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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315202

Period:
From 01/01/2023
To 12/31/2024

Parts I, II & III Date/Time Prepared:
5/13/2024 9: 29 am

					1/ 13/ 2024 7	. 2 7 aiii
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/13/2024	Time:	9: 29 8
use only	2. [] Manually prepared cost report 3. [0] If this is an amended report en 3.01 [] No Medicare Utilization. Enter '			resubmitted this	cost repor	t
Contractor use only	4. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received:	8.[N] Last 9. NPR Date: 10.[0]If I 11.Contracto 12.[F] Medi	t No. t Cost Report for this Cost Report for this F ine 4, column 1 is "4": r Vendor Code care Utilization. Enter no utilization.	Provider CCN Enter number of 4		

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 LOPATCONG CENTER (315202) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1		2	SI GNATURE STATEMENT	
1	Dia	ne Morris	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	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			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	22, 248	3, 307	0	1. 00
2.00 NURSING FACILITY	0			0	2. 00
3. 00 I CF/I I D				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
7. 10 SNF - BASED CORF I	0		0		7. 10
100. 00 TOTAL	0	22, 248	3, 307	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 LOPATCONG CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315202 Peri od: Worksheet S-2 From 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/13/2024 9: 29 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 390 RED SCHOOL LANE PO Box: 1.00 2.00 Ci ty: PHI LLI PSBURG State: NJ Zi p Code: 08865 2.00 3.00 County: WARREN CBSA Code: 10900 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: P 4.00 SNF LOPATCONG CENTER 315202 02/01/1985 N Р 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 166, 770 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 166, 77d 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) Ν 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility N 30.00 31.00 | ICF/IID Ν 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC Ν 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38.00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00

LOPATCONG CENTER In Lieu of Form CMS-2540-10
CILITY HEALTH CARE Provider No.: 315202 Period: Worksheet S-2
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/13/2024 9: 29 am
Y/N Y/N
1.00
reported in other than the Administrative and General cost N 42.00
and submit supporting schedule listing cost centers and
d in CMS Pub. 15-1, Chapter 10?
chain number and enter the name and address of the home HB0067 44.00
2.00 3.00
ization, enter the name and address of the home office on the lines
ntractor's Name: NOVITAS Contractor's Number: 12001 45.00
Box: 46.00
ate: PA Zip Code: 19348 47.00
reported in other than the Administrative and General cost and submit supporting schedule listing cost centers and din CMS Pub. 15-1, Chapter 10? Chain number and enter the name and address of the home HB0067 44.0 2.00 3.00 ization, enter the name and address of the home office on the lines ntractor's Name: NOVITAS Contractor's Number: 12001 45.0 Box:

	Financial Systems	LOPATCONG CENT		N- 215202		eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	IY HEALIH CARE	Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
					Y/N	5/13/2024 9: 2 Date	29 alli
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy)	ses enter in column	1, "Y" fo	r Yes or "N" 1	1.00 for No. For all	2.00 the date	
	Completed by All Skilled Nursing Facilites Provider Organization and Operation				_		
1. 00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1.00	Date 2.00	V/I 3. 00	
2.00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of			N			2.00
3. 00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider on I, or members of the	es, drug its e board	Y			3.00
	relationships: (see Histractions)			Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports					1 0.00	
4.00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit complete and the statement of the control of the cont	" for Audited, "C" t te copy or enter da	for te	Y	С		4.00
5.00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different	from	N			5. 00
	, cooler, rutt on.				Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2:	Is the	provider the	N	l N	6. 00
7. 00 8. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program. Were approvals and/or renewals obtained duri	s? (Y/N) see instru	ctions.		N N		7. 00 8. 00
8.00	School and/or Allied Health Program? (Y/N) so		ig perrou	TOT Nutstrig	IN .	Y/N	8.00
	Bad Debts					1. 00	
9. 00 10. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				t reporting	Y N	9. 00 10. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coi nsurance wai	ved? If "	Y", see instr	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting peri	od? If "Y			N	12. 00
		Description	n	Y/N	rt A Date	Part B Y/N	
	DC+D Do+o	0		1. 00	2. 00	3. 00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			N		N	13. 00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			Y	03/09/2024	Y	14.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?			N		N	17. 00
18. 00	Describe the other adjustments: Was the cost report prepared only using the			N		N	18.00

Heal th	Financial Systems LOPATCO	NG CEN	ITER			In Lie	u of Form CMS	-2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CA X REIMBURSEMENT QUESTIONNAIRE	RE	Provi der	No.: 315202		riod: om 01/01/2023 12/31/2023		epared:
			1.	00		2. (00	
	Cost Report Preparer Contact Information							
19. 00	Enter the first name, last name and the title/position	JEAN	I		PI	RICE		19. 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	GENE	SIS HEALTH	ICARE				20.00
	preparer.							
21. 00	Enter the telephone number and email address of the cost	4108	3044481		IJ	EAN. PRI CE@GENE	ESI SHCC. COM	21. 00
	report preparer in columns 1 and 2, respectively.	I			ı			II

Health Financial Systems

LOPATCONG CENTER

In Lieu of Form CMS-2540-10

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEX REIMBURSEMENT QUESTIONNAIRE

LOPATCONG CENTER

In Lieu of Form CMS-2540-10

Period:
From 01/21/2023 Part II

COMPLE	A RETWIDURSEWENT QUESTIONNALRE			To 12/31/2023	Date/Time Prep 5/13/2024 9: 29	
		Part B Date 4.00				
	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.)					13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	03/09/2024				14.00
15. 00	1					15. 00
16. 00						16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		REIMBURSEMENT ANALYST			19. 00
20. 00	, ,	report				20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21. 00

In Lieu of Form CMS-2540-10 LOPATCONG CENTER

 Heal th
 Financial
 Systems
 LOPATCONG

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

Provi der No.: 315202

						5/13/2024 9: 29	
				I np	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	158	57, 670	0	5, 633	27, 413	1. 00
2.00	NURSING FACILITY	0	0	0		0	2. 00
3.00	I CF/II D	0	0			0	3. 00
4.00	HOME HEALTH AGENCY COST		0	0	0	0	4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	U				5. 00 6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	0	0	0	ol	7. 00
8.00	Total (Sum of lines 1-7)	158	57, 670	Ō	5, 633		8. 00
		Inpatient [Days/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	6. 00	7. 00	8.00	9. 00	10.00	
1. 00	SKILLED NURSING FACILITY	7, 684	40, 730	0.00			1. 00
2.00	NURSING FACILITY	0	0	Ö		0	2. 00
3.00	ICF/IID	0	0			o	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						6. 00
6. 10	SNF-Based CORF		_	_	_	_	6. 10
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	7, 684		0	150 rage Length of		8. 00
		Di sch	ai yes	Avei	age Length of	Stay	
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	181	383	0.00	37. 55	l .	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						6. 00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	181	383	0.00		527. 17	8. 00
		Average Length of Stay		Admis	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16. 00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	106. 34	0	164			1. 00
2.00	NURSING FACILITY	0. 00	0		0		2. 00
3.00	I CF/IID	0. 00			0	0	3.00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0. 00				0	4. 00 5. 00
6. 00	SNF-Based CMHC	0.00				١	6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0.00	0	0	0	o	7. 00
8.00	Total (Sum of lines 1-7)	106. 34	0	164			8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
			Payrol I	Workers			
		21. 00	22. 00	23. 00			
1.00	SKILLED NURSING FACILITY	391	87. 08	0. 00			1. 00
2.00	NURSING FACILITY	0	0.00				2.00
3.00	ICF/IID	0	0.00	0.00			3.00
4.00	HOME HEALTH AGENCY COST		0.00				4.00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	0. 00 0. 00				5. 00 6. 00
6. 10	SNF-Based CORF		0.00				6. 10
7. 00	HOSPI CE	0	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	391	87. 08			ļ	8. 00
			'	'	•	'	

Health Financial Systems
SNF WAGE INDEX INFORMATION LOPATCONG CENTER

 FER
 In Lieu of Form CMS-2540-10

 Provider No.: 315202
 Period: Worksheet S-3 From 01/01/2023
 Part II

					rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre 5/13/2024 9:2	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Sal ari es (col.		Wage (col. 3 ÷	
		Reported	Worksheet A-6		Salary in col.		
			WOTKSHEET A U	1 1 001. 2)	3	COI. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	5, 711, 919	0	5, 711, 919	181, 116. 36	31. 54	1.00
2.00	Physician salaries-Part A	0	0	C	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	C	0.00	0.00	3. 00
4.00	Home office personnel	0	0	C	0.00	0.00	4. 00
5.00	Sum of lines 2 through 4	0	0	C	0.00	0.00	5. 00
6.00	Revised wages (line 1 minus line 5)	5, 711, 919	0	5, 711, 919	181, 116. 36	31. 54	6. 00
7.00	Other Long Term Care	0	0	(0.00	0.00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0		0.00	0.00	8. 00
9.00	CMHC	0	0		0.00	0.00	9. 00
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0		0.00	0.00	10.00
11.00	Other excluded areas	0	0	(0.00	0.00	11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0		0.00	0.00	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line	5, 711, 919	0	5, 711, 919	181, 116. 36	31. 54	13.00
	12)						
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	2, 496, 996		_,,			14. 00
15. 00	Contract Labor: Physician services-Part A	70, 911	0	70, 911			15. 00
16.00	Home office salaries & wage related costs	356, 207	0	356, 207	7, 208. 00	49. 42	16. 00
	WAGE-RELATED COSTS						
17. 00	Wage-related costs core (See Part IV)	829, 366	0	829, 366			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	()		18. 00
19. 00	Wage related costs (excluded units)	0	0	()		19. 00
20.00	Physician Part A - WRC	0	0	()		20. 00
21. 00	Physician Part B - WRC	0	0	()		21. 00
22. 00	Total Adjusted Wage Related cost (see	829, 366	0	829, 366	6		22. 00
	instructions)						

Health Financial Systems
SNF WAGE INDEX INFORMATION LOPATCONG CENTER

Provi der No.: 315202

				Ť	o 12/31/2023	Date/Time Prep 5/13/2024 9: 20	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.		Wage (col. 3 ÷	
		·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	462, 336	0	462, 336	14, 085. 66	32. 82	2. 00
3.00	Plant Operation, Maintenance & Repairs	100, 266	0	100, 266	4, 219. 96	23. 76	3. 00
4.00	Laundry & Li nen Servi ce	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	0	0.00	0.00	5. 00
6.00	Di etary	0	0	0	0.00	0.00	6. 00
7.00	Nursing Administration	600, 412	-59, 954	540, 458	11, 792. 23	45. 83	7. 00
8.00	Central Services and Supply	0	36, 207	36, 207	1, 800. 68	20. 11	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	23, 747	23, 747	1, 234. 23	19. 24	10.00
11. 00	Soci al Servi ce	186, 504	0	186, 504	6, 086. 54	30. 64	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	154, 435	0	154, 435	9, 121. 17	16. 93	13.00
14.00	Total (sum lines 1 thru 13)	1, 503, 953	0	1, 503, 953	48, 340. 47	31. 11	14.00

Health Financial Systems	LOPATCONG CENTER	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315202	Peri od: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:

