 DI ETARY	624, 817	809, 171	1, 433, 98	8 0	1, 433, 988	8. 00
9.00	00900 NURSING ADMINISTRATION	1, 321, 851	75, 195	1, 397, 04	6 0	1, 397, 046	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	566, 321	566, 32	1 0	566, 321	1
11. 00	01100 PHARMACY	0	0		0	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	(0	0	12. 00
13. 00	01300 SOCIAL SERVICE	135, 684	3, 734	139, 41	8 0	139, 418	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14. 00
15. 00	01500 PATIENT ACTIVITIES	368, 126	17, 194	385, 320	0	385, 320	15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 255 504	/ 07/ 42/	10 222 024	0	10 222 020	1 20 00
30.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 255, 584	6, 976, 436	10, 232, 02	0	10, 232, 020 0	30. 00 31. 00
31. 00 32. 00	03200 CF/IID	0	0		0	0	31.00
33. 00	03300 OTHER LONG TERM CARE		0		0	0	33.00
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	5 0	0	33.00
40.00	04000 RADI OLOGY	0	39, 445	39, 44	5 0	39, 445	40. 00
41. 00	04100 LABORATORY	o	50, 919			50, 919	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	71, 236	71, 23	6 0	71, 236	43.00
44.00	04400 PHYSI CAL THERAPY	0	549, 537	549, 53	7 0	549, 537	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	497, 521			497, 521	1
46. 00	04600 SPEECH PATHOLOGY	0	137, 965			137, 965	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	317, 491	317, 49	0	317, 491	•
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			J U	0	31.00
60. 00	06000 CLINIC	0	0	1	0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	1	0	Ö	61.00
62. 00	06200 FQHC		J			Ü	62. 00
	OTHER REIMBURSABLE COST CENTERS			•	_		
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0 0	0	70. 00
71.00	07100 AMBULANCE	0	0		0 0	0	71. 00
73.00	07300 CMHC	0	0	(0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	(0	0	80. 00
81. 00	08100 I NTEREST EXPENSE		0		0	0	•
82. 00	08200 UTILIZATION REVIEW - SNF	0	0	1	0	0	82. 00
83. 00	08300 H0SPI CE	(0.40 0.50	0 (70 501	07 (40 75	0	07 (10 754	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	6, 942, 253	20, 670, 501	27, 612, 75	4 0	27, 612, 754	89. 00
90. 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		^			0	90.00
90.00	09100 BARBER AND BEAUTY SHOP		0]		0	90.00
	09200 PHYSICIANS PRIVATE OFFICES		0			0	
93. 00	09300 NONPAI D WORKERS		0		0	0	93. 00
	09400 PATIENTS LAUNDRY	O	0		o o	Ö	94. 00
100.00		6, 942, 253	20, 670, 501	27, 612, 75	4 0	27, 612, 754	100. 00
				•		-	

In Lieu of Form CMS-2540-10 Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315509 Peri od: Worksheet A From 01/01/2023 12/31/2023 Date/Time Prepared: 5/2/2024 10:06 am Cost Center Description Adjustments to Net Expenses Expenses (Fr For Allocation (col. 5 +-col. 6) Wkst A-8) 6.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 930, 514 1, 124, 287 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFLTS 3.00 0 4, 650, 462 -420, 268 4.00 00400 ADMINISTRATIVE & GENERAL 3, 123, 190 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 0 1, 104, 701 00600 LAUNDRY & LINEN SERVICE 6.00 0 334, 030 00700 HOUSEKEEPI NG 0 7.00 1, 968, 103 8.00 00800 DI ETARY 000000 1, 433, 988 9.00 00900 NURSING ADMINISTRATION 1, 397, 046 01000 CENTRAL SERVICES & SUPPLY 10.00 566, 321 11.00 01100 PHARMACY C 12.00 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 13.00 139, 418 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 15.00 01500 PATIENT ACTIVITIES 385, 320 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 10, 232, 020 0 03100 NURSING FACILITY 31.00 32.00 03200 | CF/IID 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 39, 445 41.00 04100 LABORATORY 50, 919 42. 00 04200 I NTRAVENOUS THERAPY Ω 04300 OXYGEN (INHALATION) THERAPY 43.00 71, 236

Health Financial Systems R00	SEVELT CARE CENTER A	AT OLD BRID)GE	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315509	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Pre 5/2/2024 10:0	pared:
			Increases		10,2,2021 10.0	
	Cost Cente	er	Li ne #	Sal ary	Non Salary	
	2.00		3. 00	4. 00	5. 00	
TOTALS						
100. 00	Total Reclassifica of columns 4 and 5 equal sum of colum 9)	must `		0	0	100.00

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

Health Financial Systems ROC	DSEVELT CA	ARE CENTER A	AT OLD BRI	DGE	In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS			Provi der	No.: 315509	Peri od:	Worksheet A-6)
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre	pared:
						5/2/2024 10:0	<u>6 am</u>
				Decreases			
		Cost Cente	er	Li ne #	Sal ary	Non Salary	
		6. 00		7. 00	8. 00	9. 00	
TOTALS							
100. 00					0	0	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provi der No.: 315509

						5/2/2024 10:00	6 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	190, 992	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	322, 557	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	513, 549	0	0	0	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	513, 549	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	ANNUAL OF SUMMORS AND AND THE ASSET BALANCE	6.00	7. 00				
4 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						4 00
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	100 000	0				3.00
4.00	Building Improvements	190, 992	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	322, 557	0				6. 00
7.00	Subtotal (sum of lines 1-6)	513, 549	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	513, 549	0				9. 00

Provi der No.: 315509

Peri od:

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/2/2024 10:06 am

					5/2/2024 10:0	6 am
				Expense Classification on	Worksheet A	
				To/From Which the Amount is		
					,	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	COST CENTER	LITIC NO.	
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds	B		CAP REL COSTS - BLDGS &	1.00	1. 00
1.00	(chapter 2)	ь	-0, 550	FIXTURES	1.00	1.00
2. 00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
2.00	8)		O	1	0.00	2.00
3. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers		0		0.00	4. 00
4.00	(chapter 8)		0	<u>'</u>	0.00	4.00
5. 00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
3.00	(chapter 21)		0	<u>'</u>	0.00	3.00
6. 00	Television and radio service (chapter 21)		0		0.00	6. 00
7. 00			0		0.00	7. 00
	Parking lot (chapter 21)	A-8-2	0	(0.00	7. 00 8. 00
8. 00	Remuneration applicable to provider-based	A-8-2	U	1		8.00
0.00	physician adjustment		0		0.00	0 00
9.00	Home office cost (chapter 21)		0		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0	2	0.00	11. 00
12.00	Capital expenditures (chapter 24)	4 0 1	1 012 0/5			10.00
12. 00	Adjustment resulting from transactions with	A-8-1	1, 013, 265			12. 00
12.00	related organizations (chapter 10)		0		0.00	12 00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0	2	0.00	
15. 00	Cost of meals - Guests		0		0.00	15. 00
16. 00	Sale of medical supplies to other than		0)	0.00	16. 00
	patients		_			
17. 00	Sale of drugs to other than patients		0)	0.00	17. 00
18. 00	Sale of medical records and abstracts		0)	0.00	18. 00
19. 00	Vendi ng machi nes		0	0	0.00	19. 00
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0)	0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1. 00	23. 00
				FI XTURES		
24.00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2. 00	24. 00
				EQUI PMENT		
25.00	Other adjustment (specify)		0		0.00	25. 00
25. 01	BAD DEBTS	A	-354, 955	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	MARKETI NG	Α		ADMINISTRATIVE & GENERAL	4.00	25. 02
25. 03	PROFESSIONAL SERVICES / LEGAL	A	-120, 907	ADMINISTRATIVE & GENERAL	4.00	25. 03
	MISC / REFUNDS	В		ADMINISTRATIVE & GENERAL	4.00	25. 04
	Total (sum of lines 1 through 99) (Transfer		510, 246	1		100.00
	to Worksheet A, col. 6, line 100)		,			-
(1) Do	corintian all chapter references in this co	lump portain to	CMS Dub 15 1	' -	'	1

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

 ⁽²⁾ Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

ROOSEVELT CARE CENTER AT OLD BRIDGE

Health Financial Systems ROOSEVELT CARE CENTER STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315509 OFFICE COSTS

