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 01/01/2022
From 01/01/2022
To 12/31/2023

				10 12/31/2022	5/17/2023 2	
PART I - COST F	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	oort		Date: 5/17/20	23 Time:	2:36 pm
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	ter the number	of times the provider	resubmitted thi	s cost repor	t
	3.01 [] No Medicare Utilization. Enter "	'Y" for yes or	leave blank for no.			
Contractor	4.[1]Cost Report Status	6. Contractor	No			
use only	(1) As Submitted	7.[N] First	Cost Report for this	Provi der CCN		
	(2) Settled without audit	8.[N] Last	Cost Report for this F	Provider CCN		
	(3) Settled with audit	9. NPR Date:	•			
	(4) Reopened (5) Amended	10.[0]If li	ne 4, column 1 is "4":	Enter number of	times reope	ned
	(3) Alliended	11.Contractor	Vendor Code	4		
	5. Date Received:	12.[F] Medic	are Utilization. Ente	r "F" for full, "	'L" for low,	or "N"
		for n	o utilization			

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LOPATCONG CENTER (315202) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF 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	54, 812	1, 042	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	54, 812	1, 042	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 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/17/2023 2:36 pm 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 3. 01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 1.00 2.00 3. 00 4.00 5.00 6.00 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) 12/31/2022 01/01/2022 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR 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 145, 435 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 00 145, 435 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility 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

Heal th	· · · · · · · · · · · · · · · · · · ·		In Lie	u of Form CMS-2	2540-10	
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3152	202 Peri od:	Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 01/01/2022	Part I	
				To 12/31/2022	Date/Time Pre	
					5/17/2023 2: 3	6 pm
					Y/N	
					1. 00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative	e and General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing co	st centers and		
	amounts.		_			
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and addre	ess of the home	HB0067	44.00
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address of th	ne home office on the	lines	
	bel ow.					
45.00	Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	S Cont	ractor's Number: 1200	1	45. 00
46.00	Street: 101 EAST STATE STREET	PO Box:				46. 00
47. 00	City: KENNETT SQUARE	State: PA	Zip	Code: 1934	8	47. 00
43. 00 44. 00 45. 00 46. 00	center? Enter Y or N. If yes, check boomounts. Are there any home office costs as defilf line 43 is yes, enter the home office on lines 45, 46 and 47. 1.00 If this facility is part of a chain or below. Name: GENESIS HEALTHCARE Street: 101 EAST STATE STREET	x, and submit supporting sined in CMS Pub. 15-1, Chace chain number and enter 2.00 ganization, enter the name Contractor's Name: NOVITA PO Box:	apter 10? the name and addre e and address of the	ess of the home 3.00 he home office on the cractor's Number: 1200	1.00 N Y HB0067	43. (44. (45. (46. (

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI	LOPATCONG CENTER	ovi don l	No.: 315202	In Li∈ Period:	eu of Form CMS- Worksheet S-2	
	X REIMBURSEMENT QUESTIONNAIRE	IT HEALTH CARE PI	ovidei		From 01/01/2022 Fo 12/31/2022	Part II Date/Time Pre	epared:
					Y/N	5/17/2023 2:3 Date	10 bill
			"" 6	V	1.00	2. 00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column i,	Y FOR	Yes or N 1	or No. For all	the date	
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter-				N		1. 00
	instructions)		1	Y/N	Date	V/I	
				1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of			N			2. 00
3.00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		ement drug ts oard	Υ			3. 00
	relationships? (see instructions)			Y/N	Type	Date	
	Financial Data and Danasta			1. 00	2. 00	3. 00	
4.00	Financial Data and Reports Column 1: Were the financial statements preparance (Y/N) Column 2: If yes, enter "A' Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" for		Y	A	03/27/2023	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 a	no, see instructions. revenues different from		N			5. 00
	reconciliation.				Y/N	Legal Oper.	
					1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2:	Is the p	provider the	N	N	6. 00
7. 00	legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instructi	ons.		N		7. 00
8.00	Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so		period f	for Nursing	N		8. 00
						Y/N 1. 00	
9. 00	Bad Debts Is the provider seeking reimbursement for bad	d dobte2 (V/N) soo ins	tructi or	200		Υ	9. 00
10. 00	If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	t collection policy ch	ange dur	ring this cost		N N	10.00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance waive	d? If "\	/", see instru	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting period	? If "Y			N	12. 00
		Description	-	Y/N	rt A Date	Part B Y/N	
		0		1.00	2. 00	3. 00	
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			N		N	13. 00
14. 00	4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			Υ	03/15/2023	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			N		N	16. 00
	corrections of other PS&R Report						
17. 00	"			N		N	17. 00

Heal th	Financial Systems LOPATCO	LOPATCONG CENTER			In Lieu of Form CMS-2540			40-10	
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAF X REIMBURSEMENT QUESTIONNAIRE	RΕ	Provi der	No.: 315202		riod: om 01/01/2022 12/31/2022	Date/Time Pi	epa	red:
							5/17/2023 2:	36	pm
			1.	00		2. (00		
	Cost Report Preparer Contact Information								
19. 00	Enter the first name, last name and the title/position	JEAN			PR	RICE		1	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				2	20. 00
	preparer.							_	
21. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	4108	044481		JE	EAN. PRI CE@GENE	ESI SHCC. COM	2	21. 00

Health Financial Systems LOPATCONG CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315202 Worksheet S-2 Peri od:

From 01/01/2022 To 12/31/2022 Part II Date/Time Prepared: 5/17/2023 2:36 pm COMPLEX REIMBURSEMENT QUESTIONNAIRE 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 13.00 4. (see Instructions.) 03/15/2023 14.00 14.00 Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y"

	enter the paid through date of the PS&R used			
	to prepare this cost report in columns 2 and			
	4.			
15.00	If line 13 or 14 is "Y", were adjustments			15. 00
	made to PS&R data for additional claims that			
	have been billed but are not included on the			
	PS&R used to file this cost report? If "Y",			
	see Instructions.			
16 00	If line 13 or 14 is "Y", then were			16. 00
10.00				10.00
	adjustments made to PS&R data for			
	corrections of other PS&R Report			
47.00	information? If yes, see instructions.			47.00
17. 00	If line 13 or 14 is "Y", then were			17. 00
	adjustments made to PS&R data for Other?			
	Describe the other adjustments:			
18. 00	Was the cost report prepared only using the			18. 00
	provider's records? If "Y" see Instructions.			
			3. 00	
	Cost Report Preparer Contact Information			
19.00	Enter the first name, last name and the title/p	osi ti on	REIMBURSEMENT ANALYST	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 rep	ort		20. 00
20.00	preparer.	···		20.00
21 00	Enter the telephone number and email address of	the cost		21. 00
21.00	report property in columns 1 and 2 respectively			21.00

report preparer in columns 1 and 2, respectively.

In Lieu of Form CMS-2540-10 LOPATCONG CENTER

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

Provi der No.: 315202

				T	0 12/31/2022	Date/Time Prep 5/17/2023 2:36	
				I npa	atient Days/Vis		•
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	153	55, 845	0	6, 416	28, 637	1. 00
2. 00 3. 00	NURSING FACILITY	0	0	0		0	2. 00 3. 00
4.00	HOME HEALTH AGENCY COST		U	0	0	0	4. 00
5. 00	Other Long Term Care	0	0		Š	Ĭ	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)	153 Inpatient [55, 845 Davs/Vi si ts	0	6, 416 Di scharges	28, 637	8. 00
		The tront is	ays/ vi si ts		Di Schar ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CVILLED NUDCING FACILITY	6.00	7.00	8.00	9. 00	10.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	5, 962	41, 015 0	0	172	43	1. 00 2. 00
3.00	ICF/IID	0	0	0		0	3. 00
4. 00	HOME HEALTH AGENCY COST	0	0				4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10 7. 00	SNF-Based CORF HOSPI CE	0	_	0	0	o	6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	5, 962	41, 015	0	172	43	8. 00
0.00	Trotal (cam or trines 1 7)	Di sch		Aver	age Length of		0.00
	Component	0ther 11.00	Total 12. 00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
1.00	SKILLED NURSING FACILITY	191	12.00		37. 30	665. 98	1. 00
2. 00	NURSING FACILITY	0	0			0.00	2. 00
3.00	ICF/IID	0	0			0. 00	3.00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	0				5. 00 6. 00
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)	191	406		37. 30	665. 98	8. 00
		Average Length of Stay		Admi s	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	101. 02	0	206	15	192	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3. 00 4. 00	ICF/IID HOME HEALTH AGENCY COST	0.00			0	0	3. 00 4. 00
5. 00	Other Long Term Care	0.00				0	5. 00
6.00	SNF-Based CMHC						6. 00
6. 10	SNF-Based CORF						6. 10
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	0. 00 101. 02	0		0 15	0 192	7. 00 8. 00
8.00	Total (Suil of Titles 1-7)	Admi ssi ons		Equi val ent	15	172	8.00
	Component	Total	Employees on	Nonpai d Workers			
		21. 00	Payrol I 22. 00	23. 00			
1. 00	SKILLED NURSING FACILITY	413	75. 11	0.00			1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	I CF/II D	0	0.00				3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	0	0. 00 0. 00				4. 00 5. 00
6.00	SNF-Based CMHC		0.00				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)	413	75. 11	0.00		I	8. 00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

				1	0 12/31/2022	5/17/2023 2:30	
		Amount	Reclass. of	Adjusted	Paid Hours	Average Hourly	
		Reported		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 II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	4, 712, 949	0	4, 712, 949			
2.00	Physician salaries-Part A	0	0	0	0.00		
3.00	Physician salaries-Part B	0	0	0	0.00		
4.00	Home office personnel	0	0	0	0.00	0. 00	
5.00	Sum of lines 2 through 4	0	0	0	0.00	0. 00	5. 00
6.00	Revised wages (line 1 minus line 5)	4, 712, 949	0	4, 712, 949	· ·		6. 00
7.00	Other Long Term Care	0	0	0	0.00	0. 00	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00	0. 00	
9. 10	CORF						9. 10
10.00	HOSPI CE	0	0	0	0.00		10.00
11. 00	Other excluded areas	0	0	0	0.00		11. 00
12.00	Subtotal Excluded salary (Sum of lines 7	0	0	0	0.00	0. 00	12.00
	through 11)						
13. 00	Total Adjusted Salaries (line 6 minus line	4, 712, 949	0	4, 712, 949	156, 232. 00	30. 17	13. 00
	12)						
	OTHER WAGES & RELATED COSTS	0.00/.450		0.00/.450	00 700 40	10.51	
14.00	Contract Labor: Patient Related & Mgmt	3, 986, 159	1	-, ,	· ·		
15.00	Contract Labor: Physician services-Part A	71, 721	0	, . = .			
16. 00	Home office salaries & wage related costs	432, 652	0	432, 652	8, 819. 00	49. 06	16. 00
47.00	WAGE-RELATED COSTS	704 440		704 440			47.00
17. 00	Wage-related costs core (See Part IV)	734, 443	0	734, 443			17. 00
18.00	Wage-related costs other (See Part IV)	0	0	0			18. 00
19. 00	Wage related costs (excluded units)	0	0	0			19. 00
20.00	Physician Part A - WRC	0	0	0			20. 00
21. 00	Physician Part B - WRC	704	0	704			21. 00
22. 00	Total Adjusted Wage Related cost (see	734, 443	0	734, 443			22. 00
	instructions)		l	l			

Health Financial Systems
SNF WAGE INDEX INFORMATION LOPATCONG CENTER

Provi der No.: 315202

				Ť	o 12/31/2022	Date/Time Pre 5/17/2023 2:3	
	·	Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	286, 151	0	286, 151	10, 650. 00	26. 87	2. 00
3.00	Plant Operation, Maintenance & Repairs	85, 577	0	85, 577	3, 924. 00	21. 81	3. 00
4.00	Laundry & Linen Service	0	0	C	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	C	0.00	0.00	5. 00
6.00	Di etary	0	0	C	0.00	0.00	6. 00
7.00	Nursing Administration	644, 682	-42, 345	602, 337	14, 254. 00	42. 26	7. 00
8.00	Central Services and Supply	0	17, 771	17, 771	981.00	18. 12	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	24, 574	24, 574	1, 222. 00	20. 11	10.00
11. 00	Social Service	169, 450	0	169, 450	5, 838. 00	29. 03	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	149, 202	0	149, 202	9, 418. 00	15. 84	13.00
14. 00	Total (sum lines 1 thru 13)	1, 335, 062	0	1, 335, 062	46, 287. 00	28. 84	14. 00

Health Financial Systems			
SNF WAGE RELATED COSTS	Provi der No.: 315202	From 01/01/2022 Part IV	_
		To 12/31/2022 Date/Time Prepared	ŀ

