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

OMB NO. 0938-0463

Expires: 12/31/2021

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provi der CCN: 315146	From 01/01/2022 To 12/31/2022	Worksheet S Parts I, II & III Date/Time Prepared: 5/30/2023 11:08 am
--	-----------------------	----------------------------------	---

				3730	72023 1	1.00 am
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/30/2023	Ti me:	11:08 am
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	er the number	of times the provider	resubmitted this cos	t repor	·t
	3.01 [] No Medicare Utilization. Enter "	Y" for yes or	leave blank for no.			
Contractor	4.[1]Cost Report Status	6. Contractor	No	<u></u>		
use only	(1) As Submitted	7.[N] First	Cost Report for this	Provider CCN		
	(2) Settled without audit	8.[N] Last Cost Report for this 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				ened
	(5) Amended		Vendor Code	4		
	5. Date Received:	12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N"				or "N"
		TOF	no utilization.			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARE CONNECTION RAHWAY, LLC (315146) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Sa	am Stern	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	Sam Stern			2
3	Signatory Title	CF0			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	-25, 276	0	0	1. 00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	-25, 276	0	0	100. 00

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

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

Health Financial Systems CARE CONNECTION RAHWAY, LLC In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315146 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 11:08 am 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 865 STONE STREET PO Box: 1.00 2.00 City: RAHWAY State: NJ Zi p Code: 07065 2.00 3.00 County: UNI ON CBSA Code: 35084 Urban/Rural: U 3.00 3. 01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XI X 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CARE CONNECTION RAHWAY, 315146 01/01/1967 N Р Ν 4.00 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) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 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 3.658 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 23.00 3.658 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) N 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 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 0

Heal th	ealth Financial Systems CARE CONNECTION RAHWAY, LLC In Lieu					2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3151	46 Peri od:	Worksheet S-2	
COMPLE	COMPLEX INDENTIFICATION DATA From 01/01/2022					
	To 12/31/2022					pared:
					5/30/2023 11:	08 am_
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid losse	and General cost	N	42. 00		
	center? Enter Y or N. If yes, check box	k, and submit supporting s	schedule listing co	st centers and		
	amounts.					
43.00	43.00 Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?					
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addre	ss 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	e and address of th	ne home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Cont	ractor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zi p	Code:		47. 00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315146 Period	Heal th	Financial Systems	CARE CONNECTION RAH	WAY, LLC		In lie	eu of Form CMS-	2540-10
Seneral Instruction: For all column 1 responses enter in column 1, "V" for Yes or "N" for No. For all the date responses. The Forent of III be (enr.dat/yyyy). Seneral Instruction: For all column 1 responses enter in column 1, "V" for Yes or "N" for No. For all the date responses. The Forent of III be (enr.dat/yyyy). Descripting porting the Chapter of the Chapter	SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILI			No.: 315146	Period: From 01/01/2022	Worksheet S-2 Part II	2
Seneral Instruction, For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date presented. The final State (1997) The seneral State (1997) The sen							5/30/2023 11:	
responses the formal will be (emiddly/yyy) Completed by All Skill by Musting Facilities Provided forganization and Operation Total Control of Organization and Operation Total Control of Operation Total Control operation Total Co						1. 00	2.00	
1.00		responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fc	r Yes or "N"	for No. For all	the date	
V/N	1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter	ly prior to the beg the date of the cha	inning of nge in col	the cost umn 2. (see	N		1.00
2.00 Institute provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 to date of termination and in column 3 yes. Provided the column 1 is yes, enter in column 2 to date of termination and in column 3 yes. Provided the provided yes. Provid							1	
1.00 1.5 the provider involved in business transactions, including management of contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or 1ts officers, medical strift, management personnel, or members of the board relationships? (see instructions) 7.00	2. 00	column 1 is yes, enter in column 2 the date	Ş			2.00	3. 00	2. 00
Financial Data and Reports	3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personned of directors through ownership, control, or	., chain home offic d to the provider o I, or members of th	es, drug r its e board	N			3.00
Financial Data and Reports								
Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see Instructions) If no. see Instructions.					1.00	2.00	3.00	
Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit	4.00	Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" te copy or enter da	for te	Y	С	06/30/2023	4. 00
Approved Educational Activities	5. 00	Are the cost report total expenses and total those on the filed financial statements? If	revenues different	from	N			5. 00
Approved Educational Activities 6.00 Column 1: Were costs call and for Nursing School? (Y/N) Column 2: Is the provider the N N N 6.00 legal operator of the program? (Y/N) 7.00 Were costs call and for All ide Heal th Programs? (Y/N) see instructions. N 7.00 School and/or All ide Heal th Program? (Y/N) see instructions. N N 7.00 School and/or All ide Heal th Program? (Y/N) see instructions. N N 8.00 School and/or All ide Heal th Program? (Y/N) see instructions. N 1.00 School and/or All ide Heal th Program? (Y/N) see instructions. N 1.00 If I line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting N 10.00 If I line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 11.00 Bed Complement 12.00 Have total beds available changed from prior cost reporting period? If "Y", see instructions. N 12.00 Section of the PS&R bata 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 prepared using the PS&R N N N 14.00 Was the cost report prepared using the PS&R N N N N 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see instructions. N N N N N N N N N N N N N N N N N N N								
legal operator of the program? (Y/N) 7.00 Were costs claimed for Allied Heal th Programs? (Y/N) see instructions. N 7.00 No.								
Section Were approvals and/or renewals obtained during the cost reporting period for Nursing N School and/or Allied Heal th Program? (Y/N) see instructions. Y/N 1.00		legal operator of the program? (Y/N)			provider the		N	
Bad Debts 1.00	8. 00			ng period	for Nursing	N	V/NI	8. 00
1. the provider seeking reimbursement for bad debts? (Y/N) see instructions. Y 9.00		To the second se						
11.00 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. N 12.00		Is the provider seeking reimbursement for balfline 9 is "Y", did the provider's bad deb				st reporting		
Description Part A Part B	11. 00	If line 9 is "Y", are patient deductibles and	d/or coinsurance wa	ived? If "	Y", see instr	ructi ons.	N	11. 00
PS&R Data 13.00 PS&R Data	12. 00	Have total beds available changed from prior	cost reporting per	iod? If "Y				12. 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 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: N N N N N N N N N N N N N N N N N N				n	Y/N	Date	Y/N	
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 prepared using the PS&R of 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 prepared using the PS&R of 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 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: N N N N N N N N N N N N N N N N N N N		PS&R Data	0		1.00	2. 00	3.00	
14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the	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	03/17/2023	Y	13. 00
15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: N N N N N N N N N N N N N N N N N N N	14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and			N		N	14. 00
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the	15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y",			N		N	15. 00
adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the N N 18.00	16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
18.00 Was the cost report prepared only using the N N 18.00	17. 00	adjustments made to PS&R data for Other?			N		N	17. 00
	18. 00	Was the cost report prepared only using the			N		N	18. 00

Heal th	Financial Systems	CARE CONNECTION	RAHWAY, LLC		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACIL	TY HEALTH CARE	Provi der		Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre 5/30/2023 11:	pared: 08 am
]
			1.	00	2. (00	
	Cost Report Preparer Contact Information				_		
19.00	Enter the first name, last name and the titl	e/position	CHARLES		REED		19. 00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
20.00	Enter the employer/company name of the cost	report	EXECUCARE ASSO	CI ATES			20. 00
	preparer.						
21.00	Enter the telephone number and email address	s of the cost	(609) 738-3200		CRWASSC@NETSCAF	PE. NET	21. 00
	report preparer in columns 1 and 2, respecti	vel y.					

Health Financial Systems CARE CONNECTION
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE CARE CONNECTION RAHWAY, LLC

COMPLEX REIMBURSEMENT QUESTIONNAIRE

Part 8	COMILE	A REI WIDDINGEWIENT QUESTI ONIVALIRE			To 12/31/2022	Date/Time Pre 5/30/2023 11:	
PS&R Data 4.00			Part B			07 007 2020 11.	
SSAR Data Was the cost report prepared using the PS&R O3/17/2023 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 Was the cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report in cols. 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If I in a 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If I ine 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If I ine 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments and to PS&R data for Other? Describe the other adjustments. 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Cost Report Preparer Contact Information 19.00 Enter the First name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00							
13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R data for life in 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report? If "Y" see Instructions. 20.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report			4.00				
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 for allocation? If either col. 1 or 3 is "V" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, Iast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report		PS&R Data					
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 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 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R eport information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R data for corrections of other PS&R data for corrections of other PS&R data for ther? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00 Inter the employer/company name of the cost report	13.00	Was the cost report prepared using the PS&R	03/17/2023				13. 00
prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If ei ther col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00 Enter the employer/company name of the cost report		only? If either col. 1 or 3 is "Y", enter					
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 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report							
14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "V" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R data for data for corrections of other PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00 Enter the employer/company name of the cost report							
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 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00 Enter the employer/company name of the cost report							
allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R data for data for the poscribe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report 20.00 Enter the employer/company name of the cost report	14. 00						14. 00
enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00 Enter the employer/company name of the cost report		·					
to prepare this cost report in columns 2 and 4. 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report 20.00 Enter the employer/company name of the cost report							
4. ' 15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report 15.00 the possible provided the position of the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report							
15.00 If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R data for other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report							
made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00	15 00	1 1					15 00
have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report	13.00						15.00
PS&R used to file this cost report? If "Y", see Instructions. 16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00							
see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. Cost Report Preparer Contact Information							
16.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 16.00 17.00 18.00 19.00 20.00							
adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. 17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00	16, 00						16. 00
information? If yes, see instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 18.00 Cost Report Preparer Contact Information							
17.00 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: 18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. Solution		corrections of other PS&R Report					
adj ustments made to PS&R data for Other? Describe the other adj ustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. 3.00 3.00		information? If yes, see instructions.					
Describe the other adjustments: Was the cost report prepared only using the provider's records? If "Y" see Instructions. Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 18.00 3.00 VICE-PRESIDENT 19.00 20.00	17.00						17. 00
18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions. 3.00 3.00		, ,					
provider's records? If "Y" see Instructions. 3.00 Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00							
Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 3.00 VICE-PRESIDENT 19.00 20.00	18. 00						18. 00
Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report Cost Report Preparer Contact Information 19.00 VICE-PRESIDENT 19.00 VICE-PRESIDENT 20.00		provider's records? If "Y" see Instructions.					
Cost Report Preparer Contact Information 19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report Cost Report Preparer Contact Information 19.00 VICE-PRESIDENT 19.00 VICE-PRESIDENT 20.00				3 00	_		
19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 19.00 20.00		Cost Papart Preparer Contact Information		3.00			
held by the cost report preparer in columns 1, 2, and 3, respectively. 20.00 Enter the employer/company name of the cost report 20.00	19 00		/nosition	VI CE-PRESI DENT			19 00
respectively. 20.00 Enter the employer/company name of the cost report 20.00	17.00			VI CE I RESI DENI			17.00
20.00 Enter the employer/company name of the cost report 20.00			, _, a				
	20.00		report				20. 00
			•				
21.00 Enter the telephone number and email address of the cost	21. 00						21. 00
report preparer in columns 1 and 2, respectively.		report preparer in columns 1 and 2, respective	vel y.				