OFFICE	00515					Date/Time Pro 5/2/2024 10:0	
		Li ne No.	Cost (Center	Expense		
		1.00	2.	00	3. (00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		4. 00	ADMI NI STRATI VE	& GENERAL	SUPPORT STAFF		1.00
2. 00		4. 00	ADMI NI STRATI VE	& GENERAL	TECH SUPPORT & STORAGE	RECORDS	2. 00
3. 00			CAP REL COSTS FLXTURES	- BLDGS &	INTEREST ON BOR	RROWI NG	3. 00
4.00		0. 00					4.00
5.00		0.00					5.00
6.00		0.00					6.00
7.00		0. 00					7.00
8. 00		0. 00					8.00
9.00		0. 00					9.00
	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.						10.00
	12.	Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minus			
		Cost	Wkst. A, col.	col . 5)			
			5				
		4.00	5. 00	6.00			İ
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		249, 959	249, 959	C)		1.00
2.00		76, 215	0	76, 215	5		2. 00
3.00		937, 050	0	937, 050)		3. 00
4.00		0	0	C)		4. 00
5.00		0	0	C)		5. 00
6.00		0	0	C)		6. 00
7. 00		0	0	C)		7. 00
8. 00		0	0	C)		8. 00
9. 00		0	0	C)		9. 00
	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 263, 224	249, 959	1, 013, 265			10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315509 Peri od: Worksheet A-8-1 From 01/01/2023 OFFICE COSTS Parts I-II 12/31/2023 Date/Time Prepared:

				5/2/2024 10:00	5 am
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
DART II INTERRE ATLANGUER TO BELATER ORGANIE	7.4.T.L. ONL (O)	D HOME OFFICE			

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

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

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

1.00	G	MCI A	0. 00	1.00
2.00	G	MI DDLESEX COUNTY	0.00	2. 00
3.00			0.00	3.00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6.00			0.00	6. 00
7. 00			0.00	7. 00
8.00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (financial or non-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. 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		MCI A	0.00	COUNTY IMPROVEMENT AUTHORITY	1.00
2.00		MI DDLESEX COUNTY	0.00	COUNTY GOVERNMENT	2.00
3.00			0.00		3.00
4.00			0.00		4. 00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-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.

Provider No.: 315509

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 ЗА GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1 00 1 00 1, 124, 287 1 124 287 2.00 0 2 00 3.00 00300 EMPLOYEE BENEFITS 4, 650, 462 0 4, 650, 462 3.00 00400 ADMINISTRATIVE & GENERAL 0 3, 828, 922 4 00 3, 123, 190 544 599 4 00 161, 133 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 1, 104, 701 52, 983 0 109, 798 1, 267, 482 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 334, 030 9, 853 343, 883 6.00 7.00 00700 HOUSEKEEPI NG 1, 968, 103 5, 730 0 173, 701 2, 147, 534 7.00 00800 DI ETARY 1, 927, 027 1, 433, 988 0 8 00 418, 551 8 00 74.488 9.00 00900 NURSING ADMINISTRATION 1, 397, 046 C 885, 479 2, 282, 525 9.00 01000 CENTRAL SERVICES & SUPPLY 566, 321 10.00 10.00 0 566, 321 01100 PHARMACY 11.00 0 11.00 0 C 0 01200 MEDICAL RECORDS & LIBRARY 0 12.00 0 1.724 1.724 12 00 13.00 01300 SOCIAL SERVICE 139, 418 2, 271 0 90, 892 232, 581 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 14.00 01500 PATIENT ACTIVITIES 0 695, 281 385, 320 246, 600 15.00 63, 361 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 10, 232, 020 711, 896 0 2, 180, 842 30.00 13, 124, 758 31.00 03100 NURSING FACILITY 0 0 31.00 03200 | CF/IID 32.00 0 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 39, 445 C 39, 445 40.00 04100 LABORATORY 41.00 50, 919 0 0 0 50, 919 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 0 0 0 Ω 42.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 71.236 71, 236 43.00 0 44.00 04400 PHYSI CAL THERAPY 549, 537 9, 971 0 559, 508 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 497, 521 9, 971 507, 492 45.00 04600 SPEECH PATHOLOGY 137, 965 0 46.00 6,062 144, 027 46,00 0 04700 ELECTROCARDI OLOGY 47.00 0 Ω 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9. 221 0 9, 221 48 00 48 00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 317, 491 3, 213 320, 704 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 0 0 05100 SUPPORT SURFACES 51.00 51.00 0 0 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 61.00 62 00 06200 FQHC 62 00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 n 0 0 n 70.00 07100 AMBULANCE 0 0 71.00 0 0 0 71.00 07300 CMHC 0 73.00 0 0 73 00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82 00 83.00 08300 H0SPI CE 0 Ω 83.00 4, 650, 462 SUBTOTALS (sum of lines 1-84) 28, 123, 000 1, 121, 877 28, 120, 590 89.00 0 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 2, 410 0 0 2, 410 91.00 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 C 0 09300 NONPALD WORKERS 93 00 0 0 0 93 00 Ω 0 0 94.00 09400 PATIENTS LAUNDRY 0 C 0 0 94.00 98.00 Cross Foot Adjustments 0 0 0 98.00 0 99.00 99.00 Negative Cost Centers 0 0 0 0 ō TOTAL 28, 123, 000 4, 650, 462 28, 123, 000 100. 00 100.00 1, 124, 287

Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315509 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 3, 828, 922 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 199, 764 1, 467, 246 5.00 00600 LAUNDRY & LINEN SERVICE 54.198 15, 884 413, 965 6.00 6.00 00700 HOUSEKEEPI NG 2, 495, 237 7.00 338, 466 9, 237 0 7.00 8.00 00800 DI ETARY 303, 713 120, 079 0 207, 767 2, 558, 586 8.00 9.00 00900 NURSING ADMINISTRATION 359, 742 0 9.00 01000 CENTRAL SERVICES & SUPPLY 89, 256 0 10.00 10.00 Ω 0 Ω 11.00 01100 PHARMACY 0 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 272 2, 780 4, 810 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 36, 656 3,660 6.333 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 PATIENT ACTIVITIES 109, 581 102, 141 176, 729 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 1, 147, 615 413, 965 2, 558, 586 30.00 2,068,561 1, 985, 662 31.00 03100 NURSING FACILITY 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 6, 217 0 0 0 0 40.00 41.00 04100 LABORATORY 8,025 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY Ω 0 0 42 00 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 11, 227 C 0 0 43.00 04400 PHYSI CAL THERAPY 88, 182 16,074 27, 812 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 79, 984 16,074 0 27, 812 0 45.00 04600 SPEECH PATHOLOGY 46 00 22, 700 0 16, 908 46 00 9, 772 0 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 453 14, 865 0 25, 721 48.00 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 50, 545 5. 180 0 8, 962 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 50.00 0 C 0 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C О 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 61.00 0 61.00 0 C 0 0 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 0 07100 AMBULANCE O 71.00 0 r 0 Λ 71.00 73.00 07300 CMHC 0 0 0 0 73.00 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 83.00 SUBTOTALS (sum of lines 1-84) 3, 828, 542 413, 965 2, 558, 586 1, 463, 361 2, 488, 516 89.00 89.00 NONREIMBURSABLE COST CENTERS

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09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

TOTAL

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

Provi der No.: 315509

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/2/2024	10:06 am

					12/31/2023	5/2/2024 10: 0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9.00	10.00	11. 00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE 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	2, 642, 267					9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	2,012,207	655, 577				10. 00
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13. 00	· ·		0	0	7, 300 O	279, 230	13. 00
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15.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	· η	U	U	U	15.00
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45. 00		0	0	0	0	0	45. 00
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47. 00	1	0	0	0	0	0	47. 00
48. 00	1	0	0	0	0	0	48. 00
49. 00		0	217, 937	0	0	0	49. 00
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	OUTPATIENT SERVICE COST CENTERS	1					
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	OTHER REIMBURSABLE COST CENTERS	T					
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73. 00		0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS	,					
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	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00		0	0	0	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	o	0	0	0	93. 00
94.00		0	o	0	0	0	94.00
98.00	Cross Foot Adjustments	0	o				98. 00
99. 00	Negative Cost Centers	0	o	0	0	0	99. 00
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COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315509 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am OTHER GENERAL SERVI CE Cost Center Description NURSING AND PATI ENT Subtotal Post Stepdown Total ALLIED HEALTH ACTI VI TI ES Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 PATIENT ACTIVITIES 15.00 1,083,732 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 1, 083, 732 25, 751, 602 0 25, 751, 602 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 0 0 32.00 03200 | CF/IID 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 33.00 O O 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 45, 662 45, 662 41.00 04100 LABORATORY 0000000000 0 58, 944 0 58, 944 41.00 04200 I NTRAVENOUS THERAPY 42 00 42 00 Ω C 0 43.00 04300 OXYGEN (INHALATION) THERAPY 82, 463 82, 463 43.00 04400 PHYSI CAL THERAPY 691, 576 691, 576 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 631.362 631, 362 45.00 04600 SPEECH PATHOLOGY 46.00 Ω 193, 407 193, 407 46.00 0 47.00 04700 ELECTROCARDI OLOGY 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 51, 260 48 00 51, 260 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 603, 328 603, 328 49.00 05000 DENTAL CARE - TITLE XIX ONLY 50 00 r C 0 Λ 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CF 83.00 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 1,083,732 28, 109, 604 28, 109, 604 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 00000 0 91.00 09100 BARBER AND BEAUTY SHOP 0 13, 396 13, 396 91.00 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 92.00 09300 NONPALD WORKERS 93.00 0 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY Ω 0 94 00 0 98.00 Cross Foot Adjustments C 0 0 98.00

