

PHILIP D. MURPHY Governor SHEILA Y. OLIVER Lt. Governor TRENTON, N.J. 08625-0360 www.nj.gov/health

JUDITH M. PERSICHILLI, RN, BSN, MA Commissioner

June 3, 2022

### SENT VIA E-MAIL

TO: Facility Administrators

**New Jersey Nursing Homes** 

FROM: Erica Holmes, Executive Director

Office of Health Care Financing New Jersey Department of Health

Casi Golaszewski, Executive Director Office of Long Term Care Resiliency New Jersey Department of Health

SUBJECT: Nursing Home Financial Reporting – Public Law (P.L.) 2021, chapter 457

The purpose of this memorandum is to inform all nursing homes, as defined in N.J.S.A. 26:2H-29, licensed to operate in New Jersey regarding additional financial reporting requirements, pursuant to P.L. 2021, chapter 457, which will take effect on November 1, 2022.

Pursuant to P.L. 2021, chapter 457, subsection b(1), all licensed nursing homes, whether non-profit or for-profit, must post to their internet websites the following information, and provide to the Department of Health (Department) a direct link to the internet website page where that information is posted:

- annual owner-certified financial statements, which for non-profit nursing homes can be a copy of their most recent Internal Revenue Service (IRS)
   Form 990, along with all schedules and supporting documentation required to be submitted to the IRS in conjunction with Form 990; and
- most recent cost report submitted to the federal Centers for Medicare and Medicaid Services (CMS).

Nursing Home Financial Reporting –P.L. 2021, chapter 457 Page 2

Please note that nursing homes that are part of a health care system may post financial statements and CMS cost reports that aggregate the financial data across all nursing homes that are a part of that health care system.

To ensure initial compliance with P.L. 2021, chapter 457, subsection b(1), all nursing homes must post the required financial information to their internet websites and submit a direct link to the Department via email at <a href="mailto:Financial.Reports@doh.nj.gov">Financial.Reports@doh.nj.gov</a>, no later than November 1, 2022, but the Department strongly encourages all nursing homes to make this information available as soon as possible. Thereafter, the Department will ensure all website links received from nursing homes are available on the Department's website.

Relative to continued financial reporting compliance, all nursing homes must ensure annual owner-certified financial statements and CMS cost reports are kept current on their internet websites. To that end, should the direct website link to this information change, the nursing home must submit an updated website link to the Department.

The Department appreciates your time and attention to this matter. Should you have any questions about the contents of this memorandum, or requirements under P.L. 2021, chapter 457, please feel free to reach out to the Department at the above email address. Thank you.

Cc: Robin Ford, Deputy Commissioner, Health Systems Branch
Deborah Hartel, Deputy Commissioner, Integrated Health
Stefanie Mozgai, Assistant Commissioner, Division of Certificate Need and
Licensing

Richard Goldin, Health Care Consultant, Office of Health Care Financing

1. "Annual owner-certified financial statements" – Not exactly sure what this means? We have audited financials from Baker Tilly, and I do sign a rep letter, so I guess you could say they are "owner-certified".

Response: The Department is able to share some general guidance around financial reporting at this time but would flag that the Department is also currently working on promulgating regulations that will provide further and more detailed clarity in this space. In the interim, financial reporting of this nature generally involves disclosing information and documents including, but not limited to, balance sheets, statements of operations/P&Ls, statements of cash flows, etc. In addition, for non-profit nursing homes, this financial reporting can also be accomplished by submitting their most recently filed public inspection copy of IRS Form 990 and applicable schedules/supporting documentation. To this end, the Department would note that nursing home facility submissions received via email thus far have largely been consistent and all tend to include the same type of financial information and supporting documents as outlined here.

- 2. We, like nearly every other organization, are very reluctant to post 990's as they include compensation data...We intend to simply post consolidated audited financials...this would also alleviate having to post eight separate 990's
  - o Are you hearing if this approach is acceptable?

Response: For non-profit nursing homes, they have the option of submitting their most recently filed public inspection copy of IRS Form 990 and applicable schedules/supporting documentation to meet the annual owner-certified financial statement requirement. The statute also allows nursing homes that are part of a larger health system to post financial statements and cost reports that aggregate financial data across all nursing homes that are part of that health system.

3. Is there any requirement as to where or how prominent the link needs to be, or how it is classified (e.g. "Financial Information") on our intranet site?

Response: No, the statute only requires nursing homes to post the required information on their Internet websites and include a link to the financial information contained on the Department's LTC Dashboard, which is scheduled for a November 1, 2022 launch. It does not specify where those links need to be located and/or how the information is to be classified; however, the information should be easily identifiable and somewhere easily accessible by the public. Please also note that nursing homes must also provide to the Department via email a direct link to where this information can be found so that the Department can include that link on its Internet website/LTC Dashboard.

4. The 990 is rolled up with all the businesses and doesn't show the nursing homes' performance. Is it safe to assume that posting that doesn't meet the spirit of the law? It indicates that if using the 990 then we'd need to provide the supporting

documentation for it. Wouldn't that be the financial statements anyway? Or do you think that because we're not for profit that they're requiring the 990 and support?

Response: Pursuant to subsection 3.b.(1) of the statute, which pertains to reporting requirements; as well as standardization, and consolidation of reporting requirements, all licensed nursing homes, whether for-profit, non-profit or not-for-profit, must comply with the statute and post to their internet websites two separate and distinct pieces of information, as follows:

- Annual owner-certified financial statements; and
- Most recent CMS cost reports.

Nursing homes that are non-profit may submit their most recent public inspection copy of IRS Form 990 with corresponding schedules and supporting documents in place of annual owner-certified financial statements. For nursing homes that do not file a Form 990, they have to submit the owner-certified financial statements. Please see prior response to #1.

5. The law doesn't indicate what type of financial information needs to be provided, just that it's a financial statement. Is it indicated anywhere minimally what information needs to be provided? Many companies' financial statements look different from one another - some including more and some including less information. Do they just want to see a few lines, like revenues, expenses and net profit/loss or does it need to include all revenue sources, all departmental expenses, ppds, and ultimate net profit/loss?

Response: Please see prior response to #1.

6. A question was raised internally here regarding compliance with the financial transparency terms of P.L. 2021, c. 457 in advance of the November 1, 2022 effective date. I've briefly reviewed the law and concede that "annual owner-certified financial statements" is an ambiguous term absent a statutory definition.

Response: Understood. The Department would agree with your assessment and, as noted in our prior response to #1, is currently working on promulgating regulations that will provide further and more detailed clarity in this space.

# DMAVA Menlo Park Veterans' Memorial Home- all Fur Revenues, Expenditures and Fund Balances (thousands of dollars)

Fiscal Year Ending June 30, 2021

			Re	Resources				
	Begi	Beginning		Revenues /		Other		
	Balanc	Balances July 1		Appropriation		Adjustments		Available
General State Funds	\$	380	\$	25,294	\$	-	\$	25,674
Federal Funds		-		7,774		-		7,774
Other Funds		-		-		-		-
Total	<b>\$</b>	380	<b>\$</b>	33,068				

nds

		F	Ending
		Bala	nces June
Exp	enditures		30
\$	24,261	\$	1,413
	7,721		53
	-		-
\$	31,982	\$	1,466

# DMAVA Paramus Veterans' Memorial Home- all Func Revenues, Expenditures and Fund Balances (thousands of dollars)

Fiscal Year Ending June 30, 2021

			R	Resources				
	Be	Beginning		Revenues /		Other		
	Balances July 1		Appropriation		Adjustments		Net Available	
General State Funds	\$	2,334	\$	24,727	\$	-	\$	27,061
Federal Funds		-		8,002		-		8,002
Other Funds		-		14		-		14
Total	<i>\$</i>	2,334	<b>\$</b>	32,743	<b>\$</b>	-	<b>\$</b>	35,077

		F	Ending
		Bala	nces June
Exp	enditures		30
\$	26,133	\$	928
	7,993		9
	-		14
\$	34,126	<b>\$</b>	951

# DMAVA Vineland Veterans' Memorial Home- all Func Revenues, Expenditures and Fund Balances (thousands of dollars)

Fiscal Year Ending June 30, 2021

			Re	esources				
	Begi	inning	Re	evenues /	(	Other		
	Balanc	es July 1	App	ropriation	Adjı	ustments	Net	Available
General State Funds	\$	382	\$	27,543	\$	-	\$	27,925
Federal Funds		-		6,651		-		6,651
Other Funds		-		-		-		-
Total	<i>\$</i>	382	\$	34,194	\$	-	<i>\$</i>	34,576

		H	Ending
		Bala	nces June
Exp	enditures		30
\$	27,081	\$	844
	6,651		-
	-		-
\$	33,732	\$	844

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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315459 Worksheet S Parts I, II & III Peri od: From 07/01/2020 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 06/30/2021 Date/Time Prepared: 11/19/2021 9:14 am PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 11/19/2021 Time: 9:14 am use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended 11. Contractor Vendor Code

for no utilization.

### PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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

### CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NEW JERSEY VETERANS HOME - MENLO PAR ( 315459 ) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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		
			SI GNATURE STATEMENT		
1	Rob	yn Martin	Y	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	Robyn Martin			2
3	Signatory Title	BUSI NESS MANAGER			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	0	-1, 157	0	1. 00
2.00	NURSING FACILITY	0			0	2. 00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	0	-1, 157	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 NEW JERSEY VETERANS HOME - MENLO PAR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315459 Peri od: Worksheet S-2 From 07/01/2020 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2021 11/19/2021 9:14 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 132 EVERGREEN RD PO Box: 1.00 2.00 City: EDISON State: NJ Zi p Code: 08818 2.00 3.00 County: MI DDLESEX CBSA Code: 35614 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF NEW JERSEY VETERANS 315459 10/26/1999 N Р Ν 4.00 HOME - MENLO PAR 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12 00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2020 06/30/2021 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR Υ 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related N 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 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare 19.01 N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 786 359 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 786, 359 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) N 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0 0

Heal th	Financial Systems	NEW JERSEY VETERANS HOMI	E - MENLO PAR	In Lieu	u of Form CMS-2	2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31	5459 Peri od:	Worksheet S-2	
COMPLE	X INDENTIFICATION DATA			From 07/01/2020	Part I	
00 EE	and the Entire to one of the Entire			To 06/30/2021	Date/Time Pre	pared:
					11/19/2021 9:	14 am_
	Y/N					
					1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrati	ve and General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing	cost centers and		
	amounts.		ŭ			
43.00	Are there any home office costs as def	ned in CMS Pub. 15-1, Cha	apter 10?		N	43.00
44.00	If line 43 is yes, enter the home office	ce chain number and enter	the name and add	ress of the home		44. 00
	office on lines 45, 46 and 47.					
	1.00	2. 00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address of	the home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Cor	ntractor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zij	p Code:		47. 00

Heal th	Financial Systems NEW J	JERSEY VETERANS HOME	E - MENLO	PAR	In Lie	u of Form CMS	-2540-10
SKI LLE	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der	No.: 315459	Period: From 07/01/2020 To 06/30/2021	Date/Time Pr	epared:
					Y/N	11/19/2021 9 Date	14 alli
					1. 00	2. 00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column	1, "Y" fo	r Yes or "N"	for No. For all	the date	
	Provider Organization and Operation						
1.00	Has the provider changed ownership immediately reporting period? If column 1 is "Y", enter to instructions)				N		1. 00
	Thisti detrons)			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 3, "V" for voluntary or "I" for involuntary.			N			2. 00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or fi relationships? (see instructions)	., chain home offic d to the provider o l, or members of the	es, drug r its e board	N			3. 00
	relationships: (see Histi detrons)			Y/N	Type	Date	
				1.00	2.00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements preparaccountant? (Y/N) Column 2: If yes, enter "A"  Compiled, or "R" for Reviewed. Submit complet	' for Audited, "C" <sup>.</sup> te copy or enter da	for te	Y	С		4.00
5. 00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If creconciliation.	revenues different	from	N			5. 00
					Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
6. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	, ,		provi der the	N	N	6. 00
7. 00 8. 00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	ng the cost reporti		for Nursing	N N		7. 00 8. 00
						Y/N	
	Bad Debts					1. 00	
9. 00 10. 00	Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt				it reporting	N N	9. 00 10. 00
11. 00	period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wa	ived? If "	Y", see instr	ructi ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	iod? If "Y	", see instru	icti ons.	N	12. 00
				Pa	art A	Part B	
		Descriptio	n	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			Y	10/07/2021	Y	13. 00
14. 00	4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and			N		N	14. 00
15. 00	4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been hilled but are not included on the			N		N	15. 00

Ν

Ν

Ν

Ν

16.00

17.00

18.00

16.00

have been billed but are not included on the PS&R used to file this cost report? If "Y",

see Instructions.
If line 13 or 14 is "Y", then were adjustments made to PS&R data for

adjustments made to PS&R data for Other?
Describe the other adjustments:

18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions.

corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were

Health Financial Systems NEW JERSEY VETERANS HOME - MENLO PAR In Lieu of Form CMS-2540-							
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR	E	Provi der No.: 315459	Peri od:	Worksheet S-2		
COMPLE	X REIMBURSEMENT QUESTIONNAIRE	_		From 07/01/2020 To 06/30/2021		pared: 14 am	
			1. 00	2.	00		
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	CHRI	S	GUI LBAULT		19. 00	
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
20.00	Enter the employer/company name of the cost report	HEAL	TH CARE RESOURCES			20.00	
	preparer.						
21.00	Enter the telephone number and email address of the cost	609-	987-1440	CHRI S. GUI LBAUL	T@HCRNJ. NET	21. 00	
	report preparer in columns 1 and 2, respectively.						

| Period: | Worksheet S-2 | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems NEW JERSEY VETERANS
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315459 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 06/30/2021	Date/Time Prepared: 11/19/2021 9:14 am
		Part B			
		Date			
		4. 00			
	PS&R Data				
13.00	Was the cost report prepared using the PS&R	10/07/2021			13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and				
14.00	4. (see Instructions.)				14.00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for				14. 00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15.00	If line 13 or 14 is "Y", were adjustments				15. 00
	made to PS&R data for additional claims that				
	have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
1/ 00	see Instructions.				16. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for				16.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
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		3.00		
19. 00	Enter the first name, last name and the title	e/position (	COST REPORT PREPARER		19.00
	held by the cost report preparer in columns 1				
	respecti vel y.				
20. 00	Enter the employer/company name of the cost r	report			20. 00
	preparer.	_			
21. 00	Enter the telephone number and email address				21. 00
	report preparer in columns 1 and 2, respectiv	vei y.		I	

 
 Health Financial
 Systems
 NEW JERSEY VETERANS HOME - MENLO PAR

 SKILLED
 NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 Provider No.:
 COMPLEX STATISTICAL DATA

Provi der No.: 315459

Peri od: Worksheet S-3
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared: 11/19/2021 9: 14 am

						11/19/2021 9:	14 am
				I npa	atient Days/Vis	si ts	
Component		Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
1.00 SKILLED NURSING FAC 2.00 NURSING FACILITY 3.00 ICF/IID 4.00 HOME HEALTH AGENCY 5.00 Other Long Term Car 6.00 SNF-Based CMHC	COST	328 0 0	119, 720 0 0	0	2, 467 0	0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 HOSPI CE	- 1 7)	0	110.720	0	0	0	7. 00
8.00 Total (Sum of lines	5 1-7)	328 Inpatient D	119, 720 avs/Vi si ts	U	2, 467 Di scharges	0	8. 00
		- Impactiont 5			21 301.a. gaa		
Component		Other	Total	Title V	Title XVIII	Title XIX	
4 00 CVIII ED NUDCINO EAG	N. I. T.V.	6.00	7.00	8. 00	9. 00	10. 00	4 00
1.00   SKILLED NURSING FAC 2.00   NURSING FACILITY 3.00   ICF/IID	T LITY	62, 593 0 0	65, 060 0 0	0	24	0 0 0	1. 00 2. 00 3. 00
4.00 HOME HEALTH AGENCY 5.00 Other Long Term Car 6.00 SNF-Based CMHC		0	0				4. 00 5. 00 6. 00
7. 00 HOSPI CE		o	0	0	0	0	7. 00
8.00 Total (Sum of lines	5 1-7)	62, 593	65, 060		24	0	8. 00
		Di scha			age Length of	,	
Component		Other	Total	Title V	Title XVIII	Title XIX	
1.00 SKILLED NURSING FAC	NII I TV	11.00	12. 00 258	13.00	14. 00 102. 79	15. 00	1. 00
2. 00 NURSING FACILITY	JI ET TT	234	0	0.00	102. 79	0.00	2. 00
3.00   ICF/IID		o	0			0.00	3. 00
4.00 HOME HEALTH AGENCY							4. 00
5.00 Other Long Term Car	re e	0	0				5. 00
6.00 SNF-Based CMHC 7.00 HOSPICE			0	0.00	0.00	0. 00	6. 00 7. 00
8.00 Total (Sum of lines	s 1-7)	234	258			0.00	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 FAC	CILITY	252. 17	0		0	125	1. 00
2.00 NURSING FACILITY		0.00	0		0	0	2.00
3.00   I CF/II D 4.00   HOME HEALTH AGENCY	COST	0.00			U	U	3. 00 4. 00
5.00 Other Long Term Car		0.00				0	5. 00
6.00 SNF-Based CMHC							6.00
7. 00 HOSPI CE	4.7)	0.00	0		0	0	7. 00
8.00 Total (Sum of lines	5 1-1)	252. 17 Admi ssi ons	Full Time	131 Equi val ent	0	125	8. 00
Component		Total	Employees on	Nonpai d			
Component		Total	Payrol I	Workers			
		21. 00	22. 00	23. 00			
1.00 SKILLED NURSING FAC	CILITY	256	316. 70				1. 00
2.00 NURSING FACILITY 3.00 ICF/IID		0	0. 00 0. 00				2. 00 3. 00
4.00 HOME HEALTH AGENCY	COST		0.00				4. 00
5.00 Other Long Term Car		o	0. 00				5. 00
6.00 SNF-Based CMHC			0. 00				6. 00
7.00 HOSPICE 8.00 Total (Sum of lines	. 1 7)	0 256	0. 00 316. 70				7. 00 8. 00
o. oo protar (sum or tries	5 1-1)	200	310.70	J 0.00			0.00

Health Financial Systems
SNF WAGE INDEX INFORMATION Provider No.: 315459

			_	T	0 06/30/2021	Date/Time Pre 11/19/2021 9:	
		Amount	Reclass. of	Adj usted	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						
1 00	SALARI ES	22 022 004	1 0	22 022 004	(50, (20, 00	22.44	1 00
1.00	Total salaries (See Instructions)	22, 022, 804	0	22, 022, 804			
2.00	Physician salaries-Part A	0	0	0	0.00		
3.00	Physician salaries-Part B	0	0	0	0.00		3. 00
4.00	Home office personnel	0	0	0	0.00		4. 00
5.00	Sum of lines 2 through 4	00 000 004	0	0 00 004	0.00		
6.00	Revised wages (line 1 minus line 5)	22, 022, 804	0	22, 022, 804	i i		
7.00	Other Long Term Care	0	0	0	0.00		
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00		
10.00	HOSPI CE	0	0	0	0.00		
11. 00	Other excluded areas	563, 606			· ·		
12. 00	Subtotal Excluded salary (Sum of lines 7	563, 606	-50, 000	513, 606	5, 788. 00	88. 74	12. 00
40.00	through 11)	04 450 400	F0 000	04 500 400	/50 054 00	00.05	10.00
13. 00	Total Adjusted Salaries (line 6 minus line	21, 459, 198	50, 000	21, 509, 198	652, 851. 00	32. 95	13. 00
	12) OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	1, 034, 723	1 0	1, 034, 723	17, 051. 00	40.40	14. 00
15. 00	Contract Labor: Patrent Related & Mgmt  Contract Labor: Physician services-Part A	1,034,723	0	1,034,723	0.00		
16. 00	Home office salaries & wage related costs	0		0	0.00		
16.00	WAGE-RELATED COSTS	U			0.00	0.00	16.00
17. 00	Wage-related costs core (See Part IV)	11, 727, 143	0	11, 727, 143			17. 00
18. 00	Wage-related costs other (See Part IV)	11, 727, 143		11, 727, 143			18. 00
19. 00	Wage related costs other (see rait iv)	300, 120		300, 120			19. 00
20. 00	Physician Part A - WRC	300, 120		300, 120			20.00
21. 00	Physician Part B - WRC	0					20.00
22. 00	Total Adjusted Wage Related cost (see	11, 427, 023		11, 427, 023			22. 00
22.00	instructions)	11,421,023		11,421,023			22.00
	Thisti dott ons)	l	I	I	I		

| Peri od: | Worksheet S-3 | From 07/01/2020 | Part III | To 06/30/2021 | Date/Time Prepared: | Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315459

						11/19/2021 9:	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	1, 489, 835	50, 000		·	39. 39	2. 00
3.00	Plant Operation, Maintenance & Repairs	1, 140, 927	0	1, 140, 927	36, 112. 00	31. 59	3. 00
4.00	Laundry & Linen Service	0	91, 720	91, 720	3, 878. 00	23. 65	4. 00
5.00	Housekeepi ng	1, 717, 773	-91, 720	1, 626, 053	64, 825. 00	25. 08	5. 00
6.00	Di etary	2, 339, 812	0	2, 339, 812	99, 111. 00	23. 61	6. 00
7.00	Nursing Administration	0	0	0	0.00	0.00	7. 00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11. 00	Soci al Servi ce	381, 194	0	381, 194	6, 274. 00	60. 76	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	941, 593	0	941, 593	21, 681. 00	43. 43	13.00
14. 00	Total (sum lines 1 thru 13)	8, 011, 134	50, 000	8, 061, 134	270, 972. 00	29. 75	14. 00

Health Financial Systems	NEW JERSEY VETERANS HOME - MENLO PAR	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315459 Peri od	Worksheet S-3

	F	rom 07/01/2020 o 06/30/2021	Part IV Date/Time Prep	
			11/19/2021 9:	14 am
			Amount	
			Reported	
	DADT LV WACE DELATED COCTO		1. 00	
	PART IV - WAGE RELATED COSTS Part A - Core List			
	RETIREMENT COST			
1. 00	401K Employer Contributions		0	1.00
2. 00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3. 00	Qualified and Non-Qualified Pension Plan Cost		4, 778, 948	3.00
4. 00	Prior Year Pension Service Cost		4, 770, 740	4. 00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		U	4.00
5. 00	401K/TSA Plan Administration fees		0	5. 00
6. 00	Legal /Accounting/Management Fees-Pensi on Plan		0	6. 00
7. 00	Employee Managed Care Program Administration Fees		0	7. 00
,, 00	HEALTH AND INSURANCE COST		, and the second	7.00
8. 00	Heal th Insurance (Purchased or Self Funded)		4, 955, 131	8. 00
9. 00	Prescription Drug Plan		0	9. 00
10. 00			0	10.00
11. 00			0	11. 00
12. 00	, , ,		0	12. 00
13. 00			0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	Workers' Compensation Insurance		220, 228	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required	by FASB 106.	0	16. 00
	Non cumulative portion)	,		
	TAXES			
17. 00	FICA-Employers Portion Only		1, 365, 414	17. 00
18. 00	Medicare Taxes - Employers Portion Only		319, 331	18. 00
	Unemployment Insurance		0	19. 00
20.00	State or Federal Unemployment Taxes		88, 091	20. 00
	OTHER			
21. 00			0	21. 00
	Day Care Cost and Allowances		0	22. 00
	Tuition Reimbursement		0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 - 23)		11, 727, 143	24. 00
			Amount	
			Reported	
	Don't D. Other than Com Delated Cost		1. 00	
25.00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)			25.00
∠5. 00	OTHER WAGE RELATED COSTS (SPECIFY)	I	υĮ	25. 00

Provider No.: 315459 | Period: | Worksheet S-3 | Part V | Health Financial Systems
SNF REPORTING OF DIRECT CARE EXPENDITURES

				T	o 06/30/2021	Date/Time Pre	
	Occupational Category	Amount	 Fri nge	Adj usted	Paid Hours	11/19/2021 9: Average Hourly	14 am
	occupational category	Reported		Salaries (col.		Wage (col. 3 ÷	
		Reported	Delie I I I S		Salary in col.		
				1 + COI. 2)	3	COI. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	Di rect Sal ari es			•			
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 864, 938	993, 079	2, 858, 017	56, 456. 00	50. 62	1.00
2.00	Licensed Practical Nurses (LPNs)	1, 978, 425	1, 053, 511	3, 031, 936	65, 948. 00	45. 97	2.00
3.00	Certified Nursing Assistant/Nursing	4, 972, 370	2, 647, 787	7, 620, 157	259, 475. 00	29. 37	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	8, 815, 733	4, 694, 377	13, 510, 110	381, 879. 00		4.00
5.00	Physical Therapists	0	0	0	0.00		5.00
6.00	Physical Therapy Assistants	0	0	0	0.00		6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11. 00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respi ratory Therapi sts	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations				<del> </del>		
	Registered Nurses (RNs)	0		0			
15. 00		0		0	0.00		
16. 00	Certified Nursing Assistant/Nursing	0		0	0.00	0.00	16. 00
	Assi stants/Ai des	_		_			
17. 00	Total Nursing (sum of lines 14 through 16)	0		0	0.00		
18. 00	Physical Therapists	437, 769		437, 769			18. 00
19. 00	Physical Therapy Assistants	0		0			19. 00
20. 00	Physical Therapy Aides	0		0	0.00		20.00
21. 00		488, 129		488, 129			
22. 00		0		0			
23. 00	Occupational Therapy Aides	0		0	0.00		
24. 00	Speech Therapists	108, 825		108, 825	i i		
25. 00	Respiratory Therapists	0		0			
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider No.: 315459 Peri od: Worksheet S-7 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/19/2021 9:14 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 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 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 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 30.00 HD1 31.00 HC<sub>2</sub> 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 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 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB<sub>2</sub> 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52 00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75. 00 PA<sub>2</sub>

Health Financial Systems N	EW JERSEY VETERANS HOW	IE - MENLO	PAR	In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Period: From 07/01/2020 To 06/30/2021	Worksheet S-7 Date/Time Pro 11/19/2021 9:	epared:
				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 expenses. For lines 101 through 106: Enter column 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y with direct patient care and related expenses (See instructions)	xpected this increase r in column 1 the amou for each category to " for yes or "N" for r	to be used int of the total SNF in if the s	for direct p expense for e revenue from pending refle	atient care and ach category. Er Worksheet G-2, F cts increases as	related nter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)					101. 00 102. 00 103. 00 104. 00 105. 00 106. 00

		JERSEY VETERANS H	OME - MENLO I	PAR	In Lie	u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					rom 07/01/2020 o 06/30/2021		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	11/19/2021 9: Reclassified Trial Balance (col. 3 +- col. 4)	14 am
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		404, 512	404, 512	0	404, 512	1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS		0		0	0	2. 00 3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	1, 489, 835	557, 752	2, 047, 587	50,000	2, 097, 587	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 140, 927	1, 427, 102	2, 568, 029		2, 568, 029	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	0	_, _, _, _,			6. 00
7.00	00700 HOUSEKEEPI NG	1, 717, 773	149, 361	1, 867, 134	-91, 720	1, 775, 414	7. 00
8.00	00800 DI ETARY	2, 339, 812	508, 534	2, 848, 346	0	2, 848, 346	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	C	0	0	9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY	0	609, 622	609, 622	0	609, 622	
11. 00	01100 PHARMACY	0	0		0	0	11.00
12. 00 13. 00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	381, 194	0	201 10/		0 381, 194	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	301, 194	0	381, 194		301, 194 N	14. 00
15. 00	01500 RECREATION	941, 593	0	941, 593		941, 593	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	7117070	<u> </u>	7117070	,	7117070	10.00
30.00	03000 SKILLED NURSING FACILITY	13, 448, 064	2, 269, 033	15, 717, 097	-2, 156, 855	13, 560, 242	30. 00
31.00	03100 NURSING FACILITY	0	0	C	0	0	31. 00
32. 00	03200   CF/IID	0	0	C	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		ما		0 417	0.417	40.00
40. 00 41. 00	04000 RADI 0LOGY 04100 LABORATORY	0	0			9, 417 1, 074, 023	1
41.00	04200 I NTRAVENOUS THERAPY		0		1,074,023	1,074,023	1
43. 00	04300 OXYGEN (INHALATION) THERAPY		0			0	43. 00
44. 00	04400 PHYSI CAL THERAPY	o	O	d	437, 769	437, 769	1
45.00	04500 OCCUPATI ONAL THERAPY	0	0		488, 129	488, 129	1
46.00	04600 SPEECH PATHOLOGY	0	0	C	108, 825	108, 825	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	C	0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40.000	40.000	0	0	
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS   05000 DENTAL CARE - TITLE XIX ONLY	0	48, 983	48, 983	0	48, 983 0	1
51. 00	05100 SUPPORT SURFACES		0			0	ł
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		,		31.00
60.00	06000 CLI NI C	0	0	C	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	61. 00
62. 00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS			_	-		
	07000 HOME HEALTH AGENCY COST	0	0			0	
	07100 AMBULANCE	0	0	-			71. 00 73. 00
73.00	O7300   CMHC   SPECIAL PURPOSE COST CENTERS	<u> </u>	U		0	0	73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	(	0	0	80.00
	08100   NTEREST EXPENSE		Ö		o o	Ö	1
82.00	08200 UTILIZATION REVIEW - SNF	0	0	Ċ	0	0	1
83.00	08300 H0SPI CE	0	0	C	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	21, 459, 198	5, 974, 899	27, 434, 097	50, 000	27, 484, 097	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0			0 0	
	09300 NONPALD WORKERS		0			0	ı
	09400 PATIENTS LAUNDRY		ol			0	ı
	09500 PHYSICIANS AND NURSE PRACTITIONERS	0	O		o	0	ı
	09501 PHYSI CI ANS	563, 606	7, 966				1
100.00	TOTAL	22, 022, 804	5, 982, 865	28, 005, 669	0	28, 005, 669	100. 00