	To 12/31/20	D23 Date/Time Pre 5/13/2024 9: 2	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS	'	
	Part A - Core List		İ
	RETIREMENT COST		İ
1.00	401K Employer Contributions	8, 675	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Heal th Insurance (Purchased or Self Funded)	168, 191	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	
	Accident Insurance (If employee is owner or beneficiary)	0	
13. 00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14. 00		0	
	Workers' Compensation Insurance	129, 413	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.		
	Non cumulative portion)		
	TAXES	<u>'</u>	
17.00	FICA-Employers Portion Only	428, 504	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
	State or Federal Unemployment Taxes	67, 567	20.00
	OTHER	<u> </u>	
21.00	Executive Deferred Compensation	0	21.00
		0	22. 00
23.00	Tuition Reimbursement	27, 016	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	829, 366	
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
		•	•

					o 12/31/2023	Date/Time Prep 5/13/2024 9: 20	
	Occupational Category	Amount	Fri nge	Adjusted	Paid Hours	Average Hourly	
		Reported		Salaries (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				_	3	ĺ	
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 334, 857	176, 135				1.00
2.00	Licensed Practical Nurses (LPNs)	1, 177, 331	171, 293	1, 348, 624			2.00
3.00	Certified Nursing Assistant/Nursing	1, 695, 778	287, 935	1, 983, 713	72, 483. 74	27. 37	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	4, 207, 966	635, 363	4, 843, 329			4.00
5.00	Physi cal Therapists	0	0	0	0.00		5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0. 00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respi ratory Therapi sts	O	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15. 00	Licensed Practical Nurses (LPNs)	48, 344		48, 344	781. 31	61. 88	15.00
16.00	Certified Nursing Assistant/Nursing	48, 015		48, 015	1, 393. 02	34. 47	16.00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	96, 359		96, 359	·		17.00
18.00	Physi cal Therapists	278, 663		278, 663	3, 537. 00	78. 79	18.00
19.00	Physical Therapy Assistants	192, 141		192, 141	3, 957. 00	48. 56	19.00
20.00	Physi cal Therapy Ai des	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	146, 300		146, 300	2, 253. 00	64. 94	21.00
22.00	Occupational Therapy Assistants	195, 047		195, 047	4, 023. 00	48. 48	22.00
23. 00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	105, 094		105, 094	1, 641. 00	64. 04	24.00
25.00	Respi ratory Therapi sts	3, 398		3, 398	71. 00	47. 86	25.00
26.00	Other Medical Staff	70, 911		70, 911	834.00	85. 03	26.00

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:29 am Provi der No.: 315202

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12.00 RUA 12.00 RUB 14.00 RUB RUB 14.00 RUB RUB 14.00 RUB					
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	75. 00		PA2		75. 00

Health Financial Systems	LOPATCONG CENTE	:R		In Lieu of Form CMS-2540-10			
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	F	Provi der	No.: 315202	Peri od:	Worksheet S-7	1	
				From 01/01/2023 To 12/31/2023	Date/Time Pro 5/13/2024 9:2		
				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 Recrui tment						102.00	
103.00 Retention of employees						103. 00	
104. 00 Training						104. 00	
105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	no 1 column 2)					105. 00 106. 00	
100.00 Total Sivi revenue (WorkSheet G-2, Part I, II	ile i, coruilli 3)	I		1		1100.00	

Health Financial Systems	LOPATCONG CE	ENTER		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
				10 12/01/2020	5/13/2024 9: 2	
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Reclassi fied	
			+ col. 2)	ons	Trial Balance	
				Increase/Decre	(col. 3 +-	
				ase (Fr Wkst A-6)	col . 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS			2.20		¥. ¥.	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES		1, 486, 646	1, 486, 64	6 0	1, 486, 646	1.00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT		32, 963	32, 96	3 0	32, 963	2.00
3.00 00300 EMPLOYEE BENEFITS	0	803, 135	803, 13		803, 135	3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL	462, 336	1, 950, 158			2, 412, 494	4. 00
5.00 O0500 PLANT OPERATION, MAINT. & REPAIRS 6.00 O0600 LAUNDRY & LINEN SERVICE	100, 266	469, 346	569, 61		569, 612	5. 00 6. 00
6.00 00600 LAUNDRY & LINEN SERVICE 7.00 00700 HOUSEKEEPING		218, 646 399, 334	218, 64 399, 33		218, 646 399, 334	7. 00
8. 00 00800 DI ETARY		1, 050, 219	1, 050, 21		1, 050, 219	8. 00
9. 00 00900 NURSING ADMINISTRATION	600, 412	173, 066	773, 47		713, 524	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0	77, 791	77, 79		113, 998	10.00
11. 00 01100 PHARMACY	0	0		О	0	11.00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	0		23, 747	23, 747	12.00
13. 00 01300 SOCIAL SERVICE	186, 504	649	187, 15	3 0	187, 153	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	47/ 40	0	0	14.00
15. 00 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	154, 435	21, 748	176, 18	3 0	176, 183	15. 00
30. 00 03000 SKILLED NURSING FACILITY	4, 207, 966	336, 325	4, 544, 29	1 0	4, 544, 291	30. 00
31. 00 03100 NURSI NG FACILITY	4, 207, 700	330, 323	4, 344, 27		4, 344, 271	31. 00
32. 00 03200 CF/IID	o	0		o o	0	32. 00
33.00 03300 OTHER LONG TERM CARE	0	0		0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	23, 588	23, 58		23, 588	40.00
41. 00 04100 LABORATORY	0	86, 429	86, 42		86, 429	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0	17, 207	17, 20		17, 207	42. 00
43.00 04300 0XYGEN (I NHALATION) THERAPY 44.00 04400 PHYSI CAL THERAPY	0	18, 313 385, 383	18, 31, 385, 38		18, 313 385, 383	43. 00 44. 00
45. 00 04500 OCCUPATI ONAL THERAPY		377, 465	377, 46		377, 465	45. 00
46. 00 04600 SPEECH PATHOLOGY	o	140, 258	140, 25		140, 258	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	,	0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o c	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	210, 197	210, 19	7 0	210, 197	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	40.45	0	0	50.00
51. 00 05100 SUPPORT SURFACES 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	10, 152 0	10, 15		10, 152 0	51. 00 52. 00
OUTPATIENT SERVICE COST CENTERS	l ol	U	'	J	0	32.00
60. 00 06000 CLI NI C	O	0		0	0	60. 00
61.00 06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62. 00 06200 FQHC						62.00
63.00 O6300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	63.00
OTHER REI MBURSABLE COST CENTERS				ما ما		70.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0		0	0	
71. 00 07100 AMBULANCE 72. 00 07200 CORF		0			0	71. 00 72. 00
73. 00 07300 CMHC		0			0	73.00
74. 00 07400 OTHER REIMBURSABLE COST	o	0			0	74. 00
SPECIAL PURPOSE COST CENTERS						
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80.00
81. 00 08100 INTEREST EXPENSE		0		0 0	0	81. 00
82. 00 08200 UTI LI ZATI ON REVI EW	0	0		0	0	82.00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0			0	83. 00 84. 00
89. 00 SUBTOTALS (sum of lines 1-84)	5, 711, 919	8, 289, 018	14, 000, 93	7 0	14, 000, 937	89. 00
NONREI MBURSABLE COST CENTERS	3,711,717	0, 207, 010	14,000,73	7	14, 000, 737	07.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	5, 265	5, 26	5 0	5, 265	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92. 00
93. 00 09300 NONPAI D WORKERS	0	0		이	0	93.00
94. 00 09400 PATIENTS LAUNDRY	0	0		0	0	94.00
95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 100. 00 TOTAL	5, 711, 919	0 8, 294, 283	14, 006, 20		0 14, 006, 202	95. 00
100.00 TOTAL	5, 711, 717	0, 2,74, 203	17,000,20	-1 0	17,000,202	100.00

LOPATCONG CENTER In Lieu of Form CMS-2540-10

Health Financial Systems LOPA RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Peri od: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315202

				То	12/31/2023	Date/Time Prepared: 5/13/2024 9:29 am
	Cost Center Description	Adjustments to	Net Expenses			37 137 2024 7. 27 dill
			For Allocation			
		Wkst A-8)	(col. 5 +- col. 6)			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FIXTURES OO200 CAP REL COSTS - MOVABLE EQUIPMENT	0	.,,	•		1.00
3. 00	00300 EMPLOYEE BENEFITS	1, 924	,	•		3.00
4. 00	00400 ADMI NI STRATI VE & GENERAL	-685, 728	1	•		4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	569, 612	•		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	218, 646			6. 00
7.00	00700 HOUSEKEEPI NG	0	399, 334	1		7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	0	1, 050, 219	1		8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY		713, 524 113, 998			10.00
11. 00	01100 PHARMACY	0	0	1		11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	23, 747			12. 00
13. 00	01300 SOCIAL SERVICE	0	187, 153			13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	150 020	•		14.00
15. 00	01500 ACTIVITIES NPATIENT ROUTINE SERVICE COST CENTERS	-16, 345	159, 838			15. 00
30. 00	03000 SKILLED NURSING FACILITY	718	4, 545, 009			30.00
31.00	03100 NURSING FACILITY	0		1		31.00
32. 00	03200 CF/IID	0	0	•		32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0			33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY		23, 588			40. 00
41. 00	04100 LABORATORY		86, 429	1		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	17, 207	1		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	18, 313			43.00
44. 00	04400 PHYSI CAL THERAPY	0	385, 383	•		44. 00
45. 00 46. 00	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	0	377, 465	•		45. 00
47. 00	04700 ELECTROCARDI OLOGY	0	140, 258 0	1		46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	1		48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	210, 197			49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		50. 00
51.00	05100 SUPPORT SURFACES	0	10, 152	•		51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0			52. 00
60.00	06000 CLINIC	0	0			60.00
61.00	06100 RURAL HEALTH CLINIC	0	0			61. 00
62.00	06200 FQHC					62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0			63. 00
70. 00	OTHER REIMBURSABLE COST CENTERS O7000 HOME HEALTH AGENCY COST	1 0	0			70. 00
71. 00	07100 AMBULANCE	0	Ö			71. 00
72.00	07200 CORF	0	0			72. 00
73. 00	07300 CMHC	0	0	1		73. 00
74. 00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0	0			74. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0			80.00
81. 00	08100 INTEREST EXPENSE	0	Ö			81. 00
82.00	08200 UTILIZATION REVIEW	0	0			82. 00
83. 00	08300 HOSPI CE	0	0			83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0			84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	-699, 431	13, 301, 506			89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	5, 265	1		91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0			92. 00
	09300 NONPAI D WORKERS	0	0			93.00
	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS		0			94. 00 95. 00
100.00	1	-699, 431	13, 306, 771			100.00
	1	3,,, 101		1		1.00.00

Health Financial Systems	LOPATCONG CENTE	R		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	F			Peri od: From 01/01/2023	Worksheet A-6	
				To 12/31/2023	Date/Time Pre 5/13/2024 9: 2	pared: 9 am
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3. 00	4. 00	5. 00	
(1) A - DEFAULT						
1. 00	CENTRAL SERVICES & SI	JPPLY	10. 0	0 36, 207	0	1. 00
2. 00	MEDICAL RECORDS & LII	BRARY	12. 0	0 23, 747	0	2. 00
TOTALS						
100. 00	Total Reclassification	ons (Sum		59, 954	0	100.00
	of columns 4 and 5 mi	ust				
	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	LOPATCONG CENTER			In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6		
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/13/2024 9:2	pared: 9 am		
	Decreases						
	Cost Cente	Cost Center		Sal ary	Non Salary		
	6.00		7. 00	8. 00	9. 00		
(1) A - DEFAULT							
1. 00	NURSING ADMINISTRAT	I ON	9. 0	0 36, 207	0	1. 00	
2. 00	NURSING ADMINISTRAT	ION	9. 0	0 23, 747	0	2. 00	
TOTALS							
100. 00				59, 954	0	100. 00	