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Negative Cost Centers

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Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315509 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDGS & MOVABLE Subtotal Assigned New **FLXTURES FOUL PMENT BENEFITS** Capi tal Related Costs 1.00 2.00 2A 3.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 3.00 00300 EMPLOYEE BENEFITS 0 00400 ADMINISTRATIVE & GENERAL 4.00 0 0 0 161, 133 161, 133 0 00500 PLANT OPERATION, MAINT. & REPAIRS 0 5 00 52, 983 52 983 0 00600 LAUNDRY & LINEN SERVICE 0 6.00 9, 853 9,853 0 7.00 00700 HOUSEKEEPI NG 5, 730 5, 730 0 00800 DI ETARY 00000 74, 488 0 74. 488 8 00 0 00900 NURSING ADMINISTRATION 0 9.00 C 0 0 10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 01100 PHARMACY 11.00 0 0 0 0 01200 MEDICAL RECORDS & LIBRARY 1 724 1 724 12 00 13.00 01300 SOCIAL SERVICE 2, 271 2, 271 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 PATIENT ACTIVITIES 0 0 15.00 63, 361 63, 361 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 711, 896 0 711, 896 0 03100 NURSING FACILITY 0 0 0 31.00 03200 | CF/IID 0 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 0 0 ANCILLARY SERVICE COST CENTERS 0 40.00 04000 RADI OLOGY 0 0 0 0 0 04100 LABORATORY 41.00 0 0 0 04200 I NTRAVENOUS THERAPY 42.00 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 00000000 0 0 0 04400 PHYSI CAL THERAPY 9, 971 9, 971 44.00 04500 OCCUPATIONAL THERAPY 9.971 0 9, 971 45.00 0 04600 SPEECH PATHOLOGY 0 46.00 6,062 6,062 0 04700 ELECTROCARDI OLOGY 47.00 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 221 9, 221 0 0 49 00 04900 DRUGS CHARGED TO PATIENTS 3, 213 3, 213 Ω 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 05100 SUPPORT SURFACES 0 0 51.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 62.00 06200 FQHC OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0

1.00 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 15.00 30.00 31.00 32.00 33.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49 00 50.00 51.00 60.00 61.00 62.00 70.00 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82 00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 0 1, 121, 877 0 1, 121, 877 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 90 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 09100 BARBER AND BEAUTY SHOP 0 0 91.00 2, 410 2, 410 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 92.00 0 0 0 93.00 09300 NONPALD WORKERS 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 94 00 94 00 C 0 0 98.00 Cross Foot Adjustments 0 98.00 Negative Cost Centers 99.00 99.00 1, 124, 287 0 100.00 100.00 TOTAL 0 1, 124, 287

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Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315509 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 4.00 7.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFITS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 161, 133 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 8, 407 61, 390 5.00 00600 LAUNDRY & LINEN SERVICE 2, 281 6.00 12, 799 6.00 665 00700 HOUSEKEEPI NG 7.00 14, 245 386 C 20, 361 7.00 1, 695 8.00 00800 DI ETARY 12, 782 5,024 0 93, 989 8.00 9.00 00900 NURSING ADMINISTRATION 15, 140 0 9.00 0 01000 CENTRAL SERVICES & SUPPLY 3, 756 10.00 0 0 10.00 C Ω 11.00 01100 PHARMACY 0 r 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 11 116 0 39 0 12.00 01300 SOCIAL SERVICE 13.00 0 52 13.00 1.543 0 153 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 PATIENT ACTIVITIES 4,612 4, 274 1, 442 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 12, 799 16, 203 93, 989 30.00 87 047 48, 015 03100 NURSING FACILITY 31.00 0 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 262 0 0 0 0 40.00 04100 LABORATORY 41.00 338 0 0 0 41.00 o 42 00 04200 I NTRAVENOUS THERAPY Ω 0 42 00 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 473 C 0 0 43.00

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04400 PHYSI CAL THERAPY

04600 SPEECH PATHOLOGY

04700 ELECTROCARDI OLOGY

05100 SUPPORT SURFACES

06100 RURAL HEALTH CLINIC

06000 CLI NI C

07100 AMBULANCE

08300 H0SPI CE

06200 FQHC

07300 CMHC

04500 OCCUPATIONAL THERAPY

04900 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST

SPECIAL PURPOSE COST CENTERS

08200 UTILIZATION REVIEW - SNF

NONREIMBURSABLE COST CENTERS

09100 BARBER AND BEAUTY SHOP

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

08100 INTEREST EXPENSE

09300 NONPALD WORKERS

TOTAL

09400 PATIENTS LAUNDRY

05000 DENTAL CARE - TITLE XIX ONLY

04800 MEDICAL SUPPLIES CHARGED TO PATIENTS

08000 MALPRACTICE PREMIUMS & PAID LOSSES

SUBTOTALS (sum of lines 1-84)

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315509

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/2/2024 10:06 am	

					7 12/31/2023	5/2/2024 10: 0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9. 00	10.00	11. 00	12. 00	13.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	15, 140					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	3, 756				10.00
11.00	01100 PHARMACY	0	0	0			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	1, 890		12.00
13.00	01300 SOCI AL SERVI CE	0	ol	0	0	4, 019	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	ol	ol	o	0	0	14. 00
15. 00	01500 PATIENT ACTIVITIES	0	ol	0	0	Ō	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	٩١	9			
30. 00	03000 SKILLED NURSING FACILITY	15, 140	2, 507	0	1, 890	4, 019	30. 00
31. 00	03100 NURSING FACILITY	13, 140	2, 307	o	1,070	4,019	31. 00
		-1	o o	· ·	0		
32.00	03200 CF/IID	0	0	0	0	_	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS					1	
40. 00	04000 RADI 0L0GY	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	o	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	ol	o	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	٥	0	0	0	Ö	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	ő	48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS		1, 249	0	0	0	49. 00
				0	0		
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	U	0	50.00
51. 00	05100 SUPPORT SURFACES	0	U	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS					1	
60. 00	06000 CLI NI C	0	0	0	0		60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	ol	0	0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS	-1	<u> </u>	-	-		
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE		1				81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						
					0		82. 00
83. 00	08300 HOSPI CE	0	0	0	1 222	0	
89. 00	SUBTOTALS (sum of lines 1-84)	15, 140	3, 756	0	1, 890	4, 019	89. 00
	NONREI MBURSABLE COST CENTERS					1	
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	o	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	ol	0	0	0	94.00
98. 00	Cross Foot Adjustments	n	n	n			98. 00
99. 00	Negative Cost Centers	ا	n o	o	0	0	99. 00
100.00		15, 140	3, 756	· ·	1, 890		100. 00
. 55. 50	1.000	10, 140	3, 730	١	1, 370	1,017	

Provider No.: 315509

Peri od:

Part II

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/2/2024 10:06 am OTHER GENERAL SERVI CE Cost Center Description NURSING AND PATI ENT Subtotal Post Step-Down Total ALLIED HEALTH ACTI VI TI ES Adjustments EDUCATI ON 17.00 14.00 15.00 16.00 18.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9.00 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 12.00 01300 SOCIAL SERVICE 13 00 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 01500 PATIENT ACTIVITIES 15.00 0 15.00 73,689 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 73, 689 1, 067, 194 0 1,067,194 30.00 31.00 03100 NURSING FACILITY 0 0 0 31.00 0 32.00 03200 | CF/IID 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 33.00 O 0 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 262 262 41.00 04100 LABORATORY 0000000000 0 338 0 338 41.00 04200 I NTRAVENOUS THERAPY 0 42 00 42 00 C Ω 43.00 04300 OXYGEN (INHALATION) THERAPY 473 473 43.00 04400 PHYSI CAL THERAPY 14, 582 44.00 0 14, 582 44.00 04500 OCCUPATIONAL THERAPY 45.00 14. 237 14.237 45.00 04600 SPEECH PATHOLOGY 46.00 7, 564 7, 564 46.00 47.00 04700 ELECTROCARDI OLOGY 0 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 10, 114 48 00 10, 114 48.00 6, 879 49.00 04900 DRUGS CHARGED TO PATIENTS 0 6, 879 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 C C Λ 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83 00 83.00 0 Λ 89.00 SUBTOTALS (sum of lines 1-84) 0 73,689 1, 121, 643 1, 121, 643 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 00000 91.00 09100 BARBER AND BEAUTY SHOP C 2,644 2,644 91.00 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 09300 NONPALD WORKERS 93.00 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY Ω 0 94.00 0 98.00 Cross Foot Adjustments C 0 0 98.00 99. 00 Negative Cost Centers 0 99.00 100.00 TOTAL 73, 689 1, 124, 287 1, 124, 287 100. 00