Health Financial Systems NEW JERSEY VETT RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315459 

					ime Prepared: ′2021 9:14 am
	Cost Center Description	Adjustments to	Net Expenses	1 17 177	2021 7. 11 dill
	·	Expenses (Fr	For Allocation	1	
		Wkst A-8)	(col. 5 +-		
			col . 6)	_	
	OFNEDAL CEDIU OF COCT OFNEDO	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES	792, 285	1, 196, 797	,	1.00
2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES	192, 203	1, 190, 797		2.00
3. 00	00300 EMPLOYEE BENEFITS	11, 727, 143		•	3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	760, 148	1		4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	2, 568, 029	l .	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	91, 720		6. 00
7.00	00700 HOUSEKEEPI NG	0	1, 775, 414		7. 00
8.00	00800 DI ETARY	0	2, 848, 346		8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	609, 622		10.00
11.00	01100 PHARMACY	0	0		11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	0	1	12.00
13. 00 14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	381, 194	1	13. 00 14. 00
15. 00	01500 RECREATION		941, 593		15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS		741, 373	·	13.00
30.00	03000 SKILLED NURSING FACILITY	0	13, 560, 242		30.00
31.00	03100 NURSING FACILITY	0	0		31. 00
32.00	03200   CF/IID	0	0		32. 00
33.00	03300 OTHER LONG TERM CARE	0	0		33. 00
	ANCILLARY SERVICE COST CENTERS				
40. 00	04000 RADI OLOGY	0	.,		40. 00
41. 00	04100 LABORATORY	0	1, 074, 023		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	U 427 740		43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	437, 769 488, 129		44. 00 45. 00
46. 00	04600 SPEECH PATHOLOGY	0	108, 825		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	l .	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	o o	•	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	48, 983	3	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51. 00	05100 SUPPORT SURFACES	0	0		51. 00
	OUTPATIENT SERVICE COST CENTERS				
60.00	06000 CLINIC	0	l ~	l .	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	)	61.00
62. 00	O6200   FOHC     OTHER REIMBURSABLE COST CENTERS				62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0		70. 00
71. 00	07100 AMBULANCE	0	38, 692	l .	71.00
	07300 CMHC	Ö	0		73. 00
	SPECIAL PURPOSE COST CENTERS	•	•		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0		80.00
	08100 I NTEREST EXPENSE	0	0		81. 00
	08200 UTILIZATION REVIEW - SNF	0	0		82. 00
	08300 H0SPI CE	0	_	1	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	13, 279, 576	40, 763, 673	3	89. 00
00 00	NONREI MBURSABLE COST CENTERS		^		00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		0	l control of the cont	90.00
	I I		0		92.00
	09300 NONPALD WORKERS	0			93. 00
	09400 PATIENTS LAUNDRY	0	Ö	)	94. 00
	09500 PHYSICIANS AND NURSE PRACTITIONERS	0	0		95. 00
	09501 PHYSI CI ANS	0	521, 572		95. 01
100.00	TOTAL	13, 279, 576	41, 285, 245	<u>i</u>	100.00

Health Financial Systems	NEW JERSEY VETERANS HOW	E - MENLO PAR	In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der No.: 315459		Worksheet A-6	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	oared:
				11/19/2021 9:	
		Increases			
	Cost Cente	er Line#	Sal ary	Non Salary	
	2.00	2 00	4 00	E 00	

		Increases				
		Cost Center	Li ne #	Sal ary	Non Salary	
		2.00	3. 00	4. 00	5. 00	
	(1) A - DEFAULT					
1.00		ADMINISTRATIVE & GENERAL	4.00	50, 000	0	1.00
2.00		SPEECH PATHOLOGY	46.00	0	108, 825	2.00
3.00		OCCUPATI ONAL THERAPY	45.00	0	488, 129	3. 00
4.00		PHYSI CAL THERAPY	44.00	0	437, 769	4. 00
5.00		LABORATORY	41.00	0	1, 074, 023	5. 00
6.00		AMBULANCE	71. 00	0	38, 692	6.00
7. 00		RADI OLOGY	40.00	0	9, 417	7. 00
8. 00		LAUNDRY & LINEN SERVICE	6.00	91, 720	0	8. 00
	TOTALS					
100.00		Total Reclassifications (Sum		141, 720	2, 156, 855	100.00
		of columns 4 and 5 must				
		equal sum of columns 8 and				
		9)				

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

Health Financial Systems	NEW JERSEY VETERANS HOME	E - MENLO PAR	In Lie	u of Form CMS-2540-10
RECLASSI FI CATI ONS		Provi der No.: 315459	Peri od: From 07/01/2020	Worksheet A-6
			To 06/30/2021	Date/Time Prepared:

				11/19/2021 9:	14 am
		Decreases			
	Cost Cente	r Line#	Sal ary	Non Salary	
	6. 00	7. 00	8. 00	9. 00	
(1) A - DEFAULT					
1.00	PHYSI CI ANS	95.	01 50, 000	0	1.00
2. 00	SKILLED NURSING FAC	ILITY 30.	00 0	108, 825	2.00
3. 00	SKILLED NURSING FAC	ILITY 30.	00 0	488, 129	3.00
4. 00	SKILLED NURSING FAC	ILITY 30.	00 0	437, 769	4.00
5. 00	SKILLED NURSING FAC	ILITY 30.	00 0	1, 074, 023	5.00
6. 00	SKILLED NURSING FAC	ILITY 30.	00 0	38, 692	6.00
7. 00	SKILLED NURSING FAC	ILITY 30.	00 0	9, 417	7.00
8. 00	HOUSEKEEPI NG	7.	00 91, 720	0	8.00
TOTALS					
100. 00			141, 720	2, 156, 855	100. 00

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

NEW JERSEY VETERANS HOME - MENLO PAR

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2540-10 Provi der No.: 315459 

				'	0 00/00/2021	11/19/2021 9:	14 am
				Acqui si ti ons			
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2, 527	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	35, 386, 173	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	35, 388, 700	0	0	0	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	35, 388, 700	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	I	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		_				
1.00	Land	2, 527	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	35, 386, 173	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	Subtotal (sum of lines 1-6)	35, 388, 700	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	35, 388, 700	0				9. 00

Provi der No.: 315459 Peri od:

From 07/01/2020 | Worksheet A-8 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared:

	10 06/30/2021   Date/II me Prepare   11/19/2021 9:14 a					
				Expense Classification on		14 (1111
				To/From Which the Amount is		
				Toy I Tom Will cit the Amount 13	to be haj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	200011 pt. 0.1. (1)	Adjustment	711104111		2	
		1.00	2.00	3.00	4. 00	
1. 00	Investment income on restricted funds		0		0.00	1. 00
	(chapter 2)		_			
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2.00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4.00	Rental of provider space by suppliers		0		0.00	4.00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5.00
	(chapter 21)					
6.00	Television and radio service (chapter 21)		0		0.00	6.00
7. 00	Parking Lot (chapter 21)		0		0.00	
8.00	Remuneration applicable to provider-based	A-8-2	0			8.00
0.00	physician adjustment		· ·			0.00
9. 00	Home office cost (chapter 21)		0		0.00	9.00
10. 00			0		0.00	
11. 00			0		0.00	
11.00	Capi tal expendi tures (chapter 24)		O		0.00	11.00
12. 00		A-8-1	0			12. 00
	related organizations (chapter 10)		· ·			12.00
13. 00			0		0.00	13. 00
14. 00			0			14. 00
15. 00	1 3		0		0.00	
16. 00			0		0.00	
10.00	patients		O		0.00	10.00
17. 00	The same state of the same sta		0		0.00	17. 00
18. 00			0		0.00	
19. 00			0		0.00	l
20.00	9		0			20.00
20.00	or penalty charges (chapter 21)		0		0.00	20.00
21. 00			0		0.00	21. 00
21.00	and borrowings to repay Medicare		O		0.00	21.00
	overpayments					
22. 00			0	UTILIZATION REVIEW - SNF	82 00	22. 00
22.00	(chapter 21)		O	STILL EXTENDED IN	02.00	22.00
23. 00	1	A	786 359	CAP REL COSTS - BLDGS &	1.00	23. 00
20.00	boprooratron barrarings and rextares	,,	, 00, 00,	FI XTURES		20.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2 00	24. 00
21.00	bopi cor att on movable equi pinent		O	EQUI PMENT	2.00	21.00
25 00	FRINGE BENEFITS	A	11, 727 143	BEMPLOYEE BENEFITS	3.00	25. 00
25. 01	CENTRAL OFFICE SALARIES	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	CENTRAL OFFICE FRINGE BENEFITS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 02	PROPERTY INSURANCE	A		CAP REL COSTS - BLDGS &	1.00	
20.00	The carrier moon moe	,,	5, 720	FIXTURES	1.00	20.03
100. 0	Total (sum of lines 1 through 99) (Transfer		13, 279, 576			100. 00
<del>-</del>	to Worksheet A, col. 6, line 100)		-, , , -, -			
	•	. '		•	•	

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315459 | Period: | From 07/01/20

Period: Worksheet B
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared:

			To	06/30/2021	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		11/19/2021 9:	14 am
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	col. 7) 0	1.00	2. 00	3. 00	3A	
GENERAL SERVICE COST CENTERS		1.00	2.00	0.00	571	
1.00 O0100 CAP REL COSTS - BLDGS & FLXTUF 2.00 O0200 CAP REL COSTS - MOVABLE EQUIPM		1, 196, 797	0			1. 00 2. 00
3. 00 00300 EMPLOYEE BENEFITS	11, 727, 143	0	0	11, 727, 143	0 70/ 045	3. 00
4.00   00400   ADMINISTRATIVE & GENERAL 5.00   00500   PLANT OPERATION, MAINT. & REPA	2, 857, 735 AIRS 2, 568, 029	108, 618 146, 034	0	819, 962 607, 544	3, 786, 315 3, 321, 607	4. 00 5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	91, 720	41, 117	0	48, 841	181, 678	6. 00
7. 00   00700   HOUSEKEEPI NG	1, 775, 414	2, 056	Ō	865, 873	2, 643, 343	7. 00
8. 00   00800   DI ETARY	2, 848, 346	72, 729	0	1, 245, 950	4, 167, 025	8. 00
9. 00 00900 NURSI NG ADMINI STRATI ON	0	0	0	0	0	9. 00
10. 00   01000   CENTRAL SERVI CES & SUPPLY	609, 622	46, 531	0	0	656, 153 0	10. 00 11. 00
12. 00   01100   PHARWACT 12. 00   01200   MEDI CAL   RECORDS & LI BRARY		0	0	0	0	12.00
13. 00   01300   SOCIAL SERVICE	381, 194	6, 168	0	202, 986	590, 348	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUC		0	0	0	0	14. 00
15. 00 01500 RECREATION	941, 593	0	0	501, 398	1, 442, 991	15. 00
INPATIENT ROUTINE SERVICE COST CENT		740 007		7 4/4 004	04 440 070	00.00
30. 00   03000   SKILLED NURSING FACILITY 31. 00   03100   NURSING FACILITY	13, 560, 242	718, 927	0	7, 161, 094	21, 440, 263 0	30. 00 31. 00
32. 00   03200   CF/IID		0	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	o	O	Ō	o	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	9, 417	0	0	0	9, 417	40.00
41. 00   04100   LABORATORY 42. 00   04200   I NTRAVENOUS THERAPY	1, 074, 023	0	0	0	1, 074, 023 0	41. 00 42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY		0	0	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	437, 769	18, 448	Ö	Ö	456, 217	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	488, 129	12, 184	0	0	500, 313	45. 00
46. 00 04600 SPEECH PATHOLOGY	108, 825	0	0	0	108, 825	46. 00
47. 00   04700   ELECTROCARDI OLOGY	O O	0	0	0	0	47. 00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PA	ATI ENTS 0 48, 983	0	0	0	0 48, 983	48. 00 49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	40, 703	ő	Ö	o	40, 703	50.00
51.00 05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00   06000   CLI NI C	0	0	0	0	0	60.00
61. 00   06100   RURAL HEALTH CLINIC 62. 00   06200   FOHC	0	0	0	0	0	61. 00 62. 00
OTHER REIMBURSABLE COST CENTERS						02.00
70.00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 07100 AMBULANCE	38, 692	0	0	0	38, 692	71. 00
73. 00 07300 CMHC	0	O	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS  80.00   08000   MALPRACTI CE PREMI UMS & PAI D LO	nsses					80. 00
81. 00   08100   INTEREST EXPENSE	33323					81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00 SUBTOTALS (sum of lines 1-84)	40, 763, 673	1, 172, 812	0	11, 453, 648	40, 466, 193	89. 00
NONREI MBURSABLE COST CENTERS  90.00 O9000 GIFT, FLOWER, COFFEE SHOPS & (	CANTEEN O	O	0	ما	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	CANTELN	0	0	0	0	91.00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	o	O	Ō	o	0	92.00
93.00 09300 NONPALD WORKERS	0	О	0	0	0	93. 00
94. 00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95. 00 09500 PHYSICIANS AND NURSE PRACTITION	1	0	0	0	910.053	95.00
95. 01   09501   PHYSI CLANS 98. 00   Cross Foot Adjustments	521, 572 0	23, 985	0	273, 495 0	819, 052 0	95. 01 98. 00
99.00 Negative Cost Centers		ol	0	ol	0	99. 00
100. 00 TOTAL	41, 285, 245	1, 196, 797	0	11, 727, 143	41, 285, 245	

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315459 Peri

Peri od: Worksheet B From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

11/19/2021 9:14 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 3, 786, 315 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 335, 386 3, 656, 993 5.00 00600 LAUNDRY & LINEN SERVICE 159, 599 18.344 359, 621 6.00 6.00 00700 HOUSEKEEPI NG 7.00 266, 901 7, 980 C 2, 918, 224 7.00 282, 304 8.00 00800 DI ETARY 420, 749 0 236, 093 5, 106, 171 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 0 Ω 01000 CENTRAL SERVICES & SUPPLY 180, 613 0 Λ 10.00 10.00 66, 252 151,048 11.00 01100 PHARMACY 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 01300 SOCIAL SERVICE 23, 940 0 13.00 13.00 59.608 20.021 0 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 14.00 15.00 01500 RECREATION 145, 700 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 790, 557 30.00 03000 SKILLED NURSING FACILITY 359, 621 5, 106, 171 30.00 2, 164, 856 2, 333, 764 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 32.00 0 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 951 0 0 0 0 40.00 41.00 04100 LABORATORY 108, 445 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 0 0 42 00 0 Ω 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 C 0 0 43.00 04400 PHYSI CAL THERAPY 46,065 71, 607 59, 885 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 50, 517 47, 294 0 39, 553 0 45.00 04600 SPEECH PATHOLOGY 46 00 10, 988 0 46 00 0 0 04700 ELECTROCARDI OLOGY 47.00 C 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 48.00 0 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 4,946 0 0 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 0 50.00 0 Ω 05100 SUPPORT SURFACES 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 0 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70.00 70.00 0 0 0 07100 AMBULANCE 3, 907 O 71.00 r 0 Λ 71.00 73.00 07300 CMHC 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 3<u>59, 621</u> SUBTOTALS (sum of lines 1-84) 2, 840, 364 3, 703, 615 3, 563, 894 5, 106, 171 89.00 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 C 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 Ω 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 09500 PHYSICIANS AND NURSE PRACTITIONERS 95.00 0 0 Λ 95.00 95.01 09501 PHYSI CI ANS 82,700 93, 099 0 77,860 Ω 95.01 98.00 Cross Foot Adjustments 0 0 98.00 99.00 99.00 Negative Cost Centers C 0 359, 621 2, 918, 224 100.00 TOTAL 3, 786, 315 3, 656, 993 5, 106, 171 100. 00

| Peri od: | Worksheet B | From 07/01/2020 | Part | | To 06/30/2021 | Date/Time Prepared: | Provi der No.: 315459

			To	06/30/2021	Date/Time Pre 11/19/2021 9:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11 (4)11
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LIBRARY		
CENEDAL CEDVICE COCT CENTEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES						1 00
1.00   00100   CAP REL COSTS - BLDGS & FLXTURES 2.00   00200   CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3.00   00300   EMPLOYEE BENEFITS						3. 00
						4. 00
4.00   00400   ADMINISTRATIVE & GENERAL 5.00   00500   PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00 00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00   00700   HOUSEKEEPI NG						7. 00
8. 00   00800 DI ETARY						8. 00
9. 00 O0900 NURSING ADMINISTRATION	0					9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	o	1, 054, 066				10.00
11. 00   01100   PHARMACY	o	0	О			11. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	o	O	0	0		12.00
13. 00   01300   SOCIAL SERVICE	o	0	О	0	693, 917	13. 00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	o	0	o	0	0	14. 00
15. 00 01500 RECREATION	0	0	0	0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	0	1, 054, 066	0	0	693, 917	30. 00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00   03200   I CF/I I D	0	0	0	0	0	32. 00
33.00 O3300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS			_1	_		
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   0XYGEN (I NHALATI ON) THERAPY 44.00   04400   PHYSI CAL THERAPY	0	0	0	0	0	43.00
45. 00   04400   PHYSICAL THERAPY 45. 00   04500   OCCUPATI ONAL THERAPY	0	0	0	0	0	44. 00 45. 00
46. 00   04600   SPEECH PATHOLOGY	0	0	0	0	0	46. 00
47. 00   04700   ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS		0	0	0	0	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY		0	0	0	Ö	50.00
51. 00 05100 SUPPORT SURFACES		0	Ö	0	Ö	51. 00
OUTPATIENT SERVICE COST CENTERS	-1	-,	-1			
60. 00 06000 CLI NI C	0	0	0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00 06200 FQHC						62. 00
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		71. 00
73. 00 07300 CMHC	0	0	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS	1 1		Г			
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 - SNF		0		0		82.00
83. 00 08300 HOSPI CE	0	1 054 044	0	0	(02.017	
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	J U	1, 054, 066	U U	U	693, 917	89. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	0	0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP		0	0	0	0	91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES		0	0	0	0	92.00
93. 00 09300 NONPALD WORKERS		0		0	0	93. 00
94. 00 09400 PATIENTS LAUNDRY		0	0	0	Ö	94. 00
95.00 09500 PHYSICIANS AND NURSE PRACTITIONERS		n	n	n	o o	95. 00
95. 01   09501   PHYSI CI ANS		o o	o o	0	ő	95. 01
98.00 Cross Foot Adjustments	O	o		Ĭ		98. 00
99.00   Negative Cost Centers	0	o	О	0	0	99. 00
100. 00 TOTAL	o	1, 054, 066	0	0	693, 917	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

From O7/01/2020 | Part | Prepared: | To | O6/30/2021 | Date/Time | Prepared: | Part | Prepared: | Prepared

				T	o 06/30/2021	Date/Time Pre	pared:
			OTHER GENERAL			11/19/2021 9:	14 am
			SERVI CE				
	Cost Center Description	NURSING AND	RECREATI ON	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION 14 00	15.00	1/ 00	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG						7.00
8. 00 9. 00	OO8OO   DI ETARY   OO9OO   NURSI NG ADMI NI STRATI ON						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15.00	01500 RECREATION	0	1, 588, 691				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	1, 588, 691	37, 531, 906	1	37, 531, 906	30. 00
31. 00	03100 NURSING FACILITY	0	0	(	1 1	0	31. 00
32. 00	03200   1 CF/1   D	0	0	(	1 -1	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0	0	10, 368	8 0	10, 368	40. 00
41. 00	04100 LABORATORY	0	0	1, 182, 468		1, 182, 468	1
42. 00	04200 I NTRAVENOUS THERAPY	0	ő	1, 102, 100		0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	Ċ	O	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	633, 774	0	633, 774	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	637, 677	0	637, 677	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	119, 813	0	119, 813	1
	04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	- CO 000	0	0	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	53, 929		53, 929	1
	05000   DENTAL CARE - TITLE XIX ONLY   05100   SUPPORT SURFACES	0	0	(		0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	U	U <sub>I</sub>		<u>/ </u>	0	31.00
60. 00	06000 CLINIC	0	0	(	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	Ċ	1	0	61.00
62.00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	C		0	70. 00
71. 00	07100 AMBULANCE	0	0	42, 599		42, 599	1
73. 00	07300 CMHC	0	0		0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00	08000   MALPRACTICE PREMIUMS & PAID LOSSES   08100   INTEREST EXPENSE						80. 00 81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE	0	0	(	ol	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	i o	1, 588, 691	40, 212, 534		40, 212, 534	
	NONREI MBURSABLE COST CENTERS		,		· · · · · · · · · · · · · · · · · · ·		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	(	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	C	0	0	91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0	(	0	0	92. 00
	09300 NONPALD WORKERS	0	0	(	0	0	
94. 00	09400 PATIENTS LAUNDRY	0	0	(		0	
95. 00 95. 01	09500   PHYSICIANS AND NURSE PRACTITIONERS   09501   PHYSICIANS		0	1 N70 711		0 1, 072, 711	95. 00 95. 01
98. 00	Cross Foot Adjustments		0	1, 072, 711		1, 072, 711	1
99. 00	Negative Cost Centers		ol Ol	(		0	ı
100.00		0	1, 588, 691	41, 285, 245	s o	41, 285, 245	
	•				1	•	

Period: Worksheet B
From 07/01/2020 Part II
To 04/20/2021 Part III
To 04/20/2021 Part III
To 04/20/2021 Part III
To 04/20/2021 Part III Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315459

				To	06/30/2021	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		11/19/2021 9:	14 am
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		Assigned New	FIXTURES	EQUI PMENT	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS	
		Capi tal Related Costs					
		0	1. 00	2.00	2A	3. 00	
1.00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES						1, 00
2.00	00200 CAP REL COSTS - BEDGS & FIXTURES						2.00
3.00	00300 EMPLOYEE BENEFITS	0	0	0	О	0	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	0	108, 618		108, 618	0	4. 00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	0	146, 034 41, 117		146, 034 41, 117	0	5. 00 6. 00
	00700 HOUSEKEEPI NG		2, 056		2, 056	0	7. 00
	00800 DI ETARY	0	72, 729		72, 729	0	8. 00
9. 00	00900 NURSING ADMINISTRATION	0	0	0	0	0	9. 00
	01000 CENTRAL SERVICES & SUPPLY	0	46, 531	0	46, 531	0	10.00
1	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY		0		0	0	11. 00 12. 00
1	01300 SOCI AL SERVI CE		6, 168	0	6, 168	0	13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 RECREATION	0	0	0	0	0	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	l ol	710 027	' 0	710 027	0	20.00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	718, 927 0	1	718, 927 0	0	30. 00 31. 00
	03200   CF/IID	0	0	o o	o	0	32. 00
	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				ما		
	04000  RADI OLOGY 04100  LABORATORY	0	0	0	0	0	40. 00 41. 00
	04200 I NTRAVENOUS THERAPY		0		0	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	Ö	0	Ö	ō	0	43. 00
	04400 PHYSI CAL THERAPY	0	18, 448		18, 448	0	44. 00
	04500 OCCUPATI ONAL THERAPY	0	12, 184	0	12, 184	0	45. 00
1	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY		0		0	0	46. 00 47. 00
1	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	o	0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	51.00
60. 00	06000 CLINIC	O	0	0	ol	0	60.00
	06100 RURAL HEALTH CLINIC	Ö	0	Ö	Ō	0	61.00
	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS		0		ما	0	70.00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0	1	0	0	70. 00 71. 00
1	07300 CMHC	0	0	1	ő	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
1	08100   INTEREST EXPENSE 08200   UTI LI ZATI ON REVIEW - SNF						81. 00 82. 00
	08300 HOSPI CE	0	0	o	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 172, 812		1, 172, 812	0	89. 00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	91. 00 92. 00
	09300 NONPALD WORKERS		0		ő	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	o	o	0	94. 00
1	09500 PHYSICIANS AND NURSE PRACTITIONERS	0	0	0	0	0	95. 00
	09501 PHYSI CI ANS	0	23, 985	9	23, 985	0	95. 01
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers		0	0	0	0	98. 00 99. 00
100.00	0	О	1, 196, 797		1, 196, 797		100.00
'	•	•		. '	'		

Heal th Financial Systems

NEW JERSEY VETERANS HOME - MENLO PAR

In Lieu of Form CMS-2540-10

Provider No.: 315459

Period:
From 07/01/2020
To 06/30/2021

Part II
Date/Time Prepared:
11/19/2021 9: 14 am

OPERATION,
MAINT. &
REPAIRS

4.00 5.00 6.00 7.00 8.00

GENERAL SERVICE COST CENTERS

1.00 00100 CAP REL COSTS - BLDGS & FIXTURES
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT

NEW JERSEY VETERANS HOME - MENLO PAR
In Lieu of Form CMS-2540-10
Worksheet B
Part II
Date/Time Prepared:
11/19/2021 9: 14 am
LINEN SERVICE

DIETARY

1.00 00100 CAP REL COSTS - BLDGS & FIXTURES
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT

1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT

		Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			& GENERAL	OPERATION, MAINT &	LINEN SERVICE			
SIMPRIAN SERVICE COST CHITES   1.00   0.00								
1.00			4.00	5. 00	6. 00	7. 00	8. 00	
2.00 00200 CAP REL COSTS - MOVABLE EQUI PIMENT								
3. 00 03000 [BMILDIVER ERKERT IS							  -	
4.00   00400   ADMIN STRATIVE & GENERAL   108, 618   5.00   00500   DATIO PRATIO, MAINT. & REPAIRS   9, 623   155, 687   48, 436   6.00   00600   LANIDYR* & LINEN SERVICE   526   6.703   48, 436   10, 054   7.00   00700   MUSICKEPIN W.   12, 072   12, 016   0   813   97, 630   8.00   00600   HEIRARY   12, 072   12, 016   0   813   97, 630   8.00   00600   HEIRARY ADMIN STRATION   12, 072   12, 016   0   0   0   0   0   0   0   0   0							  -	
5.00   00000   PLANT OPERATION, MAINT, & REPAIRS   9, 623   155, 637   48, 436   0   10, 054   7. 00   00700   HOUSEKEEPING   7, 658   340   0   10, 054   7. 00   00700   HOUSEKEEPING   7, 658   340   0   10, 054   7. 00   00000   HOUSEKEEPING   7, 658   340   0   0   0   0   0   0   0   0   0		1 1					  -	
0.000   0.0000   LANJINY \$ LI NEN SERVICE   5.26   6.793   48, 436   10, 0.54   7.00   8.00   0.0000   UIETARY   12,072   12,016   0   8131   97,630   8.00   0.0000   UIETARY   12,072   12,016   0   8131   97,630   8.00   0.0000   UIETARY   12,072   12,016   0   0   0   0   0   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000		1 1	1	455 (53			  -	
7. 00   00700   HOUSEKEEPING		1 1	1				  -	
8.00   0.00000   DETARY   12,072   12,016   0   813   97,630   8,00   0.00			1			10.051	  -	
9.00 009900 NURSING ADMINISTRATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1				07.400	
10. 00   10000   CENTRAL SERVICES & SUPPLY   1. 901   7. 688   0   520   0   10. 00   10. 10. 10. 10. 10. 10. 10. 10. 10. 10.			12,072		0			
11. 00   01100   PHABMACY   0			1 004	O	0	٩		
12.00   01200   MEDICAL RECORDS & LIBRARY   0 0 0 0 0 0 0 0 0 12.00			1, 901	7, 688	0	520	01	
13. 00   01300   SOCIAL SERVICE   1,710   1,010   0   69   0   13. 00     14. 00   01500   MURSIN K AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   0     14. 00   01500   MURSIN K AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   0     14. 00   01500   MURSIN K FACILITY   62,097   118,777   48,436   8,042   97,630   30. 00     30. 00   3000   SIXILLED NURSING FACILITY   0   0   0   0   0   0   31. 00     32. 00   3300   OTEP LONG TERM CARE   0   0   0   0   0   0   32. 00     33. 00   3300   OTHER LONG TERM CARE   0   0   0   0   0   0   32. 00     ANCELLARY SERVICE COST CENTERS   70   0   0   0   0   0   0   0   0     41. 00   0400   ADMINISTRY SERVICE COST CENTERS   70   0   0   0   0   0   0   0   0     42. 00   04200   ADMINISTRY SERVICE COST CENTERS   70   0   0   0   0   0   0   0   0			0	0	0	0	01	
14. 00   01400   MURSING AND ALLIED HEALTH EDUCATION		1 1	1 710	1 010	0	0	01	
15. 00   O1500   RECERTION   A   180   O   O   O   O   O   O   O   O   O		1 1	1, /10	1, 019	0	69		
IMPATI ENT ROUTINE SERVICE COST CENTERS			4 100	0	0	0		
30.00   03000   03000   03000   0300   0300   0300   03100	15.00		4, 180	0	0	U	0	15.00
33.00   03100   NURSING FACILITY	20.00		(2.007	110 777	40.424	0.043	07 (20	20.00
32. 00 03200 ICF/II D 33. 00 0330 OTHER LONG TERM CARE 0 0 0 0 0 0 32. 00  ANGILLARY SERVICE COST CENTERS  0 04000 RADIOLOGY 27 0 0 0 0 0 0 41. 00  41. 00 04000 RADIOLOGY 3,111 0 0 0 0 0 0 41. 00  42. 00 04200 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 42. 00  43. 00 04300 OVYEGEN (INHALATION) THERAPY 1,22 3,048 0 206 0 44. 00  44. 00 04400 PHYSI CAL THERAPY 1,322 3,048 0 206 0 44. 00  45. 00 04500 OCCUPATIONAL THERAPY 1,322 3,048 0 206 0 44. 00  46. 00 04600 OCCUPATIONAL THERAPY 1,349 2,013 0 136 0 45. 00  46. 00 04600 OCCUPATIONAL THERAPY 1,349 2,013 0 136 0 45. 00  46. 00 04600 SEPECH PATHOLOGY 315 0 0 0 0 0 0 0 47. 00  47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 47. 00  48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 48. 00  49. 00 04900 DRUGS CHARGED TO PATIENTS 142 0 0 0 0 0 0 0 49. 00  50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					
33. 00   03300   0718PR LONG TERN CARE   0   0   0   0   0   0   0   0   0		1 1	0		0	0	-	
ANCILLARY SERVICE COST CENTERS			0	-	0	0		
40.00	33.00		l d	0	0	U	U	33.00
41.00   04100   LABORATORY   3, 111	40.00		27	0		٥	0	40.00
42.00   04200   INTRAVERIOUS THERAPY   0   0   0   0   0   42.00   43.00   04300   OXYGEN (INHALATION) THERAPY   0   0   0   0   0   0   44.00   04400   PHYSICAL THERAPY   1, 322   3, 048   0   206   0   44.00   45.00   04500   OXCUPATIONAL THERAPY   1, 449   2, 013   0   136   0   45.00   46.00   04600   SPEECH PATHOLOGY   315   0   0   0   0   0   47.00   04700   ELECTROCARDIOLOGY   315   0   0   0   0   0   0   48.00   04600   SPEECH PATHOLOGY   315   0   0   0   0   0   0   49.00   04900   OXCUPATIONAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   49.00   04900   OXCUPATIONAL SUPPLIES CHARGED TO PATIENTS   142   0   0   0   0   0   0   51.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   61.00   05000   CLINIC   0   0   0   0   0   0   0   0   61.00   06000   CLINIC   0   0   0   0   0   0   0   0   61.00   06100   RURAL HEALTH ACINIC   0   0   0   0   0   0   0   0   61.00   06100   RURAL HEALTH AGENCY COST   0   0   0   0   0   0   0   0   61.00   07100   AMBULANCE   112   0   0   0   0   0   0   0   0   61.00   07100   AMBULANCE   112   0   0   0   0   0   0   0   0   61.00   08700   TILLI ZATION REVIEW - SNF   82.00   62.00   08200   INTEREST EXPENSE   82.00   63.00   08300   HOSPICI CE PREMI UNIS & PAID LOSSES   82.00   63.00   08300   HOSPICI CE PREMI UNIS & PAID LOSSES   82.00   69.00   09000   09000   00   0   0   0   0			1	-		-	Ŭ	1
43.00   04300   04400   PHYSI CAL THERAPY   0   0   0   0   0   43.00			1	0	0	0		
44. 00   04400   PHYSI CAL THERAPY		1 1	0	0		0		
45. 00   04500   OCCUPATI ONAL THERAPY   1, 449   2, 013   0   136   0   45. 00   46. 00   04600   SPECH PATHOLOGY   315   0   0   0   0   0   46. 00   47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   47. 00   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   48. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   142   0   0   0   0   0   0   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   50. 00   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   51. 00   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0   62. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   61. 00   63. 00   06100   RURAL HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0   64. 00   07100   AMBULANCE   112   0   0   0   0   0   0   71. 00   67. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0			1 222	2 040		206		
46. 00   04600   SPEECH PATHOLOGY   315   0 0 0 0 0 0 0 46. 00   47. 00   04700   ELECTROCARDIOLOGY   0 0 0 0 0 0 0 0 47. 00   48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0 0 0 0 0 0 0 0 48. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   142 0 0 0 0 0 0 0 49. 00   50. 00   50500   DENTAL CARE - TITLE XIX ONLY   0 0 0 0 0 0 0 0 0 50. 00   50. 00   50500   DENTAL CARE - TITLE XIX ONLY   0 0 0 0 0 0 0 0 0 0 50. 00   50. 00   50500   DENTAL CARE - TITLE XIX ONLY   0 0 0 0 0 0 0 0 0 0 50. 00   51. 00   05100   SUPPORT SURFACES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	1					
47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   47. 00   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   142   0   0   0   0   0   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   142   0   0   0   0   0   50. 00   05000   DRITAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   51. 00   OUTPATIENT SERVICE COST CENTERS   60. 00   06000   CLI NI C   0   0   0   0   0   0   61. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   62. 00   OUTPATIENT SERVICE COST CENTERS   70. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   71. 00   07100   AMBULANCE   112   0   0   0   0   0   71. 00   71. 00   07100   AMBULANCE   112   0   0   0   0   0   71. 00   71. 00   07100   AMBULANCE   112   0   0   0   0   0   71. 00   80. 00   08100   INTEREST EXPENSE   81. 00   81. 00   08100   INTEREST EXPENSE   82. 00   82. 00   08200   MOSPICE   SUBTOTALS (Sum of Lines 1-84)   106,245   151,694   48,436   9,786   97,630   89. 00   NONNEI MBURSABLE COST CENTERS   0   0   0   0   0   91. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   92. 00   09200   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   0   0   92. 00   09200   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   0   0   93. 00   09300   NONPAID WORKERS   0   0   0   0   0   0   94. 00   09400   PATIENTS LAURDRY   0   0   0   0   0   95. 01   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   0   96. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   0   96. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   0   96. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   0   96. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   97. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   97. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   97. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   97. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0   0   97. 00   09500   PHYSI CLANS PRIVATE OFFICES   0   0   0				2,013		130	0	
48.00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   48.00   49.00   04900   DRUGS CHARGED TO PATIENTS   142   0   0   0   0   0   50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   61.00   06100   SUPPORT SURFACES   0   0   0   0   0   0   61.00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   62.00   06200   FOHC   0   0   0   0   0   0   63.00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   64.00   06200   FOHC   0   0   0   0   0   0   65.00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   66.00   06200   FOHC   0   0   0   0   0   67.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   71.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   73.00   07300   CMHC   0   0   0   0   0   0   0   73.00   07300   CMHC   SPECIAL PURPOSE COST CENTERS		1 1	1	0	0	0	0	
49.00   04900   DRUGS CHARGED TO PATIENTS   142   0   0   0   0   0   49.00		1 1	1	0	0	0	0	
50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   50. 00			-1	0	0	0		
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0			1	0	0	0		
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT CLINIC   OUTPATIE			-			0		
60.00   06000   CLINIC   0   0   0   0   0   0   0   0   0	31.00		<u> </u>			<u> </u>	0	31.00
61. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   62. 00   62. 00   06200   FOHC   0   0   0   0   0   0   62. 00   70. 00   OTHER REI MBURSABLE COST CENTERS	60 00		0	0	1	O	0	60 00
62. 00   06200   FOHC   OTHER REIMBURSABLE COST CENTERS						-	0	
OTHER REIMBURSABLE COST CENTERS   O		1 1		· ·	Ĭ	Ğ	١	
70.00	02.00							02.00
71. 00	70. 00		0	0	0	0	0	70. 00
73.00   07300   CMHC   SPECIAL PURPOSE COST CENTERS   S0.00   SPECIAL PURPOSE COST CENTERS   S0.00   SPECIAL PURPOSE COST CENTERS   S0.00   S08100   INTEREST EXPENSE   S0.00   S08200   UTI LI ZATI ON REVIEW - SNF   S0.00   SUBTOTALS (sum of lines 1-84)   106, 245   151, 694   48, 436   9, 786   97, 630   89.00   SUBTOTALS (sum of lines 1-84)   106, 245   151, 694   48, 436   9, 786   97, 630   89.00   NONREI MBURSABLE COST CENTERS   S0.00   S0900   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   S0.00   S0900   PHYSI CI ANS PRI VATE OFFI CES   S0.00   S0.00   S0900   PHYSI CI ANS PRI VATE OFFI CES   S0.00   S0.00   S0900			1			_	0	
SPECIAL PURPOSE COST CENTERS   80.00		1 1	1			_		
80. 00 81. 00 81. 00 81. 00 82. 00 82. 00 82. 00 83. 00 84. 436 85. 00 8			-1	-		-1	_	
81. 00	80.00							80. 00
82. 00   08200   UTILIZATION REVIEW - SNF   0   0   0   0   0   0   83. 00							  -	
83. 00   08300   HOSPI CE   0   0   0   0   0   0   83. 00   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   91. 00   91. 00   91. 00   92. 00   92. 00   92. 00   93. 00   93. 00   94. 00   94. 00   95. 01   95. 01   95. 01   99. 00		1 1					  -	
SUBTOTALS (sum of lines 1-84)   106, 245   151, 694   48, 436   9, 786   97, 630   89.00			o	0	0	o	0	83. 00
NONREI MBURSABLE COST CENTERS   90.00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0	89. 00	SUBTOTALS (sum of lines 1-84)	106, 245	151, 694	48, 436	9, 786	97, 630	89. 00
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   90. 00   91. 00   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   0   0   93. 00   94. 00   09400   PATI ENTS LAUNDRY   0   0   0   0   0   94. 00   95. 01   09500   PHYSI CI ANS AND NURSE PRACTITIONERS   0   0   0   0   0   95. 01   98. 00   Cross Foot Adjustments   0   0   0   0   98. 00   99. 00   Negative Cost Centers   0   0   0   0   0   99. 00						,	,	
91. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   91. 00   92. 00   92. 00   93. 00   93. 00   93. 00   93. 00   94. 00   94. 00   94. 00   94. 00   95. 01   95. 01   95. 01   95. 01   97. 00   97.	90.00		0	0	0	0	0	90.00
93. 00   09300   NONPAI D WORKERS   0   0   0   0   0   93. 00   94. 00   94. 00   95. 00   95. 00   95. 00   95. 01   97. 01   98. 00   0   0   0   0   0   0   97. 01   99. 00   0   0   0   0   0   0   0   0   0	91.00		0	0	0	0	0	91.00
94. 00   94. 00   94. 00   95. 00   95. 00   95. 00   95. 00   95. 01   96. 00   97. 01   98. 00   99.	92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	92. 00
95. 00   09500   PHYSI CI ANS AND NURSE PRACTITIONERS   0   0   0   0   95. 00   95. 01   98. 00   0   0   0   95. 01   98. 00   0   0   0   0   98. 00   99. 00   0   0   0   0   0   99. 00   0   0   0   0   0   0   99. 00   0   0   0   0   0   0   0   0   0	93.00		0	0	0	О	0	
95. 00   09500   PHYSI CI ANS AND NURSE PRACTITIONERS   0   0   0   0   95. 00   95. 01   98. 00   0   0   0   95. 01   98. 00   0   0   0   0   98. 00   99. 00   0   0   0   0   0   99. 00   0   0   0   0   0   0   99. 00   0   0   0   0   0   0   0   0   0			0	0	0	o	0	
98.00   Cross Foot Adjustments   0 0 0 98.00 99.00   Negative Cost Centers   0 0 0 0 99.00			0	0	0	o	0	
98.00   Cross Foot Adjustments   0 0 0 98.00 99.00   Negative Cost Centers   0 0 0 0 99.00	95. 01	09501 PHYSI CI ANS	2, 373	3, 963	0	268	0	95. 01
99.00   Negative Cost Centers   0   0   0   0   99.00					0	o	0	
100. 00   TOTAL   108, 618   155, 657   48, 436   10, 054   97, 630 100. 00	99. 00	Negative Cost Centers	0	0	0	O	0	99. 00
	100.00	TOTAL	108, 618	155, 657	48, 436	10, 054	97, 630	100. 00

Health Financial Systems NEW JERSEY VETERANS HOME - MENLO PAR In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315459 Peri od: Worksheet B From 07/01/2020 Part II 06/30/2021 Date/Time Prepared: 11/19/2021 9:14 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE RECORDS & ADMI NI STRATI ON SERVICES & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPING 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 9 00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 10.00 56, 640 01100 PHARMACY 11.00 0 11.00 0 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 12.00 13.00 01300 SOCIAL SERVICE 0 0 8, 966 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 14.00 0 14.00 C 01500 RECREATION 15.00 0 0 Ω 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 0 0 8, 966 30.00 56, 640 03100 NURSING FACILITY 0 0 0 0 31.00 Λ 31.00 32.00 03200 | CF/IID 0 C 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 0 0 33.00 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 Λ 0 0 Λ 40.00 0 41.00 04100 LABORATORY 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000 0 0 0 0 0 0 0 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 04400 PHYSI CAL THERAPY 0 44.00 0 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 C 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 48.00 0 0 04900 DRUGS CHARGED TO PATIENTS 0 49.00 0 0 49.00 50 00 05000 DENTAL CARE - TITLE XIX ONLY Ω 0 0 50.00 05100 SUPPORT SURFACES 0 51.00 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 61.00 0 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 0 07100 AMBULANCE 0 71.00 Ω 0 71 00 73.00 07300 CMHC 0 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84)
NONREIMBURSABLE COST CENTERS 0 56, 640 0 8, 966 89.00 89.00 0 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 0 09100 BARBER AND BEAUTY SHOP 91.00 00000000 0 0 0 91.00 0

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8, 966 100. 00

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98.00

99.00

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0

56,640

92.00

93.00

94.00

95.00

95.01

98.00

99.00

100.00

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

09500 PHYSICIANS AND NURSE PRACTITIONERS

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

09501 PHYSI CI ANS

TOTAL

Period: Worksheet B
From 07/01/2020 Part II
To 04/20/2021 Part III
To 04/20/2021 Part III
To 04/20/2021 Part III
To 04/20/2021 Part III Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315459

COSE Center Description					1	o 06/30/2021	Date/Time Pre	pared:
BINESIAL SERVICE COSTS - BLOCS S FIXTURES   16.00   16.00   17.00   18.00   10.00   17.00   18.00   10.00   17.00   18.00   10.00   17.00   18.00   10.00   17.00   18.00   10.00   17.00   18.00   10.00   17.00   18.00   10.00   17.00   18.00   18.00				OTHER GENERAL			11/19/2021 9:	14 am
SENSEAL SERVICE COST SENTERS   SUBCRAFT								
SENDRAL SERVICE COST CENTERS   14,000   15,000   16,000   17,000   18,000   1,100		Cost Center Description		RECREATION	Subtotal		Total	
CENERAL SERVICE COST CENTERS						Adjustillents		
1.00				15. 00	16. 00	17. 00	18. 00	
2.00								
3.00   0.0300   EMPLOYEE BENEFIT IS								
4.00   00400   AMIN INSTINATIVE & CERREAL								
5.00		1						
1.00   00000   DIETARY		1						
8.00   0.00800   DIFTARY		· · · · · · · · · · · · · · · · · · ·						
9.00	7.00							7. 00
10.00   010000   CENTRAL SERVICES & SUPPLY								
11. 00   01100   PHARMACY								
12.00   01200   MEDICAL RECORDS & LIBRARY								
13. 00   01300   SOCIAL SERVI CE								
14. 00   O1400   RUBSING AND ALLIED HEALTH EDUCATION   0   4, 180   15, 00   1500   1500   1500   1600   1600   17, 123, 695   30, 00   30, 00   3000   3000   50								
IMPATI ENT ROUTINE SERVICE COST CENTERS	14.00		0					14. 00
30.00   03000   03000   0310   031.00   031.00   031.00   031.00   031.00   031.00   031.00   031.00   031.00   031.00   032.00   032.00   032.00   032.00   033.00	15. 00		0	4, 180				15. 00
31.00   03100   NURSING FACILITY								
32.00   03200   10F/I ID   0   0   0   0   0   0   33.00			1			-		
33. 00   03300   OTHER LONG TERN CARE			1			_		
ANCILLARY SERVICE COST CENTERS			1	-	-	_	-	
40.00	33. 00		١	<u> </u>		٥		33.00
42.00   04200   INTRAVERIOUS THERAPY   0   0   0   0   0   42.00	40.00		0	0	27	0	27	40. 00
43.00   04300   04300   0400   PHYS ICAL THERAPY   0   0   0   23.024   0   23.024   44.00   44.00   44.00   04400   PHYS ICAL THERAPY   0   0   0   15,782   0   15,782   45.00   46.00   04600   04600   04600   04600   04600   04600   04600   04600   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   04000   04.00   0	41.00		0	0	3, 111	0	3, 111	41. 00
44. 00   04400   PHYSI CAL THERAPY   0   0   23,024   0   23,024   44. 00   45. 00   04500   OCCUPATI ONAL THERAPY   0   0   0   15,782   0   15,782   45. 00   46. 00   04600   SPEECH PATHOLOGY   0   0   0   0   0   315   0   315   47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   51. 00   05000   SUPPORT SURFACES   0   0   0   0   0   0   0   0   61. 00   06000   CLINIC COST CENTERS   0   0   0   0   0   0   0   0   61. 00   06000   CLINIC COST CENTERS   0   0   0   0   0   0   0   0   61. 00   06000   CLINIC COST CENTERS   0   0   0   0   0   0   0   0   61. 00   07000   HORE HEALTH AGENCY COST   0   0   0   0   0   0   0   0   62. 00   07000   HORE HEALTH AGENCY COST   0   0   0   0   0   0   0   0   71. 00   07100   AMBULLANCE   0   0   0   0   0   0   0   0   72. 00   07300   CMHC   0   0   0   0   0   0   0   0   73. 00   07500   CMHC   0   0   0   0   0   0   0   0   74. 00   08100   INTEREST EXPENSE   82. 75. 00   08200   UTILIZATION REVIEW - SNF   82. 00   0   0   0   0   0   0   76. 00   09000   GIFT. FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   77. 00   09000		1 I	0	0	0	0		
45. 00   04500   OCCUPATIONAL THERAPY   0   0   15, 782   0   15,782   45. 00   46. 00   04600   SPEECH PATHOLOGY   0   0   0   315   0   315   46. 00   47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   47. 00   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   48. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   50. 00   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0   60. 00   06000   CLI NI C   0   0   0   0   0   0   0   0   0		1 1	0	0	0	0		
46. 00   04600   SPEECH PATHOLOGY   0   0   315   0   315   46. 00   47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   142   0   142   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   142   0   0   50. 00   50500   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   61. 00   06000   CLINI C   0   0   0   0   0   0   0   0   61. 00   06000   CLINI C   0   0   0   0   0   0   0   0   61. 00   06000   CLINI C   0   0   0   0   0   0   0   0   61. 00   05000   DENTAL HEALTH CLINI C   0   0   0   0   0   0   0   0   61. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   61. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   61. 00   07100   AMBULANCE   0   0   0   0   0   0   0   0   61. 00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   61. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   80. 00   61. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   81. 00   61. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   81. 00   61. 00   08000   MALPRACTI CE PREMI UMS & PAID LOSSES   81. 00   61. 00   09000   0			0	O O		0		
47. 00   04700   LECTROCARDI OLOGY   0   0   0   0   0   47. 00   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   49. 00   04900   DRUGS CHARGED TO PATIENTS   0   0   142   0   142   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05100   SUPPORT SURFACES   0   0   0   0   0   0   00   00   0			0	0		0		
48. 00   04800 MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   142   0   142   49. 00   49. 00   04900 DRUGS CHARGED TO PATIENTS   0   0   0   142   0   142   49. 00   50. 00   05000 DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000 DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000 DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000 DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   51. 00   05000 DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   60. 00   06000 CLINIC   0   0   0   0   0   0   0   61. 00   06000 CLINIC   0   0   0   0   0   0   0   61. 00   06000 CLINIC   0   0   0   0   0   0   0   62. 00   06000 CLINIC   0   0   0   0   0   0   62. 00   06000 CLINIC   0   0   0   0   0   0   63. 00   05000 DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   64. 00   06000 CLINIC   0   0   0   0   0   0   0   65. 00   06000 CLINIC   0   0   0   0   0   0   0   66. 00   06000 CLINIC   0   0   0   0   0   0   0   67. 00   07000 HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   71. 00   07000 HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   71. 00   07300 CMHC   0   0   0   0   0   0   0   0   71. 00   07300 CMHC   0   0   0   0   0   0   0   0   71. 00   07300 CMHC   0   0   0   0   0   0   0   71. 00   08000 MALPRACTICE PREMIUMS & PAID LOSSES   80. 00   81. 00   08000 MALPRACTICE PREMIUMS & PAID LOSSES   80. 00   82. 00   08200 UNITLIZATION REVIEW - SNF   80. 00   0   0   0   0   0   83. 00   08300 HOSPICE   0   0   0   0   0   0   0   89. 00   08000 MALPRACTICE XIVENTE   0   0   0   0   0   0   91. 00   09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   92. 00   09000 MINERABLE COST CENTERS   0   0   0   0   0   93. 00   09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   94. 00   09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   95. 00   09000 PATISTICIANS   0   0   0   0   0   96. 00   09000 PATISTICIANS   0   0   0   0   0   97. 00   09000 PATISTICIANS   0   0   0   0   0   0   97. 00		1	i o	Ö		o		
50.00     05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   50.00	48.00	1	0	0	0	0	0	48. 00
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   51.00			0	0		0	142	
OUTPATIENT SERVICE COST CENTERS			1	-	-	0		
60. 00   06000   CLINIC   0   0   0   0   0   0   0   0   0	51. 00		0	0	0	0	0	51.00
61. 00   06100   RURAL HEALTH CLINIC   0   0   0   0   0   0   62.00   62. 00   O6200   FOHC   0   0   0   0   0   62.00   62. 00   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   70. 00   O7100   AMBULANCE   0   0   0   0   0   0   71. 00   O7300   CMHC   0   0   0   0   0   0   73. 00   O7300   CMHC   0   0   0   0   0   0   74. 00   O7300   CMHC   0   0   0   0   0   0   75. 00   O7300   CMHC   0   0   0   0   0   0   76. 00   O8100   INTEREST EXPENSE   81.00   81. 00   O8100   INTEREST EXPENSE   81.00   82. 00   O8200   UTILIZATION REVIEW - SNF   82.00   83. 00   O8300   HOSPI CE   0   0   0   0   0   84. 00   SUBTOTALS (sum of lines 1-84)   0   4,180   1,166,208   0   1,166,208   89. 00   O9000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   91. 00   O9100   BARBER AND BEAUTY SHOP   0   0   0   0   0   92. 00   O9200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   94. 00   O9400   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   95. 00   O9500   PHYSI CI ANS AND NURSE PRACTITIONERS   0   0   0   0   96. 00   O9500   PHYSI CI ANS AND NURSE PRACTITIONERS   0   0   0   0   97. 00   Nogative Cost Centers   0   0   0   0   0   98. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   99. 00   Negative Cost Centers   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   0   90	60.00				0	٥	0	60 00
62. 00   06200   FOHC   OTHER REIMBURSABLE COST CENTERS			1	-		I		
70.00				J	· ·		ū	
71. 00		OTHER REIMBURSABLE COST CENTERS						
73.00			1					70. 00
SPECIAL PURPOSE COST CENTERS   80.00   08000   MALPRACTI CE PREMI UMS & PAI D LOSSES   80.00   81.00   08100   INTEREST EXPENSE   82.00   82.00   08200   UTI LI ZATI ON REVI EW - SNF   82.00   83.00   08300   HOSPI CE   0   0   0   0   0   0   0   83.00   89.00   0   0   0   0   0   0   0   0   0								
80. 00 81. 00 81. 00 81. 00 82. 00 82. 00 82. 00 82. 00 83. 00 83. 00 83. 00 85. 00 85. 00 86. 00 87. 00 88. 00 88. 00 88. 00 89. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80. 00 80	73. 00		] 0	0	0	0	0	73.00
81. 00	80 00							80 00
82. 00   08200   UTILIZATION REVIEW - SNF   0 0 0 0 0 0 0 83.00   89.00   SUBTOTALS (sum of lines 1-84) 0 4, 180 1, 166, 208 0 1, 166, 208 89.00   NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
83. 00   08300   HOSPI CE   0   0   0   0   0   0   0   83. 00   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   90000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   90. 00   91. 00   91. 00   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00   93. 00   97. 10   97								
NONREI MBURSABLE COST CENTERS   90.00   09000   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0	83.00		0	0	0	0	0	
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0	89. 00		0	4, 180	1, 166, 208	0	1, 166, 208	89. 00
91. 00   09100   BARBER AND BEAUTY SHOP   0   0   0   0   0   91. 00   92. 00   93. 00   93. 00   93. 00   93. 00   93. 00   94. 00   94. 00   94. 00   95. 00   97.			1					
92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   0   0   0   0   92. 00   93. 00   94. 00   94. 00   94. 00   94. 00   94. 00   95. 01   95. 01   95. 01   95. 01   96. 00   96. 01   96. 01   96. 00   96. 01   96. 00   96. 01   96. 00   96. 01   96. 00   96. 01   96. 00   96. 0			1		0	<u> </u>		
93. 00   09300   NONPAI D WORKERS   0 0 0 0 0 0 0 93. 00   94. 00   95. 00   95. 00   95. 00   97. 00			1	O O	0	0		
94. 00   94. 00   94. 00   95. 00   95. 00   95. 00   95. 00   95. 01   97. 00   97.		l	0	0	0	0	-	
95. 01   09501   PHYSI CI ANS   0   30, 589   0   30, 589   95. 01   98. 00   0   0   0   0   98. 00   99. 00   Negative Cost Centers   0   0   0   0   0   99. 00   0   0   0   0   0   0   0   0   0			l o	o	0	o		
98.00   Cross Foot Adjustments		l	0	o	0	o	0	
99.00   Negative Cost Centers   0   0   0   99.00			0	O	30, 589	О	30, 589	
		1 1	0	0	0	0		
100.00    101AL   0  4, 180  1, 196, 797  0  1, 196, 797 100.00			1	~	1 104 707	-	-	
	100.00	TOTAL	ı O	4, 180	1, 196, /9/	ų ų	1, 196, 797	100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider No.: 315459

					o 06/30/2021	Date/Time Pre 11/19/2021 9:	
		CAPI TAL REI	LATED COSTS			1171972021 9.	14 alli
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	SALARI ES) 3. 00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	77.	4.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	174, 642					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3. 00 4. 00	OO3OO  EMPLOYEE BENEFITS   OO4OO  ADMINISTRATIVE & GENERAL	0 15, 850	_	22, 022, 80 <sup>2</sup> 1, 539, 835		37, 498, 930	3. 00 4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	21, 310		1, 140, 927		3, 321, 607	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	6, 000		91, 720		181, 678	l
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	300		1, 626, 053		2, 643, 343 4, 167, 025	7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION	10, 613	0	2, 339, 812		4, 167, 025	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	6, 790	0	į (	0	656, 153	•
11. 00	01100 PHARMACY	0	0	(	0	0	11.00
	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	900	_	381, 194	0	0 590, 348	12. 00 13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0		301, 172			14. 00
15. 00	01500 RECREATION	0	0	941, 593	3 0	1, 442, 991	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	104 000	0	12 440 04	1	21 440 2/2	20.00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	104, 909		13, 448, 064	0	21, 440, 263 0	30. 00 31. 00
	03200   CF/IID	0		d	0	Ō	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	(	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS  04000 RADI OLOGY	0	0		) 0	9, 417	40. 00
41. 00	04100 LABORATORY		0				1
	04200 I NTRAVENOUS THERAPY	0	0	(	0	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	(	0	0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	2, 692 1, 778	l .			456, 217 500, 313	
	04600 SPEECH PATHOLOGY	0				108, 825	
	04700 ELECTROCARDI OLOGY	0	0	(	0	0	•
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	(	0	0 48, 983	48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY		0			40, 903	50.00
51. 00	05100 SUPPORT SURFACES	0	0	(	0	0	ı
	OUTPATIENT SERVICE COST CENTERS		1				
60. 00 61. 00	06000   CLINIC   06100   RURAL HEALTH CLINIC	0			-	0	60. 00 61. 00
62. 00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	1	_	1	-		
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0			-	_	70. 00 71. 00
73. 00	07300 CMHC		0				73.00
	SPECIAL PURPOSE COST CENTERS	1	1	1		1	
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	O8100  INTEREST EXPENSE   O8200  UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	0			0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	171, 142	0	21, 509, 198	-3, 786, 315	36, 679, 878	89. 00
90. 00	NONREIMBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	1 0	0			0	90.00
	09100 BARBER AND BEAUTY SHOP	0			-		91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	_		0	0	92. 00
	09300 NONPAID WORKERS	0	0	(	0	0	
94. 00 95. 00	09400 PATIENTS LAUNDRY 09500 PHYSICIANS AND NURSE PRACTITIONERS		0			0	94. 00 95. 00
95. 01	09501 PHYSI CI ANS	3, 500	0	513, 606	5 0	819, 052	•
98. 00	Cross Foot Adjustments						98. 00
99. 00 102. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 196, 797	0	11 707 145		3, 786, 315	99.00
102.00	Part I)	1, 190, 797		11, 727, 143		3, 780, 315	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	6. 852859	0. 000000	0. 532500		0. 100971	1
104. 00						108, 618	104. 00
105. 00	Part II)   Unit cost multiplier (Wkst. B, Part			0. 000000		0. 002897	105. 00
	II)						

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315459

Peri od: Worksheet B-1 From 07/01/2020

06/30/2021 Date/Time Prepared: 11/19/2021 9:14 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATI ON, LINEN SERVICE (SQUARE FEET) (MEALS SERVED) ADMINISTRATION MAINT. & (POUNDS OF REPAI RS LAUNDRY) (DI RECT (SQUARE FEET) NURSI NG) 7.00 5.00 6.00 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 137, 482 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6,000 65,060 6.00 7.00 00700 HOUSEKEEPI NG 300 131, 182 7.00 8.00 00800 DI ETARY 10, 613 10, 613 195, 180 8.00 00900 NURSING ADMINISTRATION 9 00 0 9 00 C 10.00 01000 CENTRAL SERVICES & SUPPLY 6, 790 6, 790 0 0 10.00 01100 PHARMACY C 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 0 0 0 12.00 01300 SOCIAL SERVICE 900 0 900 13 00 13 00 Ω 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C 0 0 0 14.00 01500 RECREATION 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 104, 909 65,060 104, 909 195, 180 0 30.00 03100 NURSING FACILITY 0 31.00 31.00 32.00 03200 | CF/IID 0 32.00 0 0 0 03300 OTHER LONG TERM CARE 33.00 0 Ω 0 0 0 33 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 40.00 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 0 0 0 43.00 04400 PHYSI CAL THERAPY 44.00 2.692 2,692 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 1.778 1,778 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 0 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48 00 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 r 0 0 0 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 Ω 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω  $\cap$ 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83 00 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 133, 982 65,060 127, 682 195, 180 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 C 0 91.00 09100 BARBER AND BEAUTY SHOP C 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 09300 NONPALD WORKERS 0 0 93.00 0 0 93.00 0 94 00 09400 PATIENTS LAUNDRY 0 O 94 00 Ω 0 |09500| PHYSICIANS AND NURSE PRACTITIONERS 95.00 0 Ω 0 0 95.00 09501 PHYSI CI ANS 3,500 3,500 95.01 95.01 98.00 Cross Foot Adjustments 98.00 99 00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 3, 656, 993 359, 621 2, 918, 224 5, 106, 171 0 102.00 Part I) Unit cost multiplier (Wkst. B, Part I) 26. 599795 103.00 5.527528 22. 245613 26. 161343 0.000000 103.00 0 104.00 104.00 Cost to be allocated (per Wkst. B, 10,054 97,630 155, 657 48, 436 Part II) 0. 000000 105. 00 105.00 Unit cost multiplier (Wkst. B, Part 1. 132199 0.744482 0.076642 0.500205 II)