Health Financial Systems CARE CONNECTION
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315146

				To	5 12/31/2022	Date/Time Prep 5/30/2023 11:0	
				I npa	atient Days/Vis		
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	24	8, 760	0	5, 655	0	1.00
2. 00 3. 00	NURSING FACILITY	0	0	0		0	2. 00 3. 00
4.00	HOME HEALTH AGENCY COST	٥	0	0	0	0	4. 00
5. 00	Other Long Term Care	0	0		J		5. 00
6.00	SNF-Based CMHC						6.00
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	24 Inpatient D	8, 760	0	5, 655 Di scharges	0	8. 00
		Thipatrent b	ays/ vrsi ts		Di Schai ges		
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1 00	SKILLED NURSING FACILITY	6.00	7. 00 6, 906	8. 00	9. 00	10.00	1. 00
1. 00 2. 00	NURSING FACILITY	1, 251	0, 906	0	242		2. 00
3. 00	ICF/IID		0			Ö	3. 00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC		0		0		6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	1, 251	6, 906	0	242	0	7. 00 8. 00
0.00	Trotal Common Trinos 1 1)	Di scha			age Length of		0.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Compensite	11.00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	62	304		23. 37	0.00	1. 00
2.00	NURSING FACILITY	0	0	0. 00		0.00	2.00
3. 00 4. 00	I CF/IID HOME HEALTH AGENCY COST	0	0			0. 00	3. 00 4. 00
5.00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC		3				6. 00
7.00	HOSPI CE	0	0	0. 00	0. 00		7. 00
8. 00	Total (Sum of lines 1-7)	62	304	0.00	23. 37	0.00	8. 00
		Average Length of Stay		Admi s	SLOUS		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1 00	TOWN TO NUMBER OF THE PARTY	16.00	17. 00	18. 00	19. 00	20.00	1.00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	22. 72 0. 00	0	248	0	56 0	1. 00 2. 00
3.00	ICF/IID	0.00	0		0		3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			J		4. 00
5.00	Other Long Term Care	0.00				0	5.00
6. 00	SNF-Based CMHC		_	_	_	_	6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0. 00 22. 72	0	0 248	0	0 56	7. 00 8. 00
0.00	Total (Sum of Times 1-7)	Admi ssi ons	Full Time		U	30	0.00
	Component	Total	Employees on	Nonpai d			
	Component	Total	Payrol I	Workers			
	1	21.00	22.00	23. 00			
1.00	SKILLED NURSING FACILITY	304	28. 31				1.00
2. 00 3. 00	NURSING FACILITY	0	0. 00 0. 00				2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		0.00				4. 00
5. 00	Other Long Term Care	o	0. 00				5. 00
6.00	SNF-Based CMHC		0.00				6. 00
7.00	HOSPICE	0	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	304	28. 31	0.00			8. 00

Health Financial Systems
SNF WAGE INDEX INFORMATION CARE CONNECTION RAHWAY, LLC Provi der No.: 315146

		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	1, 658, 141	0	1, 658, 141			
2.00	Physician salaries-Part A	0	0	0	0.00		2. 00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3. 00
4.00	Home office personnel	0	0	0	0.00	0.00	4. 00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5. 00
6.00	Revised wages (line 1 minus line 5)	1, 658, 141	0	1, 658, 141	58, 893. 00	28. 16	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8. 00
9.00	CMHC	0	0	0	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	1, 658, 141	0	1, 658, 141	58, 893. 00	28. 16	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	644, 865	0	644, 865			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						
17.00	Wage-related costs core (See Part IV)	245, 983	0	245, 983			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	245, 983	0	245, 983			22. 00
	instructions)	·		· ·			
	•	•	•	•			

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315146

						5/30/2023 11:0	08 am_
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	C) C	0.00	0.00	1. 00
2.00	Administrative & General	187, 426	C	187, 426	3, 433. 00	54. 60	2. 00
3.00	Plant Operation, Maintenance & Repairs	0	C)	0.00	0.00	3. 00
4.00	Laundry & Li nen Servi ce	0	C)	0.00	0.00	4. 00
5.00	Housekeepi ng	0	C)	0.00	0.00	5. 00
6.00	Di etary	0	C) c	0.00	0.00	6. 00
7.00	Nursing Administration	128, 604	C	128, 604	2, 072. 00	62. 07	7. 00
8.00	Central Services and Supply	0	C) c	0.00	0.00	8. 00
9.00	Pharmacy	0	C) c	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	C) c	0.00	0.00	10. 00
11.00	Soci al Servi ce	69, 072	c	69, 072	2, 080. 00	33. 21	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	62, 015	c	62, 015	2, 861. 00	21. 68	13. 00
14.00	Total (sum lines 1 thru 13)	447, 117	C	447, 117	10, 446. 00	42. 80	14. 00

Health Financial Systems	CARE CONNECTION RAHWAY, LLC	In Lie	u of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315146	From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2023 11:08 am

	To 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Amount	
		Reported	
		1. 00	
P	PART IV - WAGE RELATED COSTS		
-	Part A - Core List		1
	RETIREMENT COST		1
1.00 4	401K Employer Contributions	0	1.00
	Tax Sheltered Annuity (TSA) Employer Contribution	0	
	Qualified and Non-Qualified Pension Plan Cost	0	
	Prior Year Pension Service Cost	0	4. 00
	LAN ADMINISTRATIVE COSTS (Paid to External Organization)		1.00
	401K/TSA Plan Administration fees	0	5.00
	egal /Accounting/Management Fees-Pension Plan	0	
	Employee Managed Care Program Administration Fees	0	7. 00
	IEALTH AND INSURANCE COST		7.00
	Health Insurance (Purchased or Self Funded)	56, 418	8.00
	Prescription Drug Plan	0 30, 416	1
		_	
	Dental, Hearing and Vision Plan	1, 237	
	Life Insurance (If employee is owner or beneficiary)	0	
	Accident Insurance (If employee is owner or beneficiary)	0	1
	Disability Insurance (If employee is owner or beneficiary)	0	1
	ong-Term Care Insurance (If employee is owner or beneficiary)	0	
	Workers' Compensation Insurance	42, 323	
	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	AXES		
	FICA-Employers Portion Only	124, 908	
	Medicare Taxes - Employers Portion Only	0	
	Jnemployment Insurance	0	1
	State or Federal Unemployment Taxes	21, 097	20.00
	ITHER		
21. 00 E	Executive Deferred Compensation	0	21. 00
22. 00 D	Day Care Cost and Allowances	0	22. 00
23. 00 T	Tuition Reimbursement	0	23. 00
24. 00 T	Total Wage Related cost (Sum of lines 1 - 23)	245, 983	24.00
		Amount	
		Reported	
		1. 00	
Pa	Part B - Other than Core Related Cost		
	OTHER WAGE RELATED COST	0	25. 00

				T	12/31/2022		
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
		'		1 + col. 2)	Salary in col.	col . 4)	
				,	3	,	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	433, 991	65, 533		13, 419. 00		1. 00
2.00	Licensed Practical Nurses (LPNs)	393, 415	59, 406	·	12, 184. 00		2.00
3.00	Certified Nursing Assistant/Nursing	383, 618	57, 926	441, 544	22, 844. 00	19. 33	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	1, 211, 024	182, 865	1, 393, 889	48, 447. 00		4.00
5.00	Physical Therapists	0	0	0	0. 00		5.00
6.00	Physical Therapy Assistants	0	0	0	0. 00	0. 00	6. 00
7. 00	Physical Therapy Aides	0	0	0	0. 00		7. 00
8.00	Occupational Therapists	0	0	0	0. 00		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0. 00		
10.00	Occupational Therapy Aides	0	0	0	0. 00		
11. 00	Speech Therapists	0	0	0	0. 00		
12. 00	Respi ratory Therapi sts	0	0		0. 00		
13. 00	Other Medical Staff	0	0	0	0. 00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	0		0	0. 00		
15. 00	Licensed Practical Nurses (LPNs)	0		0	0.00		
16. 00	Certified Nursing Assistant/Nursing	0		0	0. 00	0. 00	16. 00
47.00	Assi stants/Ai des				0.00	0.00	47.00
17. 00	Total Nursing (sum of lines 14 through 16)	275 0/0		0 275 0/0	0.00		17. 00
18.00	Physical Therapists	275, 969		275, 969	4, 985. 00		
19. 00	Physical Therapy Assistants	0		0	0.00		19. 00
20.00	Physical Therapy Aides	000 044		000.044	0.00		
21. 00	Occupational Therapists	332, 044		332, 044	5, 866. 00		
22. 00	Occupational Therapy Assistants	0		0	0.00		
23. 00	Occupational Therapy Aides	24 053		24 050	0. 00 475. 00		
24. 00	Speech Therapists	36, 852		36, 852			
25. 00	Respiratory Therapists Other Medical Staff	0			0. 00 0. 00	0.00	25. 00 26. 00
26. 00	Tother Medical Stall	0		0	0.00	0.00	∠0. ∪∪

Provi der No.: 315146

	10	12/31/2022	Date/lime Pre 5/30/2023 11:	
		Group	Days	
1.00		1. 00 RUX	2. 00	1. 00
2.00		RUL		2.00
3.00		RVX		3. 00
4. 00		RVL		4. 00
5. 00		RHX		5.00
6. 00 7. 00		RHL RMX		6. 00 7. 00
8.00		RML		8.00
9. 00		RLX		9. 00
10. 00		RUC		10. 00
11.00		RUB		11.00
12. 00 13. 00		RUA RVC		12. 00 13. 00
14. 00		RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16.00
17. 00 18. 00		RHB RHA		17. 00 18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21.00
22. 00 23. 00		RLB RLA		22. 00 23. 00
24. 00		ES3		24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27. 00 28. 00		HE2 HE1		27. 00 28. 00
29. 00		HD2		29. 00
30. 00		HD1		30.00
31. 00		HC2		31.00
32. 00 33. 00		HC1 HB2		32. 00 33. 00
34. 00		HB1		34.00
35. 00		LE2		35. 00
36. 00		LE1		36. 00
37. 00 38. 00		LD2 LD1		37. 00 38. 00
39. 00		LC2		39.00
40. 00		LC1		40. 00
41. 00		LB2		41. 00
42.00		LB1 CE2		42.00
43. 00 44. 00		CE1		43. 00 44. 00
45. 00		CD2		45. 00
46. 00		CD1		46. 00
47. 00		CC2		47. 00
48. 00 49. 00		CC1 CB2		48. 00 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
58. 00 59. 00		SSA I B2		58. 00 59. 00
60.00		I B1		60.00
61. 00		I A2		61.00
62.00		I A1		62.00
63. 00 64. 00		BB2 BB1		63. 00 64. 00
65. 00		BA2		65. 00
66. 00		BA1		66. 00
67. 00		PE2		67.00
68. 00 69. 00		PE1 PD2		68. 00 69. 00
70.00		PD1		70.00
71. 00		PC2		71. 00
72. 00		PC1		72.00
73. 00 74. 00		PB2 PB1		73. 00 74. 00
74. 00 75. 00		PA2		75. 00
- 				

Health Financial Systems	CARE CONNECTION RAH	WAY, LLC		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der	No.: 315146	Peri od:	Worksheet S-	-7
				From 01/01/2022 To 12/31/2022		
				Group	Days	
				1. 00	2. 00	
76. 00				PA1		76. 00
99. 00				AAA		99. 00
100. 00 TOTAL						100. 00
			Expenses	Percentage	Y/N	
			1. 00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101.00 Staffing						101. 00
102.00 Recruitment						102. 00
103.00 Retention of employees						103.00
104. 00 Trai ni ng						104.00
105.00 OTHER (SPECIFY)	ing 1 column 2)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I, I	rne i, corumn 3)		I			106. 00