		То	12/31/2022	Date/Time Prep 5/17/2023 2:30	
		<u> </u>		Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			8, 947	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost			0	3. 00
4.00	Prior Year Pension Service Cost			0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6. 00
7.00	Employee Managed Care Program Administration Fees			0	7. 00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			171, 853	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	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)			0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14.00
15. 00	Workers' Compensation Insurance			133, 324	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraord	dinary accrual required by F	ASB 106.	0	
	Non cumulative portion)	9		_	
	TAXES		<u>'</u>		
17.00	FICA-Employers Portion Only			348, 219	17. 00
	Medicare Taxes - Employers Portion Only			0	18. 00
19.00	Unemployment Insurance			0	19. 00
20.00	State or Federal Unemployment Taxes			46, 444	20.00
	OTHER				
21. 00	Executive Deferred Compensation			0	21. 00
	Day Care Cost and Allowances			0	22. 00
	Tuition Reimbursement			25, 656	
	Total Wage Related cost (Sum of lines 1 - 23)			734, 443	
				Amount	
				Reported	
				1. 00	
	Part B - Other than Core Related Cost				
	rait b - other than core kerated cost				

					rom 01/01/2022 o 12/31/2022	Part V Date/Time Prep 5/17/2023 2:30	pared:
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	J pili
	occupational outegoly	Reported		Sal ari es (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				,	3	,	
		1.00	2.00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 172, 877	153, 728	1, 326, 605	25, 973. 36	51. 08	1.00
2.00	Licensed Practical Nurses (LPNs)	974, 460	132, 103	1, 106, 563	28, 267. 14	39. 15	2.00
3.00	Certified Nursing Assistant/Nursing	1, 230, 550	219, 022	1, 449, 572	55, 704. 99	26. 02	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 377, 887	504, 853	3, 882, 740	109, 945. 49	35. 32	4. 00
5.00	Physi cal Therapists	0	0	C	0.00	0. 00	5. 00
6.00	Physical Therapy Assistants	0	0	C	0.00	0. 00	
7.00	Physical Therapy Aides	0	0	C	0.00	0. 00	7. 00
8.00	Occupational Therapists	0	0	C	0.00	0.00	8. 00
9.00	Occupational Therapy Assistants	0	0	C	0.00	0.00	9. 00
10.00	Occupational Therapy Aides	0	0	C	0.00	0.00	10.00
11. 00	Speech Therapists	0	0	C	0.00	0.00	11.00
12.00	Respi ratory Therapi sts	0	0	C	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	C	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	4, 490		4, 490			
15. 00	Licensed Practical Nurses (LPNs)	531, 221		531, 221			
16. 00	Certified Nursing Assistant/Nursing	784, 763		784, 763	16, 682. 71	47. 04	16. 00
	Assi stants/Ai des						
17. 00	Total Nursing (sum of lines 14 through 16)	1, 320, 474		1, 320, 474			17. 00
18. 00	Physical Therapists	282, 768		282, 768	· ·	70. 18	
19. 00	Physical Therapy Assistants	199, 239		199, 239		46. 80	
20. 00	Physical Therapy Aides	0		C	0.00	0. 00	
21. 00	Occupational Therapists	181, 945		181, 945	· ·		
22. 00	Occupational Therapy Assistants	191, 454		191, 454			
23. 00	Occupational Therapy Aides	0		C		0. 00	
24. 00	Speech Therapists	186, 036		186, 036	· ·		
25. 00	Respiratory Therapists	1, 902		1, 902		47. 55	
26. 00	Other Medical Staff	71, 721		71, 721	843. 00	85. 08	26. 00

Peri od: Worksheet S-7 From 01/01/2022 Date/Time Prepared: 5/17/2023 2:36 pm

	10	12/31/2022	5/17/2023 2:3	
		Group	Days	
		1. 00	2. 00	1.00
1.00		RUX		1.00
2. 00 3. 00		RUL RVX		2. 00 3. 00
4.00		RVL		4. 00
5.00		RHX		5. 00
6.00		RHL		6. 00
7.00		RMX		7. 00
8.00		RML		8. 00
9.00		RLX		9. 00
10. 00		RUC		10. 00
11.00		RUB		11.00
12.00		RUA		12. 00 13. 00
13. 00 14. 00		RVC RVB		14. 00
15. 00		RVA		15. 00
16. 00		RHC		16. 00
17. 00		RHB		17. 00
18. 00		RHA		18. 00
19. 00		RMC		19. 00
20. 00		RMB		20. 00
21. 00		RMA		21.00
22.00		RLB		22. 00
23. 00 24. 00		RLA ES3		23. 00 24. 00
25. 00		ES2		25. 00
26. 00		ES1		26. 00
27.00		HE2		27. 00
28. 00		HE1		28. 00
29. 00		HD2		29. 00
30. 00		HD1		30. 00
31. 00		HC2		31. 00
32.00		HC1		32.00
33. 00 34. 00		HB2 HB1		33. 00 34. 00
35. 00		LE2		35.00
36.00		LE1		36.00
37.00		LD2		37. 00
38. 00		LD1		38. 00
39. 00		LC2		39. 00
40. 00		LC1		40. 00
41. 00		LB2		41. 00
42.00		LB1		42.00
43. 00 44. 00		CE2 CE1		43. 00 44. 00
45. 00		CD2		45. 00
46.00		CD1		46. 00
47. 00		CC2		47. 00
48. 00		CC1		48. 00
49. 00		CB2		49. 00
50. 00		CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53. 00 54. 00		SE3 SE2		53. 00 54. 00
55. 00		SE1		55. 00
56. 00		SSC		56. 00
57. 00		SSB		57. 00
58. 00		SSA		58. 00
59. 00		IB2		59. 00
60.00		I B1		60.00
61.00		I A2		61.00
62. 00 63. 00		I A1 BB2		62. 00 63. 00
64. 00		BB1		64. 00
65. 00		BA2		65. 00
66. 00		BA1		66.00
67. 00		PE2		67. 00
68. 00		PE1		68. 00
69. 00		PD2		69. 00
70.00		PD1		70.00
71. 00		PC2		71.00
72. 00 73. 00		PC1 PB2		72.00
73. 00 74. 00		PB1		73. 00 74. 00
75. 00		PA2		75. 00
			i	,

Health Financial Systems	LOPATCONG CENTER		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-	7
			From 01/01/2022 To 12/31/2022	Date/Time Pr 5/17/2023 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 payments beginning 10/01/2003. Congress expexpenses. For lines 101 through 106: Enter column 2 the percentage of total expenses 1 line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expens (See instructions)	pected this increase to be used in column 1 the amount of the for each category to total SNF for yes or "N" for no if the	d for direct p expense for e revenue from spending refle	atient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing					101. 00
102.00 Recruitment					102. 00
103.00 Retention of employees					103. 00
104. 00 Trai ni ng					104. 00
105. 00 OTHER (SPECIFY)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)				106. 00

	Financial Systems	LOPATCONG C	ENTER		In Lie	u of Form CMS-2	2540-10
RECLAS	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
						5/17/2023 2:3	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
					Increase/Decre ase (Fr Wkst	(col. 3 +- col. 4)	
					A-6)	COI. 4)	
		1.00	2. 00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 444, 216	1, 444, 216	0	1, 444, 216	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		30, 403			30, 403	2. 00
3.00	00300 EMPLOYEE BENEFITS	0	728, 719			728, 719	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	286, 151	2, 270, 353			2, 556, 504	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	85, 577	487, 339			572, 916	5.00
6. 00 7. 00	00700 HOUSEKEEPING		279, 073 350, 162			279, 073 350, 162	6. 00 7. 00
8. 00	00800 DI ETARY		1, 001, 739			1, 001, 739	8.00
9. 00	00900 NURSING ADMINISTRATION	644, 682	240, 098			842, 435	
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	51, 302			69, 073	
11. 00	01100 PHARMACY	0	0	(o	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	(24, 574	24, 574	12. 00
13. 00	01300 SOCIAL SERVICE	169, 450	342	169, 792	0	169, 792	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	0	14. 00
15. 00	01500 ACTIVITIES	149, 202	20, 972	170, 174	1 0	170, 174	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	3, 377, 887	1, 539, 583	4, 917, 470	o	4, 917, 470	30.00
31. 00	03100 NURSING FACILITY	3, 377, 007	1, 559, 565 N	4, 917, 470		4, 917, 470	31.00
32. 00	03200 CF/IID		0			0	32.00
33. 00	03300 OTHER LONG TERM CARE	o	0			0	
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-1		
40.00	04000 RADI OLOGY	0	14, 408	14, 408	0	14, 408	40. 00
	04100 LABORATORY	0	84, 813			84, 813	
42. 00	04200 I NTRAVENOUS THERAPY	0	45, 209			45, 209	
	04300 OXYGEN (INHALATION) THERAPY	0	37, 598			37, 598	
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	409, 944			409, 944	
46. 00	04500 OCCUPATIONAL THERAPY		431, 543 204, 198			431, 543 204, 198	
47. 00	04700 ELECTROCARDI OLOGY		204, 170	204, 170		204, 170	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0		o	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	226, 863	226, 863	0	226, 863	49. 00
50.00	I I	0	0	(0	0	
51. 00	05100 SUPPORT SURFACES	0	17, 082			17, 082	
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	O	0		ol ol	0	60.00
61.00	06100 RURAL HEALTH CLINIC		0			0	
62. 00	06200 FQHC		O			0	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		o	0	
	OTHER REIMBURSABLE COST CENTERS	·			'		
	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70. 00
	07100 AMBULANCE	0	0	(0	0	
	07200 CORF	0	0	(0	0	72. 00
	07300 CMHC	0	0	(0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	l ol	0		0	0	74. 00
80 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0			0	80. 00
	08100 I NTEREST EXPENSE		0			0	1
	08200 UTI LI ZATI ON REVI EW	O	0		o	0	82. 00
83.00	08300 HOSPI CE	0	0	(o	0	83. 00
84.00		0	0	(0	0	
89. 00		4, 712, 949	9, 915, 959	14, 628, 908	0	14, 628, 908	89. 00
	NONREI MBURSABLE COST CENTERS			1	J		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	4 400	4 400			90.00
	09200 PHYSICIANS PRIVATE OFFICES		6, 690 0	6, 690		0, 690	91. 00 92. 00
	09300 NONPALD WORKERS		0			0	
94.00	09400 PATIENTS LAUNDRY	O	0		ol ol	0	
	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0		o	0	95. 00
100.00		4, 712, 949	9, 922, 649	14, 635, 598	s o	14, 635, 598	100. 00

LOPATCONG CENTER In Lieu of Form CMS-2540-10

Health Financial Systems LOPATRECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