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315459

Peri od: Worksheet B-1 From 07/01/2020

06/30/2021 Date/Time Prepared: 11/19/2021 9:14 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND SERVICES & RECORDS & ALLI ED HEALTH (COSTED SUPPLY REQUIS) LI BRARY (PATIENT DAYS) **EDUCATION** (ASSI GNED (COSTED (SOUARE FEET) REQUIS) TIME) 12.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 2, 156, 921 10.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 12.00 01300 SOCIAL SERVICE 0 0 13 00 Ω 65.060 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 14.00 01500 RECREATION 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 2, 156, 921 0 0 65,060 0 30.00 03100 NURSING FACILITY 0 0 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 0 03300 OTHER LONG TERM CARE 0 33.00 0 Ω 0 33 00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 40.00 0 0 41.00 04100 LABORATORY 0 0 0 41.00 0000000 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 44.00 0 44.00 04500 OCCUPATIONAL THERAPY 0 45.00 0 45.00 04600 SPEECH PATHOLOGY 0 46.00 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 0 48.00 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 r 0 50.00 05100 SUPPORT SURFACES 0 51.00 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 C 0 61.00 0 Ω 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 70.00 0 Ω 0 0 Λ 71.00 07100 AMBULANCE 0 C 0 0 0 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 C 0 Λ 83 00 89.00 SUBTOTALS (sum of lines 1-84) 2, 156, 921 0 65,060 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GLFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 09300 NONPALD WORKERS 0 0 93.00 0 0 93.00 0 0 94 00 09400 PATIENTS LAUNDRY 0 94.00 Ω 0 |09500| PHYSICIANS AND NURSE PRACTITIONERS 0 95.00 0 0 0 95.00 09501 PHYSI CI ANS 95.01 95.01 98.00 Cross Foot Adjustments 98.00 99 00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 1,054,066 0 693, 917 0 102.00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 0.488690 0.000000 0.000000 10.665801 0.000000 103.00 8, 966 0 104.00 104.00 Cost to be allocated (per Wkst. B, 56, 640 Part II) 0. 000000 105. 00 105.00 Unit cost multiplier (Wkst. B, Part 0.026260 0.000000 0.000000 0. 137811 II)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315459 

				To 06/30/2021	Date/Time Prepared: 11/19/2021 9:14 am
			OTHER GENERAL		117 177 2021 7. 11 dill
			SERVI CE		
		Cost Center Description	RECREATION		
			(PATIENT DAYS) 15.00		
	GENER	AL SERVICE COST CENTERS	10100		
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 5. 00	1	ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS			4. 00 5. 00
6. 00	1	LAUNDRY & LINEN SERVICE			6. 00
7.00		HOUSEKEEPI NG			7. 00
8.00	4	DI ETARY			8. 00
9.00		NURSI NG ADMI NI STRATI ON			9.00
10. 00 11. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY			10.00
12. 00	1	MEDICAL RECORDS & LIBRARY			12.00
13. 00	1	SOCIAL SERVICE			13. 00
14.00	4	NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00		RECREATION	65, 060		15. 00
30. 00		ENT ROUTINE SERVICE COST CENTERS SKILLED NURSING FACILITY	65, 060		30.00
31. 00		NURSING FACILITY	03,000		31. 00
32. 00		ICF/IID	o		32. 00
33. 00		OTHER LONG TERM CARE	0		33. 00
		LARY SERVICE COST CENTERS			
40. 00 41. 00		RADI OLOGY LABORATORY	0		40. 00 41. 00
41.00	1	INTRAVENOUS THERAPY	0		42.00
43. 00	1	OXYGEN (INHALATION) THERAPY	o		43. 00
44.00		PHYSI CAL THERAPY	0		44.00
45. 00		OCCUPATI ONAL THERAPY	0		45. 00
46.00		SPEECH PATHOLOGY	0		46.00
47. 00 48. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0		47. 00 48. 00
49. 00	4	DRUGS CHARGED TO PATIENTS	o		49. 00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	O		50. 00
51. 00		SUPPORT SURFACES	0		51. 00
60. 00		TIENT SERVICE COST CENTERS CLINIC	O		60.00
61. 00	4	RURAL HEALTH CLINIC	o		61. 00
62. 00	06200	FQHC			62. 00
70.00		REI MBURSABLE COST CENTERS			70.00
70. 00 71. 00	4	HOME HEALTH AGENCY COST AMBULANCE	0		70. 00 71. 00
	07100				73.00
	_	AL PURPOSE COST CENTERS	-		
		MALPRACTICE PREMIUMS & PAID LOSSES			80.00
		INTEREST EXPENSE UTILIZATION REVIEW - SNF			81. 00 82. 00
83. 00	1	HOSPICE	0		83. 00
89. 00		SUBTOTALS (sum of lines 1-84)	65, 060		89. 00
		MBURSABLE COST CENTERS			
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90.00
91. 00 92. 00		BARBER AND BEAUTY SHOP PHYSICIANS PRIVATE OFFICES	0		91. 00 92. 00
93. 00	4	NONPALD WORKERS	0		93. 00
94. 00	4	PATI ENTS LAUNDRY	O		94. 00
95.00	09500	PHYSICIANS AND NURSE PRACTITIONERS	O		95. 00
95. 01	09501	PHYSI CI ANS	0		95. 01
98. 00 99. 00		Cross Foot Adjustments Negative Cost Centers			98. 00 99. 00
102.00		Cost to be allocated (per Wkst. B,	1, 588, 691		102.00
50		Part I)			
103.00	4	Unit cost multiplier (Wkst. B, Part I)	24. 418860		103. 00
104.00	اد	Cost to be allocated (per Wkst. B, Part II)	4, 180		104. 00
105.00	o	Unit cost multiplier (Wkst. B, Part	0. 064248		105. 00
		11)			

Health Financial Systems	NEW JERSEY VETERANS HOME	- MENLO PAR	In Lie	u of Form CMS-2540-10
DATIO OF COST TO CHARGES FOR A	NCLLLADY AND OUTDATLENT COST CENTEDS	Provider No : 315/50	Pari ad:	Workshoot C

Health Financial Systems New Jersey Veterans Home - Menlo	PAR	In Lie	u of form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS Provider		Peri od:	Worksheet C	
		From 07/01/2020 To 06/30/2021	Date/Time Prep 11/19/2021 9:	
Cost Center Description	Total (from	Total Charges	Ratio (col. 1	
	Wkst. B, Pt I	,	di vi ded by	
	col . 18)		col. 2	
	1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS				
40. 00   04000   RADI OLOGY	10, 36			
41. 00  04100  LABORATORY	1, 182, 46	8 28, 406	41. 627403	41. 00
42. 00   04200   I NTRAVENOUS THERAPY		0	0.000000	42.00
43.00   04300   OXYGEN (I NHALATI ON) THERAPY		0 0	0.000000	43.00
44. 00   04400 PHYSI CAL THERAPY	633, 77	4 539, 785	1. 174123	44.00
45. 00   04500   OCCUPATI ONAL THERAPY	637, 67	7 602, 576	1. 058252	45.00
46. 00   04600   SPEECH PATHOLOGY	119, 81	3 148, 530	0. 806659	46.00
47. 00  04700  ELECTROCARDI OLOGY		0 0	0.000000	47.00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS		0 0	0.000000	48. 00
49.00   04900   DRUGS CHARGED TO PATIENTS	53, 92	9 60, 980	0. 884372	49.00
50.00   05000   DENTAL CARE - TITLE XIX ONLY		0 0	0.000000	50.00
51. 00   05100   SUPPORT SURFACES		0 0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS				
60. 00   06000  CLI NI C		0 0	0.000000	60.00
61.00   06100   RURAL HEALTH CLINIC				61.00
62. 00   06200  FQHC				62.00
71. 00   07100   AMBULANCE	42, 59	9 38, 692	1. 100977	71.00
100. 00 Total	2, 680, 62	1, 424, 390		100. 00

Health Financial Systems NEW	JERSEY VETERANS	HOME - MENLO	PAR	In Lie	eu of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/19/2021 9:	
		Ti tl a	XVIII (1)	Skilled Nursing		14 alli
		11116	XVIII (1)	Facility	113	
		Heal th Care Pi	rogram Charges		Program Cost	
			3 3		3	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
ANCI LLARY SERVI CE COST CENTERS		T	T		Г	
40. 00 04000 RADI OLOGY	1. 912562			0 10, 368		
41. 00   04100   LABORATORY	41. 627403			0 1, 182, 468	l .	1
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 174123			0 139, 554	0	
45. 00 04500 OCCUPATI ONAL THERAPY	1. 058252			0 143, 502	<b>l</b>	
46. 00 04600 SPEECH PATHOLOGY	0. 806659			0 58, 019	1	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	0	1 .0.00
49. 00 04900 DRUGS CHARGED TO PATIENTS	0. 884372			0 45, 081	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS		1	1			
60. 00 06000 CLI NI C	0. 000000	0		0	0	
61. 00 06100 RURAL HEALTH CLINIC						61. 00
62. 00   06200   FQHC						62.00
71. 00 07100 AMBULANCE (2)	1. 100977			0	0	
100.00   Total (Sum of Lines 40 - 71)		411, 188		0 1, 578, 992	0	100.00

<sup>(1)</sup> For title V and XIX use columns 1, 2, and 4 only.

<sup>(2)</sup> 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 NEW J	JERSEY VETERANS	HOME - MENLO	PAR	In Lie	eu of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 07/01/2020 To 06/30/2021	Worksheet D Parts II-III Date/Time Pre 11/19/2021 9:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C. column 3.	line 49)	0. 884372	1.00
2.00	Program vaccine charges (From your reco					10, 005	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	vi ders, transf	er this amoun <sup>.</sup>	to Worksheet	8, 848	3. 00
	E, Part I, line 18)				_		
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health		Cost (From	& Allied	
			(From Wkst. B,			Heal th Costs	
		18	Part I, Col. 14)	Costs to Tota Costs - Part		for Pass Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		3 X 001. 4)	
		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	10, 368		0.00000			
41.00	04100 LABORATORY	1, 182, 468	C	0.00000		0	
42.00	04200 I NTRAVENOUS THERAPY	0	C	0.00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C	0.00000		0	
44. 00	04400 PHYSI CAL THERAPY	633, 774		0.00000			44.00
45. 00	04500 OCCUPATI ONAL THERAPY	637, 677		0.00000		l e	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	119, 813		0.00000 0.00000		l	46. 00 47. 00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.00000		0 1	
49. 00	04900 DRUGS CHARGED TO PATTENTS	53, 929		0.00000		0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	JJ, 727		0.00000		0	
	05100 SUPPORT SURFACES	0		0.00000		0	
100.00		2, 638, 029		1	1, 578, 992		100.00
		'	'	•			•

)MPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315459	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D-1 Parts I-II Date/Time Pre 11/19/2021 9:	epare
		Title XVIII	Skilled Nursing Facility	PPS	17 0
			raciiity	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	$\vdash$
	INPATIENT DAYS				1
00	Inpatient days including private room days			65, 060	1.
00	Private room days			0	2.
00	Inpatient days including private room days applicable to the $$			2, 467	
00	Medically necessary private room days applicable to the Progr	ram		0	
00	Total general inpatient routine service cost			37, 531, 906	5.
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges			11, 570, 270	6
00 00	General impatient routine service charges  General inpatient routine service cost/charge ratio (Line 5)	divided by line 6)		3. 243823	
00	Enter private room charges from your records	divided by Title 0)		0. 243023	1
00	Average private room per diem charge (Private room charges Li	ne 8 divided by private	room days line	0.00	
-	2)				'
00	Enter semi-private room charges from your records			0	10
00	Average semi-private room per diem charge (Semi-private room	m charges line 10, divide	d by	0.00	11
	semi-private room days)				
00	Average per diem private room charge differential (Line 9 mir			0.00	
00	Average per diem private room cost differential (Line 7 times			0.00	1 .
00	Private room cost differential adjustment (Line 2 times line General inpatient routine service cost net of private room co		minus Lino 14)	0 37, 531, 906	
00	PROGRAM INPATIENT ROUTINE SERVICE COSTS	ost differential (Line 5	III Tius TTTIE 14)	37, 331, 700	- '`
00	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		576. 88	16
00	Program routine service cost (Line 3 times line 16)	,		1, 423, 163	17
00	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18
00	Total program general inpatient routine service cost (Line 1			1, 423, 163	
00	Capital related cost allocated to inpatient routine service of	costs (From Wkst. B, Par	t II column 18,	1, 123, 695	20
00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			17 27	1
00	Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21)			17. 27 42. 605	
00	Inpatient routine service cost (Line 19 minus line 22)			1, 380, 558	
	Aggregate charges to beneficiaries for excess costs (From pr	rovi den irecords)		1, 300, 330	
00	Total program routine service costs for comparison to the cost		nus line 24)	1, 380, 558	
00	Enter the per diem limitation (1)	,		, ,	26
00	Inpatient routine service cost limitation (Line 3 times the	per diem limitation line	26) (1)		27
00	Reimbursable inpatient routine service costs (Line 22 plus		line 27)		28
	(Transfer to Worksheet E, Part II, line 4) (See instructions)				
Li	nes 26 and 27 are not applicable for title XVIII, but may be u	used for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COST	TS FOR PPS PASS-THROUGH			
00	Total SNF inpatient days			65, 060	1
00	Program inpatient days (see instructions)			2, 467	
00	Total nursing & allied health costs. (see instructions) (Do no	ot complete for titles V	or XIX)	0 0. 037919	
00	Nursing & allied health ratio. (line 2 divided by line 1)				·l 4

Health Financial Systems	NEW JERSEY VETERANS HOM	E - MENLO PAR	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FO	OR TITLE XVIII	Provider No.: 315459	From 07/01/2020	Worksheet E Part I Date/Time Prepared: 11/19/2021 9:14 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS	
	DART A LINDATIENT CERVICE DRC DROWNER COMPUTATION OF DELIMBURG	ГМЕМТ		1. 00	
1. 00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS Inpatient PPS amount (See Instructions)	EMENI		1, 663, 849	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	(monto)	+	1, 663, 649	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	ymerrts)	ł	1, 663, 849	3. 00
4. 00	Primary payor amounts			1, 003, 049	4. 00
5.00	Coi nsurance			299, 420	5. 00
6.00	Allowable bad debts (From your records)			277, 420	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		0	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)	011 0113)		0	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)			1, 364, 429	
12. 00	Interim payments (See instructions)			1, 364, 429	
13. 00	Tentati ve adjustment			0	
14. 00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15. 00	Balance due provider/program (see Instructions)			0	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		
17. 00	Ancillary services Part B			0	
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			8, 848	
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			8, 848	
20. 00	Medicare Part B ancillary charges (See instructions)			10, 005	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			8, 848	
22. 00	Pri mary payor amounts			0	22. 00
23. 00	Coi nsurance and deducti bl es			0	23. 00
24. 00	Allowable bad debts (From your records)			0	
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			8, 848	
26. 00 27. 00	Interim payments (See instructions)			10, 005	
28. 00	Tentative adjustment			0	28. 00
28. 00	Other Adjustments (See instructions) Specify Demonstration payment adjustment amount before sequestration		+	0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration		+	0	28. 50 28. 55
28. 99	Sequestration amount (see instructions)		ł	0	28. 99
29. 00	Balance due provider/program (see instructions)			-1, 157	
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub 15-2	section 115 2	-1, 137	
30.00	processes smoothed (notice) of the object of the deconstant	5 27 GHO 1 GD. 10 Z,	110.2	٥	30.00

Health Financial Systems NEW JERSE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2540-10 Peri od: From 07/01/2020 To 06/30/2021 Provi der No.: 315459 Worksheet E-1 Date/Time Prepared: 11/19/2021 9:14 am Title XVIII Skilled Nursing PPS

Inpatient Part A					Facility		
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.00			I npati en	t Part A		t B	
Total Interlim payments paid to provider   1,364,429   10,005   1.00   2.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payments payable on Individual bills, either substited or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero   3.00   3.00			1. 00		3. 00	4. 00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero	1.00	Total interim payments paid to provider		1, 364, 429		10, 005	1.00
Services rendered in the cost reporting period. If none, enter zero   1.5 to separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   0	2.00	Interim payments payable on individual bills, either		0		0	2.00
Online   Contractor   Online   Online							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
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)							
For the cost reporting period. Also show date of each	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02   3.03   3.04   3.05   3.03   3.04   3.05   3.04   3.05	0.04						0.01
3.04 3.04 3.05 3.04 3.06 3.04 3.06 3.06 3.07 3.07 3.08 3.09 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09		ADJUSTMENTS TO PROVIDER					
3. 04   0   0   3. 04   3. 05   3. 0							
3.05   Provider to Program   0							
Provider to Program   ADJUSTMENTS TO PROGRAM   0							
3. 50   ADJUSTMENTS TO PROGRAM   0   0   3. 50     3. 51   3. 52   0   0   0   3. 51     3. 52   3. 53   0   0   0   3. 52     3. 53   3. 54   0   0   0   3. 53     3. 54   0   0   0   3. 53     3. 59   -3. 98   0   0   0   3. 59     -3. 98   0   0   0   0   3. 59     -3. 98   0   0   0   0   3. 59     -3. 98   0   0   0   0   0     -3. 98   0   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -3. 98   0   0   0   0     -4. 00   Terrarsfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)   0   0   0     -5. 00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   -5. 01   TENTATIVE TO PROVIDER   0   0   0   5. 01     -5. 02   5. 03     -5. 03   Provider to Program   0   0   0   5. 50     -5. 05   0   0   0   5. 50     -5. 99   Subtotal (Sum of lines 5. 01 - 5. 49 minus sum of lines 5. 50   0   0   5. 52     -5. 99   Subtotal (Sum of lines 5. 01 - 5. 49 minus sum of lines 5. 50   0   0   5. 59     -5. 99   Determined net settlement amount (balance due) based on the cost report. (1)   0   0   0     -6. 00   PROGRAM   0   0   0   0     -7. 90   Total Medicare program liability (see instructions)   1, 364, 429   8, 848   7. 00     -7. 00   Name of Contractor   8. 00   0   0     -7. 00   Name of Contractor   8. 00   0     -7. 00   Name of Contractor   8. 00   0     -7. 00   Name of Contractor   8. 00   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0   0     -7. 00   0   0   0	3.05	Dravi dan ta Dragnam		U		U	3. 05
3.51   0   0   3.51   3.52   3.53   0   0   0   3.52   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   3.59   3.98   Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   0   3.54   3.98	2 EO						2 50
3.52   3.53   3.54   3.99   3.53   3.54   3.99   3.53   3.54   3.99   3.59		ADJUSTIMENTS TO FROGRAM		- 1			
3.53   3.54   3.54   3.59				- 1			
3.54   3.99   Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   3.54     3.99   -3.98   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 1, 2, and 3.99)   1,364,429   10,005   4.00     Total interim payments (sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   5.01     Total interim payments (sum of lines 3.01 - 3.49 minus sum of lines 5.50   0   0   5.52     Tentative To Program   0				0		-	
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   0   0   3.99    -3.98				0			
- 3.98) Total interim payments (sum of lines 1, 2, and 3.99) (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 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 0 0 0 5.02 5.03 Provider to Program  5.50 TENTATIVE TO PROGRAM  6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER  6.00 Name of Contractor  8.00 Name of Contractor  8.00 Name of Contractor  1.00 2.00  8.00 Name of Contractor  1.00 Contractor Name		Subtotal (Sum of Lines 3.01 - 3.49 minus sum of Lines 3.50		- 1			
1, 364, 429   10, 005   4, 00	0. 77			Ŭ		Ĭ	0. 77
Carasfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)   TO BE COMPLETED BY CONTRACTOR	4.00			1, 364, 429		10, 005	4.00
TO BE COMPLETED BY CONTRACTOR				.,,		,	
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		26 for Part B)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATIVE TO PROVIDER							
Description						_	
Description		TENTATI VE TO PROVI DER					
Provider to Program							
TENTATI VE TO PROGRAM	5.03	Describilities to Describe		0		0	5. 03
5.51   5.52   5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   0   5.52     5.99   Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   0   5.99     - 5.98   0   0   5.99     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0   0   0     6.01   PROGRAM TO PROVIDER   0   0   0   0     6.02   PROVIDER TO PROGRAM   0   1,157   6.02     7.00   Total Medicare program liability (see instructions)   1,364,429   8,848   7.00     8.00   Name of Contractor   Number   1.00   2.00     8.00   Name of Contractor   8.00	E E0					0	E E0
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATIVE TO PROGRAM		- 1			
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   0   5.99   - 5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   PROGRAM TO PROVIDER   0   0   0   6.01   6.02   PROVIDER TO PROGRAM   0   1,157   6.02   7.00   Total Medicare program liability (see instructions)   1,364,429   8,848   7.00     7.00   Contractor Name   Contractor Number   1.00   2.00     8.00   Name of Contractor   8.00     8.00   Name of Contractor   8.00     8.00				-			
- 5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  - 5.98)  - 6.00  - 6.00  - 7.00 O		Subtatal (Sum of Lines 5 01 5 40 minus sum of Lines 5 50		0			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Name Contractor Name 8.00 Name of Contractor  8.00 Name of Contractor  8.00 Determined net settlement amount (balance due) based on the cost report. (6.00	J. 77			U		ا	5. 77
the cost report. (1) PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Name Contractor Number 1.00 2.00  8.00 Name of Contractor  8.00	6 00						6 00
6.01 PROGRAM TO PROVIDER O	0.00	` ,					0.00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Number 1.00 2.00  8.00 Name of Contractor 8.00 Name of Contractor	6. 01			0		0	6. 01
7.00         Total Medicare program liability (see instructions)         1,364,429         8,848         7.00           Contractor Name         Contractor Number           1.00         2.00           8.00         Name of Contractor         8.00		PROVI DER TO PROGRAM		0		1, 157	6. 02
Contractor Name   Contractor Number   1.00   2.00   8.00   Name of Contractor   8.00		1		1, 364, 429			
1.00         2.00           8.00         Name of Contractor         8.00					or Name		
8.00 Name of Contractor 8.00						Number	
ļ ļ				1.	00	2. 00	
		!					8. 00

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

Health Financial Systems

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

Provi der No.: 315459

| Period: | Worksheet G | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: | 11/19/2021 9: 14 am |

oni y)		General Fund	Speci fi c	Endowment Fund	11/19/2021 9: Plant Fund	14 am
			Purpose Fund			
	Assets	1. 00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand and in banks	0		1 1	0	
2. 00 3. 00	Temporary investments Notes receivable	0			0	
4. 00	Accounts recei vable				0	
5. 00	Other recei vabl es	0			0	
6. 00	Less: allowances for uncollectible notes and accounts	O	d	o o	0	
	recei vabl e					
7. 00	Inventory	0	C	0	0	
8.00	Prepaid expenses	0	(		0	
9. 00 10. 00	Other current assets Due from other funds	0	(		0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	0		1 1	0	
11.00	FIXED ASSETS	<u> </u>		91 91		1
12. 00	Land	0	C	0	0	12. C
13. 00	Land improvements	0	C	o	0	13.0
14. 00	Less: Accumulated depreciation	0	C		0	
15. 00	Bui I di ngs	0	C	0	0	
16.00	Less Accumulated depreciation	0			0	
17. 00 18. 00	Leasehold improvements Less: Accumulated Amortization	0		1	0	
19. 00	Fixed equipment			1	0	
20. 00	Less: Accumulated depreciation	0		1	0	
21. 00	Automobiles and trucks	0		ol ol	0	1
22. 00	Less: Accumulated depreciation	0	C	o	0	22. 0
23. 00	Major movable equipment	0	C	0	0	23.0
24. 00	Less: Accumulated depreciation	0	C	이	0	1
25. 00	Mi nor equipment - Depreciable	0	(	0	0	
26. 00	Minor equipment nondepreciable	0		1	0	1
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0		1	0	
20.00	OTHER ASSETS	<u> </u>		<u> </u>		20.0
29. 00	Investments	0	C	o	0	29. C
30. 00	Deposits on Leases	0		o	0	30.0
31. 00	Due from owners/officers	0	C	o	0	31.0
32. 00	Other assets	0	C	1 1	0	1
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0		1	0	
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	0		0	0	34.0
	CURRENT LIABILITIES					1
35. 00	Accounts payable	0	C	0	0	35. C
36. 00	Salaries, wages, and fees payable	0	C	o	0	36.0
37. 00	Payroll taxes payable	0	C	0	0	
38. 00	Notes & Loans payable (Short term)	0	(	0	0	
39. 00	Deferred income	0	(		0	
40. 00 41. 00	Accelerated payments Due to other funds		(		0	40. C
42. 00	Other current liabilities			1	0	1
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	0			0	
	LONG TERM LIABILITIES					
44. 00	Mortgage payable	0	C		0	1
45. 00	Notes payable	0	(	0	0	1
46. 00	Unsecured Loans	0	(	0	0	
47. 00	Loans from owners:	0			0	1
48. 00 49. 00	Other long term liabilities OTHER (SPECIFY)	0			0	
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		1	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	0		1	0	
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	0				52.0
53.00	Specific purpose fund		C			53.0
54.00	Donor created - endowment fund balance - restricted			0		54. (
55.00	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance Plant fund balance - invested in plant			١	0	56. ( 57. (
	prantrunu barance - rnvesteu III prant				0	
57. 00	Plant fund halance - reserve for plant improvement				U	1 50.
57. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					
57. 00 58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	0	C	0	0	59. (
56. 00 57. 00 58. 00 59. 00 60. 00	repl acement, and expansion	0	(	0 0	0	

In Lieu of Form CMS-2540-10 Health Financial Systems NEW JERSEY VETERANS HOME - MENLO PAR STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315459 Peri od: Worksheet G-1 From 07/01/2020 Date/Time Prepared: 11/19/2021 9: 14 am 06/30/2021 General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 11, 128, 846 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -11, 128, 846 2.00 3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 0 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 0 13.00 0000 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) 12.00

0

0

0

0

0

13.00

14. 00 15. 00

16.00

17.00

18.00

19.00

13. 00 14. 00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 13 - 17)

sheet (Line 11 - line 18)

Fund balance at end of period per balance

Heal th	Financial Systems NEW JERSEY VETERANS HOM	E - MENLO	PAR	In Li€	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 07/01/2020 To 06/30/2021		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1. 00	SKILLED NURSING FACILITY		11, 570, 27	'0	11, 570, 270	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		11, 570, 27	0	11, 570, 270	5. 00
	All Other Care Services		1			
6.00	ANCI LLARY SERVI CES		1, 424, 39	0	1 1, 121,070	6. 00
7.00	CLINIC			C	0	7. 00
8. 00	HOME HEALTH AGENCY COST			C	0	8. 00
9.00	AMBULANCE			C	0	9. 00
10. 00	RURAL HEALTH CLINIC			C	0	10. 00
10. 10	FQHC			C	0	10. 10
11. 00	CMHC			C	0	11. 00
	HOSPI CE			0 0	0	12. 00
13. 00	OTHER (SPECIFY)			0 0	1	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 Worksheet G-3, Line 1)	to	12, 994, 66	00 0	12, 994, 660	14. 00
	Cost Center Description		1			
	·			1. 00	2.00	
-	PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				28, 005, 669	1. 00
2.00	Add (Specify)			C		2. 00
3.00				C		3. 00
4.00				C		4. 00
5.00				C		5. 00
6.00				C		6. 00
7.00				C		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9.00	Deduct (Specify)			C		9. 00
10.00				C		10.00
11. 00				C		11. 00
12.00				C		12. 00
13.00				C		13. 00
14.00	Total Deductions (Sum of lines 9 - 13)				0	14. 00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				28, 005, 669	15. 00

Health Financial Systems	NEW JERSEY VETERANS HOME	E – MENLO	PAR			In Lie	u of Form CMS-2540	)-10
OTATEMENT OF BATHERIT BENEFILIES AND	ODEDATI NO EVENIONO			045450	D			

lealth Financial Systems NEW JERSEY VETERA	ANS HOME - MENLO PAR	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315459	Peri od: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prep 11/19/2021 9:	pared:
			1. 00	
1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3,			12, 994, 660	1.00
2.00 Less: contractual allowances and discounts on patients a	ccounts		0	2.00
8.00 Net patient revenues (Line 1 minus line 2)			12, 994, 660	3.00
1.00 Less: total operating expenses (From Worksheet G-2, Part	II, line 15)		28, 005, 669	4.00
5.00 Net income from service to patients (Line 3 minus 4)			-15, 011, 009	5.00
Other income:				
contributions, donations, bequests, etc			0	6.00
7.00 Income from investments			0	7. 00
3.00 Revenues from communications (Telephone and Internet se	rvi ce)		0	8.00
P.00 Revenue from television and radio service			0	9.00
0.00 Purchase di scounts			0	10.00
1.00 Rebates and refunds of expenses			0	11.00
2.00 Parking Lot receipts			0	12.00
3.00 Revenue from Laundry and Linen service			0	13.00
4.00 Revenue from meals sold to employees and guests			0	14.00
5.00 Revenue from rental of living quarters			0	15.00
6.00 Revenue from sale of medical and surgical supplies to other	her than patients		0	16.00
7.00 Revenue from sale of drugs to other than patients	•		0	17. 00
8.00 Revenue from sale of medical records and abstracts			0	18.00
9.00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
0.00 Revenue from gifts, flower, coffee shops, canteen			0	20.00
1.00 Rental of vending machines			0	21.00
2.00 Rental of skilled nursing space			0	22. 00
3.00 Governmental appropriations			0	23. 00
4.00 Other miscellaneous revenue (specify)			0	24. 00
4. 50 COVI D-19 PHE Funding			3, 882, 163	
5.00 Total other income (Sum of lines 6 - 24)			3, 882, 163	
6.00 Total (Line 5 plus line 25)			-11, 128, 846	
7.00 Other expenses (specify)			11, 120, 040	27. 00
8.00			0	28.00
9. 00			0	29.00
0.00 Total other expenses (Sum of lines 27 - 29)			0	30.00
81.00 Net income (or loss) for the period (Line 26 minus line	30)		-11, 128, 846	
1. 00   Met income (or 1055) for the period (Line 20 millios fine	30)	I	-11, 120, 840	31.00

Health Financia	al Systems NEW JERS	EY VETERANS H	OME - PARAMUS		U OT FORM CMS-2540-10
This separt is	required by law (42 USC 1395g; 42 CFR 413 since the beginning of the cost reporting	.20(b)), Fail	ure to report can resul	It in all interim 2 USC 1395g).	FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HE EPORT CERTIFICATION AND SETTLEMENT SUMMARY		Provider CCN: 315346	From 07/01/2020	Worksheet S Parts I, II & III Date/Time Prepared: 11/29/2021 11:27 am
PART I - COST	REPORT STATUS	A LIGHT FRANCE	TE TOTAL STREET	Date: 11/29/2	021 Time: 11:27 am
Provider use only	1. [ x ] Electronically prepared cost r 2. [ ] Manually prepared cost report 3. [ 0 ] If this is an amended report e 3.01 [ ] No Medicare Utilization. Enter	nter the numb	or leave blank for no.		
Contractor use only	4.[1]Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended  5.Date Received:	8.[ N ] Las 9.NPR Date 10.[ 0 ]If 11.Contract 12.[ F ] Med	st Cost Report for this t Cost Report for this	Provider CCN  : Enter number of	

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 NEW JERSEY VETERANS HOME - PARAMUS (315346) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
Belle		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 BIKO Hannibal			2
3 Signatory Title RUSINGS Manager			3
4 Date	-		4

Encryption Information
ECR: Date: 11/29/2021 Time: 11:27 am
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107			Tatle:	XATT		1
I ARREST		Title V	Part A	Part B	Title XIX	J.C.
THE SH		1.00	2.00	3.00	4.00	Jego
	PART III - SETTLEMENT SUMMARY				ol o	1.00
1.00	SKILLED NURSING FACILITY	0	Ů.		١	2.00
2.00	NURSING FACILITY	0			1 0	3.00
3.00	ICF/IID				٥	4.00
4.00	SNF - BASED HHA I	0	U.			5.00
5.00	SNF - BASED RHC I	0			ol	6-00
6.00	SNF - BASED FQHC I	0			ol .	7.00
	SNF - BASED CMHC I	0	0		0	100.00
100.00	TOTAL	-bl fan t	o alement of t	he above comp	The state of the s	

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.