		CARE CONNECTION F				u of Form CMS-2	2540-10
RECLASS	IFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eriod: rom 01/01/2022	Worksheet A	
				T ₁	0 12/31/2022	Date/Time Pre 5/30/2023 11:	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	oo uiii
				+ col . 2)	ons Increase/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col . 4)	
		1.00			A-6)		
G	ENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
	0100 CAP REL COSTS - BLDGS & FIXTURES		698, 740	698, 740	-459, 249	239, 491	1. 00
1	0200 CAP REL COSTS - MOVABLE EQUIPMENT		11, 661	11, 661	o	11, 661	2. 00
	0300 EMPLOYEE BENEFITS 0400 ADMINISTRATIVE & GENERAL	0 187, 426	250, 380 520, 135	250, 380 707, 561	0	250, 380 707, 561	3. 00 4. 00
	10500 PLANT OPERATION, MAINT. & REPAIRS	187, 420	1, 282	1, 282	44, 889	46, 171	5. 00
	0600 LAUNDRY & LINEN SERVICE	O	0	0	138, 120	138, 120	6. 00
	0700 HOUSEKEEPI NG	0	0	0	138, 120	138, 120	7. 00
	10800 DI ETARY 10900 NURSI NG ADMI NI STRATI ON	128, 604	16, 119 59, 520	16, 119 188, 124	138, 120	154, 239 188, 124	8. 00 9. 00
	1000 CENTRAL SERVICES & SUPPLY	120,004	92, 995	92, 995	0	92, 995	10. 00
11.00	1100 PHARMACY	O	3, 144	3, 144	o	3, 144	11. 00
	1200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
	11300 SOCIAL SERVICE 11400 NURSING AND ALLIED HEALTH EDUCATION	69, 072	0	69, 072 0	0	69, 072 0	13. 00 14. 00
1	1500 ACTIVITIES	62, 015	9, 043	71, 058	o	71, 058	15. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	33000 SKILLED NURSING FACILITY 3100 NURSING FACILITY	1, 211, 024 0	0	1, 211, 024 0	0 0	1, 211, 024 0	30. 00 31. 00
	3200 CF/11D		0	0	0	0	32.00
	3300 OTHER LONG TERM CARE	0	Ō	0	Ō	0	33. 00
_	NCILLARY SERVICE COST CENTERS		0 544	0.544	ما	0.514	40.00
1	4000 RADI OLOGY 4100 LABORATORY	0	3, 514 50, 471	3, 514 50, 471	0	3, 514 50, 471	40. 00 41. 00
1	14200 I NTRAVENOUS THERAPY	o	67, 267	67, 267	o	67, 267	42. 00
	4300 OXYGEN (INHALATION) THERAPY	0	o	0	o	0	43.00
1	4400 PHYSI CAL THERAPY	0	804, 087	804, 087 2, 999	0	804, 087	44.00
	14500 OCCUPATI ONAL THERAPY 14600 SPEECH PATHOLOGY	0	2, 999 1, 223	2, 999 1, 223	0	2, 999 1, 223	45. 00 46. 00
	4700 ELECTROCARDI OLOGY	o o	0	0	Ö	0	47. 00
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
	14900 DRUGS CHARGED TO PATIENTS 15000 DENTAL CARE - TITLE XIX ONLY	0	219, 928	219, 928	0	219, 928 0	49. 00 50. 00
	5100 SUPPORT SURFACES		115	115	0	115	51. 00
0	UTPATIENT SERVICE COST CENTERS						
	16000 CLINIC 16100 RURAL HEALTH CLINIC	0	0	0		0	60. 00 61. 00
	16200 FQHC		o o	U	U	U	62.00
O	THER REIMBURSABLE COST CENTERS						
	7000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
1	17100 AMBULANCE 17300 CMHC	0 0	14, 445 0			14, 445 0	71. 00 73. 00
	PECIAL PURPOSE COST CENTERS	<u> </u>		0	<u> </u>		73.00
	8000 MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80. 00
	8100 INTEREST EXPENSE		0	0	0	0	81.00
1	18200 UTILIZATION REVIEW - SNF 18300 HOSPICE	0	0	0	0	0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 658, 141	2, 827, 068	4, 485, 209	Ö	4, 485, 209	89. 00
	ONREI MBURSABLE COST CENTERS		-1		_1		
	19000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 19100 BARBER AND BEAUTY SHOP	0	0	0	0	0	90. 00 91. 00
	19200 PHYSICIANS PRIVATE OFFICES		ol	0	o	0	91.00
93.00	9300 NONPALD WORKERS	O	o	0	o	0	93. 00
94. 00 0 100. 00	19400 PATIENTS LAUNDRY TOTAL	1 650 141	2 927 069	0 4, 485, 209	0	0 4, 485, 209	94.00
100.00	IOTAL	1, 658, 141	2, 827, 068	4, 400, 209	니 이	4, 400, 209	100.00

 Heal th Financial
 Systems
 CARE CONNE

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315146 | Period: | Worksheet A | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				To	12/31/2022	Date/Time Prepared: 5/30/2023 11:08 am
	Cost Center Description	Adjustments to	Net Expenses			3/30/2023 11.06 alli
	, , , , , , , , , , , , , , , , , , ,		For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
	GENERAL SERVICE COST CENTERS	6.00	7. 00			
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	0	239, 491			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		11, 661			2. 00
3.00	00300 EMPLOYEE BENEFITS	o	250, 380			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	34, 970	742, 531			4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	46, 171			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	138, 120			6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	0	138, 120			7.00
9. 00	00900 NURSI NG ADMI NI STRATI ON		154, 239 188, 124			8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY		92, 995			10.00
11. 00	01100 PHARMACY	o	3, 144			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	o	0			12. 00
13.00	01300 SOCIAL SERVICE	0	69, 072			13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			14. 00
15. 00	01500 ACTIVITIES	0	71, 058			15. 00
30. 00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	71, 166	1, 282, 190			30.00
31. 00	03100 NURSING FACILITY	/1, 100	1, 262, 190			31.00
32. 00	03200 CF/11D		0			32.00
	03300 OTHER LONG TERM CARE	Ö	O			33. 00
	ANCILLARY SERVICE COST CENTERS					
40.00	04000 RADI OLOGY	0	3, 514			40. 00
41. 00	04100 LABORATORY	0	50, 471			41.00
42.00	04200 I NTRAVENOUS THERAPY	0	67, 267			42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	-528, 118	0 275, 969			43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	329, 045	332, 044			45. 00
46. 00	04600 SPEECH PATHOLOGY	35, 629	36, 852			46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	219, 928			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			50.00
51. 00	O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	115			51. 00
60 00	06000 CLINIC	l ol	0			60.00
61. 00	06100 RURAL HEALTH CLINIC		0			61. 00
62. 00	06200 FQHC					62. 00
	OTHER REIMBURSABLE COST CENTERS					
70. 00	07000 HOME HEALTH AGENCY COST	0	0			70. 00
	07100 AMBULANCE	0	14, 445			71.00
73. 00	O7300 CMHC SPECIAL PURPOSE COST CENTERS	0	0			73. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	O	0			80.00
	08100 I NTEREST EXPENSE		0			81.00
	08200 UTILIZATION REVIEW - SNF	o	0			82. 00
83.00	08300 H0SPI CE	o	0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-57, 308	4, 427, 901			89. 00
00.05	NONREI MBURSABLE COST CENTERS	_1	-1			20
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0			91. 00 92. 00
	09300 NONPAID WORKERS		0			93. 00
	09400 PATIENTS LAUNDRY		Ö			94. 00
100.00		-57, 308	4, 427, 901			100.00

Health Financial Systems CARE CONNECTION RAHWAY, LLC In Lieu of Form CMS					2540-10
RECLASSIFICATIONS Provider No.: 315146		No.: 315146	Peri od:	Worksheet A-6	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2.00	3.00	4. 00	5. 00	
(1) A - RECLASS HOSP PROVIDED MAINT					
1.00	PLANT OPERATION, MAINT. &		0 0	44, 889	1. 00
	REPAIRS				
2. 00	LAUNDRY & LINEN SERVICE	6. (0 0	138, 120	2. 00
3. 00	HOUSEKEEPI NG	7. (0 0	138, 120	3.00
4.00	DI ETARY	8. (0 0	138, 120	4. 00
TOTALS					
100. 00	Total Reclassifications (Sum		0	459, 249	100. 00
	of columns 4 and 5 must				
	equal sum of columns 8 and				
	9)				

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

Health Financial Systems	CARE CONNECTION RAHWAY, LLC		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Provi der		Peri od:	Worksheet A-6	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 11:	pared: 08 am
		Decreases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	6. 00	7. 00	8. 00	9. 00	
(1) A - RECLASS HOSP PROVIDED MAINT					
1.00	CAP REL COSTS - BLDGS & FLXTURES	1. C	0 0	44, 889	1. 00
2.00	CAP REL COSTS - BLDGS & FIXTURES	1.0	0 0	138, 120	2. 00
3.00	CAP REL COSTS - BLDGS & FIXTURES	1.0	0 0	138, 120	3. 00
4.00	CAP REL COSTS - BLDGS & FIXTURES	1.0	0 0	138, 120	4. 00
TOTALS					
100. 00			0	459, 249	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CARE CONNECTION RAHWAY, LLC In Lieu of Form CMS-2540-10

Provi der No.: 315146 | Peri od: | Worksheet A-7 | From 01/01/2022 | To 12/31/2022 | Date/Ti me Prepa

				Т	o 12/31/2022	Date/Time Prep 5/30/2023 11:0	oared: 08 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	5		_	_	_	
1.00	Land	0	0	(0	0	1. 00
2.00	Land Improvements	0	0	(0	0	2. 00
3.00	Buildings and Fixtures	0	0	(0	0	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fi xed Equi pment	0	0	(0	0	5. 00
6.00	Movable Equipment	23, 075	0	(0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	23, 075	0	(0	0	7. 00
8.00	Reconciling Items	0	0	C	0	0	8. 00
9. 00	Total (line 7 minus line 8)	23, 075	0	C	0	0	9. 00
	Description	Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	23, 075	0				6. 00
7.00	Subtotal (sum of lines 1-6)	23, 075	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	23, 075	0				9. 00

Provi der No.: 315146

From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				10 12/31/2022	5/30/2023 11:	
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
					•	
		(-) -			1	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment	0.00	2.00	4.00	
1 00		1.00	2.00	3.00	4.00	1 00
1. 00	Investment income on restricted funds	В	-10, 760	ADMINISTRATIVE & GENERAL	4.00	1. 00
2. 00	(chapter 2) Trade, quantity, and time discounts (chapter		o		0.00	2. 00
2.00	8)				0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		a		0.00	3. 00
4. 00	Rental of provider space by suppliers				0.00	
4.00	(chapter 8)			,	0.00	4.00
5.00	Telephone services (pay stations excluded)		o		0.00	5. 00
	(chapter 21)		_			
6.00	Television and radio service (chapter 21)		O		0.00	6. 00
7.00	Parking Lot (chapter 21)		o		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	o			8. 00
	physician adjustment					
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		0.00	11. 00
	Capital expenditures (chapter 24)					
12. 00	Adjustment resulting from transactions with	A-8-1	-931			12. 00
	related organizations (chapter 10)		_			
13. 00	Laundry and linen service		0		0.00	
14.00	Revenue - Employee meals		0	l .	•	14. 00
15.00	Cost of meals - Guests		0		0.00	
16. 00	Sale of medical supplies to other than patients		0)	0.00	16. 00
17. 00	Sale of drugs to other than patients		o		0.00	17. 00
18. 00	Sale of medical records and abstracts			l .	0.00	
19. 00	Vending machines				0.00	
20. 00	Income from imposition of interest, finance				0.00	
20.00	or penalty charges (chapter 21)			,	0.00	20.00
21. 00	Interest expense on Medicare overpayments		o		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	PRIVATE BAD DEBTS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 01	BAD DEBTS	A	19, 212	ADMINISTRATIVE & GENERAL	4.00	
25. 02			0	2	0.00	
25. 03			0		0.00	
25. 04	T + 1 (C 1 1 1 20) (T C		57.000	1	0.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-57, 308	3		100. 00
(1) 5	to Worksheet A, col. 6, line 100)	 	CMC Dub 45 4	1	I	
(I) De	scription - all chapter references in this co	ruiiii pertarn to) UNS PUD. 15-1	l.		

⁽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.