SEWINAL SERVICE COST CENTERS Sewinal Cost					To 12/31/2022	Date/Time Prepared: 5/17/2023 2:36 pm
		Cost Center Description	Adjustments to	Net Expenses		371772023 2.36 piii
Col. 6. 00 7.00		·				
CARDINAL SERVICE COST CENTERS			Wkst A-8)			
			6.00			
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 0 30,403 2,00 4.00 00400 JAMIN STRATION 5.00 5		GENERAL SERVICE COST CENTERS	0.00	7.00		
3.00 0.0300 EMPLOYEE BENEFITS	1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0	1, 444, 216		1.00
4.00 0.0400 AMM IN ISTRATI VE & CEMERAL -702, 312 1,854,1902 5.00 0.0500 CHAT OPERATION, JAIN IT. & REPAIRS 0.00 279,073 6.00 0.0600 AURIDESCEPT INC 0.00 0.0000 AURIDESCEPT INC 0.00 0.00 0.0000 FTAW 0.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000			_		•	
5.00 00500 PLANT OPERATION, MAINT, & REPAIRS 0 572, 916 0 00500		1		1	1	
0.000 0.00			-702, 312		•	
7.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00		· · · · · · · · · · · · · · · · · · ·	0			
8.00 0.0800 DIETARY 0 1.001,739 8.00 0.000 0.000 UNISH NA ARMINISTRATION 0 842,435 9,00 0.0					•	
9.00 0.000			0		1	
11.00 01000 PHARMACY 0 0 24.574 12.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 15.00		l	0		•	
12.00 01200 MEDICAL RECORDS & LIBRARY 0 24,574 13.00 130.00 130.00 130.00 130.00 130.00 130.00 130.00 130.00 130.00 130.00 130.00 140.00	10.00		0	69, 073		10.00
13.00 1300 SOCIAL SERVICE 0 169,792 13.00 14.00 15.00		1	0		1	
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 15. 08 15. 08 15. 00 0500 ACTIVITIES 1.6, 387 15. 287 15. 08 0.00 0.00 ACTIVITIES SERVICE COST CENTERS		1	0		•	
15.00			0		•	
INPATI ENT ROUTI NE SERVICE COST CENTERS 30. 00 31.			_16 397		•	
30.00	13.00		- 10, 307	133,767		13.00
32.00 03200 CIFFL LONG TERM CARE	30.00		-56, 141	4, 861, 329		30.00
33.00 03300 OTHER LONG TERNI CARE 0 0 0 0 0 0 0 0 0	31.00	03100 NURSING FACILITY	0	0		31.00
ANCILLARY SERVICE COST CENTERS			0	l .	•	
40, 00 04000 PADI DLOCY	33. 00		0	0		33. 00
41.00 04100 LABORATORY 0 84, 813 41.00 42.00 04200 NITRAVENOUS THERAPY 0 37, 598 43.00 43.00 04300 OXYGEN (I NHALATI ON) THERAPY 0 37, 598 43.00 44.00 04400 PHYSI CAL THERAPY 0 479, 944 44.00 45.00 04500 DCUPATI ONAL THERAPY 0 431, 543 45.00 46.00 04500 SPEECH PATHOLOGY 0 204, 198 46.00 47.00 04700 ELECTROCARGIOLOGY 0 47, 000 48.00 04800 BOID CAL SUPPLIES SCHARGED TO PATIENTS 0 0 48.00 49.00 04900 DRIUGS CHARGED TO PATIENTS 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 05000 OTHER ANCHEROUS COST CENTERS 0 0 0 50.00 05000 OTHER NOWING COST CENTERS 0 0 0 50.00 05000 OTHER NOWING COST CENTERS 0 0 0 50.00 05000 OTHER NOWING CENTERS 0 0 0 50.00 05000 OTHER SECIAL PURPOSE COST CENTERS 0 0 0 50.00 05000 OTHER SECIAL PU	40.00			14 400		40.00
42 00 04200 INTRAVENOUS THERAPY 0 45, 209 43, 00 04400 04400 PHYSI CAL THERAPY 0 409, 944 44, 00 04400 PHYSI CAL THERAPY 0 409, 944 44, 00 04500			0			
43. 00 04300 0AYSEN (INHALATION) THERAPY 0 37, 598 43. 00 44. 00 04400 PHYSI CAL THERAPY 0 409, 944 44. 00 04400 PHYSI CAL THERAPY 0 431, 543 45. 00 46. 00 04600 SEPECH PATHOLOGY 0 204, 198 46. 00 04600 SEPECH PATHOLOGY 0 0 47. 00 47. 00 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0					1	
44.00 04400 PHYSI CAL THERAPY 0 409, 944 44.00 450.00 450.00 04500 0CCUPATIONAL THERAPY 0 431, 543 45.00 460.00 04600 SPEECH PATHOLOGY 0 204, 198 46.00 47.00 04700 04700 04700 04700 04700 04700 04700 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0		1	
46. 00 04500 04500 047	44.00		0	1	•	44. 00
47. 00 04700 CATOO 04700 CALECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0			0	431, 543		45. 00
48. 00 04900 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0		1	0		1	
49.00 04900 DRUGS CHARGED TO PATIENTS 0 226, 863 50.00 5			0	1	1	
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0			0	_	1	
51.00 05100 SUPPORT SURFACES 0 17,082 52.00 05200 OTHER ARCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0			0		1	
52. 00				_	1	
60. 00 61. 00 61. 00 61. 00 61. 00 61. 00 61. 00 61. 00 61. 00 62. 00 62. 00 62. 00 63. 00 06200 FOHC 0 00 00 00 00 00 00 00 00 00 00 00 00			0	l ·	•	
61. 00 06100 RURAL HEALTH CLINIC 0 0 0 62.00 62.00 63.00 05000 FOHC 0 63.00 05000 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 0 0 0 0						
62. 00 06200 FOHC FOHC G3. 00 O O O O O O O O O		1	_		•	
63. 00 06300 OTHER OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0			0	0		
OTHER REIMBURSABLE COST CENTERS			0	0		
70. 00	03.00			0	<u> </u>	03.00
72. 00	70.00		0	0		70.00
73. 00	71. 00		0	0		71. 00
74. 00			0	0		
SPECIAL PURPOSE COST CENTERS SO			0			
80. 00	74.00		0	0		74.00
81. 00	80 OO		1	0		80.00
82. 00 08200 UTILIZATION REVIEW 0 0 0 0 82.00 83. 00 08300 HOSPICE 0 0 0 0 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 85. 00 SUBTOTALS (sum of lines 1-84) -748,023 13,880,885 90. 00 NONREI MBURSABLE COST CENTERS 0 0 0 90. 00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91. 00 O9100 BARBER AND BEAUTY SHOP 0 6,690 92. 00 O9200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 93. 00 O9300 NONPAI D WORKERS 0 0 0 94. 00 O9400 PATI ENTS LAUNDRY 0 0 0 95. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 96. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 97. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 98. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99. 00 O9500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 99			0		•	
84. 00 89. 00 89. 00 SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 90. 00 91. 00 92. 00 92. 00 93. 00 93. 00 94. 00 94. 00 95. 00 96. 00 97. 00 9			0			
89. 00 SUBTOTALS (sum of lines 1-84)	83.00	08300 H0SPI CE	0	0		83.00
NONRE MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0		1	0	0		
90. 00	89. 00		_748, 023	13, 880, 885		89. 00
91. 00 09100 BARBER AND BEAUTY SHOP 0 6,690 91. 00 92. 00 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 095. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95. 00 095. 0	00 00					90.00
92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 92. 00 93. 00 94. 00 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0				_	1	
93. 00 09300 NONPAI D WORKERS 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_	1	
94. 00 09400 PATI ENTS LAUNDRY 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0			0	Ö		
		l	0	0		
100.00 101AL -748,023 13,887,575 100.00		l	0	0		
	100.00	IOTAL	-748, 023	13, 887, 575	l	100. 00

Health Financial Systems	LOPATCONG CENTER	?		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Pr	rovi der 1		Period: From 01/01/2022	Worksheet A-6	
				To 12/31/2022	Date/Time Pre 5/17/2023 2:3	
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3.00	4. 00	5. 00	
(1) A - DEFAULT						
1. 00	CENTRAL SERVICES & SU	IPPLY	10.0	0 17, 771	0	1.00
2. 00	MEDICAL RECORDS & LIB	RARY	12. 0	0 24, 574	0	2.00
TOTALS						
100. 00	Total Reclassificatio	ns (Sum		42, 345	0	100.00
	of columns 4 and 5 mu	ıst				
	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 CENTE	R		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Period: From 01/01/2022	Worksheet A-6	
					Date/Time Pre 5/17/2023 2:3	pared: 6 pm
			Decreases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - DEFAULT						
1. 00	NURSING ADMINISTRATI	ON	9. 0	0 17, 771	0	1.00
2. 00	NURSING ADMINISTRATI	ON	9. 0	0 24, 574	0	2.00
TOTALS						
100. 00				42, 345	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 LOPATCONG CENTER In Lieu of Form CMS-2540-10 Provider No.: 315202 | Period: | Worksheet A-7 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				To	12/31/2022		
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
	Description Beginning Balances Donation Total Disposals and Retirements 1.00 2.00 3.00 4.00 5.00						
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5					
1.00		0	0	0	0	0	1.00
	Land Improvements		0	0	0	0	
			0	0	0	0	
					•		
		7, 250, 327	121, 490	0	121, 490	0	
		0	0	0	0	0	
9. 00	· · · · · · · · · · · · · · · · · · ·			0	121, 490	0	9. 00
	Description	Endi ng Bal ance					
	TANALYSIS OF SURVISION IN SARITAL ASSET BALANCES		7. 00				
4 00							4 00
		1	0				
	· ·		0				
			0				
			0				
			0				
		1	0				
		7, 371, 817	0				
		0	0				
9. 00	lotal (line 7 minus line 8)	7, 371, 817	0			ļ	9. 00

Peri od: Worksheet A-8 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/17/2023 2:3	
	,			Expense Classification on		l piii
				To/From Which the Amount is		
				To Troin will circ the function 13	to be maj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	bescription (1)	Adjustment	Amount	COST CENTER	LITIC NO.	
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds	1.00	2.00		0.00	1. 00
1.00	(chapter 2)				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)		(0.00	3. 00
4. 00	Rental of provider space by suppliers				0.00	4.00
4.00	(chapter 8)				0.00	7.00
5. 00	Tel ephone services (pay stations excluded)		(0.00	5. 00
3.00	(chapter 21)				0.00	3.00
6. 00	Television and radio service (chapter 21)	A	-16 397	ACTI VI TI ES	15.00	6.00
7. 00	Parking Lot (chapter 21)	^	- 10, 307	NCTIVITES	0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2			0.00	8.00
8.00	physician adjustment	A-0-2	C			0.00
9. 00	Home office cost (chapter 21)		Ċ		0.00	9. 00
10. 00	Sale of scrap, waste, etc. (chapter 23)				0.00	
11. 00	Nonallowable costs related to certain				0.00	
11.00	Capital expenditures (chapter 24)		C		0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	192, 033			12. 00
12.00	related organizations (chapter 10)	A-0-1	172, 033			12.00
13. 00	Laundry and Linen service		C		0.00	13. 00
14. 00	Revenue - Employee meals			1		14. 00
15. 00	Cost of meals - Guests		C	1	0.00	1
16. 00			C		0.00	
16.00	Sale of medical supplies to other than patients		C		0.00	16.00
17. 00	Sale of drugs to other than patients		C		0.00	17. 00
18. 00	Sale of medical records and abstracts		C		0.00	
19. 00					0.00	
	Vending machines		C		l .	•
20. 00	Income from imposition of interest, finance		C	,	0.00	20. 00
21. 00	or penalty charges (chapter 21) Interest expense on Medicare overpayments		_		0.00	21. 00
21.00	and borrowings to repay Medicare		C		0.00	21.00
	, ,					
22. 00	overpayments Utilization reviewphysicians' compensation		_	UTILIZATION REVIEW	82.00	22. 00
22.00	(chapter 21)		C	JUTILIZATION REVIEW	82.00	22.00
23. 00	Depreciationbuildings and fixtures		_	CAP REL COSTS - BLDGS &	1.00	23. 00
23.00	beprecrationburidings and fratures		C	FIXTURES	1.00	23.00
24.00	Dangasi ati an mayahla agui nmant		_		2.00	24.00
24. 00	Depreciationmovable equipment		C	CAP REL COSTS - MOVABLE EQUIPMENT	2. 00	24. 00
25 00	MISC INCOME	D D	2.010		4 00	25 00
	MISC INCOME	В		ADMINISTRATIVE & GENERAL	4.00	1
25. 01	UNALLOWED A & G	A		ADMINISTRATIVE & GENERAL		25. 01
25. 02	WORKERS COMPENSATION	A		EMPLOYEE BENEFITS	3.00	
25. 03	HEPARI N/SALI NE	A		SKILLED NURSING FACILITY	30.00	25. 03
100.00	Total (sum of lines 1 through 99) (Transfer		-748, 023	5		100. 00
	to Worksheet A, col. 6, line 100)			I	I	I

⁽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				To 12/31/2022 Parts 1-11	
	Line No.	Cost (Center	5/17/2023 Expense I tems	2:36 pm
	1, 00		00	3. 00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI					
CLAIMED HOME OFFICE COSTS:	KED AS A KESOLI	OI TIVINGACTIO	NO WITH KELATE	D ORGANI ZATI ONS OR	
1.00	4. 00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE A&G	1.00
2. 00	4. 00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE CAPITAL	2.00
3. 00	44.00	PHYSICAL THERA	PY	PT	3.00
4.00	45. 00	OCCUPATIONAL T	HERAPY	OT	4.00
5. 00	46. 00	SPEECH PATHOLO	GY	ST	5.00
6. 00	30.00	SKILLED NURSIN	G FACILITY	NURSING PURCHASED SERVICES	6.00
7. 00	43.00	OXYGEN (INHALA	TION) THERAPY	RT	7.00
8. 00	4.00	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	е				
12.					
	Amount	Amount	Adjustments		
	Allowable In	Included in	(col. 4 minus		
	Cost	Wkst. A, col.	col. 5)		
		5			
DART I COOTS INCURRED AND AR WOTHERTO RESULT	4.00	5.00	6.00	22 020111 7171 0110 02	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
CLAIMED HOME OFFICE COSTS:	686, 981	516, 660	170, 321		1.00
2.00	78, 958		78, 958		2.00
3.00	409, 044				3.00
4.00	431, 396				4.00
5.00	204, 013				5.00
6.00	1, 258, 739				6.00
7.00	8, 694				7.00
8.00	71, 721	71, 721			8.00
9.00	/1, /21	/1, /21			9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column	3, 149, 546	1	1		10.00
6, line 100 to Worksheet A-8, column 3, line		2, 937, 313	172,033		10.00
12.	1	I	1		1

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315202 Peri od: Worksheet A-8-1 From 01/01/2022 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2022 5/17/2023 2:36 pm

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.
- 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	ization(s) and/	or Home Office	
Name	Percentage of	Type of Business	
11	Ownershi p	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
4.00	5.00	6. 00	1

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2.00		POWERBACK	100.00	PT OT ST	2.00
3.00		CAREER STAFF UNLIMITED	100.00	NURSING PURCHASED SERVICES	3.00
4.00		POWERBACK RESPIRATORY	100.00	RT	4.00
5.00		GENESIS PHYSICIAN SERVICES	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 (financial or non-financial)		0.00		100. 00
	speci fy:				