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315509

COST Center Description						o 12/31/2023	Date/Time Pre 5/2/2024 10:0	
COLUMN FEATURES COLUMN			CAPITAL REI	_ATED COSTS			37272024 10.0	o alli
		Cost Center Description	FI XTURES	EQUI PMENT	BENEFITS (GROSS	Reconci I i ati on	& GENERAL	
1.00			1.00	2.00		4A	4. 00	
2.00			101.075	Г	T	1	T	
0.0300 EMPLOYEE BENEFITS		l l	104, 975	1				1
0.000 0.0000 ADMIN STRATIVE & GENERAL 15, 045 0 812, 982 -3, 828, 922 24, 294, 078 4. 0.0			0					
0.0000 LAUNDRY & LINEN SERVICE		00400 ADMINISTRATIVE & GENERAL	15, 045	O			24, 294, 078	1
7. 00 007000 HOUSEKEEPING 5.35 0 259, 302 0 2, 147, 534 7, 00 9. 00 009000 NURSIN ADMINISTRATION 0 0 1, 321, 881 0 2, 282, 525 9, 00 10. 00 0 0 0 0 0 0 56, 521 10, 00 11. 00 0 0 0 0 0 0 0 0 11, 00 12. 00 0 0 0 0 0 0 0 0 0 0 11, 00 13. 00 0 0 0 0 0 0 0 0 0 0 11, 00 13. 00 0				0	1			
8.00 00000 DIETARY 0 1.927,027 8.00 0				l .	1	_		
9.00 00000 NURSING ADMINI STRATION 0 0 1.3.21,851 0 2.282,525 9.00 11.00 0 1000 CENTRAL SERVICES & SUPPLY 0 0 0 0 56.321 10.00 11.00 11.00 PHARMACY 0 0 0 0 56.321 10.00 11.00 11.00 PHARMACY 16.1 0 0 0 0 56.321 11.00 13.00 DEDICAL SERVICE 212 0 135.684 0 232,581 13.00 0 1500 DEDICAL SERVICE 212 0 135.684 0 232,581 13.00 0 1500 NURSING ADM ALLED HEALTH EDUCATION 0 0 0 0 0 0 0 14.00 15.00 1500 NURSING ADM ALLED HEALTH EDUCATION 0 0 0 0 0 0 0 15.00 15.00 15.00 NURSING ADM ALLED HEALTH EDUCATION 0 0 0 0 0 0 0 0 15.00 NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				l				1
10. 00 010000 CENTRAL SERVICES & SUPPLY 0 0 0 0 566, 321 10. 00 10. 00 10. 00 10. 10. 00 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.			0,700	Ö				1
12. 00 01200 MEDICAL RECORDS & LIBRARY 161	10.00	01000 CENTRAL SERVICES & SUPPLY	0	O	0	0	566, 321	10. 00
13.00 01300 SOCIAL SERVICE 212 0 135,684 0 232,581 31.00 14.00 01400 NURSIN GAD ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 14.00 01500 NURSIN GAD ALLIED SERVICE COST CENTERS 15.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 1		l l	0	0	0	0		1
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0				0	125 404	0		1
15. 00 01500 PATIENT ACTIVITIES 5, 916 0 368, 126 0 695, 281 15. 00			212		133, 664			1
30.00 03000 03000 081 LED NURSI NG FACILITY			5, 916	Ö	368, 126	_	1	
31 00 03100 NURSI NG FACILITY								
32.00 03200 10FF 10NG TERM CARE		1 I	66, 470	1	1			
33.00 03300 0716FR LONG TERM CARE			0	_	1			
ANCILLARY SERVICE COST CENTERS			0		1			
41.00 04100 LABORATORY 0 0 0 0 0 50,919 41.00					-			
42.00 04200 04200 NTRAVENOUS THERAPY 0 0 0 0 0 0 42.00		1 I	0					
43.00 04300 0XYGEN (I NHALATION) THERAPY 0 0 0 0 71, 236 43.00 44.00 04400 PHYSI CAL THERAPY 931 0 0 0 559, 508 44.00 44.00 04500 0CCUPATIONAL THERAPY 931 0 0 0 559, 508 44.00 46.00 04600 SPEECH PATHOLOGY 566 0 0 0 144, 027 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 861 0 0 0 0 9, 221 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 300 0 0 0 0 320, 704 49.00 04900 DRUGS CHARGED TO PATIENTS 300 0 0 0 0 0 51.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51.00 05000 CLINI C 0 0 0 0 0 0 61.00 06000 CLINI C 0 0 0 0 0 0 61.00 06000 CLINI C 0 0 0 0 0 0 61.00 05000 DENTAL HEALTH AGENCY COST 0 0 0 0 0 0 71.00 07300 CMHC 0 0 0 0 0 0 0 71.00 07300 CMHC 0 0 0 0 0 0 71.00 07300 CMHC 0 0 0 0 0 0 71.00 07300 CMHC 0 0 0 0 0 0 71.00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81.00 71.00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81.00 71.00 09000 0500 CLINI CE 0 0 0 0 0 0 71.00 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 07000 71.00 07000 07000 07000 07000 07000 07000 07000 71.00 07000 07000 070000 07000 07000 07000 07000 71.00 07000 07000		1 I	0	0	1			
44. 00 04400 PHYSI CAL THERAPY 931 0 0 0 559, 508 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 931 0 0 0 507, 492 45. 00 46. 00 04600 SPEECH PATHOLOGY 566 0 0 0 0 144, 027 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 861 0 0 0 0 9, 221 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 861 0 0 0 0 9, 221 48. 00 04900 DRUGS CHARGED TO PATIENTS 300 0 0 0 0 320, 704 49. 00 04900 DRUGS CHARGED TO PATIENTS 300 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0			0	0				1
45. 00 04500 OCCUPATI (ONAL THERAPY 931 0 0 0 507, 492 45. 00 46. 00 04600 SPEECH PATHOLOGY 566 0 0 0 144, 027 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 861 0 0 0 0 0 9, 221 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 861 0 0 0 0 0 320, 704 49. 00 04900 DRUGS CHARGED TO PATI ENTS 300 0 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 61. 00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 61. 00 06200 FOHC 0 0 0 0 0 0 0 62. 00 06200 FOHC 0 0 0 0 0 0 0 71. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 71. 00 07100 MIBULANCE 0 0 0 0 0 0 0 0 71. 00 07300 CMHC 0 0 0 0 0 0 0 89. 00 08200 UTILIZATION REVIEW - SNF 82. 00 89. 00 08200 UTILIZATION REVIEW - SNF 82. 00 89. 00 08200 UTILIZATION REVIEW - SNF 82. 00 89. 00 SUBTORALS (sum of lines 1-84) 104,750 0 6,942,253 -3,828,922 24,291,668 89. 00 09000 0000 0000 0000 0000 0000 91. 00 09000 0000 0000 0000 0000 92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 93. 00 09300 00NONPAID WORKERS 0 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 95. 00 0000 0000 0000 0000 0000 00 0000 95. 0000 000000 000000 00000 00000 00000 95. 0000 000000 000000			931	Ö				
47. 00	45.00		931	o	0	0		1
48. 00		I I		0	1	_	1	1
49. 00 04900 DRUGS CHARGED TO PATIENTS 300 0 0 0 320,704 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50. 00 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 50. 00 0UTPATIENT SERVICE COST CENTERS 60. 00 06000 CLINIC 0 0 0 0 0 0 0 0 60. 00 61. 00 06200 FOHC 0 0 0 0 0 0 0 0 61. 00 62. 00 06200 FOHC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-	0		0		1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 50.00						0		1
OUTPATIENT SERVICE COST CENTERS O				Ö				1
60. 00	51.00		0	0	0	0	0	51.00
61. 00					J			
62. 00 06200 FOHC OTHER REIMBURSABLE COST CENTERS		l l	_					1
OTHER REIMBURSABLE COST CENTERS O				9	,	0	0	
71. 00		OTHER REIMBURSABLE COST CENTERS						
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 0			0		•			
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTI LI ZATI ON REVI EW - SNF 82.00 83.00 08300 HOSPI CE 0 0 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 104,750 0 6,942,253 -3,828,922 24,291,668 89.00 89.00 89.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 91.00 92.00 91.00 91.00 91.01 91.00 91.0			0					
80. 00	73.00				ıj U	0] /3.00
82. 00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 0 0 0 83.00 89. 00 SUBTOTALS (sum of lines 1-84) 104,750 0 6,942,253 -3,828,922 24,291,668 89. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	80. 00							80. 00
83. 00 08300 HOSPI CE 0 0 0 0 0 0 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 104,750 0 6,942,253 -3,828,922 24,291,668 89. 00								
89. 00 SUBTOTALS (sum of lines 1-84) 104,750 0 6,942,253 -3,828,922 24,291,668 89. 00								
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0			104 750		•			
90. 00	89.00		104, 750		0, 942, 233	-3, 020, 722	24, 291, 000	09.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92. 00 93. 00 9300 NONPAI D WORKERS 0 0 0 0 0 93. 00 94. 00 94. 00 94. 00 0 0 0 0 94. 00	90.00		1 0	О	0	0	0	90.00
93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 94. 00			225	0	1			
94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00			0	0	1	_		
			0	0		0		
98.00 Cross Foot Adjustments 98.00	98. 00	Cross Foot Adjustments			,	0	0	
99.00 Negative Cost Centers 99.00		1 1						
102.00 Cost to be allocated (per Wkst. B,	102.00		1, 124, 287	0	4, 650, 462		3, 828, 922	102. 00
Part I) 102.00 Unit cost multiplier (West P. Part I) 10.710045 0.000000 0.660979 0.157607102.00	102.00		10 710045	0.000000	0 440070		0 157407	102 00
103.00 Unit cost multiplier (Wkst. B, Part I) 10.710045 0.000000 0.669878 0.157607 103.00 104.00 Cost to be allocated (per Wkst. B, 0 161, 133 104.00			10. /10045	0.000000	U. 0098/8			
Part II)	154.00	Part II)					101, 133	
105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.006633 105.00	105.00	Unit cost multiplier (Wkst. B, Part			0.000000		0. 006633	105. 00
		11)	1	l	1		I	I