In Lieu of Form CMS-2540-10

Health Financial Systems CARE CONNECTION RAHWAY, LLC In Lieu of Form CMS-254

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315146 Period: From 01/01/2022 Parts I-II

OFFICE	COSTS				rom 01/01/2022 o 12/31/2022	Parts I-II Date/Time F 5/30/2023	
		Li ne No.	Cost (Center	Expense		
		1. 00		00	3. (
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:				D ORGANIZATIONS	OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00		30. 00 44. 00 44. 00 45. 00 46. 00	ADMINISTRATIVE SKILLED NURSIN PHYSICAL THERA PHYSICAL THERA OCCUPATIONAL T SPEECH PATHOLO	G FACILITY PY PY HERAPY	ADVANTAGE ADMINTRANSPORTERS PHYSICAL THERAFMCARE PART A SE OCCUPATIONAL THE SPEECH THERAPY	PY RVC-THRPY	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00		0. 00	l .				7. 00
8. 00		0. 00	l .				8. 00
9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	0. 00					9. 00 10. 00
		Amount	Amount	Adjustments			
		Allowable In Cost	Included in Wkst. A, col. 5	(col. 4 minus col. 5)			
		4.00	5. 00	6. 00			
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:					OR	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00		91, 347 71, 166 275, 969 0 332, 044 36, 852	0 3, 000 801, 087 2, 999	-801, 087 329, 045			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00		0	0	0			7. 00 8. 00 9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	807, 378	808, 309	-931			10.00

OFFICE COSTS

Parts I-II Date/Time Prepared:

5/30/2023 11:08 am

12/31/2022

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

1.00	A	AVERY EISENREICH	99. 00	1.00
2.00	A	RIVKA JACOBOWITZ	1.00	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
DART LL LATERDEL ATLANGUER TO RELATER ARRANGE	4. 00	5. 00	6.00

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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	ADVANTAGE THERAPY	99. 00 REHAB	1.00
2.00	ADVANTAGE THERAPY	1. 00 REHAB	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.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2022 12/31/2022	Part I Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/30/2023 11:	J8 am
	Cost Center Description	Net Expenses	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
		for Cost Allocation	FIXTURES	EQUI PMENT	BENEFI TS		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES	239, 491	239, 491	11 //1			1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	11, 661 250, 380	0	11, 661 0	250, 380		2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	742, 531	3, 976	194	28, 301	775, 002	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	46, 171	0	0	0	46, 171	5. 00
6.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	138, 120	0	0	0	138, 120	6. 00
7. 00 8. 00	00800 DI ETARY	138, 120 154, 239	0	0	0	138, 120 154, 239	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	188, 124	8, 217	400	19, 419	216, 160	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	92, 995	0	0	0	92, 995	
11. 00 12. 00	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY	3, 144	0	0	0	3, 144 0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE	69, 072	2, 827	0 138	10, 430	82, 467	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTIVITIES	71, 058	30, 218	1, 471	9, 364	112, 111	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	1, 282, 190	187, 096	9, 110	182, 866	1, 661, 262	30. 00
31. 00	03100 NURSING FACILITY	1, 282, 190	187, 040	9, 110	182, 800	1, 001, 202	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	3, 514	0	0	0	3, 514	40. 00
41. 00	04100 LABORATORY	50, 471	0	0	o	50, 471	41. 00
42.00	04200 I NTRAVENOUS THERAPY	67, 267	0	0	O	67, 267	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	7 157	0	0	0	43. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	275, 969 332, 044	7, 157 0	348 0	0	283, 474 332, 044	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	36, 852	0	0	Ö	36, 852	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0 219, 928	0	0	0	0 219, 928	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	219, 928	0	0	o	217, 720	50.00
51.00	05100 SUPPORT SURFACES	115	0	0	0	115	
	OUTPATIENT SERVICE COST CENTERS		٥			-	
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		Ŭ.	J	J	O .	62. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	14 445	0	0	0	0 14, 445	70. 00 71. 00
73.00	07300 CMHC	14, 445	0	0	0	14, 445	
	SPECIAL PURPOSE COST CENTERS	-	-	-	-,	-	
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	o	0	0	o	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	4, 427, 901	239, 491	11, 661	250, 380	4, 427, 901	89. 00
00.00	NONREI MBURSABLE COST CENTERS		٥		0		00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	90. 00 91. 00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES		0	0	ol	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	98. 00 99. 00
100.00		4, 427, 901	239, 491	11, 661	250, 380	4, 427, 901	
	•						

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315146

Period: Worksheet B From 01/01/2022 Part I

Date/Time Prepared: 12/31/2022 5/30/2023 11:08 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 775,002 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 9, 796 55, 967 5.00 00600 LAUNDRY & LINEN SERVICE 29.305 167, 425 6.00 6.00 00700 HOUSEKEEPI NG 7.00 29, 305 C 167, 425 7.00 8.00 00800 DI ETARY 32,724 0 186, 963 8.00 9.00 00900 NURSING ADMINISTRATION 45, 862 1, 953 0 5, 842 9.00 19, 730 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 C Ω 11.00 01100 PHARMACY 667 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 01300 SOCIAL SERVICE 17, 497 672 0 2,010 13.00 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 ACTI VI TI ES 23, 786 7, 181 21, 482 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 186, 963 30.00 352 466 44, 460 167, 425 133,003 03100 NURSING FACILITY 31.00 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 746 0 0 0 0 40.00 41.00 04100 LABORATORY 10, 708 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 14, 272 0 0 42 00 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY C 0 0 43.00 04400 PHYSI CAL THERAPY 60, 144 1, 701 5, 088 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 70, 449 0 0 0 0 45.00 04600 SPEECH PATHOLOGY 0 46 00 7.819 0 46 00 Ω 0 04700 ELECTROCARDI OLOGY 0 0 47.00 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 48.00 0 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 46, 661 0 0 0 0 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 0 Ω 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 0 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 07100 AMBULANCE O 71.00 3.065 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) 775, 002 55, 967 167, 425 167, 425 186, 963 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 91.00 0 0 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 C 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00 C 0 98.00 Cross Foot Adjustments 0 C 0 0 Λ 98.00 99.00 Negative Cost Centers 0 0 0 99.00 100.00 TOTAL 775,002 55, 967 167, 425 167, 425 186, 963 100. 00

Provi der No.: 315146

				12/31/2022	5/30/2023 11:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	7.5 11. 0 11 11.	SUPPLY		LI BRARY		
	9. 00	10.00	11.00	12. 00	13.00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3. 00 00300 EMPLOYEE BENEFITS						3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL						4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 00700 HOUSEKEEPI NG						7. 00
8. 00 00800 DI ETARY						8. 00
9.00 O0900 NURSING ADMINISTRATION	269, 817					9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	112, 725				10.00
11. 00 01100 PHARMACY	0	0	3, 811			11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	0	0	0	0		12.00
13. 00 01300 SOCIAL SERVICE	0	0	0	0	102, 646	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	o	o	0	0	0	14.00
15. 00 01500 ACTI VI TI ES	o	o	0	0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS			<u>'</u>		,	
30. 00 03000 SKILLED NURSING FACILITY	269, 817	112, 725	3, 811	0	102, 646	30. 00
31. 00 03100 NURSING FACILITY	0	112, 720	0,011	0	l .	31. 00
32. 00 03200 CF/IID	ő	ő	0	0		32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0	0	0		33. 00
ANCI LLARY SERVI CE COST CENTERS	J U	υ	U		0	33.00
	0	O	0	0	0	40.00
40. 00 04000 RADI OLOGY	_	ĭ	_	-		40.00
41. 00 04100 LABORATORY	0	0	0	0	_	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	0	0	0	0	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o	0	0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	o	o	0	0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	o	o	0	0	0	50.00
51. 00 05100 SUPPORT SURFACES	l ol	ol	0	0	0	51.00
OUTPATIENT SERVICE COST CENTERS	-1	-1	- 1			
60. 00 06000 CLI NI C	0	ol	0	0	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC	Ö	Ö	ő	0		61. 00
62. 00 06200 FQHC		٩	O	O		62.00
OTHER REIMBURSABLE COST CENTERS						02.00
		٥	0	0	0	70.00
· · · · · · · · · · · · · · · · · · ·	0	0				70.00
71. 00 07100 AMBULANCE	0	0	0	0		71.00
73. 00 07300 CMHC	0	U	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS					T	
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 08100 I NTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	269, 817	112, 725	3, 811	0	102, 646	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	lol	ol	0	0	0	91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	أم	Ö	0	0	Ō	92. 00
93. 00 09300 NONPALD WORKERS	ام	n	n	n	ő	93. 00
94. 00 09400 PATI ENTS LAUNDRY	١	٥	١	0	Ö	94. 00
98.00 Cross Foot Adjustments		0		0		98. 00
99.00 Negative Cost Centers		0		0	0	99.00
	240 017	112, 725	2 011	0		
100. 00 TOTAL	269, 817	112, 725	3, 811	U	102, 646	100.00