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

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

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Provi der No.: 315202

			То	12/31/2022	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/17/2023 2: 3	o piii
	l <u>-</u>					
Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TIXTURES	LQUIFWLINI	DEINETT 13		
	(from Wkst A					
	col . 7)	4.00	0.00	2.00		
GENERAL SERVICE COST CENTERS	0	1. 00	2.00	3. 00	3A	
1. 00 O0100 CAP REL COSTS - BLDGS & FLXTURES	1, 444, 216	1, 444, 216				1. 00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	30, 403		30, 403			2. 00
3. 00 00300 EMPLOYEE BENEFITS	755, 536	40, 994	863	797, 393		3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL	1, 854, 192	30, 561	643	48, 414	1, 933, 810	4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE	572, 916 279, 073	43, 937 78, 914	925 1, 661	14, 479	632, 257 359, 648	5. 00 6. 00
7. 00 00700 HOUSEKEEPI NG	350, 162	23, 159		o	373, 809	7. 00
8. 00 00800 DI ETARY	1, 001, 739	71, 382	1, 503	0	1, 074, 624	8. 00
9.00 O0900 NURSING ADMINISTRATION	842, 435	43, 807	922	101, 911	989, 075	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	69, 073	2, 035	43	3, 007	74, 158	10.00
11. 00 01100 PHARMACY 12. 00 01200 MEDI CAL RECORDS & LI BRARY	24, 574	17, 661	372	4, 158	0 46, 765	11. 00 12. 00
13. 00 01300 SOCI AL SERVI CE	169, 792	15, 411	324	28, 670	214, 197	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	О	0	0	14. 00
15. 00 01500 ACTI VI TI ES	153, 787	19, 783	416	25, 244	199, 230	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 SKI LLED NURSI NG FACI LI TY	4, 861, 329	963, 676	20, 287	571, 510	6, 416, 802	30. 00
31. 00 03100 NURSING FACILITY	0	0 ,03,070	20, 207	0	0, 410, 662	31. 00
32. 00 03200 I CF/I I D	0	0	0	0	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCI LLARY SERVI CE COST CENTERS 40. 00 O4000 RADI OLOGY	14, 408	0	0	O	14, 408	40. 00
41. 00 04100 LABORATORY	84, 813	0	o	Ö	84, 813	41. 00
42.00 04200 I NTRAVENOUS THERAPY	45, 209	0	0	0	45, 209	42. 00
43. 00 04300 0XYGEN (INHALATION) THERAPY	37, 598	2, 164	46	0	39, 808	43.00
44. 00 04400 PHYSI CAL THERAPY 45. 00 04500 OCCUPATI ONAL THERAPY	409, 944 431, 543	46, 318 27, 488	975 579	O	457, 237 459, 610	44. 00 45. 00
46. 00 04600 SPEECH PATHOLOGY	204, 198	27, 400 0	3/9	0	204, 198	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	O	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 658	182	0	8, 840	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS 50.00 05000 DENTAL CARE - TITLE XIX ONLY	226, 863	8, 268	174	0	235, 305 0	49. 00 50. 00
51. 00 05100 SUPPORT SURFACES	17, 082	0		o	17, 082	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS		ما		ما		
60. 00 06000 CLI NI C 61. 00 06100 RURAL HEALTH CLI NI C	0	0	0	0	0	60. 00 61. 00
62. 00 06200 FQHC		O ₁			O	62. 00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS		٥				70.00
70.00 07000 HOME HEALTH AGENCY COST 71.00 07100 AMBULANCE	0	0	0	0	0	70. 00 71. 00
72. 00 07200 CORF		0	Ö	0	0	72.00
73. 00 07300 CMHC	0	0	O	0	0	73. 00
74. 00 O7400 OTHER REIMBURSABLE COST	0	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 08100 I NTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW						82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83. 00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 89.00 SUBTOTALS (sum of lines 1-84)	13, 880, 885	0 1, 444, 216	30, 403	797, 393	0 13, 880, 885	84. 00 89. 00
NONREI MBURSABLE COST CENTERS	13, 660, 663	1, 444, 210	30, 403	777, 373	13, 000, 003	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, 690	0	0	0	6, 690	
92. 00 09200 PHYSICIANS PRIVATE OFFICES 93. 00 09300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94. 00 09400 PATI ENTS LAUNDRY		o o	0	0	0	94.00
95.00 09500 OTHER NONREIMBURSABLE COST CENTERS	0	o	O	o	0	95. 00
98.00 Cross Foot Adjustments	0	0	0	O	0	98. 00
99.00 Negative Cost Centers 100.00 TOTAL	0 13, 887, 575	0 1, 444, 216	30, 403	0 797, 393	0 13, 887, 575	99. 00 100. 00
100. 00 101AL	13,007,070	1, 444, ∠10	30, 403	171, 373	13,007,575	1100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared:

				To	0 12/31/2022	Date/Time Prep 5/17/2023 2:30	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	o piii
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	1, 933, 810	704 540				4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	102, 283 58, 182	734, 540 43, 625	1			5. 00 6. 00
7. 00	00700 HOUSEKEEPING	60, 473	12, 803		447, 085		7. 00
8. 00	00800 DI ETARY	173, 846	39, 461		26, 017	1, 313, 948	8. 00
9.00	00900 NURSING ADMINISTRATION	160, 007	24, 217	1	15, 967	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	11, 997	1, 125	0	742	0	10. 00
11. 00	01100 PHARMACY	0	0	_	0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	7, 565	9, 764	1	6, 437	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	34, 652	8, 519		5, 617	0	13. 00 14. 00
15. 00	01500 ACTIVITIES	32, 230	10, 936		7, 210	0	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	02,200	10,700		7,2.0		10.00
30.00	03000 SKILLED NURSING FACILITY	1, 038, 072	532, 735	461, 455	351, 237	1, 313, 948	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	2, 331	0	0	٥	0	40. 00
41. 00	04100 LABORATORY	13, 721	0		0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	7, 314	0	ő	Ö	Ö	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	6, 440	1, 197	0	789	0	43.00
44.00	04400 PHYSI CAL THERAPY	73, 969	25, 605	1	16, 882	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	74, 353	15, 196	1	10, 019	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	33, 034	0	0	0	0	46. 00 47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 430	4, 786		3, 155	0	47.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	38, 066	4, 780		3, 013	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51.00	05100 SUPPORT SURFACES	2, 763	0	0	o	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
(0.00	OUTPATIENT SERVICE COST CENTERS				ما		(0.00
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FQHC		0		J	٥	62. 00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	o	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0	0	0	0	71.00
72. 00 73. 00	07200 CORF 07300 CMHC	0	0		0	0	72. 00 73. 00
	07400 OTHER REIMBURSABLE COST	0	0	0	0		74. 00
, 00	SPECIAL PURPOSE COST CENTERS	<u> </u>			٥,	- J	7 00
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	0	0	0	0	0	83. 00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	1 022 729	734, 540	461, 455	447, 085	1 212 049	84. 00 89. 00
07.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	1, 932, 728	734, 340	401, 433	447,000	1, 313, 948	07.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	1, 082	0	0	o	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	94.00
95. 00 98. 00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments		0		0	0	95. 00 98. 00
99. 00	Negative Cost Centers		0		0	0	99.00
100.00	1 1 9	1, 933, 810	734, 540	461, 455	447, 085		

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

					10 12/31/2022	5/17/2023 2:3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		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 8. 00 9. 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 00800 DIETARY 00900 NURSING ADMINISTRATION	1, 189, 266					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	88, 022				10.00
11. 00	01100 PHARMACY	o	0		0		11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 70, 531		12. 00
13.00	01300 SOCIAL SERVICE	0	0		0	262, 985	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	1
15. 00	01500 ACTI VI TI ES	0	0		0 0	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 400 0//	00.000		50 500	0/0.005	1 00 00
30.00	03000 SKILLED NURSING FACILITY	1, 189, 266	88, 022		0 59, 522	1	
31. 00 32. 00	03100 NURSING FACILITY	0 0	0		0 0	0	
33. 00	03300 OTHER LONG TERM CARE		0		0 0	1	
33. 00	ANCI LLARY SERVI CE COST CENTERS	١	<u> </u>		0 0	,	33.00
40.00	04000 RADI OLOGY	0	0		0 51	0	40. 00
41.00	04100 LABORATORY	0	0		0 335	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 134	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		8 0	0	
44. 00	04400 PHYSI CAL THERAPY	0	0		0 3, 946	1	44.00
45. 00	04500 OCCUPATIONAL THERAPY	0	0		0 4, 095		
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY		0		0 1, 644		
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		787		49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	o	0		0 0	o o	50.00
51.00	05100 SUPPORT SURFACES	0	0		0 9	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 CLINIC	0	0		0	0	
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0	٥	61.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	1
00.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	,	00.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70. 00
71.00	07100 AMBULANCE	0	0		0	0	71. 00
72.00	07200 CORF	0	0		0	0	72. 00
73. 00	07300 CMHC	0	0		0	0	1
74. 00	07400 OTHER REIMBURSABLE COST	0	0		0 0) 0	74. 00
80. 00	SPECIAL PURPOSE COST CENTERS						90.00
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
83. 00	08300 HOSPI CE	0	0		0	o	1
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	o	1
89. 00	SUBTOTALS (sum of lines 1-84)	1, 189, 266	88, 022		0 70, 531	262, 985	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0			0	
94. 00 95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS		0				1
98. 00	Cross Foot Adjustments		o O]		98. 00
99. 00	Negative Cost Centers		Ö		0	0	1
100.00	1 1 0	1, 189, 266	88, 022		0 70, 531	262, 985	100.00

					10 12/31/2022	Date/Time Pre 5/17/2023 2:3	
			OTHER GENERAL			7 37 177 2023 2.3	O PIII
			SERVI CE				
Cost Cente	er Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
	•	ALLI ED HEALTH			Adjustments		
		EDUCATI ON					
		14.00	15. 00	16.00	17. 00	18. 00	
GENERAL SERVICE		<u></u>					
	OSTS - BLDGS & FLXTURES						1. 00
	OSTS - MOVABLE EQUIPMENT						2. 00
3.00 00300 EMPLOYEE I							3. 00
4. 00 00400 ADMI NI STRA							4. 00
1 1	RATION, MAINT. & REPAIRS						5. 00
6. 00 00600 LAUNDRY &							6.00
7. 00 00700 HOUSEKEEP	ING						7.00
8. 00 00800 DI ETARY 9. 00 00900 NURSI NG AI	OMINI CTDATI ON						8. 00 9. 00
	ERVICES & SUPPLY						10.00
11. 00 01100 PHARMACY	LKVICLS & SUFFLI						11.00
	ECORDS & LIBRARY						12.00
13. 00 01300 SOCIAL SEI				•			13. 00
	ND ALLIED HEALTH EDUCATION	0					14. 00
15. 00 01500 ACTI VI TI E		0	249, 606	j			15. 00
	NE SERVICE COST CENTERS			•	•		
30. 00 03000 SKI LLED N		0	249, 606	11, 963, 650	0	11, 963, 650	30. 00
31.00 03100 NURSING FA	ACILITY	0	0		0	0	31.00
32.00 03200 I CF/IID		0	l e		0	0	32. 00
33. 00 03300 OTHER LONG		0	0		0	0	33. 00
	CE COST CENTERS	_		1			
40. 00 04000 RADI OLOGY		0	0	1 .0, , ,			40.00
41. 00 04100 LABORATOR' 42. 00 04200 I NTRAVENOI		0	0	98, 869		98, 869	41.00
	NHALATION) THERAPY	0	0	52, 65 ⁻ 48, 242		52, 657 48, 242	42. 00 43. 00
44. 00 04400 PHYSI CAL		0	0	577, 63°		577, 639	1
45. 00 04500 0CCUPATI 0I			0	563, 27		563, 273	1
46. 00 04600 SPEECH PA		0	0	238, 876		238, 876	46. 00
47. 00 04700 ELECTROCAL		0	Ö			0	47. 00
48. 00 04800 MEDICAL SI	JPPLIES CHARGED TO PATIENTS	0	0	18, 21 ⁻	0	18, 211	48. 00
49.00 04900 DRUGS CHAI	RGED TO PATIENTS	0	0	281, 742	0	281, 742	49. 00
	RE - TITLE XIX ONLY	0	0		0	0	50. 00
51. 00 05100 SUPPORT SI		0		19, 85		19, 854	51.00
	ILLARY SERVICE COST CENTERS	0	0	(0	0	52.00
	ICE COST CENTERS	1		.I			
60. 00 06000 CLI NI C 61. 00 06100 RURAL HEAI	TH CLINIC	0 0	0		0	0	60. 00 61. 00
61. 00 06100 RURAL HEAI 62. 00 06200 FQHC	LIH CLINIC	0	U	1	J U	U	62.00
	PATIENT SERVICE COST CENTER	0	0	,	0	0	63.00
-	BLE COST CENTERS			1	9		03.00
70. 00 07000 HOME HEAL		0	0	(0	0	70. 00
71. 00 07100 AMBULANCE		0	l .		0	0	71.00
72. 00 07200 CORF		0	0		0	0	72. 00
73.00 07300 CMHC		0	0		0	0	73. 00
74. 00 07400 OTHER REII		0	0	(0	0	74. 00
SPECIAL PURPOSE							
, , , , , , , , , , , , , , , , , , ,	CE PREMIUMS & PAID LOSSES						80. 00
81. 00 08100 I NTEREST							81.00
82. 00 08200 UTI LI ZATI (JN REVIEW						82.00
83. 00 08300 HOSPI CE 84. 00 08400 OTHER SPE	CLAL PURPOSE COST CENTERS	0 0				0	83. 00 84. 00
	(sum of lines 1-84)			13, 879, 80		13, 879, 803	89. 00
NONREI MBURSABLE			247,000	13, 677, 60	<u> </u>	13, 077, 003	07.00
	WER, COFFEE SHOPS & CANTEEN	0	0		0	0	90. 00
91. 00 09100 BARBER ANI		0	0	7, 772	0	7, 772	91.00
	S PRIVATE OFFICES	0	0		0	0	92. 00
93. 00 09300 NONPALD W		0	0		0	0	93. 00
94. 00 09400 PATI ENTS		0	0	(0	0	94. 00
	REIMBURSABLE COST CENTERS	0	0		0	0	95. 00
	t Adjustments	0	J			0	98.00
99.00 Negative (100.00 TOTAL	Cost Centers	0 0		13, 887, 57!) 0 5 0	0 13, 887, 575	99.00
100.00 101AL		1	249, 000	13,007,37	ار ا	13,007,375	1100.00