Provi der No.: 315509

				'	0 12/31/2023	5/2/2024 10:0	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(PATIENT			(5) 5507	
		REPAIRS	CENSUS)			(DI RECT	
		(SQUARE FEET) 5.00	6. 00	7. 00	8. 00	NURSI NG) 9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	84, 983					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	920	1				6.00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY	535		83, 528			7.00
8. 00 9. 00	00900 NURSI NG ADMI NI STRATI ON	6, 955	0	6, 955	182, 064	261, 287	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY				0	201, 207	10.00
11. 00	01100 PHARMACY		0		Ö	Ö	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	161	Ö	161	0	Ō	12. 00
13.00	01300 SOCIAL SERVICE	212	0	212	. 0	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. 00
15. 00	01500 PATIENT ACTIVITIES	5, 916	0	5, 916	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	66, 470		66, 470	182, 064	261, 287	30.00
31.00	03100 NURSING FACILITY	0	•		0	0	31.00
32.00	03200 TUFP LONG TERM CARE	0		C	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS				J U	U	33. 00
40. 00	04000 RADI OLOGY				0	0	40.00
41. 00	04100 LABORATORY		ĺ	Ì	_	Ö	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	d	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	C	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	931	0	931		0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	931	0	931		0	45. 00
46. 00	04600 SPEECH PATHOLOGY	566	0	566		0	46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY	861	0	861	_	0 0	47. 00 48. 00
49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	300		300		0	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0		300		0	50.00
51. 00	05100 SUPPORT SURFACES			ĺ	_	Ö	51.00
	OUTPATIENT SERVICE COST CENTERS	•	•				İ
60. 00	06000 CLI NI C	0	0	C		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	61. 00
62. 00	06200 FOHC						62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0	1	0	0	70 00
70.00	07100 AMBULANCE	0	1	C	_	0	70. 00 71. 00
73.00	07300 CMHC						73.00
70.00	SPECIAL PURPOSE COST CENTERS				<u> </u>		70.00
80.00							80.00
81.00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	84, 758	60, 688	83, 303	182, 064	261, 287	89. 00
00.00	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0		0	0	90.00
90. 00 91. 00	09100 BARBER AND BEAUTY SHOP	225		1	_	_	91.00
92. 00	09200 PHYSI CLANS PRI VATE OFFICES	223		223		0	92.00
93. 00	09300 NONPALD WORKERS		•	Ì	_	Ö	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	d	0	0	94.00
98. 00	Cross Foot Adjustments						98. 00
99. 00	1 1 9						99. 00
102.00	1 1	1, 467, 246	413, 965	2, 495, 237	2, 558, 586	2, 642, 267	102. 00
100 0	Part I)	47 0/5434	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20. 07001	14 050000	10 110500	100.00
103.00		17. 265171				10. 112508	•
104.00	Cost to be allocated (per Wkst. B, Part II)	61, 390	12, 799	20, 361	93, 989	15, 140	104. 00
105.00		0. 722380	0. 210898	0. 243763	0. 516242	0. 057944	105.00
. 50. 00	II)	3. 722300]	1.0.0212		
		•				•	

COST ALLOCATION - STATISTICAL BASIS Provider No.: 315509 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/2/2024 10:06 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND SERVICES & RECORDS & ALLI ED HEALTH (COSTED SUPPLY REQUIS) LI BRARY (PATI ENT **EDUCATION** (ASSI GNED (COSTED (PATIENT CENSUS) REQUIS) CENSUS) TIME) 13.00 10.00 11.00 12.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 955, 048 10.00 11. 00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 60,688 12.00 01300 SOCIAL SERVICE 0 60, 688 13 00 13 00 C 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 14.00 01500 PATIENT ACTIVITIES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 637, 557 0 60, 688 60, 688 0 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 Ω 0 33 00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 40.00 C 41.00 04100 LABORATORY 00000 0 0 0 0 0 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 317, 491 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 r 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC C 0 61.00 0 0 Ω 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 955, 048 60,688 60, 688 0 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP C 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 0 93.00 09300 NONPALD WORKERS 0 0 93.00 94 00 09400 PATIENTS LAUNDRY 0 O ol 94 00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 Cost to be allocated (per Wkst. B, 102.00 655, 577 9,586 279, 230 0 102.00 Part I) 4.601074 0.000000 103.00 103 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.157955 0.686434 104.00 Cost to be allocated (per Wkst. B, 1,890 0 104.00 3,756 4,019 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.003933 0.000000 0.031143 0.066224 11)

Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315509 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/2/2024 10:06 am

			10 12/31/2023	5/2/2024 10:06 am
		OTHER GENERAL		37272024 10:00 dill
		SERVI CE		
	Cost Center Description	PATI ENT		
		ACTI VI TI ES		
		(PATI ENT		
		CENSUS)		
	CENEDAL CEDULCE COCT CENTERS	15. 00		
1. 00	GENERAL SERVI CE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3. 00	00300 EMPLOYEE BENEFITS			3.00
4. 00	00400 ADMINISTRATIVE & GENERAL			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6. 00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			10.00
11.00	1 1			11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY			12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION			13. 00 14. 00
15. 00	01500 PATIENT ACTIVITIES	60, 688		15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00,000		19.00
30. 00	03000 SKILLED NURSING FACILITY	60, 688		30.00
31. 00		0		31.00
32.00	03200 CF/IID	0		32.00
33. 00	03300 OTHER LONG TERM CARE	0		33.00
	ANCILLARY SERVICE COST CENTERS			
40. 00	04000 RADI OLOGY	0		40. 00
41. 00	04100 LABORATORY	0		41.00
42.00	+ I	0		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0		43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0		44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	0		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00		l o		48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50. 00
51.00	05100 SUPPORT SURFACES	0		51. 00
	OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLI NI C	0		60.00
61.00	06100 RURAL HEALTH CLINIC	0		61.00
62. 00	06200 FQHC OTHER REIMBURSABLE COST CENTERS			62. 00
70. 00		0		70. 00
71. 00	+ I	0		71.00
73. 00		l o		73. 00
	SPECIAL PURPOSE COST CENTERS			
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			80.00
81. 00	· · · · · · · · · · · · · · · · · · ·			81. 00
82. 00	08200 UTILIZATION REVIEW - SNF			82. 00
83. 00	08300 HOSPI CE	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	60, 688		89. 00
00.00	NONREI MBURSABLE COST CENTERS			00.00
90. 00 91. 00	The state of the s	0		90. 00 91. 00
91.00	09200 PHYSICIANS PRIVATE OFFICES	0		92.00
93. 00	09300 NONPALD WORKERS	0		93. 00
94. 00		l o		94. 00
98. 00	Cross Foot Adjustments			98. 00
99. 00				99. 00
102.00		1, 083, 732		102. 00
	Part I)			
103.00		17. 857435		103. 00
104.00		73, 689		104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	1. 214227		105. 00
100.00	II)	1. 214221		103.00
		1		1