WAY, LLC In Lieu of Form CMS-2540-10
Provider No.: 315146 Period: Worksheet B
From 01/01/2022 Part I
12/21/2022 Part J Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	01/01/2022	Date/Time Pre 5/30/2023 11:	pared:
			OTHER GENERAL			5/30/2023 11.	UO AIII
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLIED HEALTH EDUCATION			Adjustments		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 3. 00
4.00	00400 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 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY						10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCI AL SERVI CE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15.00	01500 ACTIVITIES	0	164, 560				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	164, 560		0	3, 199, 138	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0			0	31. 00 32. 00
32.00	03300 OTHER LONG TERM CARE	0	0	_		0	32.00
33. 00	ANCI LLARY SERVI CE COST CENTERS				9		33.00
40.00	04000 RADI OLOGY	0	0	4, 260	0	4, 260	40. 00
41. 00	04100 LABORATORY	0	0	61, 179	0	61, 179	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	81, 539	. 1	81, 539	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	350, 407 402, 493	0	350, 407 402, 493	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	402, 493	0	402, 493	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0	0	Ö	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	266, 589	0	266, 589	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	115	0	115	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	0	O	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0			0	61. 00
62. 00	06200 FQHC			J		ŭ	62. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	_			0	70. 00
71. 00	07100 AMBULANCE	0	0		I	17, 510	1
73. 00	07300 CMHC	0	0	0	0	0	73. 00
80 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	164, 560	4, 427, 901	0	4, 427, 901	89. 00
00.05	NONREI MBURSABLE COST CENTERS	-	-	=1	_1	-	00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		-	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0	0		0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS		0	0	- 1	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	o o	Ö	-	0	94. 00
98. 00	Cross Foot Adjustments	0	0	0	o	0	98. 00
99. 00	Negative Cost Centers	0	0	0	o	0	99. 00
100.00	TOTAL	0	164, 560	4, 427, 901	0	4, 427, 901	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				To	12/31/2022	Date/Time Pre 5/30/2023 11:	pared:
			CAPI TAL REI	LATED COSTS		373072023 11.	Oo alli
	Cost Center Description	Di rectly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	oost denter beserretten	Assigned New	FIXTURES	EQUI PMENT	Subtotai	BENEFITS	
		Capital Related Costs					
		0	1. 00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS	0	0	О	0	0	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	3, 976	194	4, 170	0	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	0	0	0	0	0	6. 00 7. 00
8. 00	00800 DI ETARY	l ő	0		ő	0	8. 00
9. 00	00900 NURSING ADMINISTRATION	0	8, 217	400	8, 617	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	11. 00 12. 00
13. 00	01300 SOCIAL SERVICE		2, 827	138	2, 965	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VITIES	0	30, 218	1, 471	31, 689	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY		187, 096	9, 110	196, 206	0	30.00
31. 00	03100 NURSING FACILITY		167, 090		190, 200	0	31.00
32. 00	03200 CF/IID	0	0		ō	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		0	O	ol	0	40. 00
41. 00	04100 LABORATORY		0		0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	O	0	Ö	ō	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	7, 157		7, 505	0	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY		0	0	0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	O	0	Ö	Ö	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES		0	0	0	0	50. 00 51. 00
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		01.00
60.00	06000 CLI NI C	0	0		0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61.00
62. 00	OTHER REIMBURSABLE COST CENTERS						62.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	o	0		o	0	
73. 00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	73. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	0 239, 491	0 11, 661	0 251, 152	0	83. 00 89. 00
69.00	NONREI MBURSABLE COST CENTERS	l o	239, 491	11,001	251, 152	0	09.00
90.00		0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	_	0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0	0	0	0	1
98. 00	Cross Foot Adjustments		0		ő	Ü	98. 00
99. 00	Negative Cost Centers		0	0	0	0	
100.00	D TOTAL	0	239, 491	11, 661	251, 152	0	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					Ť	0 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	oo alii
		·	& GENERAL	OPERATI ON,	LINEN SERVICE			
				MAINT. &				
			4.00	REPAI RS 5. 00	6. 00	7. 00	8. 00	
	GENER	AL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	1	CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	1	EMPLOYEE BENEFITS						3. 00
4. 00 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS	4, 170 53	53	,			4. 00 5. 00
6. 00	1	LAUNDRY & LINEN SERVICE	158	0	1			6. 00
7. 00		HOUSEKEEPI NG	158	Ö		158		7. 00
8.00	00800	DI ETARY	176	0	0	o	176	8. 00
9.00		NURSING ADMINISTRATION	247	2	. 0	6	0	9. 00
10.00	1	CENTRAL SERVICES & SUPPLY	106	0	0	0	0	10.00
11. 00 12. 00		PHARMACY MEDICAL RECORDS & LIBRARY	4	0	0	0	0	11. 00 12. 00
13. 00	1	SOCIAL SERVICE	94	1	,	2	0	13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	Ö	ol ö	0	0	14. 00
15.00	1	ACTIVITIES	128	7	0	20	0	15. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00	1	SKILLED NURSING FACILITY	1, 895	41	1	125	176	
31.00	1	NURSING FACILITY	0	0	1	0	0	31.00
32. 00 33. 00		ICF/IID OTHER LONG TERM CARE	0	0		0	0	32. 00 33. 00
33. 00		LARY SERVICE COST CENTERS	<u> </u>		,	<u> </u>		33.00
40.00		RADI OLOGY	4	O	0	0	0	40. 00
41.00	04100	LABORATORY	58	0	0	0	0	41. 00
42. 00	1	INTRAVENOUS THERAPY	77	0	0	0	0	42. 00
43. 00		OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44. 00 45. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	324 379	2		5	0	44. 00 45. 00
46. 00	1	SPEECH PATHOLOGY	42	0		0	0	46. 00
47. 00		ELECTROCARDI OLOGY	0	Ö	o o	o	0	47. 00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	48. 00
49. 00		DRUGS CHARGED TO PATIENTS	251	0	1	0	0	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0	1	0	0	50.00
51. 00		SUPPORT SURFACES TIENT SERVICE COST CENTERS	0	0	0	0	0	51. 00
60. 00		CLINIC	0	O	0	O	0	60.00
61. 00	1	RURAL HEALTH CLINIC	o	0	1	o	0	61. 00
62.00	06200	FQHC						62. 00
		REIMBURSABLE COST CENTERS						
70.00		HOME HEALTH AGENCY COST AMBULANCE	0	0	1	0	0	70.00
71. 00 73. 00	07300		16	0		0	0	71. 00 73. 00
73.00		AL PURPOSE COST CENTERS	<u> </u>		,, ,	<u> </u>		73.00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF		_	_	_	_	82. 00
83.00	08300	HOSPI CE	0	0		0	0	
89. 00	NONDE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	4, 170	53	158	158	176	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	O	0	o	0	90. 00
91.00	1	BARBER AND BEAUTY SHOP		0	•	o	0	91. 00
92.00	1	PHYSICIANS PRIVATE OFFICES	0	0	1	0	0	
93.00	1	NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00 98. 00	09400	PATIENTS LAUNDRY	0	O	0	0	0	
98.00		Cross Foot Adjustments Negative Cost Centers		n		0	0	
100.00		TOTAL	4, 170	53				100. 00
	1					,,		

Provi der No.: 315146

					12/31/2022	5/30/2023 11:	
	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	г					2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	6					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	8, 872					9. 00
10.00		l ol	106				10.00
11. 00	1 1	l ol	o	4			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	l ol	o	0	0		12. 00
13.00	01300 SOCIAL SERVICE	l ol	0	0	o	3, 062	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATI	ON	0	0	o	0	14. 00
15.00	01500 ACTI VI TI ES	l ol	0	0	o	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	8, 872	106	4	0	3, 062	30.00
31.00	03100 NURSING FACILITY	o	0	0	o	0	31. 00
32.00	03200 CF/IID	l ol	0	0	o	0	32.00
33.00	03300 OTHER LONG TERM CARE	l ol	0	0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	ol	0	0	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	ol	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	ol	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	ol	0	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	o	0	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	ol	0	0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	lol	0	0	0	0	47. 00
48.00	1	ENTS O	0	0	0	0	48. 00
49.00	1	l ol	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	l ol	0	0	o	0	50.00
51.00	1 1	ol	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	o	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	0	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSI	ES					80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0	0	83. 00
89. 00		8, 872	106	4	0	3, 062	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00		TEEN O	0	0	0	0	90.00
91. 00		0	0	0	0	0	91. 00
92.00		0	0	0	0	0	92.00
93. 00		0	0	0	0	0	93. 00
94.00		0	0	0	0	0	94. 00
98. 00		0	0	0			98. 00
99. 00		0	0	0	0	0	
100.00	O TOTAL	8, 872	106	4	0	3, 062	100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315146

				Т	o 12/31/2022	Date/Time Pre 5/30/2023 11:	
			OTHER GENERAL			5/30/2023 11.	UG alli
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION 14.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	18.00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						6.00
7. 00 8. 00	00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	•					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY						10. 00
11. 00	01100 PHARMACY						11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTIVITIES	0	31, 844				15. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		21 044	242 400		242 400	20.00
30.00	03000 SKI LLED NURSING FACILITY	0	31, 844	1		242, 489	30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0			0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		I	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>		٥١		00.00
40.00	04000 RADI OLOGY	0	0	4	0	4	40. 00
41.00	04100 LABORATORY	0	0	58	0	58	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	77	0	77	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0		0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	7, 836	l .	7, 836	1
45. 00 46. 00	04500 OCCUPATIONAL THERAPY	0	0	379		379	45. 00
46.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	42		42 0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	Ö	251	0	251	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	O		Ö	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	О	0	51. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0			0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	06200 FOHC						62.00
70. 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	0	0	0	ol	0	70. 00
71. 00	07100 AMBULANCE	0	0			16	
73. 00	07300 CMHC	0	0			0	1
	SPECIAL PURPOSE COST CENTERS	_			-1		
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83.00	08300 HOSPI CE	0	0			0	
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	31, 844	251, 152	0	251, 152	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	ol	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	1 0	0			0	1
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		0	Ö		0	1
93. 00	09300 NONPAI D WORKERS	0	0	Ö		0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	O	0	
98. 00	Cross Foot Adjustments	0	0	0		0	
99. 00	Negative Cost Centers	0	0	0		0	
100.00	TOTAL	0	31, 844	251, 152	0	251, 152	1100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					o 12/31/2022	Date/Time Pre 5/30/2023 11:	
		CAPITAL REI	ATED COSTS			37 307 2023 11.	OO diii
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3.00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES	5, 421	Γ	I	T	Γ	1. 00
2. 00 3. 00 4. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	0 90	5, 421 0 90	1, 658, 141		3, 652, 784	2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	0	0	0	0	46, 171 138, 120 138, 120	5. 00 6. 00 7. 00
8. 00 9. 00 10. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0 186	0 186	· ·		154, 239 216, 160 92, 995	8. 00 9. 00
11. 00 12. 00 13. 00	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0 0	0 0	0	0	3, 144 0 82, 467	11. 00 12. 00 13. 00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0 684	0 684	0	0	0	14. 00 15. 00
30. 00	03000 SKILLED NURSING FACILITY	4, 235	1	1			30. 00
31. 00 32. 00 33. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0 0	O	0	0	31. 00 32. 00 33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	Ι ο	0	0	0	3, 514	40. 00
41. 00 42. 00 43. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	0	0	50, 471 67, 267	41. 00 42. 00 43. 00
44. 00 45. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATIONAL THERAPY	162	162	0	0	283, 474 332, 044	44. 00 45. 00
46. 00 47. 00 48. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	36, 852 0 0	46. 00 47. 00 48. 00
49. 00 50. 00 51. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 0	0 0	0 0	0	219, 928 0 0	49. 00 50. 00 51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS O6000 CLINIC	1 0	0	0	0	0	60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	l	1		l	61. 00 62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	1 0	0	0	0	0	70. 00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	O	0	14, 445	ł
80. 00 81. 00 82. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						80. 00 81. 00 82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 5, 421	0 5, 421				83. 00 89. 00
90. 00	NONREI MBURSABLE COST CENTERS O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0				91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		_	0	92. 00 93. 00
94.00	09400 PATIENTS LAUNDRY	0	o	O	_	0	94. 00
98. 00 99. 00 102. 00		239, 491	11, 661	250, 380		775, 002	98. 00 99. 00 102. 00
103. 00 104. 00	Cost to be allocated (per Wkst. B,	44. 178380	2. 151079	0. 151000 0		0. 212167 4, 170	103. 00 104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part 			0. 000000		0. 001142	105. 00

Provi der No.: 315146

				'	0 12/31/2022	5/30/2023 11:	
	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 DAYS)			/	
		REPAI RS				(PATIENT DAYS)	
		(SQUARE FEET)	4.00	7.00	0.00	0.00	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						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, 331					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	6, 906	,			6. 00
7.00	00700 HOUSEKEEPI NG	0	0	5, 331			7. 00
8.00	00800 DI ETARY	0	0) c	,		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	186	l .	186	0	6, 906	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	10.00
11.00	01100 PHARMACY	0	0		0	0	11.00
12. 00 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	64	0	4	0	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	04		64	0		14. 00
15. 00	01500 ACTIVITIES	684		684	0	0	15. 00
13.00	I NPATIENT ROUTINE SERVICE COST CENTERS	1 004		1 004	·		13.00
30. 00	03000 SKILLED NURSING FACILITY	4, 235	6, 906	4, 235	20, 718	6, 906	30.00
31. 00	03100 NURSING FACILITY	0	1	,, _ ,		0	31.00
32.00	03200 CF/IID	0	0	ol c	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	C	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40. 00	l l	0	0) C	0	0	40. 00
41. 00	04100 LABORATORY	0	0		0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	1	1,0	ή	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	162	l	162		0	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY					0	46.00
47. 00	04700 ELECTROCARDI OLOGY					0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS		o o	i c	o o	Ö	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	ol c	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	C	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	,					
60.00	06000 CLI NI C	0	1			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			J			70.00
70.00	07000 HOME HEALTH AGENCY COST	0	l	1		· -	70.00
71. 00 73. 00	07100 AMBULANCE	0	1		-	1	71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS		,ı <u></u>	1) 0	0	73.00
80. 00							80. 00
	08100 NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 H0SPI CE	0	0	ol c	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	5, 331	6, 906	5, 331	20, 718	6, 906	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00		0		1	_	1	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		1	_		91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	_	1	_	1	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY	0	0	C	0	0	93. 00 94. 00
98. 00			0		,	0	98.00
99. 00							99.00
102.00		55, 967	167, 425	167, 425	186, 963	269, 817	
. 52. 00	Part I)				.55, 766]	
103.00	1 1 -	10. 498406	24. 243412	31. 405928	9. 024182	39. 069939	103. 00
104.00		53	l	1			104. 00
	Part II)						
105.00	· · · · · · · · · · · · · · · · · · ·	0. 009942	0. 022879	0. 029638	0. 008495	1. 284680	105. 00
	11)	1	I	I	I	I	I