					127 017 2022	5/17/2023 2:3	6 pm
			CAPI TAL REI	ATED 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	40, 994	863	41, 857	41, 857	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	30, 561	643	31, 204	2, 541	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	43, 937	925	44, 862	760	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	٥	78, 914		80, 575	0	6.00
7. 00	00700 HOUSEKEEPI NG		23, 159		23, 647	0	7. 00
8. 00	00800 DI ETARY	0	71, 382	1, 503	72, 885	0	8. 00
9. 00	00900 NURSI NG ADMINI STRATI ON		43, 807	922	44, 729	5, 349	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY				2, 078		
11. 00	01100 PHARMACY		2, 035	43	2, 070	158 0	11.00
			17 //1	-	10 022	_	
12.00	01200 MEDICAL RECORDS & LIBRARY	0	17, 661	372	18, 033	218	12.00
13.00	01300 SOCIAL SERVICE	0	15, 411	324	15, 735	1, 505	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	10.700	0	00 400	0	14.00
15. 00	01500 ACTIVITIES	0	19, 783	416	20, 199	1, 325	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	963, 676	20, 287	983, 963	30, 001	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		0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	0	0	40.00
41.00	04100 LABORATORY	0	0	0	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	2, 164	46	2, 210	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	46, 318	975	47, 293	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	27, 488	579	28, 067	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	o	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	o	0	l ol	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 658	182	8, 840	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	8, 268	174	8, 442	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0, 200	0	0,	0	50.00
51. 00	05100 SUPPORT SURFACES	o	0	0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	0	52.00
32.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	32.00
60. 00	06000 CLINIC	O	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC		0	0	0	0	61.00
62. 00	06200 FQHC	J J	0	٩	U	U	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
03.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	03.00
70. 00	07000 HOME HEALTH AGENCY COST	O	0	0	0	0	70.00
71.00	07100 AMBULANCE		0	0	0	0	71.00
			0	_	0	0	
72. 00		1 7	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
	SPECIAL PURPOSE COST CENTERS	1					
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	0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 444, 216	30, 403	1, 474, 619	41, 857	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00		0	0	0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	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				ol		98. 00
99. 00	Negative Cost Centers		0	o	o	0	99. 00
100.00		0	1, 444, 216	30, 403	1, 474, 619	41, 857	100.00
		. '					•

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315202

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/17/2023 2:36 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 33, 745 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 1, 785 47, 407 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 1.015 2, 816 84, 406 6.00 00700 HOUSEKEEPI NG 7.00 1,055 826 C 25.528 7.00 8.00 00800 DI ETARY 3,034 2.547 0 1, 486 79, 952 8.00 9.00 00900 NURSING ADMINISTRATION 2, 792 0 912 9.00 1.563 0 01000 CENTRAL SERVICES & SUPPLY 209 0 10.00 10.00 72 42 Ω 11.00 01100 PHARMACY 0 C 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 132 630 0 368 0 12.00 01300 SOCIAL SERVICE 0 13.00 13.00 605 550 321 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 0 0 14.00 15.00 01500 ACTI VI TI ES 562 706 412 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 84, 406 79. 952 30.00 18 116 34, 381 20 054 03100 NURSING FACILITY 31.00 0 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 41 0 0 0 0 40.00 41.00 04100 LABORATORY 239 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 128 C 0 ol 42 00 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 112 77 45 0 43.00 04400 PHYSI CAL THERAPY 1, 291 1, 653 964 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 1, 297 981 0 572 0 45.00 04600 SPEECH PATHOLOGY 46 00 0 46 00 576 C 0 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 25 309 0 180 48.00 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 664 295 0 172 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 C 0 0 51.00 05100 SUPPORT SURFACES 48 C 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 0 0 0 0 06100 RURAL HEALTH CLINIC 61.00 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 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 0 0 07200 CORF 0 72.00 0 0 72.00 0 73.00 07300 CMHC 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 84.00 33, 726 25, 5<u>28</u> 89.00 SUBTOTALS (sum of lines 1-84) 47, 407 84, 406 79, 952 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90 00 90.00 0 Λ 09100 BARBER AND BEAUTY SHOP 91.00 19 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 92.00 0 0 09300 NONPALD WORKERS 0 93.00 93.00 0 0 09400 PATIENTS LAUNDRY 0 0 0 94.00 C 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 99 00 Negative Cost Centers 99 00 0 0 0 100.00 **TOTAL** 33, 745 47, 407 84, 406 25, 528 79, 952 100. 00

| In Lieu of Form CMS-2540-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/17/2023 2:36 pm | COSCHIER | FORM | FOR

							5/17/2023 2: 3	6 pm
		Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	RECORDS &	SOCIAL SERVICE	
			9. 00	SUPPLY 10. 00	11.00	LI BRARY 12. 00	13. 00	
	GENER	AL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	1	EMPLOYEE BENEFITS						3. 00
4.00	00400	ADMINISTRATIVE & GENERAL						4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600	LAUNDRY & LINEN SERVICE						6. 00
7.00	4	HOUSEKEEPI NG						7. 00
8. 00	4	DI ETARY						8. 00
9.00		NURSI NG ADMINI STRATI ON	55, 345	2.5/0				9.00
10. 00 11. 00	4	CENTRAL SERVICES & SUPPLY PHARMACY	0	2, 560				10. 00 11. 00
12. 00	4	MEDICAL RECORDS & LIBRARY		0		19, 381		12.00
13. 00	1	SOCIAL SERVICE		0		0	18, 716	•
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	o	0	l c	0	0	ı
15.00	1	ACTIVITIES	0	0	C	0	0	1
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30.00		SKILLED NURSING FACILITY	55, 345	2, 560	C	16, 356	18, 716	30. 00
31. 00		NURSING FACILITY	0	0		_	0	31. 00
32.00	4	ICF/IID	0	0		_	0	32.00
33. 00		OTHER LONG TERM CARE	0	0	C	0	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	O	0	С	14	0	40. 00
41. 00		LABORATORY		0			0	•
42. 00	1	INTRAVENOUS THERAPY	o	0	l d	37	Ö	
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	C	2	0	43.00
44.00	04400	PHYSI CAL THERAPY	0	0	C	1, 084	0	44. 00
45.00		OCCUPATIONAL THERAPY	0	0	C	1, 125	0	45. 00
46. 00	4	SPEECH PATHOLOGY	0	0	C	452	0	46. 00
47. 00	1	ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00	4	DRUGS CHARGED TO PATIENTS	0	0		216	0	49.00
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0		3	0	50. 00 51. 00
52. 00	1	OTHER ANCILLARY SERVICE COST CENTERS		0		0	0	52.00
02.00		TIENT SERVICE COST CENTERS	<u> </u>				<u> </u>	02.00
60.00		CLINIC	0	0	C	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	o	0	C	0	0	61. 00
62. 00	06200							62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0	0	63. 00
70.00		REI MBURSABLE COST CENTERS					0	70.00
70. 00 71. 00	4	HOME HEALTH AGENCY COST AMBULANCE	0	0		0	0	
71.00	07100			0		0	0	72.00
73. 00	07300			0	Ö	0	Ö	73.00
74. 00		OTHER REIMBURSABLE COST	O	0	i c	0	0	74. 00
		AL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82. 00	1	UTILIZATION REVIEW	_	_	_	_	_	82. 00
83.00		HOSPI CE	0	0			0	1
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	55, 345	0 2, 560	1		10 714	1
69.00	NONRE	IMBURSABLE COST CENTERS	33, 343	2, 560		19, 301	18, 716	09.00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	n	0	C	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	o	0			0	1
92.00		PHYSICIANS PRIVATE OFFICES	0	0		O	0	•
93. 00		NONPALD WORKERS	0	0	C	0	0	93. 00
94. 00	1	PATIENTS LAUNDRY	0	0		_	0	•
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	1	_	0	95.00
98. 00		Cross Foot Adjustments	0	0			_	98. 00
99. 00 100. 00		Negative Cost Centers TOTAL	55, 345	2, 560	C	_	0 18 716	99. 00 100. 00
100.00	1	IOIAL	1 55, 545	2, 360	1	17, 301	10,710	1100.00

						0 12/31/2022	Date/lime Pre 5/17/2023 2:3	
				OTHER GENERAL				
				SERVI CE				
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
			EDUCATION			Aujustillerits		
			14. 00	15. 00	16. 00	17. 00	18. 00	
		AL SERVICE COST CENTERS	1		1			
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS						2. 00 3. 00
3. 00 4. 00	1	ADMINISTRATIVE & GENERAL						4.00
5. 00		PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00		LAUNDRY & LINEN SERVICE						6. 00
7.00		HOUSEKEEPI NG						7. 00
8.00	1	DI ETARY						8. 00
9.00	1	NURSING ADMINISTRATION						9.00
10. 00 11. 00		CENTRAL SERVICES & SUPPLY PHARMACY						10. 00 11. 00
12. 00		MEDICAL RECORDS & LIBRARY						12.00
13.00		SOCIAL SERVICE						13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTI VI TI ES	0	23, 204				15. 00
		I ENT ROUTI NE SERVI CE COST CENTERS	1		1 2/7 25	ا.	4 0/7 054	
30.00	1	SKILLED NURSING FACILITY	0	,			1, 367, 054	30.00
31. 00 32. 00		NURSING FACILITY ICF/IID	0	0			0	31. 00 32. 00
33. 00		OTHER LONG TERM CARE					0	33.00
		LARY SERVICE COST CENTERS	_					
40.00		RADI OLOGY	0	0			55	•
41.00		LABORATORY	0	0			331	•
42. 00	1	INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	0	0			165	•
43. 00 44. 00	1	PHYSICAL THERAPY	0	0			2, 446 52, 285	•
45. 00	1	OCCUPATIONAL THERAPY		٥		1	32, 042	1
46. 00		SPEECH PATHOLOGY	0	Ō		1	1, 028	ı
47.00	04700	ELECTROCARDI OLOGY	0	0	C	o	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9, 354		9, 354	1
49. 00		DRUGS CHARGED TO PATIENTS	0	0	9, 789		9, 789	ł
50. 00 51. 00		DENTAL CARE - TITLE XIX ONLY SUPPORT SURFACES	0	0	-		0 51	50. 00 51. 00
52. 00	1	OTHER ANCILLARY SERVICE COST CENTERS					0	ł
02.00		TIENT SERVICE COST CENTERS				,		02.00
60.00		CLI NI C	0	0			0	60. 00
61. 00		RURAL HEALTH CLINIC	0	0	C	0	0	61.00
62. 00 63. 00	06200	OTHER OUTPATIENT SERVICE COST CENTER	0	0		o	0	62. 00 63. 00
03.00		REIMBURSABLE COST CENTERS				<u>, </u>	0	03.00
70.00		HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71. 00		AMBULANCE	0	0	C		0	
	07200		0	0			0	1
	07300	OTHER REIMBURSABLE COST	0	0	1	′	0	
74.00		AL PURPOSE COST CENTERS				را ال	0	74.00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100	INTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW						82. 00
83.00		HOSPI CE	0	0		0	0	•
84. 00 89. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0 23, 204		0	1 474 600	
69.00	NONRE	SUBTOTALS (sum of lines 1-84) MBURSABLE COST CENTERS	0	23, 204	1, 474, 600)l Ol	1, 474, 600	09.00
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	0	0	19	0	19	1
92.00		PHYSICIANS PRIVATE OFFICES	0	0	(0	0	1
93.00		NONPALD WORKERS	0	0			0	
94. 00 95. 00	1	PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST CENTERS					0	
98. 00	0,300	Cross Foot Adjustments	0				0	1
99. 00		Negative Cost Centers	0	Ö		o o	0	
100.00)	TOTAL	0	23, 204	1, 474, 619	ol ol	1, 474, 619	100. 00