Peri od: Worksheet C Provi der No.: 315509

		o 12/31/2023	Date/Time Pre 5/2/2024 10:0	
Cost Center Description	Total (from	Total Charges	Ratio (col. 1	
	Wkst. B, Pt I,		di vi ded by	
	col . 18)		col. 2	
	1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS				
40. 00 04000 RADI OLOGY	45, 662	·	1. 696778	
41. 00 04100 LABORATORY	58, 944	28, 949		1
42. 00 04200 I NTRAVENOUS THERAPY	C	0	0. 000000	
43.00 O4300 OXYGEN (INHALATION) THERAPY	82, 463		0. 000000	
44. 00 04400 PHYSI CAL THERAPY	691, 576	744, 761	0. 928588	
45. 00 04500 OCCUPATI ONAL THERAPY	631, 362	650, 566	0. 970481	45. 00
46. 00 04600 SPEECH PATHOLOGY	193, 407	277, 548		
47. 00 04700 ELECTROCARDI OLOGY	C	0	0. 000000	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	51, 260		0. 000000	48. 00
49.00 O4900 DRUGS CHARGED TO PATIENTS	603, 328	207, 227	2. 911435	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	C	0	0. 000000	50. 00
51. 00 05100 SUPPORT SURFACES	C	0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS				
60. 00 06000 CLI NI C	C	0	0. 000000	
61. 00 06100 RURAL HEALTH CLINIC				61. 00
62. 00 06200 FQHC				62. 00
71. 00 07100 AMBULANCE	C	0	0. 000000	1
100. 00 Total	2, 358, 002	1, 935, 962		100. 00

atio of Cost to Charges Fr. Wkst. C Column 3) 1.00 T COST		(VIII (1)		Date/Time Pre 5/2/2024 10:0 PPS Program Cost Part B (col. 1 x col. 3)	06 am
to Charges Fr. Wkst. C Column 3) 1.00 T COST	Health Care Pr	Ogram Charge:	To 12/31/2023 Skilled Nursing Facility Health Care Part A (col. 1 x col. 2)	Date/Time Pre 5/2/2024 10:0 PPS Program Cost Part B (col. 1 x col. 3)	06 am
to Charges Fr. Wkst. C Column 3) 1.00 T COST	Heal th Care Pr	ogram Charge Part B	Skilled Nursing Facility Health Care Part A (col. 1 x col. 2)	5/2/2024 10:0 PPS Program Cost Part B (col. 1 x col. 3)	06 am
to Charges Fr. Wkst. C Column 3) 1.00 T COST	Heal th Care Pr	ogram Charge Part B	Facility S Health Care Part A (col. 1 x col. 2)	Program Cost Part B (col. 1 x col. 3)	
to Charges Fr. Wkst. C Column 3) 1.00 T COST	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
to Charges Fr. Wkst. C Column 3) 1.00 T COST	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
to Charges Fr. Wkst. C Column 3) 1.00 T COST			x col. 2)	x col. 3)	
to Charges Fr. Wkst. C Column 3) 1.00 T COST			x col. 2)	x col. 3)	
to Charges Fr. Wkst. C Column 3) 1.00 T COST			x col. 2)	x col. 3)	
Fr. Wkst. C Col umn 3) 1.00 T COST 1.696778	2.00	3.00	ŕ	·	
1. 00 1. 00 T COST	2.00	3.00	4. 00		
1. 00 T COST 1. 696778	2.00	3.00	4. 00		
T COST 1. 696778	2.00	3.00		5. 00	+
1. 696778				5.00	
					i
	23, 873		0 40, 507	0	40.00
2. 036133	24, 215		0 49, 305	l .	
0. 000000	0		0 0	Ō	
0. 000000	o		0 0	0	43.00
0. 928588	358, 910		0 333, 280	0	44.00
0. 970481	332, 020		0 322, 219	0	45.00
0. 696842	157, 433		0 109, 706	0	46.00
0. 000000	o		0 0	0	47.00
0.000000	0		0 0	0	48.00
2. 911435	140, 488		0 409, 022	0	49.00
0. 000000	0		0	,	50.00
0. 000000	0		0 0	0	51.00
0. 000000	0		0	0	60.00
					61.00
					62.00
0. 000000			0		71.00
	1, 036, 939		0 1, 264, 039	0	100.00
	0. 696842 0. 000000 0. 000000 2. 911435 0. 000000 0. 000000 0. 000000	0. 000000 0 0. 000000 0 2. 911435 140, 488 0. 000000 0 0. 000000 0	0. 000000 0 0. 000000 0 2. 911435 140, 488 0. 000000 0 0. 000000 0	0. 000000 0	0. 000000 0

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

Health Financial Systems ROOSEVELT CARE CENTER AT OLD BRIDGE In Lieu of Form CMS-2540-10								
	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Parts II-III	pared:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS		
	Cost Center Description					1. 00		
	PART II - APPORTIONMENT OF VACCINE COST							
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3,	line 49)	2. 911435	1. 00	
2.00	Program vaccine charges (From your reco					2, 962	2. 00	
3.00								
	E, Part I, line 18) Cost Center Description Total Cost Nursing & Ratio of Program Part A Part A Nursing							
	cost center bescription	(From Wkst. B,			Cost (From	& Allied		
			(From Wkst. B,			Heal th Costs		
		18		Costs to Tota		for Pass		
			14)	Costs - Part		Through (Col.		
	(Col. 2 / Col. 3 x Co							
		1. 00	2.00	3.00	4. 00	5. 00		
	PART III - CALCULATION OF PASS THROUGH COSTS		ALLI ED HEALTH			0.00		
	ANCILLARY SERVICE COST CENTERS							
	04000 RADI OLOGY	45, 662	l					
41. 00	04100 LABORATORY	58, 944	C	0.00000		l		
42.00	04200 I NTRAVENOUS THERAPY	0	C	0.00000		0		
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	82, 463	l	0.00000 0.00000		0		
44.00	04500 OCCUPATIONAL THERAPY	691, 576 631, 362	l	0.00000			45.00	
46. 00	04600 SPEECH PATHOLOGY	193, 407		0.00000			46.00	
47. 00	04700 ELECTROCARDI OLOGY	0	Č	0.00000		0		
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	51, 260	Ċ	0. 00000		Ö		
49.00	04900 DRUGS CHARGED TO PATIENTS	603, 328	c	0.00000	00 409, 022	0	49. 00	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	0.00000		0		
	05100 SUPPORT SURFACES	0	C	0.00000		0	0 00	
100.00	Total (Sum of lines 40 - 52)	2, 358, 002	C	P	1, 264, 039) 0	100. 00	

	Financial Systems ROOSEVELT CARE CENTER			u of Form CMS-2		
COMPU ⁻	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315509	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Parts I-II Date/Time Preps/2/2024 10:00	pared:	
		Title XVIII	Skilled Nursing Facility	PPS		
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days including private room days			60, 688		
2.00	Private room days	koaram		0 8, 191		
3. 00 4. 00	Inpatient days including private room days applicable to the P Medically necessary private room days applicable to the Progra			8, 191		
5.00	Total general inpatient routine service cost	III		25, 751, 602		
0.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			20,701,002	0.00	
6.00	General inpatient routine service charges			25, 079, 079	6.00	
7.00	General inpatient routine service cost/charge ratio (Line 5 d	ivided by line 6)		1. 026816	7. 00	
8.00	Enter private room charges from your records			0	8. 00	
9. 00	Average private room per diem charge (Private room charges lin 2)	room days, line	0.00	9. 00		
10.00	Enter semi-private room charges from your records	0				
11. 00	Average semi-private room per diem charge (Semi-private room	0. 00	11.00			
12. 00	semi -private room days)	o line 11)		0.00	12. 00	
13. 00	,					
14. 00	3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0.00	13. 00 14. 00			
15. 00		25, 751, 602				
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	,	,	., .,		
16.00	Adjusted general inpatient service cost per diem (Line 15 div	ided by line 1)		424. 33	16. 00	
17. 00				3, 475, 687		
	Medically necessary private room cost applicable to program (0		
19.00	Total program general inpatient routine service cost (Line 17		.+ 10	3, 475, 687		
20. 00	Capital related cost allocated to inpatient routine service colline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	sts (From WKSt. B, Par	T II COLUMN 18,	1, 067, 194	20. 00	
21. 00				17. 58	21. 00	
22. 00				143, 998		
	Inpatient routine service cost (Line 19 minus line 22)			3, 331, 689		
24.00	Aggregate charges to beneficiaries for excess costs (From pro	vi der records)		0	24. 00	
25.00	Total program routine service costs for comparison to the cost	nus line 24)	3, 331, 689			
26. 00				26. 00		
	Inpatient routine service cost limitation (Line 3 times the pe				27. 00	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus the Company to Workshoot F. Pont II. Line 4) (See instructions)		28. 00			
(1) Li	(Transfer to Worksheet E, Part II, line 4) (See instructions) nes 26 and 27 are not applicable for title XVIII, but may be us	ed for title V and or t	itle XIX		ı	
				1. 00		
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days			60, 688		
2.00	Program inpatient days (see instructions) Total nursing & allied health costs. (see instructions)(Do not	complete for titles V	or VIV)	8, 191 0	2.00	
3. 00 4. 00		comprete for titles v	UI AIA)	-		
	0 Nursing & allied health ratio. (line 2 divided by line 1) 0.134969 0 Program nursing & allied health costs for pass-through. (line 3 times line 4) 0					