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315146

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared:

5/30/2023 11:08 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & ALLI ED HEALTH SERVICES & (PATIENT DAYS) **SUPPLY** LI BRARY (PATIENT DAYS) **EDUCATION** (ASSI GNED (PATLENT DAYS) (PATLENT DAYS) TIME) 12.00 10.00 11.00 13.00 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 6,906 10.00 11.00 01100 PHARMACY 6, 906 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 C 6,906 12.00 01300 SOCIAL SERVICE 0 6, 906 13 00 13 00 C 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 6, 906 6, 906 6, 906 6, 906 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 0 33.00 0 33 00 Ω 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 0 41.00 04100 LABORATORY 0000000000 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 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 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 r 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 61.00 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 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 6,906 6,906 6,906 6,906 0 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 C 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, 112, 725 3, 811 102, 646 0 102.00 102.00 0 Part I) 103.00 14.863307 0.000000 103.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 16. 322763 0.551839 104.00 Cost to be allocated (per Wkst. B, 0 104.00 106 3,062 0.000000 105.00 105.00 Unit cost multiplier (Wkst. B, Part 0.015349 0.000579 0.000000 0.443383 11)

CARE CONNECTION RAHWAY, LLC In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315146

Cost Center Description					То	12/31/2022	Date/Time Prepa 5/30/2023 11:08	
SERVICE ACTIVITIES COST CENTERS 1.00				OTHER GENERAL			5/30/2023 11.00	o alli
CEREMAL SERVICE COST CENTES 15.00 1.00								
SEMERAL SERVICE COST CENTERS			Cost Center Description					
SERIESAL SERVICE COST CENTERS 1.00 00000 (APR REL COSTS - BLOCS & FIXTRES 2.00 00000 (APR REL COSTS - BLOCS & FIXTRES 3.00 00000 (APR REL COSTS - BLOCS & FIXTRES 3.00 000000 (APR REL COSTS - BLOCS & FIXTRES 3.00 00000 (APR VICE BENETY IS NITMAN 5.00 5.00 00000 (ALMT OPERATION, MAINT & REPAIRS 5.00 00000 (ALMT OPERATION, MAINT & REPAIRS 7.00 00000 (ALMT OPERATION) 7.00 00000 (ALMT OPERATION, MAINT & REPAIRS 7.00 00000 (ALMT OPERATION) 7.00 0.								
1.00		GENER	AL SERVICE COST CENTERS	15.00				
3.00 03300 EMPLOYEE BENEFITS 3.00 5.00	1.00							1. 00
4. 00 0.00		00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
		1	•					3.00
6.00 0.000 LANIDRY & LINEN SERVICE 6.00 7.00 8.00 0.0000 DETARY 8.00 9.00 0.0000 MESIS MA ADMINISTRATION 9.00 10.00 0.0000 DETARY 10.00 10.00 0.0000 MESIS MA ADMINISTRATION 10.00 13.00 1.0000 CENTRAL SERVICES & SUPPLY 11.00 13.00 1.0000 MESIS MA ADMINISTRATION 11.00 13.00 1.0000 MESIN AL MAD ADMINISTRATION 11.00 15.00 1.0000 MESIN AL MAD ADMINISTRATION 11.00 15.00 1.0000 MESIN AL MAD ADMINISTRATION 11.00 15.00 1.0000 MESIN AL MAD ALLIED HEALTH FOLICATION 11.00 15.00 MESIN AL MAD ALLIED HEALTH FOLICATION 11.00 15.00 MESIN AL MAD ALLIED HEALTH FOLICATION 11.00 20.00 0.0000 SKI LLED MUSSIN OF FACILITY 0.90 32.00 0.0000 SKI LLED MUSSIN OF FACILITY 0.90 32.00 0.0000 SKI LLED MUSSIN OF FACILITY 0.90 40.00 0.0000 SKI LLED MUSSIN OF FACILITY 0.90								
0.000 0.00		1	i e					
B. 00 00800 DIETARY		1	i e					
9.00 0.0000 (NURSI IN ADMINISTRATION 0.00 11.00 0.1100 (DENTRAL SERVICE CEST SUPPLY 10.00 0.00 0.1100 (DENTRAL SERVICE SERVICE 12.00 0.1200 (DENTRAL SERVICE SERVICE 12.00 0.1200 (DENTRAL SERVICE SERVICE 13.00 0.1300 (DENTRAL SERVICE COST CENTERS 13.00 0.1300 (DENTRAL SERVICE COST CENTERS 15.00 0.1500 (DENTRAL SERVICE COST CENTERS 0.00 0.1300 (DENTRAL SERVICE SERV								
10.00 01000 CENTRAL SERVICES & SUPPLY 11.00 1100								
12.00 01200 MEDICAL RECORDS & LIBRARY	10.00	1	i e					
13.0 01300 SOCIAL SERVICE 13.0 014.0 014.0 014.0 014.0 014.0 015.0		1	i e				I	
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION							I	
15. 00							I	
INPATI ENT ROUTINE SERVICE COST CENTERS 30 00 30 00 30 00 31			i e	6 906			I	
30.00 30.00 SKILLED NURSING FACILITY 0 0 31.00 32.00 32.00 ICF/II D 0 0 32.00 32.00 ICF/II D 0 0 32.00 33.00 33.00 30.00 ICF/II D 0 0 32.00 33.00 30.00 ICF/II D 0 0 32.00 33.00 30.00 ICF/II D 0 0 32.00 33.00 30.00 ICF/II D 0 0 0	13.00			0, 700				13.00
32 00 03200 CFF/I I D 0 33 00	30.00			6, 906			;	30. 00
33 00 0718FL DOM TERM CARE 0 33 00 0718FL DOM TERM CARE 0 0 0 0 0 0 0 0 0				-			l l	
ANCIL LARY SERVICE COST CENTERS 40, 00 40, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 420, 00 420, 00 420, 00 10 10 10 10 10 10 10							l l	
40.00 04000 0400 0400 0400 0400 0400 0400 0400 0440 0400 0440 0400 0440	33. 00			0			;	33. 00
1.1 0 0.100 LABORATORY 0 4.1 0.0	40.00			0				40.00
42 00 04200 INTRAVENOUS THERAPY 0				0			I	
44. 00				Ö			I	
45. 00 04500 04500 04500 04500 04500 04500 04600	43.00	04300	OXYGEN (INHALATION) THERAPY	O			1.	43.00
46.00 04600 SPECH PATHOLOGY 0 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 48.00 48.00 48.00 48.00 48.00 49.00 49.00 49.00 49.00 49.00 49.00 51.00				0			1	
47. 00		1	i e	0			1	
A8. 00 04900 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 04900		1	•	0			1	
49.00 04900 DRUGS CHARGED TO PATIENTS 0 50.00 50.0000 50.000 50.000 50.000 50.000 50.000 50.000 50.0000 50.000 50.000 50.000 50.000 50.000 50.000 50.0000 50.000 50.000 50.000 50.000 50.000 50.000 50.0000 50.000 50.000 50.000 50.000 50.000 50.000 50.0000 50.		1	i e	0			1	
50.00				0			•	
OUTPATI ENT SERVICE COST CENTERS		1	•	Ö			1	
60.00	51.00	05100	SUPPORT SURFACES	O			!	51.00
61. 00 06100 RURAL HEALTH CLINIC 0 06200 FOHC 07100 CONTER REI IMBURSABLE COST CENTERS 0 07100 AMBULANCE 0 0 0 0 0 0 0 0 0								
62. 00 06200 FOHC OTHER REI MBURSABLE COST CENTERS				-			1	
OTHER REIMBURSABLE COST CENTERS O OTHOR HEALTH AGENCY COST OT				U			I	
70. 00 07000 HOME HEALTH AGENCY COST 0 71. 00 07100 MBULLANCE 0 71. 00 07300 CMHC 0 0 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81. 00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 08200 UTI LI ZATI ON REVI EW - SNF 82. 00 08300 HOSPI CE 0 83. 00 08300 HOSPI CE 0 83. 00 08300 HOSPI CE 0 08300 HOSPI CE 0 08300 MOSPI ALS (Sum of lines 1-84) 6,906 89. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91. 00 09200 PATI ENTS LAUNDRY 0 91. 00 09300 NONPAID WORKERS 0 92. 00 9300 NONPAID WORKERS 0 94. 00 9400 PATI ENTS LAUNDRY 0 09400 Nogati ve Cost Centers 99. 00 102. 00 Cross Foot Adj ustments 99. 00 102. 00 Cost to be allocated (per Wkst. B, 164, 560 Part I) 103. 00 Unit cost multiplier (Wkst. B, Part I) 23. 828555 103. 00 104. 00 Part II) Unit cost multiplier (Wkst. B, Part I) 4. 611063 105. 00	02.00							02.00
73. 00 07300 CMHC SPECIAL PURPOSE COST CENTERS 80. 00 80000 MALPRACTICE PREMIUMS & PAID LOSSES 81. 00 81. 00 81. 00 82. 00 81. 00 82. 00 81. 00 82. 00 83.	70.00			0				70. 00
SPECIAL PURPOSE COST CENTERS 80.00 80000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 81.00 81.00 81.00 81.00 81.00 82.00			i e	-			I	
80. 00 80. 00 80. 00 81. 00 81. 00 820. 00 82.	73. 00			0				73. 00
81.00 08100 INTEREST EXPENSE 81.00 82.00 UTI LI ZATI ON REVIEW - SNF 82.00 83.00 08300 HOSPI CE 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 6,906 89.00 NONREI MBURSABLE COST CENTERS 89.00 NONREI MBURSABLE COST CENTERS 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 92.00 PHYSI CI ANS PRI VATE OFFICES 0 92.00 93.00 09300 NONPAI D WORKERS 0 93.00 94.00 PATI ENTS LAUNDRY 0 94.00 98.00 99.00 PATI ENTS LAUNDRY 0 99.00 PATI ENTS CENTERS 99.00 102.00 Cross Foot Adjustments 98.00 99.00 Cost to be allocated (per Wkst. B, Part I) 23.828555 103.00 104.00 Part II) Unit cost multiplier (Wkst. B, Part I 4.611063 105.00	90 00							90 00
82. 00 83. 00 83. 00 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 90. 00 907.							l	
83. 00								
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 91.00 09100 BARBER AND BEAUTY SHOP 0 91.00 92.00 09200 PHYSICI ANS PRI VATE OFFICES 0 92.00 93.00 09300 NONPAID WORKERS 0 93.00 09400 PATI ENTS LAUNDRY 0 94.00 98.00 009400 PATI ENTS LAUNDRY 0 009400 PATI ENTS LAUNDRY 0 009400 093.00 009400				0				
90. 00	89. 00		,	6, 906				89. 00
91.00 99100 BARBER AND BEAUTY SHOP 0 91.00 92.00 99200 PHYSICIANS PRIVATE OFFICES 0 92.00 93.00 93.00 93.00 93.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00	00.00							00.00
92. 00				0			I	
93.00 9300 9				0				
94.00				o				
99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part III) 105.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	94.00			o				
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 23.828555 104.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst.			,					
Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part III)				4			•	
103.00 Unit cost multiplier (Wkst. B, Part I) 23.828555 104.00 Cost to be allocated (per Wkst. B, Part II) 31,844 105.00 Unit cost multiplier (Wkst. B, Part II) 4.611063	102.00)		164, 560			10	02. 00
104.00 Cost to be allocated (per Wkst. B, Part II) 31,844 104.00 105.00 Unit cost multiplier (Wkst. B, Part 4.611063 4.611063 105.00	103 00			23, 828555			110	03.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 4.611063 105.00								
			Part II)					
	105.00)		4. 611063			10	05. 00
		l	[11]					