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2540-10 LOPATCONG CENTER Peri od: From 01/01/2023 Provi der No.: 315202 Worksheet A-7

					To 12/31/2023	Date/Time Prep 5/13/2024 9: 20	oared: 9 am
			•	Acqui si ti ons			
	Description	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	3					
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	121, 550	0		0 0	0	2.00
3.00	Buildings and Fixtures	5, 645, 501	0		0 0	0	3.00
4.00	Building Improvements	689, 011	0		0	0	4.00
5.00	Fi xed Equipment	150, 860	7, 829		0 7, 829		5.00
6.00	Movable Equipment	764, 895	3, 564		0 3, 564		6.00
7.00	Subtotal (sum of lines 1-6)	7, 371, 817	11, 393		0 11, 393	0	7. 00
8.00	Reconciling Items	0	0		0	0	8.00
9. 00	Total (line 7 minus line 8)	7, 371, 817	11, 393		0 11, 393	0	9. 00
	Description	Endi ng Bal ance	Ful l y				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00	Land	0	0				1. 00
2.00	Land Improvements	121, 550	0				2. 00
3.00	Buildings and Fixtures	5, 645, 501	0				3. 00
4.00	Building Improvements	689, 011	0				4. 00
5.00	Fi xed Equipment	158, 689	0				5. 00
6.00	Movable Equipment	768, 459	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	7, 383, 210	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	7, 383, 210	0				9. 00

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

				10 12/31/2023	5/13/2024 9:2	
				Expense Classification on		7 alli
				To/From Which the Amount is		
				TOTT OIL WITCH THE AMOUNT 13	to be haj usted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	COST CENTER	Line No.	
		1.00	2.00	3.00	4. 00	
1.00	Investment income on restricted funds	1.00	2.00		0.00	1.00
1.00	(chapter 2)		Ĭ		0.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2.00
2.00	8)				0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers		0		0.00	
1. 00	(chapter 8)				0.00	1.00
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
0.00	(chapter 21)				0.00	0.00
6.00	Television and radio service (chapter 21)	A	-16 345	ACTI VI TI ES	15. 00	6. 00
7. 00	Parking lot (chapter 21)	1	0	18.1.1.1.20	0.00	
8. 00	Remuneration applicable to provider-based	A-8-2	0		0.00	8.00
0.00	physician adjustment	7. 0 2				0.00
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	
11.00	Capital expenditures (chapter 24)				0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	41, 585			12. 00
	related organizations (chapter 10)		,			
13.00	Laundry and Linen service	•	0		0.00	13. 00
14. 00	Revenue - Employee meals		0	1		14. 00
15. 00	Cost of meals - Guests		0		0.00	
16. 00	Sale of medical supplies to other than		0		0.00	
	patients		_			
17.00	Sale of drugs to other than patients		0		0.00	17. 00
18.00	Sale of medical records and abstracts		0		0.00	18. 00
19.00	Vending machines		0		0.00	19. 00
20.00	Income from imposition of interest, finance		l 0		0.00	20. 00
	or penalty charges (chapter 21)					
21.00	Interest expense on Medicare overpayments		0	ol .	0.00	21. 00
	and borrowings to repay Medicare					
	overpayments					
22.00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW	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	MI SC I NCOME	В	-2, 602	ADMINISTRATIVE & GENERAL	4. 00	25. 00
25. 01	UNALLOWED A & G	A	-724, 711	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	WORKERS COMPENSATION	A	1, 924	EMPLOYEE BENEFITS	3.00	
25. 03	HEP/SALI NE	A	718	SKILLED NURSING FACILITY	30.00	25. 03
100.00	Total (sum of lines 1 through 99) (Transfer		-699, 431			100. 00
	to Worksheet A, col. 6, line 100)					

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

⁽²⁾ Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

LOPATCONG CENTER

Heal th Financial Systems

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS Provi der No.: 315202

OFFICE	COSTS				o 12/31/2023	Date/Time Pr 5/13/2024 9:	
		Li ne No.	Cost	Center	Expense		29 alli
		1. 00	2.	00	3.00)	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
	CLAIMED HOME OFFICE COSTS:						_
1.00			ADMI NI STRATI VE		HOME OFFICE A&G		1.00
2.00			ADMI NI STRATI VE		HOME OFFICE CAPI	TAL	2. 00
3.00			PHYSICAL THERA		PT		3. 00
4.00			OCCUPATIONAL T		OT		4. 00
5.00			SPEECH PATHOLO		ST		5. 00
6.00			SKILLED NURSIN		NURSING PURCHASE	D SERVICES	6.00
7.00			OXYGEN (INHALA		RT		7. 00
8.00			ADMI NI STRATI VE	& GENERAL	MEDICAL DIRECTOR	?	8. 00
9.00		0. 00					9. 00
10. 00	TOTALS (sum of lines 1-9). Transfer column						10.00
	6, line 100 to Worksheet A-8, column 3, line						
	12.			1			4
		Amount	Amount	Adjustments			
		Allowable In	Included in	(col. 4 minus			
		Cost	Wkst. A, col.	col. 5)			
		4.00	5.00	6, 00			
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR				D ODCANI ZATIONS	OP.	
	CLAIMED HOME OFFICE COSTS:	KLD AS A KLSULI	OI TRANSACTIO	NO WITH KLLAIL	D ORGANIZATIONS	OK	
1.00	CEATIMED HOME OFFICE COSTS.	640, 108	631, 810	8, 298	8		1.00
2. 00		33, 287					2.00
3. 00		382, 858)		3.00
4. 00		377, 465		•			4.00
5. 00		140, 258)		5. 00
6. 00		96, 359)		6.00
7. 00		3, 398)		7. 00
8. 00		70, 911	70, 911)		8.00
9. 00		1 ,0,,,,	, , , , , ,				9.00
10.00	TOTALS (sum of lines 1-9). Transfer column	1, 744, 644	1, 703, 059	41, 585			10.00
	6, line 100 to Worksheet A-8, column 3, line	1,,,,,,	1,700,007				
	12.						
		'	'	'	1		•

			5/13/2024 9: 29	9 am
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	В	0.00	1.00
2. 00	В	0.00	2. 00
3. 00	В	0.00	3.00
4. 00	В	0.00	4. 00
5. 00	В	0.00	5. 00
6. 00		0.00	6. 00
7. 00		0.00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100. 00
speci fy:			

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

Rel ated Organi	zation(s) and/	or Home Office	
Name	Percentage of Ownership	Type of Business	
4.00	5. 00	6.00	1

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2. 00		GRS	100.00	PT OT ST	2.00
3.00		CSU	100.00	NURSING PURCHASED SERVICES	3.00
4. 00		RHS	100.00	RT	4. 00
5. 00		GPS	100.00	MEDICAL DIRECTOR	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 (financi	al 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.

				10	12/31/2023	Date/IIme Pre 5/13/2024 9:2	
			CAPITAL REL	ATED COSTS		37 137 2024 7. 2) dili
	Cost Contor Dosorintion	Not Evpopos	BLDGS &	MOVABLE	EMPLOYEE	Subtotal	
	Cost Center Description	Net Expenses for Cost	FI XTURES	EQUI PMENT	BENEFI TS	Subtotal	
		Allocation		240111112111	BEILE: 1.10		
		(from Wkst A					
		col . 7)	1 00	2.00	2.00	3A	
G	ENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	JA .	
	0100 CAP REL COSTS - BLDGS & FLXTURES	1, 486, 646	1, 486, 646				1. 00
	0200 CAP REL COSTS - MOVABLE EQUIPMENT	32, 963		32, 963			2. 00
	0300 EMPLOYEE BENEFITS	805, 059	42, 198	936	848, 193		3. 00
	0400 ADMINISTRATIVE & GENERAL	1, 726, 766	31, 459		68, 655	1, 827, 578	4.00
	10500 PLANT OPERATION, MAINT. & REPAIRS 10600 LAUNDRY & LINEN SERVICE	569, 612 218, 646	45, 228 81, 232	1, 003 1, 801	14, 889	630, 732 301, 679	5. 00 6. 00
	10700 HOUSEKEEPI NG	399, 334	23, 839	· ·	0	423, 702	7. 00
8.00 0	0800 DI ETARY	1, 050, 219	73, 479	1, 629	Ō	1, 125, 327	8. 00
	0900 NURSING ADMINISTRATION	713, 524	45, 094	1, 000	80, 255	839, 873	9. 00
	1000 CENTRAL SERVICES & SUPPLY	113, 998	2, 094	46	5, 377	121, 515	10.00
	11100 PHARMACY 11200 MEDICAL RECORDS & LIBRARY	23, 747	10 100	0	2 524	0 4E 0E4	11.00
	11300 SOCIAL SERVICE	187, 153	18, 180 15, 863	403 352	3, 526 27, 695	45, 856 231, 063	12. 00 13. 00
	11400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
	1500 ACTIVITIES	159, 838	20, 364	452	22, 933	203, 587	15. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 SKILLED NURSING FACILITY	4, 545, 009	991, 991	21, 994	624, 863	6, 183, 857	30.00
	3100 NURSING FACILITY 3200 ICF/IID	0	0	0	O O	0	31.00
	13300 OTHER LONG TERM CARE	0	0	0	0	0	32. 00 33. 00
	NCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		33.00
40.00	4000 RADI OLOGY	23, 588	0	0	0	23, 588	40. 00
	4100 LABORATORY	86, 429	0	0	0	86, 429	41. 00
	14200 I NTRAVENOUS THERAPY	17, 207	0	0	0	17, 207	42.00
	14300 OXYGEN (INHALATION) THERAPY 14400 PHYSICAL THERAPY	18, 313 385, 383	2, 228 47, 679		0	20, 590 434, 119	43. 00 44. 00
	4500 OCCUPATI ONAL THERAPY	377, 465	28, 295	627	0	406, 387	45. 00
	4600 SPEECH PATHOLOGY	140, 258	0	0	Ō	140, 258	46. 00
	14700 ELECTROCARDI OLOGY	0	O	0	0	0	47. 00
	4800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 912	198	0	9, 110	48. 00
	14900 DRUGS CHARGED TO PATIENTS 15000 DENTAL CARE - TITLE XIX ONLY	210, 197	8, 511 0	189 0	O O	218, 897 0	49. 00 50. 00
	5100 SUPPORT SURFACES	10, 152	0	0	0	10, 152	51.00
	5200 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö	Ö	Ö	0	52. 00
	UTPATIENT SERVICE COST CENTERS						
	06000 CLINIC	0	0	0	0	0	60.00
	16100 RURAL HEALTH CLINIC 16200 FOHC	0	O	0	O	0	61. 00 62. 00
	16300 OTHER OUTPATIENT SERVICE COST CENTER	0	o	o	0	0	63. 00
	THER REIMBURSABLE COST CENTERS	<u> </u>	<u>~</u>	<u> </u>	<u> </u>		00.00
	7000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
	77100 AMBULANCE	0	0	0	0	0	
1	77200 CORF	0	0	0	0	0	72.00
	17300 CMHC 17400 OTHER REIMBURSABLE COST	0	0	0	0	0	73. 00 74. 00
<u> </u>	PECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		74.00
	8000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
	8100 INTEREST EXPENSE						81. 00
	8200 UTILIZATION REVIEW						82.00
	18300 HOSPI CE 18400 OTHER SPECI AL PURPOSE COST CENTERS	0	0	0	O O	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	13, 301, 506	1, 486, 646	32, 963	848, 193	13, 301, 506	89. 00
	ONREI MBURSABLE COST CENTERS	1070017000	17 1007 0 10	027 700	0 107 170	10/001/000	07.00
90.00 0	9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
	9100 BARBER AND BEAUTY SHOP	5, 265	0	0	0	5, 265	91. 00
	19200 PHYSICIANS PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	0	0	0	92. 00 93. 00
	19300 NUNPALD WORKERS 19400 PATIENTS LAUNDRY		O O	0	0	0	93.00
	19500 OTHER NONREIMBURSABLE COST CENTERS		ol	o	ol	0	95. 00
98. 00	Cross Foot Adjustments		o	0	ō	0	98. 00
99. 00	Negative Cost Centers	0	o	0	o	0	99. 00
100.00	TOTAL	13, 306, 771	1, 486, 646	32, 963	848, 193	13, 306, 771	100. 00