Health Financial Systems	ROOSEVELT CARE CENTER AT	OLD BRIDGE	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SE	ETTLEMENT FOR TITLE XVIII		From 01/01/2023 To 12/31/2023	Worksheet E Part I Date/Time Prepared: 5/2/2024 10:06 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	FMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	EMEIV1		6, 306, 862	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	3		6, 306, 862	
4.00	Primary payor amounts			38, 276	•
5.00	Coinsurance		789, 200	5. 00	
6.00	Allowable bad debts (From your records)			174, 818	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		74, 444	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			113, 632	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			5, 593, 018	11.00
12.00	Interim payments (See instructions)			5, 509, 349	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14. 00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration	0			
14. 75	Sequestration for non-claims based amounts (see instructions)	2, 273			
14. 99	Sequestration amount (see instructions)	109, 588			
15. 00	Balance due provider/program (see Instructions)	-28, 192			
16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)					16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			8, 624	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			8, 624	
20.00	Medicare Part B ancillary charges (See instructions)			2, 962	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			2, 962	
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)	-+:>		0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	CTIONS)		0	
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			2, 962	
26. 00 27. 00	Interim payments (See instructions)			1, 887	
	Tentative adjustment			0	
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55 28. 99	Demonstration payment adjustment amount after sequestration Sequestration amount (see instructions)			0 59	28. 55 28. 99
28. 99	Balance due provider/program (see instructions)				28. 99
	Protested amounts (Nonallowable cost report items) in accordance	a with CMS Dub 15 2	section 115 2	1,018	
30.00	processed amounts (Nonarrowable cost report realis) ill accordance	C WI III GWO I UD. 13-2, :	30001011 113.2	٥١	30.00

Health Financial Systems ROOSEVELT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2540-10 Provi der No.: 315509 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/2/2024 10:06 am Title XVIII Skilled Nursing PPS

Total interim payments paid to provider 1.00			11 (1	e AVIII	Facility	PPS	
Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.887 1.00 1.00 1.187 1.00 1.00 1.187 1.00 1.00 1.187 1.00 1.00 1.187 1.00 1.			Inpatien	t Part A		t B	
Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.887 1.00 1.00 1.187 1.00 1.00 1.187 1.00 1.00 1.187 1.00 1.00 1.187 1.00 1.			/ - - /	A	/ -l -l /	A +	
Total interin payments payable on individual bills, either subhilted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero							
Interfim payments' payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero	1 00	Total interim nayments haid to provider	1.00		3.00		1 00
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero				3, 307, 347 O			
Services rendered in the cost reporting period. If none, enter zero	2.00			Ö		Ĭ	2.00
enter Zero anount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 4.01 3.55 3.59 4.00 1.01 3.59 4.00 3.59 4.00 3.59 4.00 3.59 4.00 3.59 4.00 3.59 4.00 5.01 5.01 5.02 5.03 5.03 5.04 5.03 5.04 5.04 5.05 5.05 5.05 5.05 5.05 5.05							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00	List separately each retroactive lump sum adjustment					3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02	0.04						0.01
3.04 0		ADJUSIMENTS TO PROVIDER				- 1	
3.04 0 0 0 3.04 3.05				-		1 - 1	
3.05						- 1	
Provider to Program ADJUSTMENTS TO PROGRAM 0				-			
ADJUSTMENTS TO PROGRAM	3.03	Provider to Program		<u> </u>		0	3. 03
3.51 3.52 3.53 0	3.50			0		0	3. 50
3.53 3.54 3.54 3.54 3.55 3.55 3.55 3.55 3.56 3.57 3.58 3.57 3.58 3.59				-		o	
3.54 3.99	3.52			0		o	3. 52
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 0 0 3.99 -3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.98 Total interim payments (sum of lines 1, 2, and 3.99) -3.99 Total interim payments (sum of lines 1, 2, and 3.99) -3.90 Tetrial interim payments (sum of lines 1, 2, and 3.99) -3.90 Tetrial interim payments (sum of lines 1, 2, and 3.99) -3.90 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.49 minus sum of lines 5.50 -3.91 -3.01 Tetrial interim payments (sum of lines 3.50 -3.49 minus sum of lines 5.50 -3.91 -3.01 Tetrial interim payments (sum of lines 3.50 -3.49 minus sum of lines 5.50 -3.51 -3.01 Tetrial interim payments (sum of lines 3.50 -3.49 minus sum of lines 5.50 -3.51 -3.01 Tetrial interim payments (sum of lines 3.50 -3.49 minus sum of lines 5.50 -3.51 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial interim payments (sum of lines 3.50 -3.01 -3.01 Tetrial inte	3.53			0		0	3. 53
-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program to Provider Tenantive settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Tenantive To Provider Tenantive To Provider Tenantive To Provider Tenantive To Provider Tenantive To Program	3.54			0		0	3.54
Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wsxt. E, Part I line 12 for Part A, and line 26 for Part B) To BE COMPLETED BY CONTRACTOR	3. 99			0		0	3. 99
CTransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR							
26 for Part B TO BE COMPLETED BY CONTRACTOR	4.00			5, 509, 349		1, 887	4. 00
TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O O O O O O O O O O O O O O O O O O							
5.00							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
S. 02 S. 03 Provider to Program							
Solidar to Program Solidar	5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM	5.03			0		0	5. 03
5.51 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Number							
5.52 0 0 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 5.99 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 1,016 6.01 6.01 PROGRAM TO PROVIDER 0 1,016 6.01 6.02 PROVIDER TO PROGRAM 28,192 0 6.02 7.00 Total Medicare program liability (see instructions) 5,481,157 2,903 7.00 Contractor Name Contractor Number		TENTATI VE TO PROGRAM		-			
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 the cost report. (1) 0 1,016 6.01 PROGRAM TO PROVIDER 0 1,016 6.01 PROVIDER TO PROGRAM 28,192 0 6.02 7.00 Total Medicare program liability (see instructions) 5,481,157 2,903 7.00 Contractor Name Contractor Number 1.00 2.00 Contractor Number Contr				-			
- 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 5.98) 0				0			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1.00 2.00	5. 99			0		U	5. 99
the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00	6 00						6 00
6. 01 PROGRAM TO PROVIDER 0 1,016 6. 01 6. 02 PROVIDER TO PROGRAM 28, 192 0 6. 02 7. 00 Total Medicare program liability (see instructions) 5, 481, 157 2,903 7. 00 Contractor Name Contractor Number 1. 00 2. 00	0.00						0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) 28, 192 5, 481, 157 2, 903 7.00 Contractor Name Contractor Number 1.00 2.00	6. 01			0		1. 016	6. 01
7.00 Total Medicare program liability (see instructions) 5,481,157 2,903 7.00 Contractor Name Contractor Number Number 1.00 2.00				28, 192			
Contractor Name Contractor Number		· · · · · · · · · · · · · · · · · · ·		·		2, 903	
1.00 2.00				Contract	or Name	Contractor	
8 00 Name of Contractor		In the second second		1.	00	2. 00	
(1) On lines 2. 5, and 6, where an amount is due provider to program, show the amount and date on which the provider		·				I	8. 00

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

Health Financial Systems ROOSEVELT CARE CENTRE BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column onl y)