Health Financial Systems	CARE CONNECTION RAHWAY, LLC	In Lieu of Form CMS-2540-10		
RATIO OF COST TO CHARGES FOR ANCILLARY	AND OUTPATIENT COST CENTERS Provider No.: 315146	Peri od: Worksheet C		

To 12/31/2022 Date/Time Prepared: 5/30/2023 11:08 am Cost Center Description Total (from Total Charges Ratio (col. 1 Wkst. B, Pt I, col. 18) 1.00 di vi ded by col . 2 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 4, 260 3, 514 1. 212294 40.00 41.00 04100 LABORATORY 61, 179 50, 471 1. 212161 41.00 42. 00 04200 I NTRAVENOUS THERAPY 81, 539 67, 267 1. 212169 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 0.000000 43.00 44. 00 04400 PHYSI CAL THERAPY 350, 407 804, 087 0. 435782 44.00 04500 OCCUPATIONAL THERAPY 0. 434469 45.00 402, 493 926, 403 45.00 04600 SPEECH PATHOLOGY 46.00 0.585442 46.00 44, 671 76, 303 47. 00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 48.00 49. 00 04900 DRUGS CHARGED TO PATIENTS 1. 212165 49.00 219, 928 266, 589 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 Ω 05100 SUPPORT SURFACES 51.00 115 115 1.000000 51.00 OUTPATIENT SERVICE COST CENTERS 06000 CLINIC 60.00 0.000000 60.00 0 0 61.00 06100 RURAL HEALTH CLINIC 61.00 62. 00 06200 FQHC 62.00 71. 00 07100 AMBULANCE 17, 510 71.00 14, 445 1. 212184

1, 228, 763

2, 162, 533

100. 00

100.00

Total

Health Financial Systems	CARE CONNECTION RAHWAY, LLC			In Lieu of Form CMS-2540-10		
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/30/2023 11:	
		Title	XVIII (1)	Skilled Nursing		00 4111
				Facility		
		Heal th Care Pi	rogram Charges	s Health Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	,	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Col umn 3)	2.00	2.00	4.00	F 00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	ITENT COST					1
40. 00 04000 RADI OLOGY	1. 212294	1 0	I		0	40.00
41. 00 04100 LABORATORY	1. 212161				0	
42. 00 04200 NTRAVENOUS THERAPY	1. 212169				0	
43. 00 04300 0XYGEN (INHALATION) THERAPY	0. 000000	l .			0	1
44. 00 04400 PHYSI CAL THERAPY	0. 435782	l .		0 187, 614	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 434469		1	0 175, 033	0	
46. 00 04600 SPEECH PATHOLOGY	0. 585442			0 35, 169	•	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000)	0 0	0	1
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 212165	0)	0 0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0)	0		50.00
51. 00 05100 SUPPORT SURFACES	1. 000000	0		0 0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0)	0	0	
61.00 06100 RURAL HEALTH CLINIC						61. 00
62. 00 06200 FQHC						62. 00
71. 00 07100 AMBULANCE (2)	1. 212184	l .		0	0	
100.00 Total (Sum of lines 40 - 71)		893, 462		0 397, 816	0	100. 00

(1) For title V and XIX use columns 1, 2, and 4 only.

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

APPORTI		CARE CONNECTION	I RAHWAY, LLC		In Lie	u of Form CMS-2	2540-10
	ONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315146	Peri od: From 01/01/2022 To 12/31/2022		pared: 08 am
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
F	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00							1.00
2.00	Program vaccine charges (From your reco				,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	/iders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,			Cost (From	& Allied Health Costs	
		18	(From Wkst. B, Part I, Col.	Costs to Tota		for Pass	
		10		Costs to Tota		Through (Col.	
			1 1)	(Col . 2 / Col		3 x Col . 4)	
				1)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
	ANCILLARY SERVICE COST CENTERS			1		_	
	04000 RADI OLOGY	4, 260	0			0	40.00
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	61, 179	0	0. 00000 0. 00000		0	41. 00 42. 00
	04300 OXYGEN (INHALATION) THERAPY	81, 539 0	0	0.0000		0	42.00
	04400 PHYSI CAL THERAPY	350, 407	0	0.0000		0	44.00
	04500 OCCUPATI ONAL THERAPY	402, 493	0	0.0000		0	45. 00
	04600 SPEECH PATHOLOGY	44, 671	0	0. 00000		0	
	04700 ELECTROCARDI OLOGY	0	0	0.0000		0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	00	0	48. 00
	D4900 DRUGS CHARGED TO PATIENTS	266, 589	0	0. 00000		0	
	D5000 DENTAL CARE - TITLE XIX ONLY	0	0	0. 00000		0	
	05100 SUPPORT SURFACES	115	0	0.0000		0	
100.00	Total (Sum of lines 40 - 52)	1, 211, 253	0	1	397, 816	0	100. 00

	Financial Systems CARE CONNECTION F ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315146	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Parts I-II Date/Time Pre 5/30/2023 11:0	pare
		Title XVIII	Skilled Nursing Facility	PPS	
			lacifity		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				-
00	INPATIENT DAYS Inpatient days including private room days		T	6, 906	1.
00	Private room days			0, 400	1
00	Inpatient days including private room days applicable to the	Program		5, 655	
00	Medically necessary private room days applicable to the Progr			0	
00	Total general inpatient routine service cost			3, 199, 138	5.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges			4, 810, 754	
00	General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		0. 664997	1
00	Enter private room charges from your records	0		0	
00	Average private room per diem charge (Private room charges li 2)	ne 8 divided by private	room days, line	0. 00	9
. 00	Enter semi-private room charges from your records			0	10
. 00	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	d by	0. 00	11
. 00	semi-private room days) Average per diem private room charge differential (Line 9 min	us lina 11)		0. 00	12
. 00	Average per diem private room cost differential (Line 7 times			0.00	
. 00				0	
. 00			minus line 14)	3, 199, 138	15
. 00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		463. 24	
. 00	Program routine service cost (Line 3 times line 16)			2, 619, 622	
. 00	Medically necessary private room cost applicable to program	,		0	
. 00	Total program general inpatient routine service cost (Line 1		.+	2, 619, 622	
. 00	Capital related cost allocated to inpatient routine service cline 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From WRSt. B, Par	t II COLUMN 18,	242, 489	
. 00	Per diem capital related costs (Line 20 divided by line 1)			35. 11	
. 00	Program capital related cost (Line 3 times line 21)			198, 547 2, 421, 075	
. 00	Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From pr	ovi der records)		2, 421, 0/5	
. 00	, ,		nus Line 24)	2, 421, 075	
. 00		t Trim tatron (Erne 20 iiii	nus iine zij	2, 121, 070	26
. 00		er diem limitation line	26) (1)		27
. 00	Reimbursable inpatient routine service costs (Line 22 plus t (Transfer to Worksheet E, Part II, line 4) (See instructions)		line 27)		28
) Li	nes 26 and 27 are not applicable for title XVIII, but may be u		itle XIX	l	'
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COST	S FOR PPS PASS-THROUGH	'		
00	Total SNF inpatient days			6, 906	
00	Program inpatient days (see instructions)			5, 655	
00	Total nursing & allied health costs. (see instructions)(Do no Nursing & allied health ratio. (line 2 divided by line 1)	t complete for titles V	or XIX)	0	
	imprespar allead bootth rates. (Line 2 divided by Line 1)			0. 818853	4

OMPUTA	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315146	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2023 11:0	pare
		Title XIX	Skilled Nursing Facility		
				1 00	
1	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	I NPATI ENT DAYS				
00	Inpatient days including private room days			6, 906	1
	Private room days			0	2
00	Inpatient days including private room days applicable to the Pr	ogram		0	3
00	Medically necessary private room days applicable to the Program			0	4
00	Total general inpatient routine service cost			3, 199, 138	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges			4, 810, 754	6
	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 664997	7
	Enter private room charges from your records	0 4: : 4-4 b		0	8
0	Average private room per diem charge (Private room charges line 2)	8 divided by private	room days, line	0. 00	9
	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private room c semi-private room days)	harges line 10, divide	d by	0. 00	11
00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	11
	Average per diem private room cost differential (Line 7 times I			0.00	
	Private room cost differential adjustment (Line 2 times line 13			0.00	14
	General inpatient routine service cost net of private room cost		minus line 14)	3, 199, 138	15
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divi	dod by Line 1)	T	463. 24	 16
	Program routine service cost (Line 3 times line 16)	ded by TTNe T)		403. 24	17
4	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18
00	Total program general inpatient routine service cost (Line 17)			0	19
	Capital related cost allocated to inpatient routine service cos		t II column 18,	242, 489	
00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1)			35. 11	2
	Program capital related cost (Line 3 times line 21)			0	22
	Inpatient routine service cost (Line 19 minus line 22)			0	23
00	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		0	24
1	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	0	25
- 1	Enter the per diem limitation (1)			0. 00	
	Inpatient routine service cost limitation (Line 3 times the per			0	27
00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	lesser of line 25 or	line 27)	0	28
Li r	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX	'	
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		50	
	Total SNF inpatient days			6, 906	1
no l	Program inpatient days (see instructions)			0	Ιo

0

0

0.000000

2.00 3. 00

4.00

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)
Program nursing & allied health costs for pass-through. (line 3 times line 4)

MCRI F32	-	10.	12.	175.	6

2. 00

4.00

5.00

Health Financial Systems	CARE	CONNECTION RAHWAY, LLC		In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	NT FOR TITLE XVIII	Provi der		From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prepared: 5/30/2023 11:08 am
		Ti t	le XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			3, 998, 697	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			3, 998, 697	3.00
4.00	Primary payor amounts			0	4.00
5.00	Coi nsurance			428, 873	5.00
6.00	Allowable bad debts (From your records)			249, 069	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		6, 030	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			161, 895	8.00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			3, 731, 719	11. 00
12.00	Interim payments (See instructions)			3, 710, 356	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			2, 040	
14. 99					14. 99
15. 00					15.00
16. 00					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)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24.00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	CTI ONS)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99 29. 00
29. 00	Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance	o with CMS Dub 15 2	soction 115 2	0	
30.00	Triorested amounts (Monariowanie cost report itells) ili accordanc	e with two rub. 15-2,	Section 113. 2	υĮ	30.00

From 01/01/2022 To 12/31/2022 Date

Title XVIII Skilled Nursing PPS

From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/30/2023 11: 08 am

		11 (1)	e AVIII	Facility	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00	3, 525, 225	3.00	4.00	1. 00
2. 00	Interim payments payable on individual bills, either		139, 782		0	2. 00
2.00	submitted or to be submitted to the contractor for		107/702			2.00
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				1 -	
3. 01	ADJUSTMENTS TO PROVIDER	07/19/2022	45, 349		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Dravi dan ta Dragnam		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTIVILINTS TO FROGRAM		0		0	3. 50
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		45, 349		0	3. 99
	- 3.98)		,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 710, 356		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER		0		0	F 01
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0		0	5. 02
5.05	Provider to Program		U		0	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTITIVE TO TROOK IIII		0		Ö	5. 51
5. 52			0		l o	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		0		0	6. 01
6. 02	PROVI DER TO PROGRAM		25, 276		0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 685, 080		0	7. 00
			Contract	or Name	Contractor	
			_	00	Number	
0.00	Name of Contractor		1.	00	2. 00	0.00
	Name of Contractor				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 CARE CONNECTION
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column onl y)