ă.

Y

Cost Report Preparer Contact Information

19.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

20.00 Enter the employer/company name of the cost report preparer.

21.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

provider's records? If "Y" see Instructions.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEX STATISTICAL DATA

NEW JERSEY VETERANS HOWE - FARMOS

Provider No.: 315346

Period:
From 07/01/2020
To 06/30/2021
To 06/30/2021

11/20/2021 11:27 am

	EX STATISTICAL DATA			To	06/30/2021	Date/Time Prep 11/29/2021 11:	
11-21	A Ign			Inpa	ntient Days/Vis		ET CIT
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	W.
		1.00	2.00	3.00	4.00	5.00	7.
00	SKILLED NURSING FACILITY	336	122,640	0	1,362	0	1.00
.00	NURSING FACILITY	0	0	0		0	2.00
.00	ICF/IID	0	0			0	3.0
.00	HOME HEALTH AGENCY COST			0	0	0	4.0
.00	Other Long Term Care	0	0				5.0
.00	SNF-Based CMHC						6.0
.00	HOSPICE	0	o	ol	0	0	7.0
.00	Total (Sum of lines 1-7)	336	122,640	0	1,362	0	8.0
,00	Total (Sam of Titles 1 7)	Inpatient Da			Discharges		- 1
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	6.00	7.00	8.00	9.00	10.00	
.00	SKILLED NURSING FACILITY	67,650	69,012	0	13	0	1.0
.00	NURSING FACILITY	0,1030	0	ō		0	2.00
.00	ICF/IID	ام	Ö			0	3.0
.00	HOME HEALTH AGENCY COST	ان	0				4.0
.00	Other Long Term Care	Ĭ	0				5.0
	SNF-Based CMHC	l Y	Ĭ				6.0
.00	HOSPICE		0	o	0	0	7.0
.00	Total (Sum of lines 1-7)	67,650	69,012	ő	13	0	8.0
.00	Total (Sum of Times 1-7)	Discha			age Length of S	tay	
						~1+1- vrv	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	1.0
.00	SKILLED NURSING FACILITY	39	52	0.00	104.77	1.50	2.0
.00	NURSING FACILITY	0	0	0.00		0.00	
.00	ICF/IID	0	0			0.00	3.0
.00	HOME HEALTH AGENCY COST						4.0
.00	Other Long Term Care	0	0				5.0
.00	SNF-Based CMHC						6.0
.00	HOSPICE	0	0	0.00	0.00	0.00	7.0
.00	Total (Sum of lines 1-7)	39	52	0.00	104.77	0.00	8.0
		Average Length of Stay		Admis	510115	V - 9	
	Component	Total	Title V	Title XVIII	Title XIX	Other	
	Component						
		16.00	17.00	18.00	19.00	20.00	
00	SKILLED NURSING FACILITY	16.00	17.00	18.00	19.00	20.00	1.0
	SKILLED NURSING FACILITY	1,327.15	0 0		19.00 0		1,315
.00	NURSING FACILITY	1,327.15 0.00			19.00 0 0	32	2.0
.00	NURSING FACILITY ICF/IID	1,327.15			19.00 0 0	32 0	2.0 3.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	1,327.15 0.00 0.00			19.00 0 0	32 0	2.0 3.0 4.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	1,327.15 0.00			19.00 0 0	32 0 0	2.0 3.0 4.0 5.0
.00 .00 .00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	1,327.15 0.00 0.00	0	9	19.00	32 0 0	2.0 3.0 4.0 5.0 6.0
.00 .00 .00 .00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	1,327.15 0.00 0.00 0.00			19.00 0 0 0	32 0 0	2.00 3.00 4.00 5.00 6.00 7.00
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	1,327.15 0.00 0.00	0	9 0 9	19.00 0 0 0	32 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
00 00 00 00 00 00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions	0 0	9 0 9 Equivalent	19.00 0 0 0	32 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00
.00 .00 .00 .00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	1,327.15 0.00 0.00 0.00 0.00 0.00 1,327.15	0 0 0 0 Full Time E	9 0 9	19.00 0 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0
.00 .00 .00 .00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions	0 0 0 Full Time E	9 9 Equivalent Nonpaid	19.00 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions	0 0 0 Full Time E Employees on Payroll	0 9 Equivalent Nonpaid Workers 23.00	19.00 0 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)  Component	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions Total 21.00	0 0 0 Full Time E Employees on Payroll 22.00 356.60 0.00	0 9 Equivalent Nonpaid Workers 23.00	19.00 0 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)  Component  SKILLED NURSING FACILITY NURSING FACILITY	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions Total 21.00	Full Time E Employees on Payroll 22.00 356.60	0 9 Equivalent Nonpaid Workers 23.00	19.00 0 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)  Component  SKILLED NURSING FACILITY NURSING FACILITY ICF/IID	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions Total 21.00	0 0 0 Full Time E Employees on Payroll 22.00 356.60 0.00	0 9 Equivalent Nonpaid Workers 23.00 0.00 0.00	19.00 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0
.00 .00 .00 .00 .00 .00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)  Component  SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions Total 21.00	0 0 0 Full Time E Employees on Payroll 22.00 356.60 0.00 0.00	0 9 Equivalent Nonpaid Workers 23.00 0.00 0.00	19.00 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0
.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)  Component  SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions Total 21.00 41 0	Full Time E Employees on Payroll 22.00 356.60 0.00 0.00 0.00 0.00	0 9 Equivalent Nonpaid Workers 23.00 0.00 0.00 0.00 0.00	19.00 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0 1.0 2.0 3.0 4.0 5.0
00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)  Component  SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	1,327.15 0.00 0.00 0.00 0.00 1,327.15 Admissions Total 21.00 41 0	0 0 0 Full Time E Employees on Payroll 22.00 356.60 0.00 0.00	0 9 Equivalent Nonpaid Workers 23.00 0.00 0.00 0.00	0 0 0	32 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0

Health Financial Systems
SNF WAGE INDEX INFORMATION

Provider No.: 315346

				1	0 06/30/2021	11/29/2021 11	
		Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)		Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - DIRECT SALARIES						
	SALARIES						
1.00	Total salaries (See Instructions)	23,581,856	0	23,581,856			1.00
2.00	Physician salaries-Part A	0	0	[ C	0,00		2.00
3.00	Physician salaries-Part B	0	0	[ C	0.00		
4.00	Home office personnel	0	0	[ C	0.00		
5.00	Sum of lines 2 through 4	0	0	[ C	0.00		
6.00	Revised wages (line 1 minus line 5)	23,581,856	0	23,581,856			
7.00	Other Long Term Care	0	0	[ C	0.00		
8.00	HOME HEALTH AGENCY COST	0	0	[ C	0.00		
9.00	CMHC	0	0	[ C	0.00		
10.00	HOSPICE	0	0	[ C	0.00	1	
11.00	Other excluded areas	180,446	0	180,446			
12.00	Subtotal Excluded salary (Sum of lines 7	180,446	0	180,446	2,080.00	86.75	12.00
	through 11)						
13.00	Total Adjusted Salaries (line 6 minus line 12)	23,401,410	0	23,401,410	739,700.00	31.64	13.00
	OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	0	0	C	0.00		14.00
15.00	Contract Labor: Physician services-Part A	0	0	[ C	0.00		15.00
16.00	Home office salaries & wage related costs	0	0	C	0.00	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	12,557,339	0	12,557,339	i		17.00
18.00	Wage-related costs other (See Part IV)	0	0	C			18.00
19.00	wage related costs (excluded units)	96,087	0	96,087			19.00
20.00	Physician Part A - WRC	0	0	0	)		20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	12,461,252	0	12,461,252	!		22.00

Health Financial Systems SNF WAGE INDEX INFORMATION

				Т	o 06/30/2021	Date/Time Pre	
-		Amount	Reclass. of	Adjusted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	wage (col. 3 ÷	
			worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
		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		1.00
2.00	Administrative & General	1,912,519	0	1,912,519			
3.00	Plant Operation, Maintenance & Repairs	999,622	0	999,622	100000		
4.00	Laundry & Linen Service	0	0	0	0,00		
5.00	Housekeeping	1,485,075	.0	1,485,075	43,680.00		
6.00	Dietary	2,864,531	0	2,864,531	97,760.00		
7.00	Nursing Administration	200,780	0	200,780	4,160.00		
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	.0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	10.00
11.00	Social Service	518,117	0	518,117	21,840.00	23.72	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	748,945	0	748,945	43,680.00	17.15	13.00
	Total (sum lines 1 thru 13)	8,729,589		8,729,589	280,020.00	31.17	14.00

	то 06/30/	2021	Date/Time Prep 11/29/2021 11:	
			Amount Reported 1.00	
	NAME TO A PAGE OF LATER COSTS		1.00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETIREMENT COST	-	0	1.0
.00	401K Employer Contributions		0	2.0
.00	Tax Sheltered Annuity (TSA) Employer Contribution		5,117,263	3.
.00	Qualified and Non-Qualified Pension Plan Cost		0,117,203	4.
.00	Prior Year Pension Service Cost	_	0	٦.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		0	5.
.00	401K/TSA Plan Administration fees		0	6.
.00	Legal/Accounting/Management Fees-Pension Plan		0	7.
.00	Employee Managed Care Program Administration Fees	_	U	/.
	HEALTH AND INSURANCE COST	_	5 205 010	
.00	Health Insurance (Purchased or Self Funded)		5,305,918	
.00	Prescription Drug Plan		0	9.
	Dental, Hearing and Vision Plan		0	
	Life Insurance (If employee is owner or beneficiary)		0	11.
2.00	Accident Insurance (If employee is owner or beneficiary)		0	
3.00	Disability Insurance (If employee is owner or beneficiary)		0	
1.00	Long-Term Care Insurance (If employee is owner or beneficiary)			
	Workers' Compensation Insurance		235,819	
5.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 10 Non cumulative portion)	6,	0	16.
- 1	TAXES			
	FICA-Employers Portion Only		1,462,075	17.
	Medicare Taxes - Employers Portion Only		341.937	
	Unemployment Insurance			19.
	State or Federal Unemployment Taxes		94.327	
	OTHER	_	23,122	
	Executive Deferred Compensation		0	21.
			اه	
	Day Care Cost and Allowances Tuition Reimbursement		o o	
			12,557,339	
4.00	Total Wage Related cost (Sum of lines 1 - 23)		Amount	24.
			Reported	
			1.00	_
	and a selection show some balance see	-	1.00	
	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)			25.

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No.: 315346 | Period: From 07/01/2020 | Worksheet S-3 Part V

				Ť	o 06/30/2021	Date/Time Pre 11/29/2021 11	
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)		Average Hourly Wage (col. 3 ÷	
		1.00	2.00	3.00	4.00	5.00	
-	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	4,640,252	2,452,025				1.00
2.00	Licensed Practical Nurses (LPNs)	1,814,458	958,805				2.00
3.00	Certified Nursing Assistant/Nursing	8,217,113	4,342,128	12,559,241	303,680.00	41.36	3.00
	Assistants/Aides					40.70	4 00
4.00	Total Nursing (sum of lines 1 through 3)	14,671,823	7,752,958	22,424,781			4.00
5.00	Physical Therapists	0	0	0	0.00		
6.00	Physical Therapy Assistants	0	0	0	0.00		
7.00	Physical Therapy Aides	0	0	0	0.00		
8.00	Occupational Therapists	0	0	0	0.00		
9.00	Occupational Therapy Assistants	0	0	0	0.00	L/	
10.00	Occupational Therapy Aides	0	0	0	0.00		
11.00	Speech Therapists	0	0	0	0.00		
12.00	Respiratory Therapists	0	0	0	0.00		
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations				0.00	0.00	14 00
	Registered Nurses (RNs)	0		0	0.00		14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00		15.00
16.00	Certified Nursing Assistant/Nursing	0			0.00	0.00	16.00
4= 00	Assistants/Aides	2			0.00	0.00	17.00
	Total Nursing (sum of lines 14 through 16)	0		0	0.00		18.00
	Physical Therapists	0		0	0.00		19.00
	Physical Therapy Assistants	0		0	0.00		
	Physical Therapy Aides	0		0	0.00		
21.00	Occupational Therapists	0		0	0.00		
	Occupational Therapy Assistants	0		0	0.00		
	12	0		0	0.00		24.00
24.00	Speech Therapists	0		0	0.00		25.00
25.00	Respiratory Therapists Other Medical Staff	0		0	- 0.000.00		26.00
26.00	Other Medical Starr	0		1	0.00	0.00	20.00

Provider No.: 313596   Perform (1971)	Health Financial Systems	NEW JERSEY VETERANS HO	DME - PARAMUS		ieu of Form CM	
1.00   1.00	A STATE OF THE STA			Period:	Worksheet S	5-7
				From 07/01/202	0   1   Date/Time F	renared.
1.00				10 00/30/202		
1.00	TIE					
2.00 3.00 4.00 8.00 8.00 8.00 8.00 8.00 8.00 8					2.00	1.00
3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00						2.00
A						3.00
5.00  5.00						4.00
Section   Sect						5.00
RML   10   10   10   10   10   10   10   1				RHL		6.00
9.00 11.00 11.00 11.00 11.1000 11.1	7.00					7.00
10.00						8.00
111.00						9.00
12.00						10.00 11.00
13.00						12.00
14.00						13.00
13.00  14.00  15.00  16.00  17.00  18.00  18.00  19						14.00
16.00  18.00  18.00  18.00  19.00  10						15.00
17,00						16.00
18,00   9,00   8MC   11   20,00   8MC   12   20,00   8MG   21   22,00   8MB   22   23,00   8BB   32   24,00   8BB   32   25,00   8BB   32   25,00   8BB   32   27,00   8BB   32   27,00   8BB   32   28,00   8BB   32   29,00   8BB   32   20,00   8BB   33   30,00   8BB   33   34,00   8BB   33   35,00   8BB   34   35,00   8BB   35   35,00   35,0						17.00
19.00   SMC   15   22.00   SMB   23.30   SMB						18.00
20,00   RMB				RMC		19.00
RLB	20.00					20.00
RLA   22   24   25   26   26   27   27   27   28   28   27   27   28   28						21.00
24.00						22.00
25.00 26.00 27.00 28.00 28.00 28.00 28.00 29.00 31.00 31.00 31.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 35.00 35.00 35.00 35.00 35.00 36.00 37.00 38.00						23.00
ES1   22   22   23   20   24   24   25   25   25   25   26   26   26   26						25.00
22.00						26.00
28.00 29.00 30.00 31.00 31.00 32.00 32.00 33.00 33.00 34.00 33.30 34.00 35.00 36.00 37.00 38.00 38.00 38.00 40.10 40.20 40.30 40.00 40.10 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 44.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 49.00 40.00						27.00
MD2						28.00
30.00   H01   33   33   32   32   30   H62   33   33   30   H61   33   34   30   H62   33   34   30   H62   33   35   36   30   H61   33   35   36   30   H61   33   35   36   30   H61   33   36   30   H61   33   38   30   H61   33   36   40   40   H61   33   38   40   H61   44   42   42   40   H61   44   42   42   40   H61   44   42   40   H61   44   42   40   H61   44   43   40   H61   44   44   45   40   H61   44   45   40   H61   44   45   40   H61   44   45   40   H61   45   45   45   45   45   45   45   4						29.00
31.00   HC2   33 32.00   HC1   33 33.00   HE2   33 34.00   HB1   33 35.00   LE2   33 36.00   LE1   33 37.00   LE1   33 38.00   LE1   33 38.00   LD2   33 38.00   LD1   33 38.00   LD1   34 44.00   LC2   33 44.00   LC1   44 45.00   LE1   44 48.00   CE2   44 48.00   CE1   44 48.00   CC2   44 48.00   CC2   44 48.00   CC3   45 48.00   CC3   45 48.00   CC4   55 55.00   C68   C68   55 55.00   C68   C6				HD1		30.00
33.00 34.00 35.00 36.00 37.00 38.00				HC2		31.00
34.00 35.00 36.00 37.00 38.00	32.00					32.00
35.00 36.00 37.00 38.00 40.00 40.00 41.00 42.00 44.00 45.00 46.00 46.00 46.00 46.00 47.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 48.00 59.00 60.00						33.00
Let						34.00
100   100						35.00
SR   DO   C  C  C  SR   SR   SR   SR   SR   SR						36.00 37.00
19,00						38.00
40.00						39.00
A1.00						40.00
LB1   44   43   30   44   43   44   43   45   44   45   45						41.00
43.00 44.00 CE1 44.00 CD2 46.00 CD2 48.00 CC2 48.00 CC1 48.00 CC1 48.00 CC2 48.00 CC1 48.00 CC2 48.00 CC3 CC1 CC3 CC2 CC3 CC3 CC3 CC3 CC3 CC3 CC3 CC3						42.00
45.00 46.00 46.00 47.00 46.00 CD2 48.00 CC2 48.00 CC1 48.00 CC1 49.00 CC1 49.00 CC2 55.00 CC2 55.00 CC2 55.00 CC2 CC3 CC3 CC3 CC3 CC3 CC3 CC3 CC3 CC3				CE2		43.00
46.00 47.00 48.00 CC2 44.40.00 CC2 44.80.00 CC2 44.80.00 CC3 48.00 CC2 44.80.00 CC2 44.80.00 CC2 44.80.00 CC3 48.00 CC3 48.00 CC3 CC3 CC3 CC3 CC4 CC3 CC4 CC3 CC4 CC5 CC5 CC5 CC5 CC6 CC6 CC7 CC7 CC7 CC8 CC8 CC8 CC8 CC8 CC8 CC8	44.00					44.00
47.00   CC2   44.00   CC1   48.00   CC2   44.00   CB2   45.00   CB2   45.00   CB2   CB1   S5.00   CA2   S5.00   CA1   S5.00						45.00
48.00 49.00 50.00 60 60 60 61 51.00 52.00 53.00 53.00 54.00 55.00						46.00
49.00 50.00						47.00
50.00       CB1       SI         51.00       CA2       SI         52.00       CAI       SI         53.00       SE3       SI         54.00       SE2       SI         55.00       SE1       SI         56.00       SSC       SI         57.00       SSS       SS         58.00       SSB       SI         59.00       IB2       SI         60.00       IB1       60         61.00       IB1       60         62.00       IB1       60         63.00       BB2       60         64.00       BB2       60         66.00       BA2       60         67.00       BA3       60         68.00       PE1       60         69.00       PP2       60         70.00       PP2       60         77.00       PP2       77         77.00       PP3       77         77.00       PP8       77         77.00       PP8       77						48.00 49.00
51.00       CA2       55         52.00       SE3       55         53.00       SE3       55         55.00       SE1       55         55.00       SSC       56         57.00       SSC       55         57.00       SSB       55         58.00       SSA       55         59.00       IB2       59         60.00       IB1       66         61.00       IA2       65         62.00       BB2       66         63.00       BB2       66         64.00       BB2       66         65.00       BA2       66         66.00       BA1       66         67.00       PE2       66         68.00       PD1       77         70.00       PC2       71         71.00       PC2       71         72.00       PC1       73         74.00       PB2       72         74.00       PB1       72						50.00
52.00       CA1       55         53.00       SE3       55         54.00       SE2       55         55.00       SE1       55         56.00       SSC       56         57.00       SSB       55         58.00       SSB       55         59.00       IB2       55         60.00       IB1       66         61.00       IA2       66         62.00       IA1       66         64.00       BB2       66         65.00       BB1       66         66.00       BA2       66         67.00       BA3       66         69.00       PP1       70         70.00       PP1       77         71.00       PP2       77         72.00       PP1       77         73.00       PP3       77         74.00       PP8       77						51.00
53.00       SE3       SE2       SE2       SE5       SE5 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>52.00</td></td<>						52.00
54.00       SE2       55         55.00       SE1       55         56.00       SSC       56         57.00       SSB       55         58.00       SSA       58         59.00       IB2       59         60.00       IB1       60         61.00       IA1       60         62.00       BB2       60         64.00       BB1       64         65.00       BB1       64         66.00       BA2       66         67.00       BA1       66         69.00       PE1       68         69.00       PD1       70         70.00       PD1       70         71.00       PC2       77         72.00       PC1       72         74.00       PB1       74						53.00
55.00       SE1       SE         56.00       SSC       SE         57.00       SSB       SE         58.00       SSA       SE         59.00       IB2       SE         60.00       IB1       6         61.00       IA2       6         62.00       IA1       6         63.00       BB2       6         64.00       BB1       6         65.00       BA2       6         66.00       BA3       6         67.00       BA4       6         69.00       PE1       6         70.00       PD2       6         69.00       PD1       7         71.00       PC2       7         72.00       PB2       7         74.00       PB1       7				SE2		54.00
\$\frac{57.00}{58.00}\$ \$\frac{58}{58.00}\$ \$\frac{59.00}{182}\$ \$\frac{59}{59.00}\$ \$\frac{60.00}{181}\$ \$\frac{61.00}{62.00}\$ \$\frac{63.00}{182}\$ \$\frac{63}{64.00}\$ \$\frac{64.00}{65.00}\$ \$\frac{66.00}{67.00}\$ \$\frac{66.00}{67.00}\$ \$\frac{68.00}{69.00}\$ \$\frac{70.00}{70.00}\$ \$\frac{70.00}{7	55.00					55.00
58.00       SSA       58         59.00       IB2       58         60.00       IB1       60         61.00       IA2       66         62.00       IA1       66         63.00       BB2       66         64.00       BB1       66         65.00       BA2       66         66.00       BA1       66         67.00       BA1       66         68.00       PE2       66         69.00       PD2       69         70.00       PD1       70         72.00       PC1       72         73.00       PB2       73         74.00       PB1       74						56.00
59.00       IB2       59.00         60.00       IB1       60.00         61.00       IA2       60.00         62.00       IA1       60.00         64.00       BB2       60.00         65.00       BA2       60.00         66.00       BA1       60.00         67.00       BA1       60.00         69.00       PE1       60.00         70.00       PD1       70.00         71.00       PC2       73.00         74.00       PB2       73.00         74.00       PB1       74.00						57.00
60.00 61.00 61.00 62.00 62.00 62.00 63.00 64.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 72.00 73.00 74.00 69.00 74.00 69.01 72.00 74.00 69.01 72.00 74.00 69.01 74.00 74.00 74.00 74.00 74.00						58.00
61.00 62.00 63.00 64.00 65.00 66.00						59.00 60.00
62.00 63.00 66.00 66.00 66.00 66.00 67.00 68.00 69.00 70.00 70.00 72.00 72.00 73.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 74.00 69.00 75.00						61.00
63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.00 71.00 72.00 73.00 74.00  BB2 BB1 66 BA2 67 BA1 66 CF						62.00
64.00     8B1     64.06       65.00     66.00     65.00       66.00     67.00     68.1     66.00       67.00     68.00     69.00     69.00     69.00     69.00       70.00						63.00
65.00 66.00 67.00 68.00 68.00 69.00 70.00 71.00 72.00 72.00 73.00 74.00  BA2 BA1 G6 G7 G8 BA1 G8 G7 G7 G8						64.00
66.00     BA1     66       67.00     PE2     67       68.00     PE1     68       69.00     PD2     69       70.00     PD1     70       71.00     PC2     71       72.00     PC1     72       73.00     PB2     73       74.00     PB1     74						65.00
68.00     PE1     68       69.00     PD2     66       70.00     PD1     70       71.00     PC2     71       72.00     PC1     72       73.00     PB2     73       74.00     PB1     74				BA1		66.00
69.00     PD2     69       70.00     PD1     70       71.00     PC2     71       72.00     PC1     72       73.00     PB2     73       74.00     PB1     74						67.00
70.00						68.00
71.00 PC2 77.00 PC1 77.00 PC1 77.00 PR2 77.4.00 PB1 77.00 PR1 77.00 PR1						69.00
72.00 PC1 77.00 PB2 77.00 PB1 74.00 PB1 74.00 PB1 74.00 PB1						70.00
73.00 PB2 73.00 PB1 74.00 PB1 74.00 PB1						71.00
74.00 PB1 74						72.00 73.00
						74.00
73.VV I PA7 I I /	75.00			PA2		75.00

HEAlth Financial Systems NEW JERSEY VE PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider n	No.: 315346	Period: From 07/01/2020 To 06/30/2021	Worksheet S Date/Time P 11/29/2021	repared;
			Group	Days	
			1.00	2.00	
76.00			PA1		76.0
99.00			AAA		99.0
100.00 TOTAL					100.0
We will be the second of the s		Expenses	Percentage	Y/N	
	-	1 00	2.00	2 00	
A notice published in the Federal Register volume 68, payments beginning 10/01/2003. Congress expected this	increase to be used	for direct	patient care and	related	
payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column 1 column 2 the percentage of total expenses for each cat line 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each (See instructions)  101.00 Staffing	increase to be used the amount of the e egory to total SNF r "N" for no if the sp	003 provided for direct expense for revenue from pending refl	for an increase patient care and each category. En Worksheet G-2, F ects increases as	in the RUG related ter in eart I, sociated	101.0
payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column 1 column 2 the percentage of total expenses for each cat line 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each (See instructions)  101.00 Staffing 102.00 Recruitment	increase to be used the amount of the e egory to total SNF r "N" for no if the sp	003 provided for direct expense for revenue from pending refl	for an increase patient care and each category. En Worksheet G-2, F ects increases as	in the RUG related ter in eart I, sociated	102.0
payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column 1 column 2 the percentage of total expenses for each cat line 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each (See instructions)  101.00 Staffing 102.00 Recruitment 103.00 Retention of employees	increase to be used the amount of the e egory to total SNF r "N" for no if the sp	003 provided for direct expense for revenue from pending refl	for an increase patient care and each category. En Worksheet G-2, F ects increases as	in the RUG related ter in eart I, sociated	102.0
payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column 1 column 2 the percentage of total expenses for each cat line 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each (See instructions)  101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training	increase to be used the amount of the e egory to total SNF r "N" for no if the sp	003 provided for direct expense for revenue from pending refl	for an increase patient care and each category. En Worksheet G-2, F ects increases as	in the RUG related ter in eart I, sociated	102.0 103.0 104.0
payments beginning 10/01/2003. Congress expected this expenses. For lines 101 through 106: Enter in column 1 column 2 the percentage of total expenses for each cat line 1, column 3. Indicate in column 3 "Y" for yes or with direct patient care and related expenses for each	increase to be used the amount of the ecegory to total SNF reservations of the spacetostates of the spacetostates. (If column	003 provided for direct expense for revenue from pending refl	for an increase patient care and each category. En Worksheet G-2, F ects increases as	in the RUG related ter in eart I, sociated	102. 103.