				1	Γο 12/31/2022	Date/Time Pre 5/17/2023 2:3	
		CAPI TAL REI	ATED COSTS			371772023 2.3	O piii
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FIXTURES	EQUI PMENT	BENEFI TS		& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2. 00	3. 00	4A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES	33, 363				I	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		33, 363				2. 00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	947 706	947 706			11, 953, 765	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 015		85, 577		632, 257	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 823	1	(0	359, 648	6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	535 1, 649	l			373, 809 1, 074, 624	7. 00 8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	1, 012	1, 012	602, 337		989, 075	9. 00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	47 0	47 0	17, 771		74, 158 0	1
12.00	01200 MEDICAL RECORDS & LIBRARY	408	408	24, 574	1 0	46, 765	12. 00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	356 0	356 0	169, 450	0	214, 197 0	13. 00 14. 00
15. 00	01500 ACTI VI TI ES	457	457	149, 202	0	199, 230	1
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	22, 262	22, 262	3, 377, 887	7 0	6, 416, 802	30.00
31. 00	03100 NURSING FACILITY	22, 202	1	3, 377, 887		0, 410, 802	31.00
32.00	03200 TUED LONG TERM CARE	0	ŀ	(0	0	32.00
33. 00	03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0		<u>) </u>	<u> </u>	33. 00
40.00	04000 RADI OLOGY	0	0	(,	1
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0		0	84, 813 45, 209	
43.00	04300 OXYGEN (INHALATION) THERAPY	50	l e		o o	39, 808	43. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	1, 070 635			0	457, 237 459, 610	1
46. 00	04600 SPEECH PATHOLOGY	0	0		o o	204, 198	1
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	200	0 200	(0	0 8, 840	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	191	191			235, 305	1
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(0	0	50.00
51. 00 52. 00	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0				17, 082 0	
	OUTPATIENT SERVICE COST CENTERS		-				
60. 00 61. 00	06000 CLI NI C 06100 RURAL HEALTH CLI NI C	0	0		0	0	60. 00 61. 00
62.00	06200 FQHC]					62. 00
63. 00	O6300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		0	0	63.00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70. 00
	07100 AMBULANCE	0	0	(0	0	
73. 00	07300 CMHC	0	0			0	73.00
74. 00	07400 OTHER REIMBURSABLE COST	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 83. 00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0		o	0	82. 00 83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	(0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	33, 363	33, 363	4, 712, 949	9 -1, 933, 810	11, 947, 075	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(0	0	90. 00
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	(0	6, 690 0	1
93. 00	09300 NONPALD WORKERS	0	ő		o o	ő	
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	94. 00 95. 00
98. 00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers	4 444 047	20 400	707 000		4 000 040	99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1, 444, 216	30, 403	797, 393	3	1, 933, 810	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	43. 287954	0. 911279			0. 161774	
104.00	Cost to be allocated (per Wkst. B, Part II)			41, 857	<u>'</u>	33, /45	104. 00
105.00	Unit cost multiplier (Wkst. B, Part			0. 008881	1	0. 002823	105. 00
)	1	I	I	I	I	I

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315202

Peri od: From 01/01/2022

12/31/2022

Worksheet B-1
Date/Time Prepared:

5/17/2023 2:36 pm Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, MAINT. & (TOTAL PATIENT REPAI RS (TOTAL PATIENT DAYS) (SQUARE FEET) DAYS) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 30.695 5.00 00600 LAUNDRY & LINEN SERVICE 41, 015 6.00 1,823 6.00 7.00 00700 HOUSEKEEPI NG 535 28, 337 7.00 8.00 00800 DI ETARY 1,649 1,649 124, 434 8.00 41, 015 00900 NURSING ADMINISTRATION 9 00 1 012 Ω 1 012 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 47 47 0 0 10.00 11.00 01100 PHARMACY 0 C 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 408 408 0 12.00 0 01300 SOCIAL SERVICE 0 13 00 Ω 356 13 00 356 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C C 0 0 14.00 01500 ACTI VI TI ES 15.00 457 457 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 22, 262 41,015 22, 262 124, 434 41,015 30.00 03100 NURSING FACILITY 31.00 31.00 0 32.00 03200 | CF/IID 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 Ω 0 33 00 33.00 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 C 0 0 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 50 50 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 44.00 1.070 1,070 44.00 04500 OCCUPATIONAL THERAPY 45.00 635 635 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 0 0 46.00 04700 ELECTROCARDI OLOGY 0 0 0 47.00 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 200 200 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 191 0 191 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 C C Λ 50.00 05100 SUPPORT SURFACES 0 0 0 51.00 51.00 0 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 n O Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 0 0 Λ 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST C 70.00 07100 AMBULANCE 71.00 71.00 0 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 72.00 73.00 07300 CMHC 0 0 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 83.00 08300 H0SPLCE Λ 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 30, 695 41,015 28, 337 124, 434 41, 015 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.00 91.00 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 92.00 0 0 93 00 09300 NONPALD WORKERS 0 93 00 Ω 0 09400 PATIENTS LAUNDRY 94.00 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 95.00 95.00 C 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 734, 540 461, 455 447, 085 1, 313, 948 1, 189, 266 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 23. 930282 11. 250884 15.777429 10. 559397 28. 995880 103. 00 104.00 Cost to be allocated (per Wkst. B, 47, 407 84, 406 25, 528 79, 952 55, 345 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 1.544453 2.057930 0.900872 0.642525 1. 349384 105. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS LOPATCONG CENTER Provi der No.: 315202

				T	o 12/31/2022	Date/Time Pre 5/17/2023 2:3	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	, p
		SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TOTAL PATIENT	ALLI ED HEALTH EDUCATI ON	
		(COSTED	,	(GROSS	DAYS)	(ASSI GNED	
		REQUI S.) 10. 00	11. 00	CHARGES) 12.00	13. 00	TIME) 14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	11.00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2. 00 3. 00
4.00	00400 ADMINISTRATIVE & GENERAL] [4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	00700 HOUSEKEEPING						7.00
8. 00	00800 DI ETARY						8. 00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	61, 649					9. 00 10. 00
11. 00	01100 PHARMACY	01,049	0				11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	23, 372, 856			12. 00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	41, 015 0		13. 00 14. 00
15. 00	01500 ACTIVITIES	0	0				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	61, 649	0				30. 00 31. 00
32. 00	03200 CF/IID	0	Ö				32.00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	16, 865	0	0	40. 00
41. 00	04100 LABORATORY	0	0	110, 853		-	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	44, 553	0	_	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0	2, 701 1, 307, 471	0	0 0	43. 00 44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	1, 356, 721	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	544, 745 0		0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	260, 779		0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0 3, 097		0	50. 00 51. 00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	l			52. 00
(0.00	OUTPATIENT SERVICE COST CENTERS			1			,,,,,,,
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0			60. 00 61. 00
62. 00	06200 FQHC	1			_		62. 00
63. 00	O6300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	63. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	_			
72. 00 73. 00	07200 CORF 07300 CMHC	0	0	0	0	0	
	07400 OTHER REI MBURSABLE COST	0	0	ő	0		
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW	_[_	_	_	_	82. 00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0	0	0	0 0	1
89. 00	SUBTOTALS (sum of lines 1-84)	61, 649	0	23, 372, 856	41, 015		1
00.00	NONREI MBURSABLE COST CENTERS		0	J			00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	1		-	90. 00 91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0	0	0	0	93. 00 94. 00
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	ő	0	0	95. 00
98. 00	Cross Foot Adjustments						98. 00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	88, 022	0	70, 531	262, 985	_	99. 00 102. 00
102.00	Part I)	00,022	O	70, 331	202, 903		
103.00		1. 427793	0. 000000	i			1
104.00	Cost to be allocated (per Wkst. B, Part II)	2, 560	0	19, 381	18, 716		104. 00
105.00	Unit cost multiplier (Wkst. B, Part	0. 041525	0. 000000	0. 000829	0. 456321	0. 000000	105. 00
	1)	1		I	l	ı	I

LOPATCONG CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/17/2023 2:36 pm Provi der No.: 315202

		5/17/2023 2: 3	6 pm
	OTHER GENERAL		
	SERVI CE		
Cost Center Description	ACTI VI TI ES		
	(TOTAL PATIENT		
	DAYS)		
	15. 00		
GENERAL SERVICE COST CENTERS	<u> </u>		
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES			1. 00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00 00300 EMPLOYEE BENEFITS			3.00
4.00 00400 ADMINISTRATIVE & GENERAL			4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS	İ		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	ł		9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	ł		10.00
11. 00 01100 PHARMACY			11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	ł		12.00
13. 00 O1300 SOCIAL SERVICE			13.00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	44 045		14. 00
15. 00 01500 ACTIVITIES	41, 015		15. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 SKILLED NURSING FACILITY	41, 015		30.00
31. 00 03100 NURSING FACILITY	0		31. 00
32. 00 03200 I CF/I I D	0		32. 00
33. 00 03300 OTHER LONG TERM CARE	0		33. 00
ANCILLARY SERVICE COST CENTERS			4 .
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 O4300 OXYGEN (INHALATION) THERAPY	0		43. 00
44. 00 O4400 PHYSI CAL THERAPY	0		44. 00
45. 00 O4500 OCCUPATI ONAL THERAPY	0		45. 00
46. 00 04600 SPEECH PATHOLOGY	0		46. 00
47. 00 04700 ELECTROCARDI OLOGY	0		47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0		49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51.00 05100 SUPPORT SURFACES	0		51. 00
52. 00 05200 OTHER ANCI LLARY SERVI CE COST CENTERS	0		52. 00
OUTPATIENT SERVICE COST CENTERS			
60. 00 06000 CLI NI C	0		60.00
61. 00 06100 RURAL HEALTH CLINIC	0		61.00
62. 00 06200 FQHC			62. 00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
OTHER REIMBURSABLE COST CENTERS			
70. 00 07000 HOME HEALTH AGENCY COST	0		70.00
71. 00 07100 AMBULANCE	0		71.00
72. 00 07200 CORF	0		72. 00
73. 00 07300 CMHC	0		73. 00
74. 00 07400 OTHER REIMBURSABLE COST	0		74. 00
SPECIAL PURPOSE COST CENTERS			
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		83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS	0		84. 00
89. 00 SUBTOTALS (sum of lines 1-84)	41, 015		89. 00
NONREI MBURSABLE COST CENTERS			
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00 09100 BARBER AND BEAUTY SHOP	0		91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0		92.00
93. 00 09300 NONPAI D WORKERS	0		93. 00
94. 00 09400 PATIENTS LAUNDRY	0		94. 00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS	U		95. 00
98.00 Cross Foot Adjustments			98. 00
99.00 Negative Cost Centers	0.40 (0.4		99. 00
102.00 Cost to be allocated (per Wkst. B,	249, 606		102. 00
Part I)	/ 005705		102.00
103.00 Unit cost multiplier (Wkst. B, Part I)	6. 085725		103.00
104.00 Cost to be allocated (per Wkst. B,	23, 204		104. 00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part	0. 565744		105. 00
	0. 505744		103.00
	I		1

Health Financial Systems	LOPATCONG CENTER	In Lieu of Form CMS-2540-10	
DATIO OF COST TO CHARGES FOR ANCILLAR	V AND OUTDATLENT COST CENTERS Provider No : 315202	Pori od: Workshoot C	

Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/17/2023 2:36 pm 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 16, 790 16, 865 0. 995553 40.00 04100 LABORATORY 98, 869 110, 853 0.891893 41.00 41.00 42.00 04200 I NTRAVENOUS THERAPY 52, 657 44, 553 1. 181896 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 48, 242 2, 701 17.860792 43.00 44. 00 04400 PHYSI CAL THERAPY 577, 639 1, 307, 471 0.441799 44.00 04500 OCCUPATIONAL THERAPY 45.00 563, 273 1, 356, 721 0. 415172 45.00 04600 SPEECH PATHOLOGY 0. 438510 46.00 238, 876 544, 745 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 211 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 49.00 260, 779 1.080386 281, 742 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 50.00 O 50.00 51.00 05100 SUPPORT SURFACES 19,854 3,097 6.410720 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 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

3, 647, 785

1, 916, 153

0.000000

71.00

100.00

71. 00 | 07100 | AMBULANCE

Total

100.00

		Drovi don	No . 21E202	Peri od:	Worksheet D	
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider		From 01/01/2022		
				To 12/31/2022		pared:
					5/17/2023 2:3	6 pm
		Title	XVIII (1)	Skilled Nursing	PPS	
				Facility		1
		Heal th Care Pr	rogram Charges	s Health Care	Program Cost	
	D 6.0 .	D 1 A	D 1 D	D A (4	D D (4	
	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges (Fr. Wkst. C			x col. 2)	x col. 3)	
	Column 3)					
	1.00	2. 00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPATI		2.00	3.00	4.00	3.00	
ANCILLARY SERVICE COST CENTERS	ENT COST					
40. 00 04000 RADI OLOGY	0. 995553	4, 420		0 4, 400	0	40.00
41. 00 04100 LABORATORY	0. 891893	6, 765		0 6,034	Ö	
42. 00 04200 I NTRAVENOUS THERAPY	1. 181896	6, 556		0 7, 749	0	
43.00 04300 0XYGEN (INHALATION) THERAPY	17. 860792	185		0 3, 304	0	
44. 00 04400 PHYSI CAL THERAPY	0. 441799	576, 883		0 254, 866	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 415172	584, 933		0 242, 848	0	45. 00
46. 00 04600 SPEECH PATHOLOGY	0. 438510	251, 917		0 110, 468	0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 080386	129, 791		0 140, 224	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51. 00 05100 SUPPORT SURFACES	6. 410720	313		0 2,007	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	52. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0. 000000	0		0 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. 000000	0		0 0	0	
71.00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)		1, 561, 763		0 771, 900	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.