					0 12/31/2023		
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	5/13/2024 9: 2 DI ETARY	9 am
	oust defined beson per on	& GENERAL	OPERATION,	LINEN SERVICE	HOUSEREEFTING	DIEMM	
			MAINT. &				
		4.00	REPAI RS	/ 00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6.00	7. 00	8. 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	1, 827, 578					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	100, 418	731, 150	1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	48, 030	43, 424	1			6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	67, 457 179, 161	12, 744 39, 279	1	,	1, 373, 090	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	133, 715	24, 106	1	17, 996	1, 373, 070	9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY	19, 346	1, 120	1	836	0	10.00
11.00	01100 PHARMACY	o	0	0	o	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	7, 301	9, 718		7, 255	0	12. 00
13.00	01300 SOCIAL SERVICE	36, 787	8, 480	1	6, 331	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	10.004	_	0 127	0	14.00
15. 00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	32, 413	10, 886	0	8, 127	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	984, 519	530, 275	393, 133	395, 874	1, 373, 090	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32.00	03200 CF/IID	o	0	0	o	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	0 755		1	ام		
40.00	04000 RADI OLOGY	3, 755	0	_	0	0	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	13, 760 2, 739	0	0	=	0	41. 00 42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	3, 278	1, 191	0	889	0	43.00
44. 00	04400 PHYSI CAL THERAPY	69, 115	25, 487	Ö		0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	64, 700	15, 126		11, 292	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	22, 330	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	1, 450 34, 850	4, 764 4, 550		3, 557 3, 396	0	48. 00 49. 00
49. 00 50. 00	05000 DENTAL CARE - TITLE XIX ONLY	34, 850	4, 550 0		3, 390	0	50.00
51.00	05100 SUPPORT SURFACES	1, 616	0	0	Ö	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	Ō	o	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	1	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00 63. 00	06200 FOHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	o	0	0	0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS	ı o		0	ı o	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	o	0	0	o	0	71. 00
72. 00	07200 CORF	0	0	0	0	0	72. 00
	07300 CMHC	0	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 INTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	o	0	0	o	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 826, 740	731, 150	393, 133	503, 903	1, 373, 090	89. 00
00.00	NONREI MBURSABLE COST CENTERS				ما	^	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0 838	0	0	0	0	90. 00 91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0.00	0	0		0	92.00
93. 00	09300 NONPALD WORKERS		0	Ö	o	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	o	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	95. 00
98.00	Cross Foot Adjustments	0	0	0	0	0	98.00
99.00	Negative Cost Centers	1 027 570	721 150	0	[0	1 272 000	99.00
100.00	D TOTAL	1, 827, 578	731, 150	393, 133	503, 903	1, 373, 090	1100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315202 Peri od:

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

5/13/2024 9: 29 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 1,015,690 9 00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 142, 817 01100 PHARMACY 11.00 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 70, 130 12.00 13.00 01300 SOCIAL SERVICE 0 0 282, 661 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 14.00 C 0 0 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 1, 015, 690 142, 817 0 59, 810 282, 661 30.00 03100 NURSING FACILITY 0 31.00 Ω 31.00 32.00 03200 | CF/IID 0 C 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 04000 RADI OLOGY 40.00 0 0 98 Λ 40.00 41.00 04100 LABORATORY 0 0 0 326 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000000 0 58 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 3 0 04400 PHYSI CAL THERAPY 0 44.00 0 3,885 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 3, 873 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 1, 301 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 0 0 771 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY Ω 0 0 50.00 0 05100 SUPPORT SURFACES 0 51.00 0 5 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 0 n O 60 00 60 00 06000 CLI NI C 0 0 06100 RURAL HEALTH CLINIC 61.00 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 Ω 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 n 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 07200 CORF 0 0 0 72.00 72.00 0 0 Οl 07300 CMHC 73.00 0 C 0 0 73 00 74.00 07400 OTHER REIMBURSABLE COST 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPI CE 0 O 83.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 84.00 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 1,015,690 142, 817 0 70, 130 282, 661 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 09300 NONPALD WORKERS 0 o 93.00 0 93.00 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 95.00 0 C 0 0 95.00 98.00 Cross Foot Adjustments 0 98.00 99. 00 Negative Cost Centers 0 99.00 Ω TOTAL 1, 015, 690 0 70, 130 282, 661 100. 00 100.00 142, 817

| Peri od: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315202

					10 12/31/2023	5/13/2024 9:2	
			OTHER GENERAL			07 107 202 1 712	, <u>u</u>
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATI ON	45.00	14.00	17.00	40.00	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES		I	I			1.00
2.00	00200 CAP REL COSTS - BLDGS & FIXTURES						2.00
3.00	00300 EMPLOYEE BENEFITS		•				3.00
4. 00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7. 00
8.00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0					13. 00 14. 00
15. 00	01500 ACTIVITIES			,			15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		255, 015	'			13.00
30. 00	03000 SKILLED NURSING FACILITY	0	255, 013	11, 616, 73	9 0	11, 616, 739	30.00
31. 00	03100 NURSING FACILITY			1	o o		31.00
32. 00	03200 CF/IID	0			0	l	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0				,	1
41. 00	04100 LABORATORY	0		100, 51		100,010	1
42. 00	04200 I NTRAVENOUS THERAPY	0	_	20, 00		20, 004	1
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	25, 95		25, 951	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	551, 63		551, 633	44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY			501, 37 163, 88		501, 378 163, 889	46.00
47. 00	04700 ELECTROCARDI OLOGY				0 0	103, 869	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		Ö	18, 88	-	18, 881	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	Ö	262, 46		262, 464	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	11, 77	3 0	11, 773	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0)	0 0	0	52. 00
	OUTPATIENT SERVICE COST CENTERS		_				
60.00	06000 CLINIC	0	l .	1	0		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0)	0 0	0	61.00
62. 00 63. 00	06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	62. 00 63. 00
03.00	OTHER REIMBURSABLE COST CENTERS		<u> </u>	'	0 0	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0)	0 0	0	70.00
71. 00	07100 AMBULANCE			1	0 0	Ö	71.00
72. 00		0			o o	Ō	72. 00
73.00	07300 CMHC	0	0		0 0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0		0 0	0	74. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		ļ				80. 00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW						82.00
83. 00	08300 HOSPI CE	0			0	0	83.00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0		12 200 44	0	1	84. 00 89. 00
69.00	NONREI MBURSABLE COST CENTERS		255, 013	13, 300, 66	0 0	13, 300, 668	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0)	0 0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP			6, 10	3 0	6, 103	1
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0		0 0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0)	0 0	0	94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	95. 00
98. 00	Cross Foot Adjustments	0	0)	0	0	98. 00
99. 00	Negative Cost Centers	0		12 22 77	0	0	99.00
100.00	D TOTAL	0	255, 013	13, 306, 77	1 0	13, 306, 771	1100.00

						5/13/2024 9: 2	9 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		Assigned New	FI XTURES	EQUI PMENT		BENEFI TS	
		Capi tal					
		Related Costs					
		0	1. 00	2.00	2A	3. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS	o	42, 198	936	43, 134	43, 134	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	31, 459		32, 157	3, 492	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS		45, 228		46, 231	757	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE		81, 232		83, 033		6.00
7. 00	00700 HOUSEKEEPI NG	0	23, 839		24, 368		7. 00
8. 00	00800 DI ETARY						ł
		0	73, 479		75, 108		8.00
9.00	00900 NURSING ADMINISTRATION	0	45, 094		46, 094	4, 082	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	2, 094		2, 140	273	10.00
11.00	01100 PHARMACY	0	0	0	10.500	0	11.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	18, 180		18, 583	179	12.00
13. 00	01300 SOCIAL SERVICE	0	15, 863		16, 215	1, 408	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 ACTI VI TI ES	0	20, 364	452	20, 816	1, 166	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	991, 991	21, 994	1, 013, 985	31, 777	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	0	o	0	33.00
	ANCILLARY SERVICE COST CENTERS	•					
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41. 00	04100 LABORATORY	o	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		2, 228		2, 277	Ö	43. 00
44. 00	04400 PHYSI CAL THERAPY		47, 679		48, 736	o	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY		28, 295		28, 922	Ö	45. 00
46. 00	04600 SPEECH PATHOLOGY		20, 273	027	20, 722	0	46.00
47. 00	04700 ELECTROCARDI OLOGY		0	0	0	0	47.00
			0.013	1	0 110		48.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 912		9, 110	0	•
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	8, 511	189	8, 700	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	_	0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	-	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
72.00	07200 CORF	0	0	0	0	0	72.00
73.00	07300 CMHC	0	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	o	0	74.00
	SPECIAL PURPOSE COST CENTERS	•					
80.00							80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	0	0	0	0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS		0	0	0	Ö	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)		1, 486, 646	32, 963	1, 519, 609	-	89. 00
07.00		<u> </u>	1, 400, 040	32, 703	1, 317, 007	43, 134	09.00
00 00	NONREI MBURSABLE COST CENTERS		^		0	^	00.00
90.00		0	0		0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	이	0	93. 00
94.00	09400 PATIENTS LAUNDRY		0	0	0	0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments				0	 	98. 00
99. 00			0	0	0	0	99. 00
100.00	D TOTAL	0	1, 486, 646	32, 963	1, 519, 609	43, 134	100. 00