23,581,856

0

6,335,907

29,917,763

0

0 93.00

0 94.00

29,917,763 100.00

93.00 09300 NONPAID WORKERS

94.00 09400 PATIENTS LAUNDRY

TOTAL

100.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315346

Adjustments to   Not Expenses   Part   Par					To 06/30/2021 Date/Time Pre	
CENTRAL SERVICE COST CENTES   6.00		Cost Center Description	Adjustments to	Net Expenses		
			Expenses (Fr			
GENERAL SERVICE COST CENTERS			Wkst A-8)			
CENERAL SERVICE COST CENTERS   1,007,649   1,108,741   1.00   00100 (2AP REL COSTS - BUDGS & FIXTURES   1,027,649   1,108,741   1.00   00200 (2AP REL COSTS - BUDGS & FIXTURES   1,027,649   1,108,741   2.00   3.00   00300 (BMCLYCE REDEETIS   2.00   3.17,705   3.00   00300 (BMCLYCE REDEETIS   2.597,338   2.597,338   3.00   00300 (BMCLYCE REDEETIS   2.597,338   2.597,338   3.00   00300 (BMCLYCE REDEETIS   2.597,338   2.597,338   3.00   00300 (BMCLATCH SERVICE   0   1,704,434   7.00   0.00			5.00			
1.00		T	6.00	7.00		-
2.00   00200   CAP REL COSTS - MAYABLE EQUIPMENT   0   2.00   0.00   0.000	4 00		1 007 640	1 100 741		1 00
0.0300   DePUTYER BENEFITS			1,027,649	1,108,741		
1.00   00.400   ADMINISTRATION & GENERAL   778,688			12 557 229	12 557 228		
0.0500   PLANT OPERATION, MINIT, & REPAIRS   0   1,750,691   5.00   0.						
0.0500   LAUNDRY & LINEN SERVICE			770,000			
0.000   0.00						
8.00						
9.00 00900 NURSING ADMINISTRATION 0 247,095 10.00 11.00 11.00 11.00 CENTRAL SERVICES & SUPPLY 0 789,993 10.00 11.00 11.00 11.00 PHARMACY 0 0 0 111.00 11.00 11.00 11.00 MEDICAL SERVICE 0 15.00 0 0 111.00 11.00 11.00 11.00 MEDICAL SERVICE 0 0 518,250 113.00 115.00 115.00 NURSING ADMINISTRATION ALLIED HEALTH EDUCATION 0 748,945 115.00 115.00 NURSING FACILITY 0 14,677,834 30.00 1300 NURSING FACILITY 0 0 0 31.00 1300 NURSING FACILITY 0 0 0 31.00 131.00 131.00 131.00 131.00 NURSING FACILITY 0 0 0 0 31.00 31.00 132.00 132.00 145.71D 0 0 0 0 31.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 31.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 31.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 31.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 132.00 132.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 132.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 132.00 132.00 132.00 145.00 NURSING FACILITY 0 0 0 0 0 132.00 132.00 145.00 145.00 NURSING FACILITY 0 0 0 0 0 132.00 132.00 145.00 145.00 NURSING FACILITY 0 0 0 0 0 132.00 132.00 145.00 145.00 NURSING FACILITY 0 0 0 0 0 132.00 132.00 145.00 145.00 NURSING FACILITY 0 0 0 0 0 132.00 145.00 145.00 NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						8.00
10.00   0.1000   CENTRAL SERVICES & SUPPLY   0   789,493   0   11.00						9.00
11.00   01100   PHARMACY   0						10.00
13.00   0.1300   0.1300   0.1300   0.1300   0.1300   0.1400   0.1400   0.1400   0.1400   0.1400   0.1400   0.1400   0.1500   0.				0		11.00
14.00	12.00	01200 MEDICAL RECORDS & LIBRARY		0		12.00
15.00	13.00	01300 SOCIAL SERVICE		518,250		
IMPATIENT ROUTINE SERVICE COST CENTERS	14.00	01400 NURSING AND ALLIED HEALTH EDUCATION		0		
30.00   03000   SATLLED NURSING FACTLITY	15.00	01500 RECREATION	(	748,945		15.00
31.00   03100   NURSING FACILITY		INPATIENT ROUTINE SERVICE COST CENTERS				
32.00   33.00   TCF/TID			(	14,677,834		
33.00				0		
ACTILLARY SERVICE COST CENTERS				0		
40.00	33.00			0		33.00
1.00   01100   LABORATORY   0   4,615   41.00   42.00   42.00   04200   1NTRAVERNOUS THERAPY   0   0   0   0   42.00   43.00   0300   0XYGEN (INHALATION) THERAPY   0   0   0   0   43.00   04500   0XYGEN (INHALATION) THERAPY   0   303,590   44.00   45.00   04500   0CCUPATIONAL THERAPY   0   0408,420   45.00   04500   0CCUPATIONAL THERAPY   0   0408,420   46.00   47.00   04700   ELECTROCARDIOLOGY   0   172,008   46.00   47.00   48.00   04800   SPEECH PATHOLOGY   0   0   0   47.00   48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   47.00   48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   49.00   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   0   0   0   0   0   0			1	35.054		40.00
42.00   04200   INTRAVENOUS THERAPY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
43.00				4,615		
44.00						
45.00   04500   0CCUPATIONAL THERAPY   0   408,420   45.00   46.00   04600   SPEECH PATHOLOGY   0   172,008   46.00   47.00   04700   ELECTROCARDIOLOGY   0   0   0   47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   48.00   04900   DENUSC CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0				303 590		
46.00 04600 SPEECH PATHOLOGY 0 172,008 46.00 47.00 04700 ELECTROCARDIOLOGY 0 0 0 47.00 04700 ELECTROCARDIOLOGY 0 0 0 47.00 04700 ELECTROCARDIOLOGY 0 0 0 47.00 048.00 06104. SUPPLIES CHARGED TO PATIENTS 0 0 0 0 48.00 06104. SUPPLIES CHARGED TO PATIENTS 0 0 0 0 49.00 050.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
47.00						
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0				0		
49.00   04900   DRUGS CHARGED TO PATIENTS   0   0   0   0   50.00				ol ol		
50.00   05000   DENTAL CARE - TITLE XIX ONLY   0 0 0 0 0   0 0				ol ol		49.00
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0				o		50.00
60.00   60.00   60.00   61.00   61.00   60.00   61.00   62.00   62.00   60.00   62.00   60.0				0		51.00
61.00 66100 RURAL HEALTH CLINIC 0 0 0 62.0		OUTPATIENT SERVICE COST CENTERS				
62.00   06200   FQHC   FQHC   FQHC   FQHC	60.00	06000 CLINIC	(	0		
OTHER REIMBURSABLE COST CENTERS   0	61.00	06100 RURAL HEALTH CLINIC		0		
70.00   07000   HOME HEALTH AGENCY COST   0   0   0   0   0   0   0   0   0	62.00					62.00
71.00 07100 AMBULANCE 0 195,525 71.00 73.00 07300 CMHC 0 0 0 0  SPECIAL PURPOSE COST CENTERS  80.00 08100 INTEREST EXPENSE 0 0 0 82.00 UTILIZATION REVIEW - SNF 0 0 0 83.00 83.00 08300 HOSPICE 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 14,363,675 44,100,992 89.00  NONREIMBURSABLE COST CENTERS  90.00 09100 BARBER AND BEAUTY SHOP 0 0 91.00 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 180,446 92.00 93.00 09400 NONPAID WORKERS 0 0 0 0 94.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00						
73.00   07300   CMHC						
SPECTAL PURPOSE COST CENTERS   80.00   80.00   81.00   81.00   82.00   82.00   82.00   82.00   82.00   83.00			1			
80.00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   0 0 0 0 0 0   81.00   82.00   08200   UTILIZATION REVIEW - SNF   0 0 0 0 0 0   83.00   Mospice   0 0 0 0 0   83.00   Mospice   0 0 0 0 0 0   83.00   Mospice   0 0 0 0 0   83.00   Mospice   0 0 0 0 0   Mospice   0 0 0 0 0   Mospice   0 0 0 0 0   Mospice   0 0 0 0 0 0   Mospice   0 0 0 0 0 0   Mospice   0 0 0 0 0 0   Mospice   0 0 0   Mospice   0 0   Mospice   0 0   Mospice   0 0 0   Mospice   0 0	73.00			)  0		/3.00
81.00 08100 INTEREST EXPENSE 0 0 0 0 82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 82.00 83.00 08300 HOSPICE 0 0 0 0 83.00 SUBTOTALS (sum of lines 1-84) 14,363,675 44,100,992 89.00 NONREIMBURSABLE COST CENTERS 0 0 0 0 90.00 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 180,446 92.00 93.00 09300 NONPAID WORKERS 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 0 94.00						- 00 00
82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 83.00 83.00 NOSPICE 0 0 0 0 83.00 NONPAID WORKERS 0 0 0 0 94.00 0 94.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
83.00 89.00    SUBTOTALS (sum of lines 1-84)   14,363,675   44,100,992   89.00						
89.00   SUBTOTALS (sum of lines 1-84)   14,363,675   44,100,992   89.00						
NONREIMBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   0   0   0   0   0   0   0   0   0			14 363 679	44 100 992		
90.00 09000 GFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 91.00 91.00 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 180,446 92.00 93.00 09300 NONPAID WORKERS 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00	05.00		17,505,07	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1
91.00 09100 BARBER AND BEAUTY SHOP 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 180,446 92.00 93.00 09300 NONPAID WORKERS 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00	90.00			0		90.00
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 180,446 92.00 93.00 09300 NONPAID WORKERS 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00			1	o o		1 20
93.00 09300 NONPAID WORKERS 0 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 94.00		William Control of the Control of th	8	180.446		
94.00 09400 PATIENTS LAUNDRY 0 0 94.00			8	0		
				0		94.00
	100.00	TOTAL	14,363,67	44,281,438		100.00

Health Financial Systems	NEW JERSEY VETERANS HOME -			u of Form CMS-	
RECLASSIFICATIONS	Pro	ovider No.: 315346	Period: From 07/01/2020 To 06/30/2021		pared:
		Increases			
	Cost Center	Line #	Salary	Non Salary	
	2.00	3.00	4.00	5.00	
(1) A - DEFAULT					
1.00	SPEECH PATHOLOGY	46.	00	172,008	
2.00	OCCUPATIONAL THERAPY	45.	00 0	408,420	
3.00	LABORATORY	41.	00 0	4,615	3.00
TOTALS					
100,00	Total Reclassifications of columns 4 and 5 must equal sum of columns 8	t <sup>ss</sup>	0	585,043	100.00

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

Health Financial Systems RECLASSIFICATIONS		Provider No.: 31534	Fron To	od: 07/01/2020 06/30/2021	Worksheet A-6 Date/Time Prep 11/29/2021 11:	pared:
		Decreas	es			
	Cost Center	Line	#	Salary	Non Salary	
	6.00	7.00		8.00	9.00	
(1) A - DEFAULT						
1.00	PHYSICAL THERAPY		44.00	0	172,008	1.00
2,00	PHYSICAL THERAPY		44.00	0	408,420	2.00
3.00	RADIOLOGY		40.00	0	4,615	3.00
TOTALS						l
100.00				0	585,043	100.00

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

In Lieu of Form CMS-2540-10

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No.: 315346

| Period: | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared:

				_ [ ]	0 06/30/2021	11/29/2021 11	
				Acquisitions		THE RESERVE	
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	KI .
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BAL	ANCES					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,393,668	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	2,393,668	0	0	0	0	7,00
8.00	Reconciling Items	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	2,393,668	0	0	0	0	9.00
	Description	Ending Balance	Fully				
			Depreciated			5 5 5 6	
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BAL	ANCES					1 00
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	O O	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,393,668	0				5.00
6.00	Movable Equipment	0	0				6.00
7,00	Subtotal (sum of lines 1-6)	2,393,668	0				7.00
8,00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	2,393,668	0				9.00

	Financial Systems NEW MENTS TO EXPENSES	JERSEY VETERANS		No.: 315346	Period: From 07/01/2020	of Form CMS-2 Worksheet A-8 Date/Time Pre 11/29/2021 11	pared
					lassification on ch the Amount is 1	Worksheet A	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		1.00	2.00		3.00	4.00	
1.00	Investment income on restricted funds		0			0.00	1.0
.00	(chapter 2) Trade, quantity, and time discounts (chapter		0			0.00	2.0
.00	Refunds and rebates of expenses (chapter 8)		20			0.00	3.6
.00	Rental of provider space by suppliers (Chapter 8)		ő			0.00	
.00	Telephone services (pay stations excluded) (Chapter 21)		0			0.00	5.
.00	Television and radio service (chapter 21)		0			0.00	
.00	Parking lot (chapter 21)		0			0.00	
.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0			0.00	8.
.00	Home office cost (chapter 21)		0			0.00	
1.00	Sale of scrap, waste, etc. (chapter 23) Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	
2.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	0				12.
3.00	Laundry and linen service		0			0.00	1/40
1.00	Revenue - Employee meals		0			0.00	
.00	Cost of meals - Guests		0			0.00	
5.00	Sale of medical supplies to other than patients		0			0.00	
	Sale of drugs to other than patients		0			0.00	
	Sale of medical records and abstracts		0			0.00	
0.00	Vending machines Income from imposition of interest, finance		0			0.00	
1.00	or penalty charges (chapter 21) Interest expense on Medicare overpayments		0			0.00	
	and borrowings to repay Medicare overpayments						
2.00	Utilization reviewphysicians' compensation (chapter 21)				REVIEW - SNF	82.00	
3.00	Depreciationbuildings and fixtures	A		CAP REL COST FIXTURES		1.00	
1.00	Depreciationmovable equipment			CAP REL COST EQUIPMENT		2.00	-512121
	FRINGE BENEFITS	A	5.44	EMPLOYEE BEN		3.00	
.01	CENTRAL OFFICE SALARIES	A			VE & GENERAL VE & GENERAL	4.00 4.00	
5.02	CENTRAL OFFICE FRINGE BENEFITS PROPERTY INSURANCE	A A		CAP REL COST		1.00	
	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		14,363,675	i			100.

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315346
From 07/01/2020
To 06/30/2021 Date/Time Prepared:
11/29/2021 11:27 am

					To 06/30/2021	Date/Time Pre 11/29/2021 11	
-			CAPITAL RELA	ATED COSTS	DV-	111/23/2021 11	L' Con
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	Subtotal	
	X	0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS	1 100 711	1 100 741				1.00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	1,108,741	1,108,741		0		2.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	12,557,338	0		0 12,557,338		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	4,137,795	86,799		0 1,018,416		4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1,750,691	58,655		0 532,299	2,341,645	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	545,839	17,105		0 0	562,944	6.00
7.00	00700 HOUSEKEEPING	1,704,434	24,624		0 790,802	2,519,860	
8.00	00800 DIETARY	4,194,415	129,764		0 1,525,363		8.00
9.00	00900 NURSING ADMINISTRATION	247,095	39,120		0 106,915	393,130	
10.00	01000 CENTRAL SERVICES & SUPPLY	789,493	20,485		0	809,978	
11.00	01100 PHARMACY	0	0		0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	7 003		0 375 907	798,139	
13.00	01300 SOCIAL SERVICE	518,250	3,992		0 275,897	796,139	14.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	740 045	35,510		0 398,813	1,183,268	
15.00	01500 RECREATION	748,945	22,110		0 390,013	1,105,200	13.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	14,677,834	669,065		0 7,812,746	23,159,645	30.00
31.00		14,077,034	0		0 0	0	31.00
32.00	03200 ICF/IID	0	Ö		0 0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
33.00	ANCILLARY SERVICE COST CENTERS						į.
40.00		35,964	0		0 0	35,964	
41.00	04100 LABORATORY	4,615	0		0	4,615	
42.00	04200 INTRAVENOUS THERAPY	0	0		0 0	0	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0 314,974	43.00
44.00		303,590	11,384			416,137	
45.00	ATAMEST A	408,420	7,717			172,008	
46.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY	172,008	0			0	47.00
47.00 48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	ő	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	o o	4,043		0 0	4,043	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	[12] G MAND [1]	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0		0		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS					0	70.00
70.00	07000 HOME HEALTH AGENCY COST	105 535	0		0 0	195,525	
71.00	07100 AMBULANCE	195,525	0			193,323	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	U		0	9	73,00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	1					80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00							82.00
83.00	08300 HOSPICE	0	O		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	44,100,992	1,108,263		0 12,461,251	44,004,427	89.00
	NONREIMBURSABLE COST CENTERS				4		
90.00	- 600 T 1700 D	0	0		0 0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	478		0 00	478	
92.00	09200 PHYSICIANS PRIVATE OFFICES	180,446	0		96,087	276,533	
93.00	09300 NONPAID WORKERS	0	0		0	0	
94.00	09400 PATIENTS LAUNDRY	0	0			0	
98.00		1 0	0			0	
99.00	Negative Cost Centers TOTAL	44,281,438	1,108,741		0 12,557,338	-	
100.00	TIOTAL	1 44'TOT'430	1,100,741		2 TE 122, 1226	, , , , , , , , , , , , ,	V

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No.: 315346 Period: Worksheet B From 07/01/2020 Part I To 06/30/2021 Date/Time Prep

					From 07/01/2020 го 06/30/2021		
	Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	Α	4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS				-10		
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						1.00 2.00 3.00
4.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	5,243,010 314,492	2,656,137				4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	75,606	47,164		4		6.00
7.00	00700 HOUSEKEEPING	338,427	67,897	//	2,926,184		7.00
8.00	00800 DIETARY	785,617	357.808		412,035		8.00
9.00	00900 NURSING ADMINISTRATION	52,799	107,868		124,216	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	108,783	56,484	I .	65,044	0	10.00
11.00	01100 PHARMACY	0	0	(	0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	12.00
13.00	01300 SOCIAL SERVICE	107,193	11,008		12,677	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION		0	(	0 0	0	14.00
15.00	01500 RECREATION	158,918	97,915	(	112,754	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	3,110,427	1,844,857	685,714	2,124,450	7,405,002	30.00
31.00	03100 NURSING FACILITY	0	0	(	0	0	31.00
32.00	03200 ICF/IID	0	0	(	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	(	0	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADIOLOGY	4,830	0	(	0	0	40.00
41.00	04100 LABORATORY	620	0	(	0 (0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	(	0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(	0	0	43.00
44.00	04400 PHYSICAL THERAPY	42,302	31,390	(	36,147	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	55,889	21,278		24,503	0	45.00
46.00	04600 SPEECH PATHOLOGY	23,101	0	(	0	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0	0		0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	543	11,149	(	12,839	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	1	0	0	60,00
61.00	06100 RURAL HEALTH CLINIC	0	0	1	0	0	
62.00	06200 FOHC						62.00
	OTHER REIMBURSABLE COST CENTERS				0		70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	1	0	0	1
71.00	07100 AMBULANCE	26,260	0		0 0	0	
73.00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS					ii	00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00							82.00
82.00	08200 UTILIZATION REVIEW - SNF					0	
83.00	08300 HOSPICE	5 205 007	2 (54 010	COF 71.	2,924,665		
89.00	SUBTOTALS (sum of lines 1-84)	5,205,807	2,654,818	685,71	2,924,003	7,403,002	89.00
00.00	NONREIMBURSABLE COST CENTERS				0	0	90.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	1 240	3	1,519	0	
91.00	09100 BARBER AND BEAUTY SHOP	64 27 120	1,319		1,319	0	92.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	37,139	0			0	
93.00	09300 NONPAID WORKERS	0	0		0	0	
94.00	09400 PATIENTS LAUNDRY	0		3	0	0	
98.00	Cross Foot Adjustments	0	0		n n	0	99.00
99.00	Negative Cost Centers	5,243,010	2,656,137	685,71	2,926,184	_	
100.00	TOTAL	3,243,010	2,000,13/	1 000,171	2,320,104	7,403,002	1200.00

In Lieu of Form CMS-2540-10 NEW JERSEY VETERANS HOME - PARAMUS Health Financial Systems Worksheet B Provider No.: 315346 Period: COST ALLOCATION - GENERAL SERVICE COSTS From 07/01/2020 Part I Date/Time Prepared: 11/29/2021 11:27 am 06/30/2021 MEDICAL SOCIAL SERVICE Cost Center Description NURSING CENTRAL PHARMACY SERVICES & RECORDS & ADMINISTRATION LIBRARY SUPPLY 9.00 10.00 11.00 12.00 13.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 2.00 3.00 00300 EMPLOYEE BENEFITS 4.00 00400 ADMINISTRATIVE & GENERAL 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE 7.00 00700 HOUSEKEEPING 8.00 00800 DIETARY 9.00 00900 NURSING ADMINISTRATION 678,013 10.00 01000 CENTRAL SERVICES & SUPPLY 1,040,289 11.00 0 01100 PHARMACY 12.00 0 01200 MEDICAL RECORDS & LIBRARY 0 929,017 01300 SOCIAL SERVICE 0 13.00 0 0 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 15.00 0 0 01500 RECREATION INPATIENT ROUTINE SERVICE COST CENTERS 1,040,289 0 0 929,017 30.00 03000 SKILLED NURSING FACILITY 678,013

1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 30.00 0 0 0 31.00 03100 NURSING FACILITY 0 31.00 0 0 32.00 0 0 32.00 03200 ICF/IID 0 0 0 0 0 33.00 33.00 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 0 0 40.00 40.00 04000 RADIOLOGY 0 0 0 41.00 0 0 41.00 04100 LABORATORY 42.00 00000 Ó 0 42.00 04200 INTRAVENOUS THERAPY 0 0 0 43.00 43.00 04300 OXYGEN (INHALATION) THERAPY 000 0 44.00 0 44.00 04400 PHYSICAL THERAPY 0 45.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 46.00 46.00 04600 SPEECH PATHOLOGY 47.00 0 04700 ELECTROCARDIOLOGY 47.00 0) 0 0 0 48.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 0 50.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 51.00 0 05100 SUPPORT SURFACES 51.00 OUTPATIENT SERVICE COST CENTERS 0 60.00 0 0 0 60.00 06000 CLINIC 0 0 0 0 61.00 61.00 06100 RURAL HEALTH CLINIC 62.00 62.00 06200 FQHC OTHER REIMBURSABLE COST CENTERS 70.00 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 0 71.00 71.00 07100 AMBULANCE 0 73.00 73.00 07300 CMHC SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 81.00 81.00 08100 INTEREST EXPENSE 82.00 82.00 08200 UTILIZATION REVIEW - SNF 83.00 08300 HOSPICE 0 0 83.00 SUBTOTALS (sum of lines 1-84) 929,017 89.00 678,013 1,040,289 0 89.00 NONREIMBURSABLE COST CENTERS 90.00 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 91.00 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 93.00 0 93.00 09300 NONPAID WORKERS 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 98.00 0 0 98.00 Cross Foot Adjustments 99.00 99.00 Negative Cost Centers 929,017 100.00 100.00 TOTAL 678,013 1.040,289

Health Financial Systems NEW JERSEY VETERANS HOME - PARAMUS

In Lieu of Form CMS-2540-10

Period: Worksheet B
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared: Provider No.: 315346 COST ALLOCATION - GENERAL SERVICE COSTS

				1	го 06/30/2021	Date/Time Pre 11/29/2021 11	
To			OTHER GENERAL			111/23/2021 11	l L
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	SERVICE RECREATION	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPING						7.00
8.00	00800 DIETARY		1				8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDICAL RECORDS & LIBRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 RECREATION	0	1,552,855				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 SKILLED NURSING FACILITY	0	1,552,855	42,530,269	0	42,530,269	
31.00	03100 NURSING FACILITY	0	0	(	0	0	
32.00	03200 ICF/IID	0	0	(	0	0	1
33.00	03300 OTHER LONG TERM CARE	0	0	(	0	0	33.00
	ANCILLARY SERVICE COST CENTERS						1
40.00	04000 RADIOLOGY	0	0	40,794	0	40,794	40.00
41.00	04100 LABORATORY	0	0	5,235	0	5,235	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	(	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	(	0	0	43.00
44.00	04400 PHYSICAL THERAPY	0	0	424,813	0	424,813	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0	517,807	0	517,807	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	195,109	0	195,109	46.00
47.00	04700 ELECTROCARDIOLOGY	0	0	(	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	28,574	1 0	28,574	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	(	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	(	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	(	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	(	0	0	61.00
62.00	06200 FOHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70.00
71.00	07100 AMBULANCE	0	0	221,785	0	221,785	71.00
73.00	07300 CMHC	0	0		0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0	0	(	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	1,552,855	43,964,386	0	43,964,386	89.00
	NONREIMBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	3,380	0	3,380	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	O	313,672		313,672	92.00
93.00	09300 NONPAID WORKERS	0	O	C	0	0	
94.00	09400 PATIENTS LAUNDRY	0	O	C	0	0	
98.00	Cross Foot Adjustments	0	o	C	0	0	1
99.00	Negative Cost Centers	0	0	C	0	0	
100.00		0	1,552,855	44,281,438	0	44,281,438	100.00
1,52	277 . W.L.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	62228.28	a. 51		1.11

In Lieu of Form CMS-2540-10

Period: Worksheet B
From 07/01/2020 Part II
To 06/30/2021 Date/Time Prepared: Provider No.: 315346

					то 06/30/2021	Date/Time Pre	pared:
			CAPITAL RELA	ATED COSTS		111/23/2021 11	L. Cui
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	i- k
		0	1.00	2.00	ZA	3.00	
	GENERAL SERVICE COST CENTERS				-50 -X		
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	0	0		0	0	3.00
4.00	00400 ADMINISTRATIVE & GENERAL	0	86,799		0 86,799	.0	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	58,655		0 58,655	0	
6.00	00600 LAUNDRY & LINEN SERVICE	0	17,105		0 17,105	0	
7.00	00700 HOUSEKEEPING	0	24,624		0 24,624	0	
8.00	00800 DIETARY	0	129,764		0 129,764		
9.00	00900 NURSING ADMINISTRATION	0	39,120		0 39,120	0	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	20,485		0 20,485	0	
11.00	01100 PHARMACY	0	0		0 0	0	
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
13.00	01300 SOCIAL SERVICE	0	3,992		0 3,992		
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
15.00	01500 RECREATION	0	35,510		0 35,510	0	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS						30.0
30.00	03000 SKILLED NURSING FACILITY	0	669,065		0 669,065		11.
31.00	03100 NURSING FACILITY	0	0		0	0	32.0
32.00	03200 ICF/IID	0	0		0	0	
33.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.0
	ANCILLARY SERVICE COST CENTERS						40.0
40.00	04000 RADIOLOGY	0	0		0	1	
41.00	04100 LABORATORY	0	0		0	0	12.0
42.00	04200 INTRAVENOUS THERAPY	0	0		0		42.0
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 11 204	0	
	04400 PHYSICAL THERAPY	0	11,384		0 11,384	111	44.0
45.00	04500 OCCUPATIONAL THERAPY	0	7,717		0 7,717	C	10.10
46,00	04600 SPEECH PATHOLOGY	0	0				
47.00	04700 ELECTROCARDIOLOGY	0	0			Ö	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4 043		0 4,043		49.0
49.00	04900 DRUGS CHARGED TO PATIENTS	0	4,043		0 4,043		
50,00	05000 DENTAL CARE - TITLE XIX ONLY		0		0		
51.00	05100 SUPPORT SURFACES	UU			0		1 32.0
-0.00	00000 CLINIC	0	0		0 0	C	60.0
60,00 61.00			o		o c		
62 00	06100 RURAL HEALTH CLINIC 06200 FOHC		٩		9	Ĭ	62.0
02.00	OTHER REIMBURSABLE COST CENTERS				-	-	7.20
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	C	70.0
71.00	07100 AMBULANCE	l ol	ő		o d		
73.00	07300 CMHC	0	Ö		o c		
3.00	SPECIAL PURPOSE COST CENTERS	0	9		Ÿ		1 5.55
20 00	a a a a a a a a a a a a a a a a a a a						80.0
	08000 MALPRACTICE PREMIUMS & PAID LOSSES   08100 INTEREST EXPENSE						81.0
32.00	08200 UTILIZATION REVIEW - SNF						82.0
	08300 HOSPICE	ام	Ó		0	C	
39.00	SUBTOTALS (sum of lines 1-84)		1,108,263		0 1,108,263		
00.00	NONREIMBURSABLE COST CENTERS	-1 - 0	1,100,203		2,100,200		1
2000	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		ol c	0	90.0
91.00	09100 BARBER AND BEAUTY SHOP		478		0 478	100	
92.00	09200 PHYSICIANS PRIVATE OFFICES	1 0	0		ol c	l c	
	09300 NONPAID WORKERS		0		0	ď	
	09400 PATIENTS LAUNDRY		0		ol o	Č	
		. 01			274		
	11.7				0		98.0
	Cross Foot Adjustments Negative Cost Centers		0		0	C	98.0

	ITION OF CAPITAL RELATED COSTS		Provider		Period: =rom 07/01/2020 Fo 06/30/2021	Worksheet B Part II Date/Time Pre 11/29/2021 11	pared: :27 am
	Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						1 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	86,799	63.060				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	5,205	63,860				5.00
6.00	00600 LAUNDRY & LINEN SERVICE	1,251	1,134				7.00
7.00	00700 HOUSEKEEPING	5,602	1,632		31,858	155 057	8.00
8.00	00800 DIETARY	13,004	8,603		4,486	155,857 0	
9.00	00900 NURSING ADMINISTRATION	874	2,593		1,352 708	0	
10.00	01000 CENTRAL SERVICES & SUPPLY	1,801	1,358		700	0	11.00
11.00	01100 PHARMACY		0			0	12.00
12.00 13.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	1,774	265		138	o o	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	1,//4	203		130	ő	14.00
15.00	01500 RECREATION	2,630	2.354		1,228	0	15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,030	2,33.		-1		
30.00	03000 SKILLED NURSING FACILITY	51,501	44,354	19,49	23,128	155,857	30.00
	03100 NURSING FACILITY	0	0		o o	. 0	31.00
	03200 ICF/IID	0	0		o o	0	32.00
	03300 OTHER LONG TERM CARE	O	0		0	0	33.00
1//	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADIOLOGY	80	0	3	0	0	40.00
41.00	04100 LABORATORY	10	0	9	0	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	3	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	3	0	0	43.00
44.00	04400 PHYSICAL THERAPY	700	755		394	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	925	512	9	267	0	
46.00	04600 SPEECH PATHOLOGY	382	0	30	0	0	
	04700 ELECTROCARDIOLOGY	0	0	3	0	0	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	9	268	10	140	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	3		0	50.00
51.00	05100 SUPPORT SURFACES	0			JI U	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0		ol lo	0	60.00
60.00 61.00	06100 RURAL HEALTH CLINIC		0			0	61.00
62.00	06200 FOHC		0	1	1 1		62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		lo lo	0	70.00
71.00	07100 AMBULANCE	435	0		ol ol	0	71.00
	07300 CMHC	0	0		0	0	73.00
, , , , ,	SPECIAL PURPOSE COST CENTERS			34			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0	0	1	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	86,183	63,828	19,49	31,841	155,857	89.00
	NONREIMBURSABLE COST CENTERS			r			00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	10.5
	09100 BARBER AND BEAUTY SHOP	1	32		17	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	615	0	9	9	0	
93.00	09300 NONPAID WORKERS	0	0			0	1
94.00	09400 PATIENTS LAUNDRY	0	0	9	0	0	9-0
98.00	Cross Foot Adjustments		0		3 3	0	
99.00 100.00	Negative Cost Centers   TOTAL	86,799	63,860	19,49	31,858	155,857	
100.00	LIOTAL	00,799	03,000	13,430	31,030	155,057	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider No.: 315346