Heal th	Financial Systems	LOPATCONG	CENTER		In Lie	eu of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS			No.: 315202	Period: From 01/01/2022 To 12/31/2022		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	_					
	DART II. ADDORTIONMENT OF MACOUNE COST					1.00	
1. 00	PART II - APPORTIONMENT OF VACCINE COST		(F W	t C1 2	1: 40)	1 00000/	1 00
2.00	Drugs charged to patients - ratio of co			t C, corumn 3	, IIne 49)	1. 080386 3. 710	
3.00	Program vaccine charges (From your reco Program costs (Line 1 x line 2) (Title			or +hio omoun	+ +a Waskahaa+	4, 008	
3.00	E, Part I, line 18)	AVIII, PPS pro	viders, transi	er this amoun	t to worksneet	4, 008 	3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
	cost center bescription	(From Wkst. B.			Cost (From	& Allied	
			(From Wkst. B,			Health Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part	A	Through (Col.	
				(Col . 2 / Col		3 x Col. 4)	
				1)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS					_	
	04000 RADI OLOGY	16, 790		0.0000			
	04100 LABORATORY	98, 869	l e	0.00000		0	41.00
	04200 I NTRAVENOUS THERAPY	52, 657		0.00000		l	
	04300 OXYGEN (INHALATION) THERAPY	48, 242		0.00000		0	
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	577, 639	l	0.0000			
	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	563, 273		0.0000			
	04700 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	238, 876		0.0000		0	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 211		0.0000		0	
	04900 DRUGS CHARGED TO PATIENTS	281, 742	l	0.0000		0	
	05000 DENTAL CARE - TITLE XIX ONLY	201, 742		0.0000		0	
	05100 SUPPORT SURFACES	19, 854		0.0000		0	
	05200 OTHER ANCILLARY SERVICE COST CENTERS	17,034		•		0	
100.00		1, 916, 153	۱ -	•	771, 900	-	100.00
.00.00	1.553. (5411 51 111155 15 52)	1, 710, 100	1	1	,,,,,	, 0	1.55.50

Heal th	Financial Systems LOPATCONG	CENTER	In Lie	u of Form CMS-	2540-1	
COMPU ⁻	TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315202	Peri od: From 01/01/2022 To 12/31/2022		pared:	
		Title XVIII	Skilled Nursing Facility			
				1. 00		
	PART I CALCULATION OF INPATIENT ROUTINE COSTS					
	I NPATI ENT DAYS					
1.00	Inpatient days including private room days			41, 015		
2. 00	Private room days			439		
3.00	Inpatient days including private room days applicable to the			6, 416		
4. 00	Medically necessary private room days applicable to the Prog	ram		0	1	
5. 00	Total general inpatient routine service cost			11, 963, 650	5.0	
, 00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			10 020 502		
5. 00 7. 00	General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5	divided by Line (1)		19, 939, 583 0. 599995		
7. 00 3. 00	Enter private room charges from your records	divided by Title 6)		226, 659		
9. 00	Average private room per diem charge (Private room charges I	ine 8 divided by private	room days line	516, 31	1	
. 00	2)	The o divided by private	Toom days, Title	310.31	7.0	
10.00	Enter semi-private room charges from your records			19, 712, 923	10.0	
1. 00	Average semi-private room per diem charge (Semi-private roo	m charges line 10, divide	ed by	485. 83	11. 0	
12. 00	semi-private room days) Average per diem private room charge differential (Line 9 mi	nus line 11)		30. 48	12. 0	
3. 00	Average per diem private room cost differential (Line 7 time	,		18. 29		
14. 00	Private room cost differential adjustment (Line 2 times line	•		8, 029		
5. 00	General inpatient routine service cost net of private room c		minus line 14)	11, 955, 621		
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	· ·	,		1	
16.00	Adjusted general inpatient service cost per diem (Line 15 d	ivided by line 1)		291. 49	16. 0	
7. 00	Program routine service cost (Line 3 times line 16)			1, 870, 200		
8.00	Medically necessary private room cost applicable to program			0	18. 0	
9. 00	Total program general inpatient routine service cost (Line			1, 870, 200		
20. 00	Capital related cost allocated to inpatient routine service line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	costs (From Wkst. B, Par	t II column 18,	1, 367, 054	20.0	
1. 00	Per diem capital related costs (Line 20 divided by line 1)			33. 33	21.0	
2. 00	Program capital related cost (Line 3 times line 21)			213, 845	22. 0	
3. 00						
4. 00						
5. 00						
6. 00	Enter the per diem limitation (1)		0() (1)		26.0	
27. 00	Inpatient routine service cost limitation (Line 3 times the	•	, , ,		27.0	
28. 00	Reimbursable inpatient routine service costs (Line 22 plus (Transfer to Worksheet E, Part II, line 4) (See instructions		iine 2/)		28.0	
´1) i	nes 26 and 27 are not applicable for title XVIII, but may be	<i>'</i>	title XIX	ı	I	
,		assa for title valid of t				
				1. 00		
				1.00		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	41, 015	1. 00
2.00	Program inpatient days (see instructions)	6, 416	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. 156431	4.00
5. 00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

Н	ealth Financial Systems		LOPATCONG CENT	TER	In Lie	u of Form CMS-2540-10
(ALCULATION OF REIMBURSEMENT SETTLEMEN	FOR TITLE XVIII		Provi der No.: 315202	From 01/01/2022	Worksheet E Part I Date/Time Prepared: 5/17/2023 2:36 pm
				Title XVIII	Skilled Nursina	PPS

		Title XVIII	Skilled Nursing Facility	PPS	
			raciiity		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)			4, 184, 488	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,		4, 184, 488	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			587, 421	5. 00
6.00	Allowable bad debts (From your records)			193, 091	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		165, 830	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			125, 509	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, 722, 576	11. 00
12.00	Interim payments (See instructions)			3, 617, 753	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			357	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			1, 582	14. 75
14. 99	Sequestration amount (see instructions)			48, 072	14. 99
15.00	Balance due provider/program (see Instructions)			54, 812	15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
	Ancillary services Part B			0	
	Vaccine cost (From Wkst D, Part II, line 3)			4, 008	
	Total reasonable costs (Sum of lines 17 and 18)			4, 008	
	Medicare Part B ancillary charges (See instructions)			3, 710	
	Cost of covered services (Lesser of line 19 or line 20)			3, 710	
				0	22. 00
	Coinsurance and deductibles			0	23. 00
	Allowable bad debts (From your records)			0	24. 00
	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			3, 710	
	Interim payments (See instructions)			2, 622	
	Tentati ve adj ustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
	Demonstration payment adjustment amount after sequestration			0	28. 55
	Sequestration amount (see instructions)			46	28. 99
	Balance due provider/program (see instructions)	040 0	11 11 0	1, 042	
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	Section 115.2	0	30. 00

Health Financial Systems	LOPATCONG CENT	TER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315202	From 01/01/2022	Worksheet E Part II Date/Time Prepared: 5/17/2023 2:36 pm
		Title XIX	Skilled Nursing	PPS

1.00			litle XIX	Facility	PPS	
COMPUTATION OF NET COST OF COVERED SERVICES				Facility		
COMPUTATION OF NET COST OF COVERED SERVICES					1 00	
Inpatient ancillary services (see Instructions)		COMPUTATION OF NET COST OF COVERED SERVICES			1.00	
2.00	1.00				0	1.00
3.00	2.00		5)		0	2.00
Utilization reviewphysicians' compensation (from provider records)	3.00				0	3. 00
1.00 1.00	4.00	Inpatient routine services (see instructions)			0	4.00
7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 7.00	5.00		ords)		0	5. 00
SUBTOTAL (Line 6 minus line 7) 0 8.00	6.00	Cost of covered services (Sum of lines 1 - 5)	ŕ		0	6. 00
SUBTOTAL (Line 6 minus line 7) 0 8.00	7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
10.00 Total Reasonable Cost (Line 8 minus line 9) 10.00 REASONABLE CHARGES	8.00		·		0	8. 00
REASONABLE CHARGES Inpatient ancillary service charges 11.00 12.00 13.00 Inpatient routine service charges 13.00 Inpatient routine service charges 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Total reasonable charges CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis on the advance of the services on a charge basis on the such payment been made in accordance with 42 CFR 413. 13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) Deductibles Subtotal (Line 20 minus line 21) Subtotal (Line 20 minus line 23) Allowable bad debts (from your records) Allowable bad debts (from your records) Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost I limit Recovery of excess depreciation resulting from provider termination or a decrease in program Utilization 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 0.0000000 18.00 0.0000000 18.00 0.0000000 18.00 0.0000000 18.00 0.0000000 18.00	9.00	Primary payor amounts			0	9. 00
11. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1. 1. 00 1.	10.00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
12. 00 Outpatient service charges 0 13. 00 Inpatient routine service charges 0 13. 00 Inpatient routine service charges 0 13. 00 Inpatient routine service charges 0 13. 00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14. 00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14. 00 Inferential in charges between semiprivate accommodations and less than semiprivate accommodations 0 15. 00 Interest of Interest		REASONABLE CHARGES				
13. 00 Inpatient routine service charges 14. 00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15. 00 Total reasonable charges CUSTOMARY CHARGES 16. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis On 17. 00 Description of the payment for services on a charge basis On 17. 00 Description of Computation of the 20 capament for services on a charge basis On 17. 00 Description of Computation of the 20 capament for services on a charge basis On 20. 00 Description of Computation On 20.000000 Description of Computation On 20.00000000 Description of Computation On 20.000000 Description On 20.0000000 Description On 20.000000 Description On 20.000000 Description On 20.000000 Description On 20.0000000 Description On 20.00000000 Description Description On 20.0000000000000000000000000000 Description On 20.00000000000000000000000000000000000	11.00	Inpatient ancillary service charges			0	11. 00
14. 00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 14. 00 15. 00 CUSTOMARY CHARGES 16. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16. 00 17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17. 00 had such payment been made in accordance with 42 CFR 413. 13(e) 18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 19. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 19. 00 Color of covered services (see Instructions) 0 21. 00 Deductibles 0 22. 00 Subtotal (Line 20 minus line 21) 0 22. 00 Coinsurance 0 23. 00 Coinsurance 0 24. 00 Subtotal (Line 22 minus line 23) 0 24. 00 Subtotal (Line 22 minus line 24) 0 25. 00 Subtotal (sum of lines 24 and 25) 0 27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 1 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program 0 29. 00 Other Adjustments (see instructions) Specify	12.00	Outpati ent servi ce charges			0	12.00
15. 00 Total reasonable charges CUSTOMARY CHARGES 16. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis on the payment that would have been realized from patients liable for payment for services on a charge basis on the payment been made in accordance with 42 CFR 413.13(e) 18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19. 00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20. 00 Deductibles 20. 00 Deductibles 20. 00 Subtotal (Line 20 minus line 21) 20. 00 Subtotal (Line 22 minus line 23) 20. 00 Allowable bad debts (from your records) 20. 00 Subtotal (sum of lines 24 and 25) 10. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29. 00 Other Adjustments (see instructions) Specify	13.00	Inpatient routine service charges			0	13. 00
CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 17.00 had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.000000 18.00 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 0 20.00 Deductibles 0 0 21.00 22.00 Subtotal (Line 20 minus line 21) 0 22.00 23.00 Coinsurance 0 23.00 Subtotal (Line 22 minus line 23) 0 24.00 Subtotal (Line 22 minus line 23) 0 25.00 Allowable bad debts (from your records) 0 25.00 Subtotal (sum of lines 24 and 25) 0 26.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of 0 27.00 cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program 0 28.00 29.00 Other Adjustments (see instructions) Specify 0 29.00	14.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14. 00
16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 20.00 Deductibles 20.00 Subtotal (Line 20 minus line 21) 21.00 Coinsurance 22.00 Subtotal (Line 22 minus line 23) 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29.00 Other Adjustments (see instructions) Specify	15. 00				0	15. 00
17. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18. 00 Ratio of line 16 to line 17 (not to exceed 1.000000) Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20. 00 Cost of covered services (see Instructions) Deductibles Subtotal (Line 20 minus line 21) Coinsurance 4. 00 Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28. 00 Other Adjustments (see instructions) Specify 17. 00 18. 00 0. 000000 18. 00 0. 000000 19. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00						
had such payment been made in accordance with 42 CFR 413.13(e)						
18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Deductibles Subtotal (Line 20 minus line 21) 23.00 Coi nsurance Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) 77.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit Ratio of line 16 to line 17 (not to exceed 1.000000) 18.00 19.00 20.00 20.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00 29.00	17. 00		payment for services o	n a charge basis	0	17. 00
19.00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) Deductibles Subtotal (Line 20 minus line 21) Coinsurance 23.00 Coinsurance 24.00 Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Cost of covered services (see Instructions) Deductibles Coinsurance Cost of covered services (see Instructions) Coinsurance Cost of covered services (see Instructions) Coinsurance Cost line 22 minus line 21) Coinsurance Cost of covered services (see Instructions) Coinsurance Cost line 22 minus line 23) Coinsurance Cost Coinsurance Coinsuran	40.00					40.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coi nsurance 24.00 Subtotal (Line 22 minus line 23) 25.00 Allowable bad debts (from your records) 26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program 29.00 Other Adjustments (see instructions) Specify 0 20.00 21.00 22.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 Other Adjustments (see instructions) Specify						•
20.00 Cost of covered services (see Instructions) 10 20.00 Deductibles 20 00 Subtotal (Line 20 minus line 21) 20 00 Coinsurance 24 00 Subtotal (Line 22 minus line 23) 25 00 Allowable bad debts (from your records) 26 00 Subtotal (sum of lines 24 and 25) 27 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29 00 Other Adjustments (see instructions) Specify	19.00				0	19.00
21. 00 Deductibles Subtotal (Line 20 minus line 21) Coinsurance Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29. 00 Other Adjustments (see instructions) Specify	20.00					20.00
22.00 Subtotal (Line 20 minus line 21) Coinsurance Subtotal (Line 22 minus line 23) 24.00 Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) Subtotal (sum of lines 24 and 25) Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program Utilization 29.00 Other Adjustments (see instructions) Specify 0 22.00 23.00 24.00 25.00 26.00 27.00 28.00 28.00 29.00		,			-	
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 erroneously collected based on correction of cost limit 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program 0 28. 00 29. 00 Other Adjustments (see instructions) Specify 0 29. 00					-	
24. 00 Subtotal (Line 22 minus line 23) 25. 00 Allowable bad debts (from your records) 26. 00 Subtotal (sum of lines 24 and 25) 27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29. 00 Other Adjustments (see instructions) Specify 0 24. 00 25. 00 26. 00 27. 00 27. 00 28. 00 29. 00		· · · · · · · · · · · · · · · · · · ·				
25. 00 Allowable bad debts (from your records) 26. 00 Subtotal (sum of lines 24 and 25) 27. 00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28. 00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29. 00 Other Adjustments (see instructions) Specify 0 25. 00 26. 00 27. 00 27. 00 27. 00 27. 00 27. 00 28. 00						
26.00 Subtotal (sum of lines 24 and 25) 27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify					-	
27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 0 27.00 27.00 28.00 29.00						•
cost limit Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00		· · · · · · · · · · · · · · · · · · ·	y call acted based on c	orroction of	-	
28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00	27.00		y corrected based on c	or rectron or	Ü	27.00
utilization 29.00 Other Adjustments (see instructions) Specify 0 29.00	28 00		tion or a decrease in	program	0	28 00
29.00 Other Adjustments (see instructions) Specify	20.00			program	Ü	20.00
	29. 00				0	29. 00
30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (0 30.00	30. 00		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	31.00		27 and 28)		0	31.00
32.00 Interim payments 0 32.00	32.00	Interim payments	-		0	32. 00
33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see 0 33.00	33.00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0	33. 00
Instructions)		Instructions)				