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Assets CURRENT ASSETS Cash on hand and in banks Temporary investments	General Fund	Speci fi c Purpose Fund 2.00	wment Fund 3.00	Plant Fund 4.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	CURRENT ASSETS Cash on hand and in banks	1.00		3. 00	4. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	CURRENT ASSETS Cash on hand and in banks					
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cash on hand and in banks					4
2.00 3.00 4.00 5.00 6.00		1, 807, 107	0	ol	0	1.00
3. 00 4. 00 5. 00 6. 00		1,807,107	0	0	0	
4. 00 5. 00 6. 00	Notes receivable	0	0	0	0	
6. 00	Accounts receivable	657, 504	0	o	0	
	Other recei vabl es	0	0	O	0	
l i	Less: allowances for uncollectible notes and accounts	-58, 800	0	О	0	6.00
1	recei vabl e					
1	Inventory	0	0	0	0	
1	Prepaid expenses Other current assets	85, 809 1, 541	0	U O	0	
4	Due from other funds	1, 341	0	0	0	
	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 493, 161	0	ő	0	
	FIXED ASSETS	, , , , , ,	-			
12. 00	Land	0	0	0	0	
4	Land improvements	0	0	0	0	
	Less: Accumulated depreciation	0	0	0	0	1
1	Buildings	0	0	0	0	
	Less Accumulated depreciation	0	0	O	0	
- 1	Leasehold improvements	0	0	O O	0	
	Less: Accumulated Amortization Fixed equipment	0	0	ol .	0	
- 1	Less: Accumulated depreciation	0	0	0	0	
1	Automobiles and trucks	0	0	0	0	
4	Less: Accumulated depreciation	0	0		0	
	Major movable equipment	23, 075	0	Ö	0	
	Less: Accumulated depreciation	-19, 271	O	ol	0	
25. 00	Mi nor equi pment - Depreci abl e	0	0	o	0	25. 00
26. 00	Mi nor equi pment nondepreci abl e	0	0	o	0	26.00
27. 00	Other fixed assets	0	0	0	0	
	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	3, 804	0	0	0	28. 00
	OTHER ASSETS			ما		
1	Investments	0	0	0	0	
1	Deposits on leases Due from owners/officers	0	0	O	0	
1	Other assets	175, 246	0		0	
1	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	175, 246	0	Ö	0	
1	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	2, 672, 211	0	o	0	
	Liabilities and Fund Balances					1
	CURRENT LIABILITIES					
	Accounts payable	321, 624	0	0	0	
	Salaries, wages, and fees payable	0	0	0	0	
	Payroll taxes payable	15, 656	0	O	0	
	Notes & Loans payable (Short term)	0	0	O	0	
	Deferred income Accelerated payments	0	U	٩	U	40.00
	Due to other funds	0	0	ام	0	
	Other current liabilities	429, 528	0	o	0	
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	766, 808	0	ol	0	
-	LONG TERM LIABILITIES					1
44.00	Mortgage payable	0	0	0	0	44. 00
	Notes payable	0	0	0	0	
1	Unsecured Loans	0	0	O	0	
1	Loans from owners:	0	0	o	0	
	Other long term liabilities	0	0	O	0	
1	OTHER (SPECIFY)	0	0	O	0	1
1	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	766, 808	0	0	0	
	CAPITAL ACCOUNTS	700,000	0	<u> </u>	0	31.00
	General fund balance	1, 905, 403				52.00
	Specific purpose fund	, , , , , , ,	0		ļ	53. 00
	Donor created - endowment fund balance - restricted			o	ļ	54.00
55. 00	Donor created - endowment fund balance - unrestricted			o	ļ	55.00
	Governing body created - endowment fund balance			0	ļ	56. 00
4	Plant fund balance - invested in plant				0	1
	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion	1 005 400			^	F0 00
	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	1, 905, 403 2, 672, 211	0	O O	0	
59. 00					0	

Provi der No.: 315146

					10 12/31/2022	5/30/2023 11:	
		Genera	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 2, 114, 696	3.00	4.00	5. 00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		292, 190		,	1	2.00
3.00	Total (sum of line 1 and line 2)		2, 406, 886				3. 00
4. 00	Additions (credit adjustments)		27 1007 000		· ·	1	4. 00
5.00	,	O			0	0	5. 00
6.00		o			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	
10. 00	Total additions (sum of line 5 - 9)		0		(10. 00
11. 00	Subtotal (line 3 plus line 10)		2, 406, 886		(11. 00
12.00	Deductions (debit adjustments)	504 400					12.00
13.00	DI STRI BUTI ONS	501, 483			0	0	13.00
14.00		0			0	0	14. 00
15. 00 16. 00		0			0	0	15. 00 16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 13 - 17)		501, 483				18.00
19. 00	Fund balance at end of period per balance		1, 905, 403	l .			19. 00
.,. 00	sheet (Line 11 - line 18)		.,,,,,,,,			1	. , , , ,
		Endowment Fund	PI ant	Fund			
4 00	TE	6.00	7. 00	8. 00			4 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	0			0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)				0		3.00
4.00	Additions (credit adjustments)	١			U		4.00
5.00	Additions (credit adjustments)		0				5. 00
6.00			0				6.00
7. 00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 5 - 9)	o			0		10.00
11.00	Subtotal (line 3 plus line 10)	o			0		11. 00
12.00	Deductions (debit adjustments)						12.00
13.00	DI STRI BUTI ONS		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16.00
17. 00	T-1-1 deductions (12 17)		0				17. 00
18.00	Total deductions (sum of lines 13 - 17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (Line 11 - line 18)	ا			U		19. 00
	Islieer (Fille II - IIIIe 10)	1		I	1		l

STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315146	Peri od: From 01/01/2022 To 12/31/2022		pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY		4, 810, 75	54	4, 810, 754	
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		4, 810, 75	54	4, 810, 754	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		2, 162, 53	33 0	2, 162, 533	6. 00
7.00	CLINIC			0	0	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11.00	CMHC			0	0	11. 00
12.00	HOSPI CE			0 0	0	12.00
13.00	OTHER (SPECIFY)			0 0	0	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	6, 973, 28	37 0	6, 973, 287	14.00
	Worksheet G-3, Line 1)					
	Cost Center Description					
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				4, 485, 209	
2.00	Add (Specify)			0		2. 00
3.00				0		3. 00
4.00				0		4. 00
5.00				0		5. 00
6.00				0		6. 00
7.00				0		7. 00
0 00	Total Additions (Sum of Lines 2 7)				l 0	0 00

8. 00

9. 00 10. 00 11. 00

12.00

13. 00 14. 00 0

4, 485, 209 15. 00

8. 00 9. 00 10. 00

11.00 12.00 Total Additions (Sum of lines 2 - 7)

15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

13.00 14.00 Total Deductions (Sum of lines 9 - 13)

Deduct (Specify)

Heal th	Financial Systems CARE CONNEC	TION RAHWAY, LLC	In Lie	u of Form CMS-2	2540-10
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315146	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	nared:
			10 12/31/2022	5/30/2023 11:	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3,	line 14)		6, 973, 287	1. 00
2.00	2.00 Less: contractual allowances and discounts on patients accounts			2, 206, 648	2. 00
3.00 Net patient revenues (Line 1 minus line 2)			4, 766, 639	3. 00	
4.00	Less: total operating expenses (From Worksheet G-2, Pari	t II, line 15)		4, 485, 209	4. 00
5.00	Net income from service to patients (Line 3 minus 4)			281, 430	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			10, 760	7. 00
8.00	Revenues from communications (Telephone and Internet se	ervi ce)		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12 00	Parking Lot receipts			l o	12 00

0 12.00

0 14.00 15.00

0 16.00

0 19.00

0 20.00

0

0 23.00

0 24. 50

0 27.00

Ωl 29.00

0 30.00

292, 190 31. 00

10, 760

292, 190

13.00

17.00

18.00

21.00

22.00

24.00

25.00

26.00

28.00 0

12.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

24. 50

25.00

26.00

27.00

28.00

29.00

30.00

Parking Lot receipts

13.00 Revenue from Laundry and Linen service

Rental of vending machines

Governmental appropriations

Total (Line 5 plus line 25)

Other expenses (specify)

OTHER REV MISC

COVI D-19 PHE Funding

Rental of skilled nursing space

14.00 Revenue from meals sold to employees and guests
15.00 Revenue from rental of living quarters

Total other income (Sum of lines 6 - 24)

Total other expenses (Sum of lines 27 - 29)

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

Revenue from sale of drugs to other than patients

Revenue from sale of medical records and abstracts

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

Revenue from gifts, flower, coffee shops, canteen

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

CARE CONNECTION RAHWAY, LLC

(a limited liability company) BALANCE SHEET **AT DECEMBER 31, 2022**

ASSETS Current assets		
Cash and cash equivalents		2,059,312
Accounts receivable - net	,	659,632
Due from previous owner		91,913
Prepaid expenses and other		467,760
r repaid expenses and other	-	407,700
Total current assets		3,278,617
Property and equipment - net		7,462
Goodwill - net		123,333
		-
TOTAL ASSETS	S	3,409,412
LIABILITIES AND MEMBERS' EQUITY Current liabilities		
Accounts payable	5	237,076
Accrued expenses		205,832
Accrued and withheld taxes		15,918
Due to private and third party payers		143,337
Deposits payable		4,188
Medicare advance - loan payable		686,834
Total current liabilities		1,293,185
Members' equity		2,116,227
TOTAL LIABILITIES AND MEMBERS' EQUITY	S	3,409,412

CARE CONNECTION RAHWAY, LLC

(a limited liability company)

STATEMENTS OF EARNINGS AND MEMBERS' EQUITY YEAR ENDED DECEMBER 31, 2022

Revenues	\$ 6,002,646
Operating expenses	 4,345,492
Earnings from operations	1,657,154
Non-operating revenue (expenses)	
Interest income	8,480
Settlement of debt	4,737
Stimulus funds	25,973
Other income - license agreement	 386,911
NET EARNINGS	2,083,255
Members' equity - beginning of year	 1,123,387
	3,206,642
Members' equity distributed	 (1,090,415)
MEMBERS' EQUITY - END OF YEAR	\$ 2,116,227

CARE CONNECTION RAHWAY, LLC (a limited liability company) STATEMENT OF CASH FLOWS YEAR ENDED DECEMBER 31, 2022

Cash flows from operating activities	
Net earnings	\$ 2,083,255
Adjustments to reconcile net earnings	
to net cash provided by operating activities	
Depreciation and amortization	43,207
(Increase) decrease in assets	
Accounts receivable	(87,710)
Prepaid expenses	(369,349)
Due from previous owner	-
Increase (decrease) in liabilities	
Accounts payable	(23,282)
Accrued expenses and withheld taxes	95,480
Due to private and third party payers	46,089
Deposits payable	 (456,897)
Net cash provided by operating activities	1,330,793
Cash flows from investing activities	
Purchase of property and equipment	(3,291)
Net cash used in financing activities	(3,291)
Cash flows from financing activities	
Medicare advance - loan repayment	(295,651)
Members' equity contributed	_
Members' equity distributed	(1,090,415)
Net cash used in investing activities	(1,386,066)
Net decrease in cash, restricted cash and cash equivalents	(58,564)
Cash, restricted cash and cash equivalents - beginning of year	2,117,876
CASH, RESTRICTED CASH AND CASH EQUIVALENTS - END OF YEAR	\$ 2,059,312

CARE CONNECTION RAHWAY, LLC (a limited liability company) SUPPLEMENTARY INFORMATION REVENUES YEAR ENDED DECEMBER 31, 2022

			Per Patient Day
Current year			
Medicare	\$	4,774,750	\$ 801.54
Medicare Part A bad debts		(82,798)	(13.90)
Private		7,200	450.00
HMO	_	750,550	683.56
		5,449,702	\$ 770.71
Prior years Medicare			
Private		(1,125)	
HMO		(1,123) $(1,956)$	
	_	(3,081)	
Ancillary revenue	_	5,975	
Employee retention credit	_	550,050	
TOTAL REVENUES	\$_	6,002,646	