				1	0 12/31/2023	5/13/2024 9:2	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, diii
	'	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
			REPAI RS				
	OFFICE OFFICE OFFICE	4. 00	5. 00	6. 00	7. 00	8. 00	
4 00	GENERAL SERVICE COST CENTERS						4 00
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00
3. 00 4. 00	00400 ADMINISTRATIVE & GENERAL	35, 649					3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 959	48, 947				5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	937	2, 907	1			6. 00
7. 00	00700 HOUSEKEEPING	1, 316	853	1	26, 537		7. 00
8. 00	00800 DI ETARY	3, 495	2, 630	1	1, 544	82, 777	8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	2, 609	1, 614	1	948	02,777	1
10. 00	01000 CENTRAL SERVICES & SUPPLY	377	75	1	44	0	1
11. 00	01100 PHARMACY	0	0		0	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	142	651	0	382	0	12. 00
13.00	01300 SOCIAL SERVICE	718	568	0	333	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	O	0	14. 00
15.00	01500 ACTI VI TI ES	632	729	0	428	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	19, 204	35, 497	86, 877	20, 848	82, 777	30.00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 I CF/I I D	0	0	0	0	0	
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS	1		1			
40. 00	04000 RADI OLOGY	73	0		0	0	
41. 00	04100 LABORATORY	268	0	0	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	53	0	0	0	0	42.00
43. 00	04300 OXYGEN (INHALATION) THERAPY	64	80	1	47	0	43. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY	1, 348	1, 706	1	1, 002	0	
46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	1, 262 436	1, 013 0	1	595 0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	430	0		0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	28	319		187	0	48.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	680	305		179	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51. 00	05100 SUPPORT SURFACES	32	0	_	o	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	o	O	0	1
	OUTPATIENT SERVICE COST CENTERS				1		
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	_	0	0	
71. 00	07100 AMBULANCE	0	0	0	0	0	
72. 00	07200 CORF	0	0	0	0	0	72. 00
	07300 CMHC	0	0	0	0	0	
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	U U	0	74. 00
00.00	SPECIAL PURPOSE COST CENTERS	1		I			00.00
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82.00
	1 1	0	0		0	0	1
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0			0	1
89. 00	SUBTOTALS (sum of lines 1-84)	35, 633	48, 947	86, 877	26, 537	82, 777	89. 00
07.00	NONREI MBURSABLE COST CENTERS	00,000	10, 717	00,077	20,007	02,777	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	16	0		· ·	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	o	O	0	1
93.00	09300 NONPALD WORKERS	0	0	0	o	0	1
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	
98. 00	Cross Foot Adjustments			0	0	0	
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	35, 649	48, 947	86, 877	26, 537	82, 777	100. 00

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

					10 12/31/2023	5/13/2024 9: 2	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Zum
		9. 00	10. 00	11. 00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	,			_	,	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00	00800 DI ETARY						8. 00
9.00	00900 NURSING ADMINISTRATION	55, 347					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	2, 909				10. 00
11. 00	01100 PHARMACY	0	0	(11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0	(19, 937		12.00
13.00	01300 SOCIAL SERVICE	0	0	9	0	19, 242	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES		0	,		0	14. 00 15. 00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	l ol	U		<u>)</u> 0	0	15.00
30. 00	03000 SKILLED NURSING FACILITY	55, 347	2, 909		17, 004	19, 242	30.00
31. 00	03100 NURSING FACILITY	0	2, 707		0 0	0	31.00
32. 00	03200 CF/IID	o	0	•	o o	0	32. 00
33.00	03300 OTHER LONG TERM CARE	O	0		0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	(28		40. 00
41. 00	04100 LABORATORY	0	0	(93		41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	9	16		42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY	0	0		1 104	0	43. 00 44. 00
45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY		0		1, 104 1, 101	0	45.00
46. 00	04600 SPEECH PATHOLOGY		0		370		46. 00
47. 00	04700 ELECTROCARDI OLOGY	o	0			0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0		o o	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	O	0		219	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	() 1	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	52.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0	,	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0			0	61.00
62. 00	06200 FQHC		J	`			62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	o	0		o	0	63. 00
	OTHER REIMBURSABLE COST CENTERS	'			<u>'</u>		
70. 00	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70. 00
71. 00	07100 AMBULANCE	0	0	(0	0	71. 00
72. 00	07200 CORF	0	0	9	0	0	72.00
73. 00 74. 00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0	(0	73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS	l o	U		0	0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81. 00
82.00	08200 UTILIZATION REVIEW						82. 00
83.00	08300 HOSPI CE	0	0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	55, 347	2, 909	(19, 937	19, 242	89. 00
	NONREI MBURSABLE COST CENTERS		_		_1	_	
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	92.00
94. 00	09400 PATIENTS LAUNDRY		0			0	94.00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		o o	ő	95. 00
98. 00	Cross Foot Adjustments	0	0				98. 00
99. 00	Negative Cost Centers	0	0		0	0	99. 00
100.00	D TOTAL	55, 347	2, 909		19, 937	19, 242	100. 00

					5/13/2024 9: 2	9 am
		OTHER GENERAL				
		SERVI CE				
Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
	ALLI ED HEALTH			Adjustments		
	EDUCATI ON	45.00	47.00	17.00	40.00	
OFNEDAL CEDIU OF COOT OFNITEDO	14.00	15. 00	16. 00	17. 00	18. 00	
GENERAL SERVICE COST CENTERS	1	Г	I	T		1 00
1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES 2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 O0300 EMPLOYEE BENEFITS						3.00
4.00 00400 ADMI NI STRATI VE & GENERAL						4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 00700 HOUSEKEEPI NG						7. 00
8. 00 00800 DI ETARY						8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON						9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00 01100 PHARMACY						11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY						12.00
13. 00 01300 SOCIAL SERVICE						13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00 01500 ACTIVITIES	0	23, 771				15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	'		•	<u>'</u>		ĺ
30.00 03000 SKILLED NURSING FACILITY	0	23, 771	1, 409, 238	3 0	1, 409, 238	30.00
31.00 03100 NURSING FACILITY	0	0	(ol ol	0	31.00
32. 00 03200 CF/IID	0	0	(ol ol	0	32. 00
33.00 03300 OTHER LONG TERM CARE	0	0	(0	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	0	l e	101	0	101	40. 00
41. 00 04100 LABORATORY	0		361		361	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0	0	69		69	42.00
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	0	2, 469		2, 469	43.00
44. 00 04400 PHYSI CAL THERAPY	0	0	53, 896		53, 896	1
45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY	0	0	32, 893		32, 893 806	45. 00 46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	806		0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9, 644		9, 644	1
49. 00 04900 DRUGS CHARGED TO PATIENTS	0	0	10, 083		10, 083	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	50.00
51. 00 05100 SUPPORT SURFACES	0	0	33	ol	33	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(o	0	52. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	0	(0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	(0	0	61. 00
62. 00 06200 FQHC						62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63. 00
OTHER REIMBURSABLE COST CENTERS	_	_		.	_	
70. 00 07000 HOME HEALTH AGENCY COST	0			0	0	70.00
71. 00 07100 AMBULANCE	0	1		0	0	71.00
72. 00 07200 CORF 73. 00 07300 CMHC	0 0				0	72. 00 73. 00
74. 00 07400 OTHER REIMBURSABLE COST	0					
SPECIAL PURPOSE COST CENTERS	0	0		<u> </u>	U	74.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 08100 I NTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW						82. 00
83. 00 08300 HOSPI CE	0	0	(ol ol	0	83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0	l			Ö	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	0	l e	1, 519, 593	-	1, 519, 593	89. 00
NONREI MBURSABLE COST CENTERS	-		., .,	-1	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	16	o	16	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	0	(ol ol	0	92.00
93. 00 09300 NONPAI D WORKERS	0	0		ol ol	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	0		o	0	94. 00
95.00 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	(o o	0	95. 00
98.00 Cross Foot Adjustments	0	0	(이	0	98. 00
99.00 Negative Cost Centers	0		(이	0	99. 00
100. 00 TOTAL	0	23, 771	1, 519, 609	이	1, 519, 609	100. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/13/2024 9: 29 am

							5/13/2024 9: 2	9 am
			CAPITAL REL	_ATED COSTS				
		Cost Center Description	BLDGS &	MOVABLE		Reconci I i ati on	ADMI NI STRATI VE	
			FIXTURES	EQUI PMENT	BENEFITS		& GENERAL	
			(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
			1.00	2.00	3.00	4A	4.00	
		AL SERVICE COST CENTERS				l	ı	
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	33, 363	33, 363				1. 00 2. 00
3.00		EMPLOYEE BENEFITS	947					3.00
4. 00		ADMINISTRATIVE & GENERAL	706				11, 479, 193	1
5.00		PLANT OPERATION, MAINT. & REPAIRS	1, 015	1		0	630, 732	
6.00		LAUNDRY & LINEN SERVICE	1, 823			0	301, 679	
7. 00 8. 00		HOUSEKEEPI NG DI ETARY	535 1, 649	l		0	423, 702 1, 125, 327	
9. 00	1	NURSING ADMINISTRATION	1, 012	1		0	839, 873	
10.00	01000	CENTRAL SERVICES & SUPPLY	47	47			121, 515	
11.00		PHARMACY	0	0	1	0	0	
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	408 356	l		0	45, 856 231, 063	
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0	0		_	251,003	1
15. 00		ACTI VI TI ES	457	457	154, 435	0	203, 587	15. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	00.040	00.040	4 007 0//		(400 057	00.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	22, 262	22, 262 0			6, 183, 857 0	1
32. 00		ICF/IID	0	0		_	0	1
33. 00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33. 00
		LARY SERVICE COST CENTERS				T		
40. 00 41. 00		RADI OLOGY LABORATORY	0	0			23, 588 86, 429	
42. 00	1	INTRAVENOUS THERAPY	0	0		0	17, 207	
43.00		OXYGEN (INHALATION) THERAPY	50			0	20, 590	
44. 00		PHYSI CAL THERAPY	1, 070	1		0	434, 119	
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	635	635 0		0	406, 387 140, 258	
47. 00	1	ELECTROCARDI OLOGY	0			0	140, 236	1
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	200			0	9, 110	1
49. 00		DRUGS CHARGED TO PATIENTS	191	191	0	0	218, 897	
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0	0	
51. 00 52. 00		SUPPORT SURFACES OTHER ANCILLARY SERVICE COST CENTERS	0	0			10, 152 0	1
02.00	OUTPA	TIENT SERVICE COST CENTERS						02:00
60.00		CLINIC	0	0				
61. 00 62. 00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61. 00 62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	1
	OTHER	REIMBURSABLE COST CENTERS			-	-		
70.00		HOME HEALTH AGENCY COST	0	0			0	
71. 00 72. 00	07100	AMBULANCE	0	0	0	0	0	
	07300		0	0		0	0	
74. 00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	
00.00		AL PURPOSE COST CENTERS				T	T	00.00
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00		UTI LI ZATI ON REVI EW						82. 00
83. 00	1	HOSPI CE	0	0	0	0	0	83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	1
89. 00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	33, 363	33, 363	5, 711, 919	-1, 827, 578	11, 473, 928	89. 00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	0	0	0	0	5, 265	
92.00		PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
93. 00 94. 00	1	NONPALD WORKERS PATLENTS LAUNDRY	0	0	0	0	0	
95. 00	1	OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	1
98. 00		Cross Foot Adjustments						98. 00
99. 00		Negative Cost Centers						99. 00
102.00	'	Cost to be allocated (per Wkst. B, Part I)	1, 486, 646	32, 963	848, 193		1, 827, 578	102. 00
103.00	,	Unit cost multiplier (Wkst. B, Part I)	44. 559722	0. 988011	0. 148495		0. 159208	103. 00
104.00	1	Cost to be allocated (per Wkst. B,			43, 134			104. 00
105 00		Part II)			0.007550		0.000107	105 00
105.00	'	Unit cost multiplier (Wkst. B, Part II)			0. 007552		0. 003106	105.00
	1	,	1	1	'	ı	1	