In Lieu of Form CMS-2540-10

Period: Worksheet B
From 07/01/2020 Part II
To 06/30/2021 Date/Time Prepared:

				То	06/30/2021	Date/Time Pre 11/29/2021 11	
	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	<del></del>					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPING						7.00
8.00	00800 DIETARY						8.00
9.00	00900 NURSING ADMINISTRATION	43,939					9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	24,352				10.00
11.00	01100 PHARMACY	0	0	0			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	6 160	
13.00	01300 SOCIAL SERVICE	0	0	0	0	6,169	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	15.00
15.00	01500 RECREATION	0	0)	O <sub>1</sub>	<u> </u>	0	13.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	43,939	24,352	0	0	6,169	30.00
30.00	03100 NURSING FACILITY	43,939	24,332	0	0	0,103	31.00
32.00	03200 ICF/IID	0	o o	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	o o	0	ő	0	33.00
33.00	ANCILLARY SERVICE COST CENTERS		YI.	9	o <sub>1</sub>		33.00
40.00	04000 RADIOLOGY	0	0	0	0	0	40.00
		0	0	0	Ö	0	41.00
42.00	04200 INTRAVENOUS THERAPY	0	0	O	ol	0	42.00
	04300 OXYGEN (INHALATION) THERAPY	o o	0	0	o	0	43.00
44.00	04400 PHYSICAL THERAPY	0	0	0	0	0	44.00
	04500 OCCUPATIONAL THERAPY	0	0	0	o	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0	0	o	0	46.00
47.00	04700 ELECTROCARDIOLOGY	0	0	0	o	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS	1 0	O	O	0	0	70.00
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE		0	0	0	0	71.00
73.00	07300 CMHC	0	0	0	0	0	1
73.00	SPECIAL PURPOSE COST CENTERS	- 0		9	- 0		73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPICE	0	0	0	0	0	83.00
89.00		43,939	24,352	0	0	6,169	89.00
	NONREIMBURSABLE COST CENTERS				100		
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	
	09100 BARBER AND BEAUTY SHOP	0	0	0	O	0	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
	09300 NONPAID WORKERS	0	.0	0	O	0	
	09400 PATIENTS LAUNDRY	0	0	0	0	0	
98.00	Cross Foot Adjustments	0	0	0			98.00
99.00		0	0	0	O	0	
100.00	TOTAL	43,939	24,352	0	O	6,169	100.00

NEW JERSEY VETERANS HOME - PARAMUS Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2540-10

Period: Worksheet B
From 07/01/2020 Part II
To 06/30/2021 Date/Time Prepared: Provider No.: 315346

					To 06/30/2021	Date/Time Pre 11/29/2021 11	
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE RECREATION	Subtotal	Post Step-Down Adjustments	Total	A
	COURT OF CONTROL CONTROL	14.00	15.00	16.00	17.00	10.00	
7 00	GENERAL SERVICE COST CENTERS						1.00
1.00 2.00 3.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						7.00
7.00	00700 HOUSEKEEPING						8.00
8.00	00800 DIETARY						9.00
9.00	00900 NURSING ADMINISTRATION						10.00
10.00	01000 CENTRAL SERVICES & SUPPLY						11.00
11.00	01100 PHARMACY						12.00
12.00	01200 MEDICAL RECORDS & LIBRARY						13.00
13.00	01300 SOCIAL SERVICE	i i					14.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	41,722				15.00
15.00	01500 RECREATION	0	41,722				15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	41,722	1,079,57	77 0	1,079,577	30.00
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	41,722	1,0/5,5/		0	
31.00		0	0			Ö	
32.00	03200 ICF/IID	0	0			Ö	
33.00	03300 OTHER LONG TERM CARE	U	U_		0		33.00
40.00	ANCILLARY SERVICE COST CENTERS	1 0	0	5	30 0	80	40.00
40.00	04000 RADIOLOGY 04100 LABORATORY	0	Ö		LO 0	10	1
41.00	04200 INTRAVENOUS THERAPY	0	0		o o	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0			Ö	1
	04400 PHYSICAL THERAPY	0	ő	13,23	13	13,233	1
45.00	04500 OCCUPATIONAL THERAPY	ŏ	ŏ	9,42	120	9,421	
	04600 SPEECH PATHOLOGY	i o	0	38	8	382	
47.00	04700 ELECTROCARDIOLOGY	0	O	-	0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	o		0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	o	4,46	50l 0	4,460	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	l o	0	,,,,,	o o	0	
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
31.00	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLINIC	0	0		0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0	0	61.00
	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	0	0	43	35 0	435	1
73.00	07300 CMHC	0	0		0 0		73.00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE	1					81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0			0		
89.00	SUBTOTALS (sum of lines 1-84)	0	41,722	1,107,59	0 8	1,107,598	89.00
	NONREIMBURSABLE COST CENTERS						00.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	20
	09100 BARBER AND BEAUTY SHOP	0	0		28 0		91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	O	6.3	L5 0	615	
	09300 NONPAID WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	0	0		0	0	
98.00	Cross Foot Adjustments	0	0		0	0	
99.00	Negative Cost Centers	0	41 700	1 100 7	0	1 100 741	
100.00	TOTAL	0	41,722	1,108,7	11 0	1,108,741	1100.00

In Lieu of Form CMS-2540-10 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS NEW JERSEY VETERANS HOME - PARAMUS

Period: worksheet B-1 From 07/01/2020 To 06/30/2021 Date/Time Prepared: Provider No.: 315346

				Т	o 06/30/2021	Date/Time Pre 11/29/2021 11	
		CAPITAL REL	LATED COSTS			1 11/ 13/ 1001 11	107
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	173,850					1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	= 2.554,05300	0				2.00
3.00	00300 EMPLOYEE BENEFITS	0	0	23,581,856	i		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	13,610	0	1,912,519			4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	9,197	100	999,622	. 0	2,341,645	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	2,682	0.549	0	0	562,944	6.00
7.00	00700 HOUSEKEEPING	3,861		1,485,075	5.000	2,519,860 5,849,542	7.00 8.00
8.00	00800 DIETARY	20,347		2,864,531 200,780		393,130	9.00
9.00	00900 NURSING ADMINISTRATION	6,134 3,212		200,780	0	809,978	
10.00	01000 CENTRAL SERVICES & SUPPLY	3,212	176.1	Ö	0	003,3.0	11.00
11.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0	O	o	o	12.00
13.00	01300 SOCIAL SERVICE	626	0	518,117	0	798,139	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 RECREATION	5,568	0	748,945	0	1,183,268	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	104,909	0	14,671,821			
31.00	03100 NURSING FACILITY	0	0	C	0		31.00
32.00	03200 ICF/IID	0	1	C	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	. 0	0		0	0	33.00
	ANCILLARY SERVICE COST CENTERS			C	0	35,964	40.00
40.00	04000 RADIOLOGY	0	0			4,615	
41.00	04100 LABORATORY	0				0	
42.00	04200 INTRAVENOUS THERAPY	0				o o	43.00
43.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	1,785		Č	ol o	314,974	
45.00	04500 OCCUPATIONAL THERAPY	1,210		ď		416,137	
46.00	04600 SPEECH PATHOLOGY	0	o	Ċ	0	172,008	46.00
47.00	04700 ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	634	0	C	0	4,043	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		C	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	C	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	1			ol o	0	60.00
60.00	06000 CLINIC	0	100	0			61.00
61.00	06100 RURAL HEALTH CLINIC	0			1	ı	62.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS	1					
70.00	07000 HOME HEALTH AGENCY COST	1 0	0	0	il o	0	70.00
71.00	07100 AMBULANCE	0	4	d	0	195,525	71.00
73.00	07300 CMHC	0	0		0	0	73.00
	SPECIAL PURPOSE COST CENTERS	"	"				Į.
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPICE	0	0	22 401 410	5 242 010	0 38,761,417	
89.00	SUBTOTALS (sum of lines 1-84)	173,775	0	23,401,410	-5,243,010	38,761,417	89.00
00.00	NONREIMBURSABLE COST CENTERS	1 0	ol ol		N 0	0	90.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	75	1	C		1	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	1000	180,446	6	276,533	
	09300 NONPAID WORKERS	0	o ő	200,300		0	
			0	C	0	0	
93.00	(F-200)	0	(1)			TI.	
	09400 PATIENTS LAUNDRY  Cross Foot Adjustments	0					98.00
93.00 94.00	09400 PATIENTS LAUNDRY	0					99.00
93.00 94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers	1,108,741	. 0	12,557,338	3	5,243,010	99.00
93.00 94.00 98.00 99.00	O9400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)						99.00 102.00
93.00 94.00 98.00 99.00 102.00	O9400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	1,108,741 6.377573		12,557,338		0.134304	99.00 102.00 103.00
93.00 94.00 98.00 99.00 102.00	O9400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,					0.134304	99.00 102.00
93.00 94.00 98.00 99.00 102.00	O9400 PATIENTS LAUNDRY  Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)					0.134304	99.00 102.00 103.00 104.00

COST	ALLOCATION	-	STATISTICAL	BASIS	
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Provider No.: 315346

						ro 06/30/2021	Date/Time Pre	
		Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPING	DIETARY	11/29/2021 11 NURSING	:27 am
		cose center bescriperon	OPERATION,	LINEN SERVICE		(MEALS SERVED)		
			MAINT. &	(POUNDS OF				
			REPAIRS	LAUNDRY)			(DIRECT	
			(SQUARE FEET)	6.00	7.00	9 00	NURSING) 9.00	
	CENED	AL CERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS - BLDGS & FIXTURES				1		1.00
2.00	40 0	CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00		EMPLOYEE BENEFITS						3.00
4.00		ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	151,043					5.00
6.00	00600	LAUNDRY & LINEN SERVICE	2,682	69,012				6.00
7.00		HOUSEKEEPING	3,861	0	144,500			7.00
8.00	J. I	DIETARY	20, 347	0	20,347			9.00
9.00		NURSING ADMINISTRATION	6,134	0	6,134		459,680	10.00
10.00		CENTRAL SERVICES & SUPPLY PHARMACY	3,212	0	3,212		0	11.00
12.00		MEDICAL RECORDS & LIBRARY	0	0		0	0	12.00
		SOCIAL SERVICE	626	0	626	0	o	13.00
		NURSING AND ALLIED HEALTH EDUCATION	0	o		0	0	14.00
		RECREATION	5,568	0	5,568	0	0	15.00
		IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	104,909	69,012	104,909	207,036	459,680	30.00
31.00	03100	NURSING FACILITY	0	0	(	0	0	31.00
		ICF/IID	0	0	(	0	0	32.00
33.00		OTHER LONG TERM CARE	0	0	(	0	0	33.00
40.00		ARY SERVICE COST CENTERS	1	0	7	0 10	0	40.00
		RADIOLOGY LABORATORY	.0	0			0	41.00
		INTRAVENOUS THERAPY	0	0			ŏ	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	0		ol o	o	43.00
	1 1	PHYSICAL THERAPY	1,785	0	1,785	0	0	44.00
45.00		OCCUPATIONAL THERAPY	1,210	0	1,210		0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	(	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	(	0	0	47.00
48.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	48.00
49.00		DRUGS CHARGED TO PATIENTS	634	0	634	0	0	49.00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0			0	51.00
51.00		SUPPORT SURFACES FIENT SERVICE COST CENTERS	U	U		0	0	31.00
60.00		CLINIC	0	0			0	60.00
61.00		RURAL HEALTH CLINIC	0	0		0	0	61.00
62.00	06200							62.00
	OTHER	REIMBURSABLE COST CENTERS						
70.00	07000	HOME HEALTH AGENCY COST	0	0		1		70.00
	0.00	AMBULANCE	0	0		0		71.00
73.00	07300		0	0	(	0	0	73.00
90.00	-	AL PURPOSE COST CENTERS						80.00
		MALPRACTICE PREMIUMS & PAID LOSSES						81.00
		INTEREST EXPENSE UTILIZATION REVIEW - SNF						82.00
		HOSPICE	0	0	(	o l	0	
89.00	00300	SUBTOTALS (sum of lines 1-84)	150,968	69,012	144,425	207,036	459,680	
03.00	NONRE	IMBURSABLE COST CENTERS						
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91.00		BARBER AND BEAUTY SHOP	75	0		G ====================================		
92.00		PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	
93.00		NONPAID WORKERS	0	0		0	0	
	09400	PATIENTS LAUNDRY	0,0	0	C	0	0	94.00
98.00		Cross Foot Adjustments Negative Cost Centers						98.00
		Cost to be allocated (per Wkst. B.	2 656 137	685,714	2,926,184	7,405,002	678,013	
102.00		Part I)	2,656,137	000,714	2,320,104	7,703,002	0/0,013	
103.00		Unit cost multiplier (Wkst. B, Part I)	17.585304	9.936156	20.250408	35.766736	1.474967	103.00
	11	Cost to be allocated (per Wkst. B,	63,860					
104.00	) 1							
104.00		Part II)						
104.00 105.00			0.422794				0.095586	105.00

0.000000

0.000000

1.317667

0.030845

24,352

0.000000

0.000000

13.461673

0.089390

6,169

0.000000 103.00

0.000000 105.00

0 104.00

Part I)

Part II)

TT)

Unit cost multiplier (wkst. B, Part I)

Cost to be allocated (per wkst. B,

Unit cost multiplier (Wkst. B, Part

103.00

104.00

105.00

			11/29/2021 1	T. 21 cm
		OTHER GENERAL		
		SERVICE		
	Cost Center Description	RECREATION		
		(PATIENT DAYS)		
		15.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2.00
3.00	00300 EMPLOYEE BENEFITS			3.00
4.00	00400 ADMINISTRATIVE & GENERAL			4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5.00
6.00	00600 LAUNDRY & LINEN SERVICE			6.00
7.00	00700 HOUSEKEEPING			7.00
8.00	00800 DIETARY			8.00
9.00	00900 NURSING ADMINISTRATION			9.00
10.00	01000 CENTRAL SERVICES & SUPPLY			10.00
11.00	01100 PHARMACY			11.00
	01200 MEDICAL RECORDS & LIBRARY			12.00
	01300 SOCIAL SERVICE			13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION			14.00
	01500 RECREATION	69,012		15.00
13.00		05,012		
20.00	03000 SKILLED NURSING FACILITY	69,012		30.00
	03100 NURSING FACILITY	05,012		31.00
-	400			32.00
	03200 ICF/IID	0		33.00
33.00	03300 OTHER LONG TERM CARE	0		- 33.00
	ANCILLARY SERVICE COST CENTERS			40.00
	04000 RADIOLOGY	0		41.00
41.00	04100 LABORATORY	0		
42.00	04200 INTRAVENOUS THERAPY	0		42.00
	04300 OXYGEN (INHALATION) THERAPY	0		43.00
44.00	04400 PHYSICAL THERAPY	0		44.00
45.00	04500 OCCUPATIONAL THERAPY	0		45.00
46.00	04600 SPEECH PATHOLOGY	0		46.00
47.00	04700 ELECTROCARDIOLOGY	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
	OUTPATIENT SERVICE COST CENTERS			
60.00	06000 CLINIC	0		60.00
61.00	06100 RURAL HEALTH CLINIC	0		61.00
62.00	06200 FOHC			62.00
	OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST	0		70.00
	07100 AMBULANCE	0		71.00
	07300 CMHC	0		73.00
	SPECIAL PURPOSE COST CENTERS			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81.00	08100 INTEREST EXPENSE			81.00
	08200 UTILIZATION REVIEW - SNF			82.00
	08300 HOSPICE	0		83.00
89.00	SUBTOTALS (sum of lines 1-84)	69,012		89.00
09.00	NONREIMBURSABLE COST CENTERS	05,012		- 03.00
90 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O		90.00
	09100 BARBER AND BEAUTY SHOP	o		91.00
		o o		92.00
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0		93.00
	Determined the second of the s			94.00
	09400 PATIENTS LAUNDRY	l o		98.00
98.00	Cross Foot Adjustments			
99.00	Negative Cost Centers			99.00
102.00		1,552,855		102.00
	Part I)	22 55555		102 0
103.00		22.501232		103.00
104.00		41,722		104.00
50	Part II)			
105.00		0.604562		105.00
	[11]			

0.000000

1.134305 71.00

221,785

1,434,117

195,525

1,736,469

60.00

61.00

62.00

100.00

60.00 06000 CLINIC

71.00 07100 AMBULANCE

62.00 06200 FQHC

100.00

61.00 06100 RURAL HEALTH CLINIC

Total

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider N	lo.: 315346	Period: From 07/01/2020 To 06/30/2021		
		Title X	VIII (1)	Skilled Nursing Facility	PPS	
. 1 -		Health Care Pro	gram Charge		Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1	Part R (col 1	-
Cost Center Description	to Charges	FAILA	Tai C B	x col. 2)	x col. 3)	
	(Fr. Wkst. C			X CO.1 27	ж солт оу	
	Column 3)			Vo.		
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPA	TIENT COST					
ANCILLARY SERVICE COST CENTERS						1
10.00 04000 RADIOLOGY	1.005298			0 7,430		10.0
11.00  04100 LABORATORY	0.575528	9,096		0 5,235	0	41.0
12.00 04200 INTRAVENOUS THERAPY	0.000000	0		0	0	42.0
3.00 04300 OXYGEN (INHALATION) THERAPY	0.000000			0	0	43.0
14.00 04400 PHYSICAL THERAPY	0.850214			0 67,875	0	44.0
\$5.00 04500 OCCUPATIONAL THERAPY	0.770331	79,793		0 61,467	0	45.0
16.00 04600 SPEECH PATHOLOGY	0.689197			0 38,147	0	46.0
17.00 04700 ELECTROCARDIOLOGY	0.000000			0	0	47.0
18.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			0 0	0	48.0
19.00 04900 DRUGS CHARGED TO PATIENTS	0.786491	36,331		0 28,574	0	1 .5.0
0.00 05000 DENTAL CARE - TITLE XIX ONLY	0.000000	0		0		50.0
51.00 05100 SUPPORT SURFACES	0.000000	0		0 0	0	51.0
OUTPATIENT SERVICE COST CENTERS						4
50.00 06000 CLINIC	0.000000	0		0 0	0	0000
51.00 06100 RURAL HEALTH CLINIC						61.0
52.00 06200 FQHC						62.0
1.00 07100 AMBULANCE (2)	1.134305			0		71.0
.00.00   Total (Sum of lines 40 - 71)	1	267,794		0 208,728	0	100.0

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

4

COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315346	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1   Parts I-II   Date/Time Pre   11/29/2021 11	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	INPATIENT DAYS				
.00	Inpatient days including private room days			69,012	1.0
.00	Private room days			0	2.0
.00	Inpatient days including private room days applicable to the	Program		1,362	3.0
.00	Medically necessary private room days applicable to the Progr	ram		0	4.0
.00	Total general inpatient routine service cost			42,530,269	5.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
.00	General inpatient routine service charges			12,586,376	
00	General inpatient routine service cost/charge ratio (Line 5	divided by line 6)		3.379072	7,.00
00	Enter private room charges from your records			0	8.0
00	Average private room per diem charge (Private room charges li	ine 8 divided by private	room days, line	0.00	9.0
	2)				20.0
	Enter semi-private room charges from your records			0	
.00	Average semi-private room per diem charge (Semi-private room	m charges line 10, divide	d by	0.00	TITE
	semi-private room days)	7: 41)		0.00	12 0
.00	Average per diem private room charge differential (Line 9 mir	1US   11NE   11)		0.00	
	Average per diem private room cost differential (Line 7 times				14.0
	Private room cost differential adjustment (Line 2 times line		minus line 140	42,530,269	
.00	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	ost differential (Line 3	minus tine 14)	42,330,203	13.0
5.00	Adjusted general inpatient service cost per diem (Line 15 di	ivided by line 1)		616.27	16.0
	Program routine service cost (Line 3 times line 16)	,		839,360	17.0
	Medically necessary private room cost applicable to program	(line 4 times line 13)		0	18.0
	Total program general inpatient routine service cost (Line 1			839,360	19.0
00.0	Capital related cost allocated to inpatient routine service of	costs (From Wkst. B, Par	t II column 18,	1,079,577	20.0
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)				
.00	Per diem capital related costs (Line 20 divided by line 1)			15.64	
.00	Program capital related cost (Line 3 times line 21)			21,302	
	Inpatient routine service cost (Line 19 minus line 22)			818,058	
	Aggregate charges to beneficiaries for excess costs (From pr			0	
	Total program routine service costs for comparison to the cos	st limitation (Line 23 mi	nus line 24)	818,058	
	Enter the per diem limitation (1)				26.0
	Inpatient routine service cost limitation (Line 3 times the p				27.0
	Reimbursable inpatient routine service costs (Line 22 plus t (Transfer to Worksheet E, Part II, line 4) (See instructions)	)			28.0
) Li	nes 26 and 27 are not applicable for title XVIII, but may be u	used for title V and or t	itle XIX	·	
				1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COST	S FOR PPS PASS-THROUGH			
00	Total SNF inpatient days	177		69,012	1,0
00	Program inpatient days (see instructions)			1,362	2,0
00	Total nursing & allied health costs. (see instructions)(Do no	ot complete for titles V	or XIX)	0	3.0
.00	Nursing & allied health ratio. (line 2 divided by line 1)			0.019736	4.0
00	Program nursing & allied health costs for pass-through. (line	3 times line 4)		0	5.0

Health Financial Systems	NEW JERSEY VETERANS H	OME - PARAMUS	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	TITLE XVIII	Provider No.: 315346	From 07/01/2020	Worksheet E Part I Date/Time Prepared: 11/29/2021 11:27 am
		Title XVIII	Skilled Nursing Facility	PPS

		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSE	EMENT			
1.00	Inpatient PPS amount (See Instructions)			970,250	
2.00	Nursing and Allied Health Education Activities (pass through page	yments)		0	
3.00	Subtotal (Sum of lines 1 and 2)			970,250	
4.00	Primary payor amounts			0	
5.00	Coinsurance			141,547	
6.00	Allowable bad debts (From your records)			0	
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru-	ctions)		0	
8.00	Adjusted reimbursable bad debts. (See instructions)			0	0
9.00	Recovery of bad debts - for statistical records only			0	
10.00	Utilization review			0	
11.00	Subtotal (See instructions)			828,703	
12.00	Interim payments (See instructions)			828,703	
13.00	Tentative adjustment				13.00
14.00	OTHER adjustment (See instructions)			0	
14.50	Demonstration payment adjustment amount before sequestration			14.50	
14.55	Demonstration payment adjustment amount after sequestration	0			
14.75	Sequestration for non-claims based amounts (see instructions)				14.75
14.99	Sequestration amount (see instructions)				14.99
15.00	Balance due provider/program (see Instructions)				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)			0	
	Total reasonable costs (Sum of lines 17 and 18)				19.00
	Medicare Part B ancillary charges (See instructions)			0	
21.00	Cost of covered services (Lesser of line 19 or line 20)			0	
	Primary payor amounts			0	
	Coinsurance and deductibles			0	
	Allowable bad debts (From your records)				24.00
	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	
	Interim payments (See instructions)			0	
	Tentative adjustment			0	
28.00	Other Adjustments (See instructions) Specify			0	
	Demonstration payment adjustment amount before sequestration		1	0	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration amount (see instructions)			0	
	Balance due provider/program (see instructions)	1.1 1 2	115 3	0	
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section TT2.5	0	30.00

0

0

0

0

0

0

0

0

Contractor Name

1.00

828,703

0

0

0 5.03

0

0

0

0 5.99

0

0

0

Contractor

Number

2.00

5.01

5.02

5.50

5.51

5.52

6.00

6.01

6.02

7.00

8.00

8.00 | Name of Contractor
(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.

Program to Provider

Provider to Program

TENTATIVE TO PROGRAM

the cost report, (1)

PROGRAM TO PROVIDER

PROVIDER TO PROGRAM

Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50

Determined net settlement amount (balance due) based on

Total Medicare program liability (see instructions)

TENTATIVE TO PROVIDER

5.01

5.02

5.03

5.50

5.51

5.52

5.99

6.00

6.01

6.02

7.00

alth Financial Systems NEW JERSEY VETERANS HOME - PARAMUS In Lieu of Form CMS-2540-10

Health Financial Systems

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

Provider No.: 315346 | Period: | Worksheet G | From 07/01/2020 | Date/Time Prepared:

only)	type accounting records, complete the General Fund Column			To 06/30/2021	Date/Time Pre	
		General Fund	Specific	Endowment Fund		127 611
		1.00	Purpose Fund 2.00	3.00	4.00	
	Assets					
1 00	CURRENT ASSETS Cash on hand and in banks	0	1	ol ol	0	1.00
1.00	Temporary investments	6	1		0	
3.00	Notes receivable	0		ol ol	0	1
4.00	Accounts receivable	Ö		o o	0	1
5.00	Other receivables	0		0 0	0	
6.00	Less: allowances for uncollectible notes and accounts	0		0 0	0	6.00
	receivable				0	7 00
7.00 8.00	Inventory Report of average	0			0	1
9.00	Prepaid expenses Other current assets	0			0	9.00
10.00	Due from other funds	0		ol ol	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	0		o o	0	11.00
	FIXED ASSETS					
12.00	Land	0		0 0	0	
13.00	· ·	0		0 0	0	
14.00	Less: Accumulated depreciation	0		0 0	0	
15.00		0			0	15.00 16.00
16.00 17.00	Less Accumulated depreciation Leasehold improvements	0			0	
18.00	Less: Accumulated Amortization				0	
19.00	Fixed equipment	0		ol ol	O	
	Less: Accumulated depreciation	0		o o	0	20.00
21.00	Automobiles and trucks	0		0 0	0	21.00
22.00	Less: Accumulated depreciation	0		0 0	0	
	Major movable equipment	0		0 0	0	
	Less: Accumulated depreciation	0		0 0	0	
	Minor equipment - Depreciable	0			0	
27.00	Minor equipment nondepreciable Other fixed assets	0			0	
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0			0	
20.00	OTHER ASSETS					
29.00	Investments	0		0 0	0	29.00
30.00	Deposits on leases	0	0 3	0 0	0	
31.00	Due from owners/officers	0		0 0	0	
32.00	Other assets	0	1		0	32.00
33.00 34.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)	0	1		0	
34.00	Liabilities and Fund Balances		-	0] 0]	0	34.00
	CURRENT LIABILITIES					1
35.00	Accounts payable	0		0 0	0	35.00
36.00	Salaries, wages, and fees payable	0		0 0	0	36.00
37.00	Payroll taxes payable	0		0 0	0	
38.00	Notes & loans payable (Short term)	0		0 0	0	
39.00	Deferred income	0		0 0	0	39.00
	Accelerated payments	0		ololo	0	40.00
42.00	Due to other funds Other current liabilities	0	U.S.		0	1
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 = 42)	Ö		0	Ö	1
10.00	LONG TERM LIABILITIES					
44.00	Mortgage payable	0		0 0	0	44.00
45.00	Notes payable	0		0	0	15.45
46.00	Unsecured loans	0	1	0	0	
47.00	Loans from owners:	0		0	0	
	Other long term liabilities	0		0	0	
49.00 50.00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0	0	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	0	111		0	
31.00	CAPITAL ACCOUNTS	<u> </u>		ol ol		31.00
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		9	0		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
	Governing body created - endowment fund balance			0	2	56.00
	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	n	i i	ol n	0	59.00
	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	ő	l i	ol ŏl	0	
	59)			]		

STATEMENT OF CHANGES IN FUND BALANCES

Provider No.: 315346

In Lieu of Form CMS-2540-10

Period: Worksheet G-1
From 07/01/2020
To 06/30/2021 Date/Time Prepared: 11/20/2021 11:27

					10 06/30/202	11/29/2021 11	
		General	Fund	Special	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period	1100	12,147,810			0	1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2)		-12,147,810 0			o	3.00
4.00	Additions (credit adjustments)						4.00
5.00		0			0	0	
6.00		0			0	0	
7.00		0			0	0	190
8.00		0			0	0	8.00 9.00
9.00	Total additions (sum of line 5 - 9)	0	0			n	10.00
10.00	Subtotal (line 3 plus line 10)		0			0	11.00
12.00	Deductions (debit adjustments)						12.00
13.00	bedace rons (debre adjustments)	0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	0.00
16.00		0			0	0	
17.00		0	2		0	0	2
18.00	Total deductions (sum of lines 13 - 17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		O			U	19.00
-	Sheet (Line II - Time Io)	Endowment Fund	Plant	Fund		2	
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)	1			0		2.00 3.00
3.00	Total (sum of line 1 and line 2)	20			:0		4.00
4.00	Additions (credit adjustments)	1	o.				5.00
6.00		1	ŏ				6.00
7.00		1	0				7.00
8.00		1	0				8.00
9.00		1 1	0				9.00
10.00	Total additions (sum of line 5 - 9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments)	1					12.00
13.00			0				13.00
14.00			0				15.00
15.00 16.00			0				16.00
17.00			Ö				17.00
18.00	Total deductions (sum of lines 13 - 17)	0	~		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	Ö			0		19.00

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

29,917,763 15.00

TATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315346	Period:	Worksheet G-3	
	SENT OF PATEENT REVENUES AND OPERATING EXPENSES	F10VIde: No.: 313340	From 07/01/2020 To 06/30/2021		
				1.00	
.00	Total patient revenues (From Wkst. G-2, Part I, col. 3,	line 14)		14,322,844	1.00
.00	Less: contractual allowances and discounts on patients accounts	counts		0	2.00
.00	Net patient revenues (Line 1 minus line 2)			14,322,844	3.00
1.00	Less: total operating expenses (From Worksheet G-2, Part 1	II, line 15)		29,917,763	4.00
.00	Net income from service to patients (Line 3 minus 4)			-15,594,919	5.00
	Other income:				
5.00	Contributions, donations, bequests, etc			0	6.00
.00	Income from investments			0	7.00
.00	Revenues from communications ( Telephone and Internet serv	vice)		0	8.0
.00	Revenue from television and radio service			0	9.0
0.00	Purchase discounts			0	10.0
1.00	Rebates and refunds of expenses			0	11.0
2.00	Parking lot receipts			0	12.0
3.00	Revenue from laundry and linen service			0	13.0
4.00	Revenue from meals sold to employees and guests			0	14.0
	Revenue from rental of living quarters			o	15.0
	Revenue from sale of medical and surgical supplies to other	er than patients		0	16.0
7.00	Revenue from sale of drugs to other than patients			0	17.0
8.00				o	18.0
9.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.0
0.00	Revenue from gifts, flower, coffee shops, canteen			o	20.0
	Rental of vending machines			ol	21.0
	Rental of skilled nursing space			o	
3.00	Governmental appropriations			ol	23.0
4.00	Other miscellaneous revenue (specify)			ol	24.0
4.50	COVID-19 PHE Funding			3,447,109	24.5
	Total other income (Sum of lines 6 - 24)			3,447,109	
	Total (Line 5 plus line 25)			-12,147,810	
7.00	Other expenses (specify)				27.0
3.00				ő	
9.00				ő	29.0
	Total other expenses (Sum of lines 27 - 29)			ő	30.0
	Net income (or loss) for the period (Line 26 minus line 3	30)		-12,147,810	

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315496 Worksheet S Parts I, II & III Peri od: From 07/01/2021 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 10/17/2022 11:50 am PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 10/17/2022 Time: 11:50 am use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date: (4) Reopened 10.[ 0 ]If line 4, column 1 is "4": Enter number of times reopened (5) Amended

11. Contractor Vendor Code

for no utilization.