Provi der No.: 315509

oni y)				F 1 F 1	5/2/2024 10:0	6 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Accete	1.00	2. 00	3. 00	4. 00	
	Assets CURRENT ASSETS					1
1.00	Cash on hand and in banks	1, 942, 021	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	
4. 00 5. 00	Accounts receivable Other receivables	3, 128, 162	0	0	0	
6. 00	Less: allowances for uncollectible notes and accounts	362, 537	0	0	0	
0.00	recei vabl e			J	O	0.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepai d expenses	0	0	0	0	
9.00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10) FIXED ASSETS	5, 432, 720	0	0	0	11. 00
12. 00	Land	1 0	0	ol	0	12.00
13. 00	Land improvements	0	0	0	0	
14. 00	Less: Accumulated depreciation	Ö	0	Ö	0	
15.00	Bui I di ngs	190, 992	0	0	0	15.00
16. 00	Less Accumulated depreciation	-127, 480	0	0	0	
17. 00	Leasehold improvements	0	0	0	0	
18.00	Less: Accumulated Amortization	0	0	0	0	
19.00	Fixed equipment	0	0	0	0	
20. 00 21. 00	Less: Accumulated depreciation Automobiles and trucks		0	0	0	
22. 00	Less: Accumulated depreciation		0	0	0	
23. 00	Major movable equipment	322, 557	0	0	0	
24. 00	Less: Accumulated depreciation	-310, 542	0	Ö	0	
25.00	Mi nor equi pment - Depreci abl e	0	0	0	0	25. 00
26. 00	Mi nor equipment nondepreciable	0	0	0	0	•
27. 00	Other fixed assets	0	0	0	0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	75, 527	0	0	0	28.00
29. 00	OTHER ASSETS Investments	1 0	0	٥	0	1 29. 00
30. 00	Deposits on Leases		0	0	0	
31. 00	Due from owners/officers	-5, 610, 062	ı	o	0	
32.00	Other assets	0	0	0	0	
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-5, 610, 062	0	0	0	33.00
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	-101, 815	0	0	0	34.00
	Liabilities and Fund Balances					-
35. 00	CURRENT LIABILITIES Accounts payable	865, 955	0	٥	0	35. OC
36. 00	Salaries, wages, and fees payable	282, 667	0	0	0	
37. 00	Payrol I taxes payable	0	Ö	o	0	
38. 00	Notes & Loans payable (Short term)	Ō	0	Ö	0	
39. 00	Deferred income	0	0	0	0	39.00
40.00	Accel erated payments	0				40.00
41.00	Due to other funds	0	0	0	0	
42.00	Other current liabilities	0	0		0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) LONG TERM LIABILITIES	1, 148, 622	0	0	0	43.00
44. 00	Mortgage payable	1 0	0	0	0	44.00
45. 00	Notes payable		0	0	0	
46.00	Unsecured Loans	0	0	0	0	
47.00	Loans from owners:	0	0	0	0	47. 00
48. 00	Other long term liabilities	0	0	0	0	
49. 00	OTHER (SPECIFY)	0	0	0	0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	1, 148, 622	0	0	0	51.00
52. 00	General fund balance	-1, 250, 437				52.00
53.00	Specific purpose fund	1,200,107	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
EO 00	replacement, and expansion	1 250 427	_		^	E0 0
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-1, 250, 437 -101, 815		0	0	
55. 50		-101, 615		٩	U	30.00
22.00	[59]					_

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315509

						5/2/2024 10:00	
		General	Fund	Speci al P	urpose Fund	Endowment Fund	
		1.00	0.00	2.00	1.00	F 00	
1 00		1.00	2.00	3. 00	4. 00	5. 00	1 00
1.00	Fund balances at beginning of period		-447, 261		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-649, 532				2.00
3.00	Total (sum of line 1 and line 2)		-1, 096, 793		0		3. 00
4.00	Additions (credit adjustments)						4. 00
5. 00 6. 00		0			0	0	5. 00
		0			0		6. 00 7. 00
7.00		0			0		
8. 00 9. 00					0		8. 00 9. 00
10.00	Total additions (sum of line 5 - 9)	١		'	٥	١	10.00
			1 007 703		0		
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments)		-1, 096, 793		0		11. 00 12. 00
12.00	OTHER DEDUCTIONS	153, 643			n	0	12.00
14. 00	ROUNDI NG	153, 643			0		14. 00
15. 00	ROUNDING						15. 00
16. 00							16. 00
17. 00					0		17. 00
18. 00	Total deductions (sum of lines 13 - 17)	١	153, 644	'	0	o l	18. 00
19. 00	Fund balance at end of period per balance		-1, 250, 437		0		19. 00
. , . 00	sheet (Line 11 - line 18)		1, 200, 10,				
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0.00	7.00		0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3.00	Total (sum of line 1 and line 2)	0					
4.00	Additions (credit adjustments)	I UI			0		3.00
	(Additions (Credit adjustments)	U			0		3. 00 4. 00
5.00	Additions (credit adjustments)	O	0		0		
5. 00 6. 00	Additions (credit adjustments)	O	0	1	0		4. 00
	Additions (credit adjustments)	U	O O O	1	0		4. 00 5. 00
6.00	Additions (credit adjustments)	O	0 0 0 0	,	0		4. 00 5. 00 6. 00
6. 00 7. 00	Additions (credit adjustments)	U	0 0 0 0	,	0		4. 00 5. 00 6. 00 7. 00
6. 00 7. 00 8. 00	Total additions (sum of line 5 - 9)	0	0 0 0 0		0		4. 00 5. 00 6. 00 7. 00 8. 00
6. 00 7. 00 8. 00 9. 00		J	0 0 0 0				4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0		0		4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS	0	0 0 0 0 0		0		4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments)	0	0 0 0 0 0		0		4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS	0	0 0 0 0 0		0		4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS	0	0 0 0 0 0		0		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
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS ROUNDING	0	0 0 0 0 0	,	0		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
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS ROUNDING Total deductions (sum of lines 13 - 17)	0 0	0 0 0 0 0		0000		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
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS ROUNDING Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0	0 0 0 0 0		0		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
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) OTHER DEDUCTIONS ROUNDING Total deductions (sum of lines 13 - 17)	0 0	0 0 0 0 0		0000		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	ROOSEVELT CARE CENTER A	AT OLD BRIDGE	In Lie	u of Form CMS-2540-10
STATEMENT OF DATIENT DEVENUES	AND ODEDATING EVDENCES	Drovi don No · 215500	Pari od:	Workshoot G_2

Heal th	Financial Systems ROOSEVELT CARE CENTER	R AT OLD BRI	DGE	In Lie	eu of Form CMS-2	2540-10
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 Fo 12/31/2023		pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services			_1		
1.00	SKILLED NURSING FACILITY		25, 079, 079	7	25, 079, 079	1.00
2.00	NURSING FACILITY		1)	0	2.00
3.00	ICF/IID		()	0	3. 00
4.00	OTHER LONG TERM CARE		05 070 07)	0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		25, 079, 07	7	25, 079, 079	5. 00
	All Other Care Services		1 005 00		4 005 0/4	, ,,
6.00	ANCI LLARY SERVI CES		1, 935, 96	0	1, 935, 961	6.00
7.00	CLINIC			0	0	7. 00
8. 00 9. 00	HOME HEALTH AGENCY COST AMBULANCE			0	0	
9. 00 10. 00	RURAL HEALTH CLINIC			0	0	9.00
				0	0	10.00
10. 10 11. 00	FQHC CMHC			0	ľ	10. 10 11. 00
12. 00	HOSPI CE			0	0	12.00
13. 00	ROUTINE CHARGES / BED HOLD		81, 34	7	81, 347	13.00
14. 00	Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column	2 +0	27, 096, 38			14. 00
14.00	Worksheet G-3, Line 1)	1 3 10	27, 090, 30	0	27,090,307	14.00
	Cost Center Description					
	obst donts. Dosor per on			1. 00	2. 00	
	PART II - OPERATING EXPENSES			1		
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				27, 612, 754	1.00
2.00	Add (Specify)			0	1	2.00
3.00				0		3. 00
4.00				0		4. 00
5.00				0		5. 00
6.00				0		6. 00
7.00				0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9.00	Deduct (Specify)			0		9. 00
10.00				0		10. 00
11. 00				0		11. 00
12.00				0		12. 00
13.00				0		13. 00
	Total Deductions (Sum of lines 9 - 13)				0	
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14	.)			27, 612, 754	15. 00

Health Financial Systems	ROOSEVELT CARE CENTER A	T OLD BRIDGE	In Lie	u of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND	OPERATI NG EXPENSES	Provi der No.: 315509	Peri od:	Worksheet G-3

near tii	Financial Systems ROOSEVELI CARE CENTER A	I ULU DRIDGE	III LI E	u or Form CNS-2	2340-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315509	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
			10 12/31/2023	5/2/2024 10: 0	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1	4)		27, 096, 387	1. 00
2.00	Less: contractual allowances and discounts on patients accounts			140, 231	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			26, 956, 156	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		27, 612, 754	4. 00
5.00	Net income from service to patients (Line 3 minus 4)			-656, 598	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			6, 536	1
8.00	Revenues from communications (Telephone and Internet service)			0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
	Purchase di scounts			0	10. 00
	Rebates and refunds of expenses			530	1
	Parking lot receipts			0	12. 00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			0	14. 00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
	Rental of vending machines			0	21. 00
	Rental of skilled nursing space			0	22. 00
	Governmental appropriations			0	23. 00
	Other miscellaneous revenue (specify)			0	24. 00
	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)			7, 066	
26. 00	Total (Line 5 plus line 25)			-649, 532	
	Other expenses (specify)			0	27. 00
28. 00				0	28. 00
29. 00				0	
	Total other expenses (Sum of lines 27 - 29)			0	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)			-649, 532	31.00