				1	0 12/31/2023	Date/lime Pre 5/13/2024 9:2	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, <u>G</u>
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(TOTAL PATIENT			CTOTAL DATIENT	
		(SQUARE FEET)	DAYS)			(TOTAL PATIENT DAYS)	
		5. 00	6.00	7. 00	8. 00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL			•			3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	30, 695					5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	1, 823	l .				6. 00
7. 00	00700 HOUSEKEEPI NG	535	1	28, 337			7. 00
8. 00	00800 DI ETARY	1, 649	l .	1, 649			8. 00
9.00	00900 NURSING ADMINISTRATION	1, 012	. 0	1, 012	0	40, 730	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	47	1	47	0	0	10.00
11. 00	01100 PHARMACY	C			_	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	408		408		0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	356	1	356	0	0	13. 00 14. 00
15. 00	01500 ACTIVITIES	457		457	0	0	15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	437		437	0		13.00
30. 00	03000 SKILLED NURSING FACILITY	22, 262	40, 730	22, 262	122, 190	40, 730	30. 00
31.00	03100 NURSING FACILITY		1	, 0	0	0	31. 00
32.00	03200 CF/IID	C	0	0	0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	C	0	0	0	0	33. 00
	ANCI LLARY SERVI CE COST CENTERS			1	1	1	
40.00	04000 RADI OLOGY	C	0	0	0	0	40.00
41. 00 42. 00	04100 LABORATORY	C		0	0	0	41. 00 42. 00
43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	50		50	0	0	42.00
44. 00	04400 PHYSI CAL THERAPY	1, 070	1	1, 070	0	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	635	ł	635		Ō	45. 00
46.00	04600 SPEECH PATHOLOGY	C	0	0	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	C	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	200	•	200	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	191		191	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	C		0	0	0	50. 00 51. 00
51. 00 52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	C		1	0		51.00
02.00	OUTPATIENT SERVICE COST CENTERS		,				02.00
60.00	06000 CLI NI C	C	0	0		0	60.00
61. 00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61. 00
62. 00	06200 FOHC	0			_	0	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS) 0	0	0		63. 00
70. 00	07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70. 00
71. 00		C	0	0	0	0	71. 00
	07200 CORF	C	0	0	0	0	72.00
	07300 CMHC	C	0	0	0	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	C	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES		1	1		I	80. 00
81. 00	08100 INTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 H0SPI CE	C	0	0	0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	84.00
89. 00	SUBTOTALS (sum of lines 1-84)	30, 695	40, 730	28, 337	122, 190	40, 730	89. 00
00.00	NONREI MBURSABLE COST CENTERS	Τ	J	ı	I .	1 0	00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C			0	0	90.00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES				0	0	91. 00 92. 00
93. 00	09300 NONPALD WORKERS				0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY		o o	Ö	0	Ö	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	C	0	0	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00							99. 00
102.00		731, 150	393, 133	503, 903	1, 373, 090	1, 015, 690	102. 00
102.00	Part I)	22 010040	0 (50170	17 700510	11 007005	24 027147	102 00
103. 00 104. 00		23. 819840 48, 947	1	1		24. 937147 55, 347	
104.00	Part II)	40, 747	00, 077	20, 557	02, 111	35, 347	104.00
105.00		1. 594625	2. 132998	0. 936479	0. 677445	1. 358876	105. 00
		1					

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der No.: 315202

				Т	0 12/31/2023	Date/Time Pre 5/13/2024 9: 2	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	
		SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TOTAL PATIENT	ALLIED HEALTH EDUCATION	
		(COSTED	,	(GROSS	DAYS)	(ASSI GNED	
		REQUI S.) 10. 00	11. 00	CHARGES) 12.00	13.00	TI ME) 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	70, 840					10.00
11. 00 12. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY		0	22, 067, 092			11. 00 12. 00
13. 00	01300 SOCI AL SERVI CE	o	0	0 22,007,072			13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0		0	14. 00
15. 00	O1500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	15. 00
30. 00	03000 SKILLED NURSING FACILITY	70, 840	0	18, 820, 091	40, 730	0	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 1 CF/I I D	0	0			0	32. 00
33. 00	O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l U	U	0	0	0	33. 00
40.00	04000 RADI OLOGY	0	0	30, 723	0	0	40. 00
41.00	04100 LABORATORY	0	0	102, 503		0	41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0	18, 104 847	0	0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	o	0	1, 222, 590	<u>۱</u>	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	1, 218, 835	l	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	409, 370		0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0 0		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	Ö	0	242, 556	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	_	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS		0	1, 473 0		0	51. 00 52. 00
02.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	0	02.00
60.00	06000 CLINIC	0		0		0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	0	0	0	61. 00 62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	О	0	0	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	0 0		0	70. 00 71. 00
	07200 CORF		0	0	0	0	71.00
73.00	07300 CMHC	O	0	0	O	0	73. 00
74. 00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE		0			0	82. 00
83. 00 84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS		0	0	0	0	83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	70, 840	0	22, 067, 092	40, 730	0	89. 00
	NONREI MBURSABLE COST CENTERS		ما		ا ما		
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0			0	90. 00 91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	o	0	ő	-	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	94. 00 95. 00
98. 00	Cross Foot Adjustments	١	J			O	98. 00
99. 00	Negative Cost Centers						99. 00
102.00	Cost to be allocated (per Wkst. B, Part I)	142, 817	0	70, 130	282, 661	0	102. 00
103.00	1 1 1	2. 016050	0. 000000	0. 003178	6. 939872	0. 000000	103. 00
104.00	Cost to be allocated (per Wkst. B,	2, 909	0	19, 937	l .		104. 00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 041064	0. 000000	0. 000903	0. 472428	0. 000000	105 00
100.00	II)	0. 04 1004	0. 000000	0.000703	0. 4/2420	0. 000000	100.00
		·			·		

In Lieu of Form CMS-2540-10 LOPATCONG CENTER

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:29 am Provi der No.: 315202

		5/13/2024 9: 2	9 am
	OTHER GENERAL		
	SERVI CE		
Cost Center Description	ACTI VI TI ES		i
	(TOTAL PATIENT		
	DAYS)		
	15. 00		
GENERAL SERVICE COST CENTERS	15.00		
	1		1 00
1. 00 00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00 00300 EMPLOYEE BENEFITS			3. 00
4.00 00400 ADMINISTRATIVE & GENERAL			4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00 00600 LAUNDRY & LINEN SERVICE			6. 00
7. 00 00700 HOUSEKEEPI NG	1		7. 00
			1
8. 00 00800 DI ETARY			8. 00
9.00 00900 NURSING ADMINISTRATION			9. 00
10.00 O1000 CENTRAL SERVICES & SUPPLY			10. 00
11. 00 01100 PHARMACY			11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	1		12.00
13. 00 01300 SOCI AL SERVI CE			13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	1		14. 00
	40.700		1
15. 00 01500 ACTIVITIES	40, 730		15. 00
INPATIENT ROUTINE SERVICE COST CENTERS			4
30.00 03000 SKILLED NURSING FACILITY	40, 730		30.00
31.00 03100 NURSING FACILITY	O		31.00
32. 00 03200 I CF/I I D	0		32. 00
33.00 03300 OTHER LONG TERM CARE	0		33. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		33.00
			40.00
40. 00 04000 RADI OLOGY	0		40.00
41. 00 04100 LABORATORY	0		41. 00
42. 00 04200 I NTRAVENOUS THERAPY	0		42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	O		43.00
44. 00 04400 PHYSI CAL THERAPY	l ol		44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00 04600 SPEECH PATHOLOGY			46. 00
47. 00 04700 ELECTROCARDI OLOGY	0		47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51.00 05100 SUPPORT SURFACES	l ol		51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0		52. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		02.00
60. 00 06000 CLI NI C	0		60.00
61. 00 06100 RURAL HEALTH CLINIC			61.00
	٩		1
62. 00 06200 FQHC	_		62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
OTHER REIMBURSABLE COST CENTERS			
70.00 07000 HOME HEALTH AGENCY COST	O		70. 00
71. 00 07100 AMBULANCE	l ol		71.00
72. 00 07200 CORF	0		72. 00
73. 00 07300 CMHC			73.00
74. 00 O7400 OTHER REIMBURSABLE COST	0		74. 00
SPECIAL PURPOSE COST CENTERS			
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00 08100 I NTEREST EXPENSE			81. 00
82.00 08200 UTILIZATION REVIEW			82. 00
83. 00 08300 HOSPI CE	l ol		83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS	l ol		84.00
89.00 SUBTOTALS (sum of lines 1-84)	40, 730		89. 00
NONREI MBURSABLE COST CENTERS	10,730	 	1 57.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
	1		
91. 00 09100 BARBER AND BEAUTY SHOP	0		91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00 09300 NONPALD WORKERS	0		93. 00
94.00 09400 PATIENTS LAUNDRY	0		94. 00
95.00 09500 OTHER NONREIMBURSABLE COST CENTERS	0		95. 00
98.00 Cross Foot Adjustments			98. 00
99.00 Negative Cost Centers			99. 00
	255, 013		102.00
**	200,013		102.00
Part I)	, , , , , , ,		400 00
103.00 Unit cost multiplier (Wkst. B, Part I)	6. 261061		103. 00
104.00 Cost to be allocated (per Wkst. B,	23, 771		104. 00
Part II)			
105.00 Unit cost multiplier (Wkst. B, Part	0. 583624		105. 00

Health Financial Systems		LOPATCONG CENTER		In Lieu of Form CMS-2540-10
	DATIO OF COST TO CHARGES FOR A	NCLLLARY AND OUTDATLENT COST CENTERS Drovi de	r No : 215202 Pori od:	Workshoot C

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9: 29 am Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col . 18 col. 2 2. 00 3. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 27, 441 30, 723 0. 893174 40.00 04100 LABORATORY 100, 515 102, 503 0. 980605 41.00 41.00 20, 004 18, 104 42.00 04200 I NTRAVENOUS THERAPY 1. 104949 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 25, 951 847 30. 638725 43.00 44. 00 04400 PHYSI CAL THERAPY 551, 633 1, 222, 590 0.451200 44.00 04500 OCCUPATIONAL THERAPY 45.00 501, 378 1, 218, 835 0. 411358 45.00 04600 SPEECH PATHOLOGY 0.400344 409, 370 46.00 163, 889 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 881 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 49.00 1.082076 262, 464 242, 556 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 50.00 51.00 05100 SUPPORT SURFACES 11,773 1, 473 7. 992532 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FQHC 62.00 63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0.000000 63.00 0

0.000000

1, 683, 929

3, 247, 001

71.00

100.00

71. 00 | 07100 | AMBULANCE

Total

100.00

ealth Financial Systems	LOLATCONG	CENTER			u of Form CMS-:	<u> 2540-10</u>
PPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/13/2024 9: 2	9 am
		Title	XVIII (1)	Skilled Nursing	PPS	
			, ,	Facility		
		Health Care Pr	rogram Charges	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	Г 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
0. 00 04000 RADI OLOGY	0. 893174	690		0 616	0	40.00
1. 00 04100 LABORATORY	0. 980605			0 1, 264	0	
2. 00 04200 I NTRAVENOUS THERAPY	1. 104949			0 5, 579	0	
3. 00 04300 OXYGEN (INHALATION) THERAPY	30. 638725			0 3,377	0	
4. 00 04400 PHYSI CAL THERAPY	0. 451200			0 239, 053	0	
5. 00 04500 OCCUPATI ONAL THERAPY	0. 411358			0 226, 162	0	
6. 00 04600 SPEECH PATHOLOGY	0. 400344			0 78, 185	0	
7. 00 04700 ELECTROCARDI OLOGY	0. 000000			0 0	0	
8.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1		ol ol	0	
9.00 04900 DRUGS CHARGED TO PATIENTS	1. 082076	1		0 90, 353	0	49.00
O. OO 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
1. 00 05100 SUPPORT SURFACES	7. 992532	38		0 304	0	51.00
2.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		o o	0	52.00
OUTPATIENT SERVICE COST CENTERS						
0. 00 06000 CLI NI C	0. 000000	0		0 0	0	60.00
1.00 06100 RURAL HEALTH CLINIC						61.00
2. 00 06200 FQHC						62.00
3.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	o		o o	0	63.00
1.00 07100 AMBULANCE (2)	0. 000000			o	0	71.00
00.00 Total (Sum of lines 40 - 71)		1, 365, 469		0 641, 516	0	100.00