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315202 | Period: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/17/2023 2:36 pm |

Title XVIII | Skilled Nursing | PPS

		ΠΤΙ	e XVIII S	Killed Nursing	PPS	
		Innation	t Part A	Facility	t B	
		<u>'</u>		-		
		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, 704, 215		2, 622	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)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER		0		0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		0			3. 01 3. 02
3. 02			0			3. 02
			0			3. 03
3.04			0			
3. 05	Provider to Program		0		0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM	06/27/2022	86, 462		0	3. 50
3. 51	ADJUSTIVILINTS TO FROGRAM	00/21/2022	00, 402			3. 50
3. 52			0		0	3. 52
3. 53			0			3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-86, 462		0	3. 99
3. 77	- 3.98)		00, 402		Ĭ	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 617, 753		2, 622	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line		, , , , , , , ,		_,	
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	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
F F0	Provi der to Program					F F0
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	C.:ht-t-1 (C.:m -6 1:m 5 01		0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		U		0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	PROGRAM TO PROVIDER		54, 812		1. 042	6. 01
6. 02	PROVI DER TO PROGRAM		34, 012		1, 042	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 672, 565		3, 664	7. 00
7.00	install mode sails program reductivity (see this tractions)			tor Name	Contractor	7.00
			00		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 progr	am show the a	mount and date	on which the	nrovi der	

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

Health Financial Systems

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

Provi der No.: 315202 | Peri od: From 01/01/2022 To 12/31/2022

Worksheet G
Date/Time Prepared: 5/17/2023 2:36 pm

J. 1. 37		General Fund	Speci fi c	Endowment Fund	5/17/2023 2:3 Plant Fund	6 pm
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	Assets	1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand and in banks	26, 617	0		0	1.0
	Temporary investments	20, 017	0	_	0	
	Notes receivable	ő	0	o	0	
	Accounts receivable	1, 788, 784	0	0	0	4.0
	Other recei vabl es	49, 552	0	0	0	
	Less: allowances for uncollectible notes and accounts	-288, 970	0	0	0	6. 0
1	recei vabl e	27 (02	0		0	7.0
	Inventory Prepaid expenses	37, 692 795, 971	0	0	0	
	Other current assets	793, 971	0	0	0	
	Due from other funds	ő	0	o	0	
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 409, 646	0	0	0	11.0
	FIXED ASSETS					
	Land	0	0	_	0	
1	Land improvements	121, 550	0		0	
	Less: Accumulated depreciation Buildings	-36, 713 5, 645, 501	0	0	0	
	Less Accumulated depreciation	-2, 154, 636	0	0	0	
	Leasehold improvements	689, 010	0	Ö	0	
	Less: Accumulated Amortization	-406, 909	0	0	0	
19. 00	Fixed equipment	150, 860	0	0	0	19. 0
	Less: Accumulated depreciation	-104, 400	0	0	0	
1	Automobiles and trucks	0	0	0	0	
	Less: Accumulated depreciation	0	0	0	0	
1	Major movable equipment	764, 895	0	0	0	
1	Less: Accumulated depreciation Minor equipment - Depreciable	-670, 653	0	0	0	
1	Mi nor equi pment nondepreci abl e	0	0	0	0	
	Other fixed assets	ő	0	Ö	0	
	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	3, 998, 505	0		0	
	OTHER ASSETS					
1	Investments	0	0	_	0	
1	Deposits on Leases	0	0	0	0	
1	Due from owners/officers	3, 920, 433	0	0	0	
	Other assets TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	3, 920, 433	0	0	0	
1	TOTAL ASSETS (Sum of Fines 11, 28, and 33)	10, 328, 584	0	_	0	
	Liabilities and Fund Balances		-	-1		1
(CURRENT LIABILITIES]
	Accounts payable	907, 615	0	0	0	
	Salaries, wages, and fees payable	0	0	0	0	
	Payroll taxes payable	0	0	0	0	
	Notes & Loans payable (Short term)	0	0	0	0	
	Deferred income Accelerated payments	0	U	U	U	40.0
	Due to other funds	3, 050	0	0	0	
	Other current liabilities	1, 716, 887	0	0	0	
	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 627, 552	0	0	0	
-	LONG TERM LIABILITIES					1
	Mortgage payable	4, 367, 151	0		0	
	Notes payable	0	0	_	0	
1	Unsecured Loans	0	0	0	0	
	Loans from owners: Other long term liabilities	0	0	0	0	
	APIC DISTRIBUTIONS; R/E EARNINGS	3, 478, 662	0	Ö	0	
1	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	7, 845, 813	0	Ö	0	
1	TOTAL LIABILITIES (Sum of lines 43 and 50)	10, 473, 365	0	О	0	51.0
	CAPITAL ACCOUNTS					
1	General fund balance	-144, 781				52. 0
	Specific purpose fund		0			53.0
1	Donor created - endowment fund balance - restricted			0		54.0
1	Donor created - endowment fund balance - unrestricted			0		55.0
1	Governing body created - endowment fund balance Plant fund balance - invested in plant			١	0	56. 0 57. 0
1	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				O	55.0
	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-144, 781	0	o	0	59. 0
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	10, 328, 584	0	O	0	60.0
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES LOPATCONG CENTER In Lieu of Form CMS-2540-10

Provi der No.: 315202

				T	o 12/31/2022	Pate/Time Prep 5/17/2023 2:30	
		General	Fund	Special Pu	rpose Fund	Endowment Fund	<i>у</i> Ми
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		0		C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-144, 781				2.00
3.00	Total (sum of line 1 and line 2)		-144, 781		C		3.00
4.00	Additions (credit adjustments)						4. 00
5.00		0		0		0	5. 00
6. 00 7. 00		0		0		0	6. 00 7. 00
8.00		0					8. 00
9. 00		0				0	9. 00
10. 00	Total additions (sum of line 5 - 9)		0		C		10. 00
11. 00	Subtotal (line 3 plus line 10)		-144, 781		C		11.00
12.00	Deductions (debit adjustments)						12.00
13. 00		0		0		0	13.00
14. 00		0		0		0	14. 00
15. 00		0		0		0	15.00
16. 00 17. 00		0		0		0	16. 00 17. 00
17.00	Total deductions (sum of lines 13 - 17)	0	0			1	17.00
19. 00	Fund balance at end of period per balance		-144, 781				19. 00
17.00	sheet (Line 11 - line 18)		111,701			1	17.00
	·	Endowment Fund	PI ant	Fund			
			7.00		-		
1 00	F d. h. l	6.00	7. 00	8.00			1. 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31)	0					2. 00
3.00	Total (sum of line 1 and line 2)	0					3. 00
4. 00	Additions (credit adjustments)			1			4. 00
5.00	, , , , , , , , , , , , , , , , , , , ,		0				5.00
6.00			0				6.00
7.00			0				7. 00
8.00			0				8. 00
9.00	T		0				9.00
10.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10)	0		0			10. 00 11. 00
11. 00 12. 00	Deductions (debit adjustments)	0					12.00
13. 00	beddetrons (debrt adjustments)		0				13. 00
14. 00			0				14. 00
15. 00			0				15.00
16.00			0)			16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 13 - 17)	0		0			18. 00
19. 00	Fund balance at end of period per balance	0		0			19. 00
	sheet (Line 11 - line 18)	1		I	I		

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315202 Period: Worksheet G-2	
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315202 Period: From 01/01/2022 Parts I-II To 12/31/2022 Date/Time Prepai	
Cost Center Description Inpatient Outpatient Total	
1.00 2.00 3.00	
PART I - PATIENT REVENUES	
General Inpatient Routine Care Services	1 00
	1.00
	2.00
	3. 00 4. 00
	5. 00
All Other Care Services (Suill of Titles 1 - 4)	5. 00
	6. 00
	7. 00
	8. 00
	9. 00
	0.00
10. 10 FQHC 0 0 1	0. 10
	1. 00
11. 10 CORF 0 0 1	1. 10
12. 00 HOSPICE 0 0 0 0 1	2.00
13. 00 OTHER (SPECIFY) 0 0 0 0 1	3.00
14.00 Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to 23,386,605 0 23,386,605 1	4.00
Worksheet G-3, Line 1)	
Cost Center Description	
1.00 2.00	
PART II - OPERATING EXPENSES	
	1.00
	2.00
	3.00
	4. 00 5. 00
	6. 00
	7. 00
	8. 00
	9. 00
	0.00
	1. 00
	2. 00
	3. 00
	4. 00
15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)	5. 00

lealth Financial Systems	LOPATCONG CENTER	In Li€	eu of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 31520	From 01/01/2022	Worksheet G-3 Date/Time Pre	
		10 12/31/2022	5/17/2023 2: 3	
			1. 00	
1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)				1. 00

	From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/17/2023 2:36 pm	
		1.00	
1.00	.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)		1. 00
2.00	00 Less: contractual allowances and discounts on patients accounts		2. 00
3.00	00 Net patient revenues (Line 1 minus line 2)		3. 00
4.00	00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)		4. 00
5.00	Net income from service to patients (Line 3 minus 4)	-171, 461	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	0	6. 00
7.00	00 Income from investments		7. 00
8.00	00 Revenues from communications (Telephone and Internet service)		8. 00
9.00	00 Revenue from television and radio service		9. 00
10.00	0. 00 Purchase di scounts		10. 00
11. 00	1.00 Rebates and refunds of expenses		11. 00
12.00	2.00 Parking Lot receipts		12. 00
13.00	3.00 Revenue from Laundry and Linen service		13. 00
14.00	4.00 Revenue from meals sold to employees and guests		14. 00
15. 00	5.00 Revenue from rental of living quarters		15. 00
16.00	6.00 Revenue from sale of medical and surgical supplies to other than patients		16. 00
17. 00			17. 00
18.00			18. 00
19.00	.00 Tuition (fees, sale of textbooks, uniforms, etc.)		19. 00
20.00	0.00 Revenue from gifts, flower, coffee shops, canteen		20. 00
21. 00	1.00 Rental of vending machines		21. 00
22. 00	2.00 Rental of skilled nursing space		22. 00
23.00	.00 Governmental appropriations		23. 00
24.00	OO MISC INCOME		24. 00
24. 50	. 50 COVI D-19 PHE Fundi ng		24. 50
25.00	00 Total other income (Sum of lines 6 - 24)		25. 00
26.00	00 Total (Line 5 plus line 25)		26. 00
27.00	00 Other expenses (specify)		27. 00
28.00	.00		28. 00
29. 00		0	29. 00
30.00	.00 Total other expenses (Sum of Lines 27 - 29)		30. 00
31.00			31. 00