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

41. 00	Heal th	Fi nan	cial Systems	LOPATCONG	CENTER		In Lie	u of Form CMS-	2540-10
PART - APPORTIONMENT OF VACCINE COST	APPORT	I ONMEN	IT OF ANCILLARY AND OUTPATIENT COSTS				From 01/01/2023	Parts II-III Date/Time Pre	
Cost Center Description					Ti tl	e XVIII		PPS	
PART - APPORTIONMENT OF VACCINE COST			Cost Center Description				,	1.00	
1.00		DADT	I - ADDODTIONMENT OF VACCINE COST					1.00	
2.00 Program vaccine charges (From your records, or the PS&R) 12,052 2.00 3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet 13,041 3.00									1 00
3.00 Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet Total Cost									
E, Part I, line 18 Cost Center Description Cost Center Descript						er this amoun	t to Worksheet		
Total Cost Center Description Crow Wkst. B, Allied Health Part I, Col. 18	0.00								
Part I, Col. (From Wkst. B, Part I, Col. Costs to Total Costs				Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
18			·	(From Wkst. B,	Allied Health	Nursing &	Cost (From	& Allied	
14) Costs - Part A (Col . 2 / Col . 1) Through (Col . 3 x Col . 4)				Part I, Col.					
Col 2 / Col 1 3 x Col 4 1) 3 x Col 4 4 1) 1				18			, , , , , , , , , , , , , , , , , , , ,		
PART I I - CALCULATI ON OF PASS THROUGH COSTS FOR NURSING & ALLI ED HEALTH ANCI LLARY SERVI CE COST CENTERS					14)				
1.00 2.00 3.00 4.00 5.00						1	•	3 x Col. 4)	
ANCI LLARY SERVI CE COST CENTERS 40. 00				1.00	2.00		4. 00	5. 00	
40. 00		PART	II - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
41. 00		ANCI LI	LARY SERVICE COST CENTERS						
42. 00 04200 INTRAVENOUS THERAPY 20,004 0 0.000000 5,579 0 42.00 43.00 04300 0XYGEN (INHALATION) THERAPY 25,951 0 0.000000 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 551,633 0 0.000000 239,053 0 44.00 45.00 04500 0CCUPATIONAL THERAPY 501,378 0 0.000000 226,162 0 45.00 46.00 04600 SPEECH PATHOLOGY 163,889 0 0.000000 78,185 0 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0.000000 0 0 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 18,881 0 0.000000 0 0 048.00 04900 DRUGS CHARGED TO PATIENTS 262,464 0 0.000000 90,353 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 0.000000 0 0.000000 0				27, 441	C	0.00000	00 616	0	
43. 00					C	1	· ·	0	
44. 00		1			C			Ĭ	
45. 00					C			_	
46. 00					C			_	
47. 00 04700 ELECTROCARDI OLOGY 0 0.000000 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 18, 881 0 0.000000 0 0 48. 00 49. 00 04900 DRUGS CHARGED TO PATI ENTS 262, 464 0 0.000000 90, 353 0 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 11, 773 0 0.000000 304 0 51. 00 52. 00 05200 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 0 0 52. 00					C	1	· ·	Ĭ	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 18,881 0 0.000000 0 0 48. 00 49. 00 04900 07000000 0 07000000 0 0 0		1		163, 889	C	1	· ·	_	
49. 00 04900 DRUGS CHARGED TO PATIENTS 262,464 0 0.000000 90,353 0 49.00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 0 50.00 51. 00 05100 SUPPORT SURFACES 11,773 0 0.000000 304 0 51.00 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 52.00				0	0			_	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0.000000 0 50.00 51.00 51.00 05100 SUPPORT SURFACES 11,773 0 0.000000 304 0 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0.000000 0 52.00					(-	
51. 00 05100 SUPPORT SURFACES 11,773 0 0.000000 304 0 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0.000000 0 52.00				262, 464				_	
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 0 0 52.00		1		11 770				-	
		1		11, //3		1		-	
	100.00		Total (Sum of lines 40 - 52)	1, 683, 929		1	641, 516		

	Financial Systems LOPAT ATION OF INPATIENT ROUTINE COSTS	CONG CENTER Provi der No.: 315202	Peri od:	u of Form CMS-2 Worksheet D-1				
			From 01/01/2023 To 12/31/2023	Parts I-II Date/Time Pre 5/13/2024 9:2				
		Title XVIII	Skilled Nursing Facility	PPS				
				1. 00				
	PART I CALCULATION OF INPATIENT ROUTINE COSTS							
	I NPATI ENT DAYS				١.			
00	Inpatient days including private room days		40, 730					
00	Private room days		289 5. 633					
00 00	Inpatient days including private room days applicable 1 Medically necessary private room days applicable to the		5, 633 0					
00	Total general inpatient routine service cost		11, 616, 739					
J	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			11,010,737	1 ~			
0	General inpatient routine service charges			18, 747, 360	6			
00	General inpatient routine service cost/charge ratio (l		0. 619647	7				
0	Enter private room charges from your records		144, 500	8				
0								
00	2) Enter semi-private room charges from your records							
00	Average semi-private room per diem charge (Semi-privat	te room charges line 10, divid	ed by	18, 602, 860 460. 00				
00	semi -pri vate room days)	0 11 11)		10.00	12			
00	Average per diem private room charge differential (Line Average per diem private room cost differential (Line 7	,		40. 00 24. 79				
00	Private room cost differential adjustment (Line 2 times			7. 164				
00	General inpatient routine service cost net of private r		minus line 14)	11, 609, 575				
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		,,	,	ĺ			
00	Adjusted general inpatient service cost per diem (Line	15 divided by line 1)		285. 04	16			
00	Program routine service cost (Line 3 times line 16)			1, 605, 630				
00	Medically necessary private room cost applicable to pro	5 ,		0	1 . ~			
00	Total program general inpatient routine service cost (1, 605, 630				
00	Capital related cost allocated to inpatient routine ser line 30 for SNF; line 31 for NF, or line 32 for ICF/III		it II column 18,	1, 409, 238	20			
00	Per diem capital related costs (Line 20 divided by lir	· ·		34.60	21			
00	Program capital related cost (Line 3 times line 21)			194, 902	22			
00	Inpatient routine service cost (Line 19 minus line 22)			1, 410, 728				
00	Aggregate charges to beneficiaries for excess costs (F	'		0	1			
00	Total program routine service costs for comparison to t	the cost limitation (Line 23 m	inus line 24)	1, 410, 728				
00	Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times		2() (1)		26			
00			27					
00	Reimbursable inpatient routine service costs (Line 22 p (Transfer to Worksheet E, Part II, line 4) (See instruc		1111e 2/)		28			
	nes 26 and 27 are not applicable for title XVIII, but ma	•	+: +I - VIV		1			

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	40, 730	1.00
2.00	Program inpatient days (see instructions)	5, 633	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3. 00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 138301	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Health Financial Systems	LOPATCONG CENTE	ER			In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII		Provi der N	o.: 315202	From C	1/01/2023	Worksheet E Part I Date/Ti me Prepared: 5/13/2024 9: 29 am
		T: 11	V0 /1 1 1	CLIL	1 81 1	DDC

		Title XVIII	Skilled Nursing Facility	PPS	7 diii
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT		1.00	
1. 00	Inpatient PPS amount (See Instructions)	LIVILINI		3, 722, 332	1.00
2. 00	Nursing and Allied Health Education Activities (pass through pa	vmants)		3, 722, 332	2.00
3.00	Subtotal (Sum of lines 1 and 2)	ymerres)		3, 722, 332	3.00
4. 00	Primary payor amounts			0, 722, 332	4. 00
5. 00	Coinsurance			623, 032	5. 00
6. 00	Allowable bad debts (From your records)			228, 021	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		190, 881	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)	01.01.0)		148, 214	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, 247, 514	
12. 00	Interim payments (See instructions)			3, 160, 316	
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, 964	14. 75
14. 99	Sequestration amount (see instructions)			61, 986	14. 99
15.00	Balance due provider/program (see Instructions)			22, 248	15. 00
16. 00	Protested amounts (Nonallowable cost report items in accordance	with CMS Pub. 15-2,	section 115.2)	0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
17. 00	Ancillary services Part B			0	17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			13, 041	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			13, 041	
20. 00	Medicare Part B ancillary charges (See instructions)			12, 052	20. 00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			12, 052	
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			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	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			-	24. 02 25. 00
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			12, 052	
26. 00 27. 00	Interim payments (See instructions) Tentative adjustment			8, 504 0	26. 00 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)			241	
29. 00	1			3, 307	29. 00
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	3, 307	30.00
30. 00	The second amounts (Mondinowable cost report richis) in accordance	C WI III OWS 1 UD. 13-2,	30001011 110.2	U	30.00

Health Financial Systems					l	_OPA	TCONG CEN	TER		In Lieu of Form CMS-2540-10		
(CALCULATION OF REIMBURSEMENT	SETTLEMENT	TITLE V	and and	TITLE	XIX	ONLY	Provi der	No.: 31520	From 01/01/2023	Worksheet E Part II Date/Time Prepared: 5/13/2024 9:29 am	
								Ti t	le XIX	Skilled Nursing	PPS	

		little XIX	Facility	PPS	
	ACCUPATION OF MET COOT OF COMPRED OFFINANCE			1. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES			0	1 00
1.00	Inpatient ancillary services (see Instructions)	F)		0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2.00
3.00	Outpatient services			0	3.00
4.00	Inpatient routine services (see instructions)	- :!>		0	4.00
5.00	Utilization reviewphysicians' compensation (from provider rec	oras)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			-	6.00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)			0	8. 00 9. 00
9.00	Primary payor amounts			-	
10. 00	Total Reasonable Cost (Line 8 minus line 9) REASONABLE CHARGES			0	10. 00
11 00				0	11 00
11.00	Inpatient ancillary service charges			0	11. 00 12. 00
12.00	Outpati ent servi ce charges			0	
13.00	Inpatient routine service charges			-	13.00
14.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14.00
15. 00	Total reasonable charges CUSTOMARY CHARGES			0	15. 00
16. 00	Aggregate amount actually collected from patients liable for pa	ymant for sorvices on	a charge basis	0	16, 00
17. 00	Amounts that would have been realized from patients liable for			0	17. 00
17.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services of	ii a ciiai ye basi s	U	17.00
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	18. 00
	Total customary charges (see instructions)			0.000000	19.00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				17.00
20. 00	Cost of covered services (see Instructions)			0	20.00
21. 00	Deducti bl es			0	21. 00
22. 00	Subtotal (Line 20 minus line 21)			0	22. 00
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	24. 00
25. 00	Allowable bad debts (from your records)			0	25. 00
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	v collected based on c	orrection of	0	27. 00
	cost limit	,			
28.00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28. 00
	utilization				
29.00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depr	eciable assets (0	30. 00
	if minus, enter amount in parentheses)				
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments			0	32. 00
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0	33. 00
	Instructions)				

Provi der No.: 315202 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:29 am Title XVIII Skilled Nursing PPS

				Facility		
		I npati en	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		3, 140, 118		8, 504	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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	05 (04 (0000	00.400			
3. 01	ADJUSTMENTS TO PROVIDER	05/31/2023	20, 198		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM				0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		0		0	3. 50 3. 51
3. 51			0		0	3. 51
			0		0	
3. 53 3. 54			0		0	3. 53 3. 54
3. 54	Subtatal (Sum of Lines 2 01 2 40 minus sum of Lines 2 FO		l ĭ		0	3. 54 3. 99
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		20, 198		ا	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 160, 316		8, 504	4. 00
4.00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		3, 100, 310		0, 304	4.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5.98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	PROGRAM TO PROVIDER		22, 248		3, 307	6. 01
6. 02	PROVIDER TO PROGRAM		22, 240		3, 307	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 182, 564		11, 811	7. 00
7.00	Total modicale program traditity (see that detrois)		Contract	or Name	Contractor	7.00
			Sorreract	o. Hallo	Number	
			1. (00	2.00	
8. 00	Name of Contractor					8. 00
					' '	

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

		OPATCONG	CENTER		In Lie	u of Form CMS-	2540-10
	E SHEET (If you are nonproprietary and do not maintain		Provi der		Peri od:	Worksheet G	
	ype accounting records, complete the "General Fund" (col umn			From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
onl y)						5/13/2024 9: 2	9 am
			General Fund	Speci fi c	Endowment Fund	Plant Fund	
		-	1. 00	Purpose Fund 2.00	3. 00	4. 00	
	Assets		1.00	2.00	3.00	4.00	
	CURRENT ASSETS						1
1.00	Cash on hand and in banks		3, 116)	0 0	0	1.00
2.00	Temporary investments		0		0 0	0	
3. 00	Notes recei vable		0	1	0 0	0	
4.00	Accounts receivable		2, 372, 704		0 0	0	
5. 00 6. 00	Other receivables Less: allowances for uncollectible notes and account	+c	13, 508	1		0	
6.00	recei vabl e	ıs	-335, 347		٩	U	0.00
7. 00	Inventory		37, 692		ol ol	0	7.00
8.00	Prepai d expenses	İ	957, 505	1	o o	0	8.00
9.00	Other current assets		0		o o	0	9.00
10.00	Due from other funds		0	•	이	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)		3, 049, 178	3	0 0	0	11. 00
40.00	FI XED ASSETS				ما ما		40.00
12.00	Land		121 550	•	0 0	0	
13. 00 14. 00	Land improvements Less: Accumulated depreciation	}	121, 550 -61, 188	1	0 0	0	
15. 00	Buildings		5, 645, 501	1		0	
16. 00	Less Accumulated depreciation		-2, 906, 120	1		0	
17. 00	Leasehold improvements		689, 010	1	ol ol	0	
18.00	Less: Accumulated Amortization		-480, 501		o o	0	18. 00
19.00	Fi xed equipment	1	158, 689		o o	0	19. 00
20.00	Less: Accumulated depreciation		-117, 760		0 0	0	
21. 00	Automobiles and trucks		0		0 0	0	
22. 00	Less: Accumulated depreciation		0)	0 0	0	
23. 00	Maj or movable equipment		768, 459	1	0 0	0	
24. 00 25. 00	Less: Accumulated depreciation Minor equipment - Depreciable	-	-698, 612	1	0 0	0	
26. 00	Minor equipment nondepreciable		0	l .		0	
27. 00	Other fixed assets		0	l .		0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)		3, 119, 028	1	ol ol	0	
	OTHER ASSETS			•	-1		
29. 00	Investments		C)	0 0	0	
30.00	Deposits on Leases		0)	0 0	0	
31. 00	Due from owners/officers		3, 927, 347	1	0 0	0	
32. 00	Other assets		2 027 247	1	0 0	0	
33. 00 34. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)		3, 927, 347 10, 095, 553	1	0 0	0	
34.00	Liabilities and Fund Balances		10, 073, 333	'	<u> </u>	0	34.00
	CURRENT LI ABI LI TI ES						1
35.00	Accounts payable		1, 129, 364		0 0	0	35. 00
36.00	Salaries, wages, and fees payable	1	0		o o	0	36.00
37. 00	Payroll taxes payable		0		0 0	0	
	Notes & Loans payable (Short term)		0)	0 0	0	
39. 00	Deferred income		0)	0 0	0	
40.00	Accel erated payments		2 001)		0	40.00
41. 00 42. 00	Due to other funds Other current liabilities		3, 091 1, 568, 242		0 0 0 0	0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)		2, 700, 697			0	
43.00	LONG TERM LIABILITIES		2, 700, 077		<u> </u>		43.00
44. 00	Mortgage payable		3, 439, 658	3	ol ol	0	44. 00
45.00	Notes payable		0	1	o o	0	
46.00	Unsecured Loans	İ	0		o o	0	46. 00
47. 00	Loans from owners:		0		o o	0	47. 00
48. 00	Other long term liabilities		0)	이	0	
49. 00	APIC DISTRIBUTIONS; R/E EARNINGS		3, 348, 580	1	0 0	0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49		6, 788, 238	1	0 0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)		9, 488, 935)	0 0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	T	606, 618	1	T		52. 00
53. 00	Specific purpose fund		000, 010	1	0		53.00
54. 00	Donor created - endowment fund balance - restricted				ol ol		54.00
55.00	Donor created - endowment fund balance - unrestricte	ed		1	o		55. 00
56. 00	Governing body created - endowment fund balance				0		56. 00
57. 00	Plant fund balance - invested in plant					0	
58. 00	Plant fund balance - reserve for plant improvement,					0	58. 00
FC 5-	replacement, and expansion						
59.00	TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	1 and	606, 618		0	0	
60. 00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 59)	ı aılu	10, 095, 553	'[0 0	0	60.00
	1 - 1	1		•	ı		

| In Lieu of Form CMS-2540-10 | Provider No.: 315202 | Period: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES LOPATCONG CENTER

Ceneral Fund Special Purpose Fund Endowment Fund						То	12/31/2023	Date/Time Pre 5/13/2024 9: 2	
1.00			General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
1.00									
2.00 Net income (loss) (from Wkst. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 5.00 6.00 7.00 8.00 9.00 10.			1.00	2.00	3.00		4. 00	5. 00	
Total (sum of line 1 and line 2)				-			0		
A.00							0		
5,00				000, 010			0		
7.00	5.00	, , , , , , , , , , , , , , , , , , , ,	0			0		0	5. 00
8.00 9.00 10.00 Total additions (sum of line 5 - 9)			0			0			
9.00 10.00 11.00 1			0			0			
10.00 Total additions (sum of line 5 - 9) 0 10.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 12.00 13.00 13.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 17.00 18.00 19			0			0			
12.00 13.00 13.00 13.00 13.00 14.00 15.00 14.00 15.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.0		Total additions (sum of line 5 - 9)		0		٥	0	Ĭ	
13.00	11. 00			606, 618			0		11. 00
14.00		Deductions (debit adjustments)							
15.00			0			0			
16.00			0			0			
18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance sheet (Line 11 - line 18) Endowment Fund Plant Fund			Ö			0		_	
19.00 Fund balance at end of period per balance Sheet (Line 11 - Line 18) Endowment Fund Plant Fund	17. 00		0			0		0	
Sheet (Line 11 - line 18)				0					
Endowment Fund	19.00			606, 618			0		19.00
Tund balances at beginning of period 0		Isheet (Erne 11 Trine 10)	Endowment Fund	PI ant	Fund			L	
Total additions (sum of line 5 - 9)									
2.00 3.00 3.00 4.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 12.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 10.0	1 00	Fund halanass at hadinaing of pariod		7. 00	8.00				1 00
3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 0 11.00 0 12.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 10.00 10.00		,	J			U			
5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) 0 5.00 6.00 7.00 8.00 9.00 10.00 11.00 Deductions (debit adjustments) 0 12.00 13.00 14.00 15.00			О			0			
6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 0 13.00 14.00 15.00		Additions (credit adjustments)							
7.00 8.00 9.00 10.00 11.00 12.00 12.00 14.00 15.00 15.00				0					
8.00 9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 14.00 15.00				0					
9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 14.00 15.00				0					
11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 13.00 14.00 15.00 15.00 10 10 15.00 10 10 10 10 10 10 10	9.00			0					9. 00
12. 00 Deductions (debit adjustments) 12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 17. 00 17. 00 18. 00			0			0			
13. 00 14. 00 15. 00 15. 00			0			0			
14. 00 15. 00		beductions (debit adjustillents)		0					
				Ö					
16.00				ŭ,					
				0					
17.00 18.00 Total deductions (sum of lines 13 - 17) 0 18.00		Total deductions (sum of lines 13 - 17)		O		0			
19. 00 Fund balance at end of period per balance 0 19. 00						-			
sheet (Line 11 - line 18)									

Heal th	Financial Systems LOPATCONG CEN	ITER		In Lie	eu of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/13/2024 9:2	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1. 00	SKILLED NURSING FACILITY		18, 820, 09	1	18, 820, 091	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4. 00	OTHER LONG TERM CARE			0	0	4. 00
5. 00	Total general inpatient care services (Sum of lines 1 - 4)		18, 820, 09	1	18, 820, 091	5. 00
	All Other Care Services		1	_		
6.00	ANCI LLARY SERVI CES		3, 262, 31		3, 262, 317	6. 00
7.00	CLI NI C			0	1	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	
9.00	AMBULANCE			0	0	9. 00
10. 00	RURAL HEALTH CLINIC			0	0	
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
11. 10	CORF			0	0	11. 10
12.00	HOSPI CE			0	0	12.00
13. 00	OTHER (SPECIFY)			0	0	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	3 to	22, 082, 40	8 0	22, 082, 408	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description			1.00	0.00	
	DART II. OPERATING EVENICES			1. 00	2. 00	
1 00	PART II - OPERATING EXPENSES				14 007 202	1 00
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				14, 006, 202	1.00
2.00	Add (Specify)			0		2.00
3.00				0		3.00
4.00				0		4.00
5.00				0		5. 00
6.00				0		6. 00
7.00	T-+-! A-			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)				0	
9. 00 10. 00	Deduct (Specify)			0		9.00
				0		10.00
11.00				0		11.00
12.00				0		12.00
13.00	Total Dadications (Compatibility 0 12)			0	_	13.00
	Total Deductions (Sum of lines 9 - 13)				0	
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				14, 006, 202	15.00

Health Financial Systems	LOPATCONG CENTER	In Lie	u of Form CMS-	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.:	From 01/01/2023	Worksheet G-3 Date/Time Pre 5/13/2024 9:2	pared:
			1 3/13/2024 9:2	Ť

STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider No.: 315202	From 01/01/2023	worksneet G-3	
			To 12/31/2023	Date/Time Pre	oared:
				5/13/2024 9: 2	
				1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1			22, 082, 408	1. 00
2.00	Less: contractual allowances and discounts on patients accounts			7, 487, 474	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			14, 594, 934	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, Ii	ne 15)		14, 006, 202	4. 00
5.00	Net income from service to patients (Line 3 minus 4)			588, 732	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from communications (Telephone and Internet service)			0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MISC INCOME			17, 886	24.00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (Sum of lines 6 - 24)			17, 886	25. 00
26.00	Total (Line 5 plus line 25)			606, 618	26. 00
27.00	Other expenses (specify)			0	27. 00
28.00				0	28. 00
29.00				0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)			0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)			606, 618	31. 00
			•	•	•