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

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

5. Date Received:

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NEW JERSEY VETERANS HOME - VINELAND ( 315496 ) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 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	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Ally	son Bailey	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	Allyson Bailey			2
3	Signatory Title	CEO CEO			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	8, 682	-1	0	1. 00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	8, 682	-1	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 NEW JERSEY VETERANS HOME - VINELAND In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315496 Peri od: Worksheet S-2 From 07/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2022 10/17/2022 11:50 am 3.00 1.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 524 N. WEST BLVD. PO Box: 1.00 2.00 City: VINELAND State: NJ Zi p Code: 08360 2.00 3.00 County: CUMBERLAND CBSA Code: 47220 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF NEW JERSEY VETERANS 315496 05/01/2006 N Р 0 4.00 HOME - VINELAND 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12 00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2021 06/30/2022 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? 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 N 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 1 580 000 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 1, 580, 000 23.00 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26.00 26.00 N (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27.00 applies? (Y/N) 28.00 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) Part A Part B Other 1.00 2.00 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν Ν 30.00 Nursing Facility 30.00 Ν 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 SNF-Based RHC 33.00 33.00 34.00 SNF-Based FQHC 34 00 35.00 SNF-Based CMHC Ν 35.00 36.00 SNF-Based OLTC 36.00 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37.00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry mal practice insurance? (Y/N) Ν 38 00 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 39.00 "claims-made" enter 1. If the policy is "occurrence", enter 2 Premi ums Pai d Losses Self Insurance 3.00 1.00 2.00 41.00 List malpractice premiums and paid losses: 41.00 0 0

Heal th	lealth Financial Systems NEW JERSEY VETERANS HOME - VINELAND In Lieu						
SKI LLE	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3154		Worksheet S-2		
COMPLE	X INDENTIFICATION DATA			From 07/01/2021	Part I		
				To 06/30/2022		pared:	
					10/17/2022 11	:50 am	
					Y/N		
		1. 00					
42.00	Are malpractice premiums and paid loss	e and General cost	N	42.00			
	center? Enter Y or N. If yes, check box	ost centers and					
	amounts.						
43 00	Are there any home office costs as def	ined in CMS Pub 15-1 Cha	apter 10?		N	43. 00	
	If line 43 is yes, enter the home office			ass of the home	**	44.00	
44.00		ce charif humber and effect	the name and addre	ess of the nome		44.00	
	office on lines 45, 46 and 47.						
	1. 00	2. 00		3. 00			
	If this facility is part of a chain or	ganization, enter the nam	e and address of t	he home office on the	lines		
	bel ow.						
45.00	Name:	ame: Contractor's Name: Contractor's Number:					
46.00	Street:	PO Box:				46. 00	
47.00	. 00 City: Zip Code: 4						

OMPL	ED NURSING FACILITY AND SKILLED NURSING FACILI	<u>JERSEY VETERANS H</u> TY HEALTH CARE		No.: 315496	Peri od:	eu of Form CMS- Worksheet S-2	
OWIF L	EX REIMBURSEMENT QUESTIONNAIRE				From 07/01/2021 To 06/30/2022		epared
					Y/N	Date	1. 50 ai
					1.00	2.00	
	General Instruction: For all column 1 responseresponses the format will be (mm/dd/yyyy)  Completed by All Skilled Nursing Facilites	ses enter in colu	mn 1, "Y" fo	r Yes or "N"	for No. For all	the date	
	Provider Organization and Operation						
. 00	Has the provider changed ownership immediatel	y prior to the b	eginning of	the cost	N		1.0
	reporting period? If column 1 is "Y", enter 1 instructions)	the date of the c	nange in coi	umn 2. (See			
	,			Y/N	Date	V/I	
. 00	Has the provider terminated participation in	the Medicare Pro	gram2 lf	1. 00 N	2. 00	3. 00	2.0
. 00	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			IN.			2.0
. 00	Is the provider involved in business transact			N			3. 0
	contracts, with individuals or entities (e.g. or medical supply companies) that are related						
	officers, medical staff, management personnel						
	of directors through ownership, control, or 1 relationships? (see instructions)	family and other	similar				
	Terationships: (see Thistructions)			Y/N	Type	Date	
				1. 00	2. 00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prepare	ared by a Certifi	ed Public	Y	С		4. (
. 00	Accountant? (Y/N) Column 2: If yes, enter "A'	' for Audited, "C	" for	'	Ü		\
	Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If						
. 00	Are the cost report total expenses and total			N			5. (
	those on the filed financial statements? If o	column 1 is "Y",	submit				
	reconciliation.				Y/N	Legal Oper.	
					1. 00	2. 00	
00	Approved Educational Activities  Column 1: Were costs claimed for Nursing Scho	ool 2 (V/N) Column	2. Is the	providor the	N	T N	6.
00	legal operator of the program? (Y/N)	or: (17N) cordilli	2. 13 the	provider the	14	"	0.
00	Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin			for Nurcina	N N		7. 8.
00	School and/or Allied Health Program? (Y/N) se		triig perrou	TOT Nut STITIS	IN		0.
						Y/N	
	Bad Debts					1.00	
				nc		Υ	
	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.  If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting						
	If line 9 is "Y", did the provider's bad debt				t reporting	N N	
0. 00		t collection poli	cy change du	ring this cos		1	10.
). 00 1. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance	cy change du	ring this cos Y", see instr	uctions.	N N	10.
1. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	d/or coinsurance	cy change du	ring this cos Y", see instr ", see instru	uctions.	N	10. (
0. 00 1. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instr ", see instru Pa Y/N	uctions. ctions. rt A Date	N N Part B Y/N	10.
). 00 I. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior	d/or coinsurance	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instr ", see instru Pa	uctions.	N N N Part B	10.
0.00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior  PS&R Data Was the cost report prepared using the PS&R	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru ", see instru Pa Y/N	uctions. ctions. rt A Date	N N Part B Y/N	10. 11. 12.
. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior  PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru ", see instru Pa Y/N 1.00	uctions.	N N Part B Y/N 3.00	10. 11. 12.
0.00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru ", see instru Pa Y/N 1.00	uctions.	N N Part B Y/N 3.00	10. 11. 12.
. 00 . 00 . 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00	uctions.	N N Part B Y/N 3.00	10. 11. 12.
. 00 . 00 . 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru ", see instru Pa Y/N 1.00	uctions.	N N Part B Y/N 3.00	10. 11. 12.
. 00 . 00 . 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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"	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00	uctions.	N N Part B Y/N 3.00	10. 11. 12.
0. 00 . 00 2. 00 3. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00	uctions.	N N Part B Y/N 3.00	10. 11. 12.
. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00  Y	uctions.	N N Part B Y/N 3.00	10. 11. 12. 13.
). 00 1. 00 2. 00 3. 00	If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  If line 13 or 14 is "Y", were adjustments	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00	uctions.	N N Part B Y/N 3.00	13.
). 00 1. 00 2. 00 3. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00  Y	uctions.	N N Part B Y/N 3.00 Y	10. 11. 12. 13.
3. 00 3. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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",	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00  Y	uctions.	N N Part B Y/N 3.00 Y	13.
1. 00 1. 00 3. 00 1. 00	If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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.	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa Y/N 1.00  Y	uctions.	N N Part B Y/N 3.00  Y N	10. 11. 12. 13. 14. 15. 15. 1
3. 00 3. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00  Y	uctions.	N N Part B Y/N 3.00 Y	10. 11. 12. 13.
1. 00 1. 00 3. 00 1. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa Y/N 1.00  Y	uctions.	N N Part B Y/N 3.00  Y N	10. 11. 12. 13. 14. 15. 15. 1
3. 00 3. 00 3. 00 4. 00	If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa Y/N 1.00  Y	uctions.	N N Part B Y/N 3.00  Y N	9. (10. (11. (11. (11. (11. (11. (11. (11
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00  Y  N	uctions.	N N N Part B Y/N 3.00  Y N N	10. ( 11. ( 12. ( 13. ( 14. ( 15. (
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles and Bed Complement  Have total beds available changed from prior  PS&R Data  Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)  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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.  If line 13 or 14 is "Y", then were	collection poli d/or coinsurance cost reporting p	cy change du waived? If "' eriod? If "Y	ring this cos Y", see instru  ", see instru  Pa  Y/N  1.00  Y  N	uctions.	N N N Part B Y/N 3.00  Y N N	10. ( 11. ( 12. ( 13. ( 14. ( 15. (

Heal th	Financial Systems NEW JERSEY VETERAL	NS HOM	1E - VINELAND	In Lieu of Form CMS-2540-10		
SKI LLE	NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR	E	Provi der No.: 315496	Peri od:		
COMPLEX REIMBURSEMENT QUESTIONNAIRE				From 07/01/2021	Part II	
				To 06/30/2022	Date/Time Pre 10/17/2022 11	: 50 am_
			1.00	2.	00	
	Cost Report Preparer Contact Information	_				
19.00	Enter the first name, last name and the title/position	CHRI	S	GUI LBAULT		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
20.00	Enter the employer/company name of the cost report	HEAL	TH CARE RESOURCES			20. 00
	preparer.					
21.00	Enter the telephone number and email address of the cost	609-	987-1440	CHRI S. GUI LBAUL	T@HCRNJ. NET	21. 00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems NEW JERSEY VETERANS SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE NEW JERSEY VETERANS HOME - VINELAND In Lieu of Form CMS-2540-10 Worksheet S-2 Part II Date/Time Prepared: 10/17/2022 11:50 am Peri od: From 07/01/2021 To 06/30/2022 Provi der No.: 315496 COMPLEX REIMBURSEMENT QUESTIONNAIRE Part B Date

		4. 00		
	PS&R Data			
13.00	Was the cost report prepared using the PS&R	09/09/2022		13. 00
	only? If either col. 1 or 3 is "Y", enter			
	the paid through date of the PS&R used to			
	prepare this cost report in cols. 2 and			
	4. (see Instructions.)			
14. 00	Was the cost report prepared using the PS&R			14. 00
	for total and the provider's records for			
	allocation? If either col. 1 or 3 is "Y"			
	enter the paid through date of the PS&R used			
	to prepare this cost report in columns 2 and			
45.00	4.			45.00
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	adjustments made to PS&R data for			10.00
	corrections of other PS&R Report			
	information? If yes, see instructions.			
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		COST REPORT PREPARER	19. 00
	held by the cost report preparer in columns	1, 2, and 3,		
	respecti vel y.			
20. 00	Enter the employer/company name of the cost	report		20.00
	preparer.			
21.00	Enter the telephone number and email address			21.00
	report preparer in columns 1 and 2, respecti	vei y.		1

In Lieu of Form CMS-2540-10

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

Provi der No.: 315496

Peri od: Worksheet S-3 From 07/01/2021 Part I To 06/30/2022 Date/Ti me Prepared:

10/17/2022 11:50 am Inpatient Days/Visits Title XVIII Number of Beds Bed Days Title V Title XIX Component Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 300 109, 500 С 2, 032 0 1.00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 0 0 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7.00 0 7.00 0 300 8.00 Total (Sum of lines 1-7) 109, 500 2.032 8.00 Inpatient Days/Visits Di scharges Title XIX Title XVIII Component Other Total Title V 6.00 7.00 8.00 9.00 10.00 1.00 SKILLED NURSING FACILITY 88, 719 90, 751 0 16 0 1.00 0 2.00 NURSING FACILITY 0 0 2.00 0 ICE/LID 3 00 3 00 C 0 4.00 HOME HEALTH AGENCY COST 0 4.00 5.00 Other Long Term Care 0 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 7.00 8.00 Total (Sum of lines 1-7) 88, 719 90, 751 16 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 13.00 11.00 12.00 14.00 15.00 1.00 SKILLED NURSING FACILITY 0.00 0.00 1.00 106 127.00 NURSING FACILITY 2.00 0 0.00 0.00 2.00 C 0 3.00 ICF/IID C 0.00 3.00 HOME HEALTH AGENCY COST 4.00 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 HOSPI CE 0.00 0.00 7.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 90 106 0.00 127.00 0.00 8.00 Average Length Admi ssi ons of Stay Title XVIII Title V Title XIX 0ther Component Total 16, 00 17.00 18.00 19 00 20.00 1.00 SKILLED NURSING FACILITY 856. 14 165 71 1. 00 NURSING FACILITY 0.00 0 2.00 2.00 0 LCF/LLD 0 3.00 0.00 0 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 0.00 5.00 SNF-Based CMHC 6.00 6.00 HOSPI CE 7 00 0 00 0 7.00 Total (Sum of lines 1-7) 856. 14 165 71 8.00 8.00 Admi ssi ons Full Time Equivalent Total Component Employees on Nonpai d Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 236 0.00 445.10 1.00 NURSING FACILITY 0.00 2.00 2.00 0 0.00 3.00 ICF/IID 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0 0.00 0.00 5.00 6.00 SNF-Based CMHC 0.00 6.00 0.00 7.00 HOSPI CE 0.00 0.00 7.00 8.00 Total (Sum of lines 1-7) 236 445.10 0.00 8.00

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315496

				T	0 06/30/2022	Date/Time Pre 10/17/2022 11	
		Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1. 00	Total salaries (See Instructions)	24, 503, 291	0	24, 503, 291	925, 949. 00		
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		
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	
6.00	Revised wages (line 1 minus line 5)	24, 503, 291	0	24, 503, 291	925, 949. 00		
7.00	Other Long Term Care	0	0	0	0.00		
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00		
9.00	CMHC	0	0	0	0.00		
10.00	HOSPI CE	0	0	0	0.00		
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	24, 503, 291	0	24, 503, 291	925, 949. 00	26. 46	13. 00
	12)						
	OTHER WAGES & RELATED COSTS		_				
14. 00	3	1, 034, 306	0	1, 034, 306	i i		14. 00
15. 00	Contract Labor: Physician services-Part A	0	0	0	0.00		15. 00
16. 00		0	0	0	0.00	0.00	16. 00
47.00	WAGE-RELATED COSTS	44.050.040		14.050.040			4
17. 00	Wage-related costs core (See Part IV)	14, 959, 260	0	14, 959, 260			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		0	0	0			20.00
21. 00		0	0	0			21. 00
22. 00	Total Adjusted Wage Related cost (see	14, 959, 260	0	14, 959, 260			22. 00
	instructions)		I	l			

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315496

							10/17/2022 11	50 am
		Amount	Reclass. o	of	Adj usted	Paid Hours	Average Hourly	
		Reported	Salaries fr	om	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A	۱-6	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	1, 422, 667		0	1, 422, 667	49, 080. 00	28. 99	2.00
3.00	Plant Operation, Maintenance & Repairs	1, 371, 653		0	1, 371, 653	67, 243. 00	20. 40	3.00
4.00	Laundry & Linen Service	0		0	0	0.00	0.00	4.00
5.00	Housekeepi ng	1, 798, 296		0	1, 798, 296	87, 112. 00	20. 64	5.00
6.00	Di etary	2, 830, 860		0	2, 830, 860	143, 113. 00	19. 78	6.00
7.00	Nursing Administration	0		0	0	0.00	0.00	7.00
8.00	Central Services and Supply	0		0	0	0.00	0.00	8.00
9.00	Pharmacy	0		0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0		0	0	0.00	0.00	10.00
11.00	Soci al Servi ce	425, 898		0	425, 898	15, 036. 00	28. 33	11.00
12.00	Nursing and Allied Health Ed. Act.							12.00
13.00	Other General Service	946, 536		0	946, 536	48, 145. 00	19. 66	13.00
14.00	Total (sum lines 1 thru 13)	8, 795, 910		0	8, 795, 910	409, 729. 00		14.00
	•		•					

Health Financial Systems	NEW JERSEY VETERANS HOME - VINELAND	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315496	Peri od: Worksheet S-3

SNF WA	GE RELATED COSTS	Provider No.: 315496	From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre	pared:
				Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	
3.00	Qualified and Non-Qualified Pension Plan Cost			6, 811, 915	
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	
6.00	Legal /Accounting/Management Fees-Pension Plan			0	0.00
7.00	Employee Managed Care Program Administration Fees			0	7. 00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			5, 954, 300	
9.00	Prescription Drug Plan			0	7.00
10. 00	Dental, Hearing and Vision Plan			0	10.00
	Life Insurance (If employee is owner or beneficiary)			0	11. 00 12. 00
	12.00 Accident Insurance (If employee is owner or beneficiary)				
	3.00 Disability Insurance (If employee is owner or beneficiary)				
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14. 00
15. 00	Workers' Compensation Insurance			245, 033	
16. 00	.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.				16. 00
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			1, 519, 204	
	Medicare Taxes - Employers Portion Only			355, 298	
	Unemployment Insurance			0	19. 00
20. 00	State or Federal Unemployment Taxes			73, 510	20. 00
	OTHER				
	Executive Deferred Compensation			0	21. 00 22. 00
22. 00					
	3.00 Tuition Reimbursement				
24. 00	Total Wage Related cost (Sum of lines 1 - 23)			14, 959, 260	24. 00
				Amount	
				Reported	
				1. 00	
05.60	Part B - Other than Core Related Cost				05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

Heal th Financial Systems

NEW JERSEY VETERANS HOME - VINELAND

Provider No.: 315496

Provider No.: 315496

Period:
From 07/01/2021
To 06/30/2022

Occupational Category

Amount
Reported

Reported

Pringe
Benefits

Adjusted
Salaries (col. 1 + col. 2)
Salary in col. 23 + col. 4)

Salary in col. 3 + col. 4)

Direct Salaries

	Occupational Category	Amount	Fringe Benefits	Adjusted		Average Houri y	
		Reported	Benefits	Salaries (col. 1 + col. 2)	Related to Salary in col.	Wage (col. 3 ÷ col. 4)	
				1 + COI. 2)	3	COI. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries	<u> </u>					
	Nursing Occupations						
1.00	Registered Nurses (RNs)	3, 826, 147	2, 335, 863	6, 162, 010	108, 044. 00	57. 03	1.00
2.00	Licensed Practical Nurses (LPNs)	3, 400, 338	2, 075, 906	5, 476, 244	117, 166. 00	46. 74	2.00
3.00	Certified Nursing Assistant/Nursing	5, 813, 550	3, 549, 172	9, 362, 722	291, 010. 00	32. 17	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	13, 040, 035	7, 960, 941	21, 000, 976	516, 220. 00	40. 68	4. 00
5.00	Physi cal Therapists	0	0	0	0.00	0.00	5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physi cal Therapy Ai des	0	0	0	0.00	0.00	7. 00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8. 00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9. 00
10.00	Occupational Therapy Aides	O	0	0	0.00	0.00	10.00
11.00	Speech Therapists	O	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	O	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations						
14.00		0		0	0.00		
	Licensed Practical Nurses (LPNs)	0		0	0.00		
16. 00		0		0	0. 00	0.00	16.00
	Assi stants/Ai des						
	Total Nursing (sum of lines 14 through 16)	0		0	0.00		17. 00
	Physi cal Therapists	296, 477		296, 477	i -		
19. 00	1 3	0		0	0.00		
20.00		0		0	0.00		
21. 00		472, 397		472, 397	· ·		
22. 00	1.5	0		0	0. 00		
23. 00	1 1	0		0	0. 00		
24.00		265, 432		265, 432			
25. 00	1 ' ' '	0		0	0. 00		
26. 00	Other Medical Staff	0		0	0.00	0.00	26. 00

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provi der No.: 315496 

	10 06/30/2022	2 Date/lime Prepared: 10/17/2022 11:50 am
	Group	Days
1.00	1. 00 RUX	2.00
2.00	RUL	2.00
3.00	RVX	3.00
4. 00	RVL	4.00
5. 00	RHX	5.00
6.00	RHL	6. 00
7. 00 8. 00	RMX RML	8.00
9. 00	RLX	9. 00
10. 00	RUC	10.00
11. 00	RUB	11.00
12.00	RUA	12.00
13. 00 14. 00	RVC RVB	13. 00 14. 00
15. 00	RVA	15. 00
16. 00	RHC	16.00
17. 00	RHB	17. 00
18.00	RHA	18.00
19. 00 20. 00	RMC RMB	19. 00 20. 00
21. 00	RMA	21. 00
22. 00	RLB	22. 00
23. 00	RLA	23. 00
24. 00	ES3	24. 00
25. 00 26. 00	ES2 ES1	25. 00 26. 00
27. 00	HE2	27. 00
28. 00	HE1	28. 00
29. 00	HD2	29. 00
30.00	HD1	30.00
31. 00 32. 00	HC2 HC1	31. 00 32. 00
33. 00	HB2	33.00
34. 00	HB1	34.00
35. 00	LE2	35. 00
36.00	LE1	36.00
37. 00 38. 00	LD2 LD1	37. 00 38. 00
39.00	LC2	39.00
40.00	LC1	40.00
41. 00	LB2	41.00
42. 00	LB1	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   51. 00	CB1 CA2	50. 00 51. 00
52. 00	CA1	52. 00
53. 00	SE3	53.00
54.00	SE2	54. 00
55. 00 56. 00	SE1 SSC	55. 00 56. 00
57. 00	SSB	57. 00
58. 00	SSA	58.00
59. 00	I B2	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 69. 00	PE1 PD2	68. 00 69. 00
70.00	PD2 PD1	70.00
71. 00	PC2	71.00
72. 00	PC1	72. 00
73.00	PB2	73.00
74. 00 75. 00	PB1 PA2	74. 00 75. 00
70.00	FAZ	1 75.00

Health Financial Systems	NEW JERSEY VETERANS HOP	ME - VINELA	AND	In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provi der		Peri od: From 07/01/2021	Worksheet S-7	7
				To 06/30/2022	Date/Time Pre	
				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 Regis payments beginning 10/01/2003. Congress expenses. For lines 101 through 106: Er column 2 the percentage of total expens line 1, column 3. Indicate in column 3 with direct patient care and related ex (See instructions)	s expected this increase ater in column 1 the amou ses for each category to "Y" for yes or "N" for n	to be used nt of the total SNF o if the s	for direct p expense for e revenue from pending refle	atient care and ach category. Er Worksheet G-2, F cts increases as	related nter in Part I, ssociated	
101. 00 Staffing						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)	l line 1 column 2)					105. 00 106. 00
106.00 Total SNF revenue (Worksheet G-2, Part	r, rine i, corumn 3)		I		I	1100.00

	Financial Systems NEW SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	JERSEY VETERANS I		No.: 315496	Peri od:	Worksheet A	2540-10
	ST. ST. OR AND ADDODREST OF TRIAL DALANGE OF	EXI ENGLG	1 1 OVI del		From 07/01/2021 To 06/30/2022	Date/Time Pre 10/17/2022 11	
	Cost Center Description	Sal ari es	Other	Total (col. 7 + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	8, 553 0 0	8, 55	3 0 0	8, 553 0 0	2.00
4. 00	00400 ADMINISTRATIVE & GENERAL	1, 422, 667	665, 691	2, 088, 35	8 0	2, 088, 358	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 371, 653	5, 348, 714	6, 720, 36		6, 720, 367	
6.00	00600 LAUNDRY & LINEN SERVICE	0	27, 581	27, 58		611, 934	
7. 00	00700 HOUSEKEEPI NG	1, 798, 296	1, 276, 681	3, 074, 97		2, 490, 624	1
8. 00	00800 DI ETARY	2, 830, 860	1, 591, 414			4, 422, 274	
9. 00	00900 NURSING ADMINISTRATION	0	0		o o	0	
10. 00	01000 CENTRAL SERVICES & SUPPLY	o	591, 506	591, 50	6 0	591, 506	10.00
11. 00	01100 PHARMACY	o	0	,	o o	0	
13. 00	01300 SOCI AL SERVI CE	425, 898	0	425, 89	8 0	425, 898	
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	,	0	0	
15. 00	01500 RECREATION	946, 536	0	946, 53	6 0	946, 536	
	INPATIENT ROUTINE SERVICE COST CENTERS		-		-1		1
30. 00	03000 SKILLED NURSING FACILITY	15, 707, 381	2, 839, 166	18, 546, 54	7 -1, 892, 279	16, 654, 268	30.00
31. 00	03100 NURSING FACILITY	0	0		0 0	0	
32. 00	03200   CF/IID	o	0		o o	0	
33. 00	03300 OTHER LONG TERM CARE	o	0		o o	0	
	ANCILLARY SERVICE COST CENTERS				-,		
40. 00	04000 RADI OLOGY	0	0		0 6, 225	6, 225	40.00
41. 00	04100 LABORATORY	O	0		0 10, 458	10, 458	41.00
42. 00	04200 I NTRAVENOUS THERAPY	O	0		o o	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		o o	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	23, 003	23, 00	3 296, 477	319, 480	44.00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0		0 472, 397	472, 397	45.00
46. 00	04600 SPEECH PATHOLOGY	0	0		0 265, 432	265, 432	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	49, 951	49, 95	1 34, 573	84, 524	49.00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60. 00	06000 CLI NI C	0	0		0	0	
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	
62. 00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS		_				ļ
70. 00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	
	07100 AMBULANCE	0	0		0 445, 390	445, 390	
73. 00	07300 CMHC	0	0		0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS				ما ما		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0	0	
81. 00	08100 I NTEREST EXPENSE		0		0	0	
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0	0	
83. 00	08300 HOSPI CE	24 502 201	12 422 240	2/ 025 55	0 0	0	
89. 00	SUBTOTALS (sum of lines 1-84)	24, 503, 291	12, 422, 260	36, 925, 55	1 -361, 327	36, 564, 224	89.00
00 00	NONREI MBURSABLE COST CENTERS		0			0	1 00 00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		0			0	
91.00	09200 PHYSICIANS PRIVATE OFFICES		0		0 261 227	361, 327	
93.00	09300 NONPALD WORKERS		0		0 361, 327	361, 327	
	09400 PATIENTS LAUNDRY		0		0 0	0	
		24, 503, 291	12, 422, 260	36, 925, 55	-	36, 925, 551	
100.00							

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315496 Peri od: Worksheet A From 07/01/2021 06/30/2022 Date/Time Prepared: 10/17/2022 11:50 am Cost Center Description Adjustments to Net Expenses Expenses (Fr For Allocation (col. 5 +-col. 6) Wkst A-8) 6.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1, 585, 926 1, 594, 479 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 2.00 00300 EMPLOYEE BENEFITS 14, 959, 259 14, 959, 259 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 577,633 2, 665, 991 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 6, 720, 367 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 0 611. 934 6.00 7.00 00700 HOUSEKEEPI NG 2, 490, 624 7.00 8.00 00800 DI ETARY 0 4, 422, 274 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 591, 506 10.00 0 11.00 01100 PHARMACY 11.00 13.00 01300 SOCIAL SERVICE 0 425, 898 13.00 0 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 14.00 01500 RECREATION 946, 536 15.00 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 16, 654, 268 30.00 03100 NURSING FACILITY 0 31 00 31 00 32.00 03200 | CF/IID 0 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40 00 04000 RADI OLOGY 40 00 0 6 225 41.00 04100 LABORATORY 0 10, 458 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 43 00 Ω 44.00 04400 PHYSI CAL THERAPY 319, 480 44.00 45. 00 04500 OCCUPATIONAL THERAPY 472, 397 45.00 04600 SPEECH PATHOLOGY 46.00 265, 432 46.00 04700 ELECTROCARDI OLOGY 47 00 47 00 Ω 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 48.00 04900 DRUGS CHARGED TO PATIENTS 0 84, 524 49.00 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 50.00 05100 SUPPORT SURFACES 51.00 51.00 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 70.00 07100 AMBULANCE 0 445, 390 71.00 71.00 07300 CMHC 73.00 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 0 81.00 0 81.00 82.00 08200 UTILIZATION REVIEW - SNF 0 0 82.00 83.00 08300 H0SPI CE 83.00 SUBTOTALS (sum of lines 1-84) 17, 122, 818 53, 687, 042 89.00 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 361, 327 92.00 93. 00 | 09300 | NONPALD WORKERS 0 93.00 94.00 94.00 09400 PATIENTS LAUNDRY 100.00 TOTAL 17, 122, 818 54, 048, 369 100.00

Health Financial Systems	NEW JERSEY VETERANS HOM	IE - VINELAND	In Lie	u of Form CMS-2540-10
RECLASSI FI CATI ONS		Provi der No.: 315496	Peri od: From 07/01/2021	Worksheet A-6
				Date/Time Prepared:

					10/17/2022 11	:50 am
		Increases				
	Cost Center	r	Li ne #	Sal ary	Non Salary	
	2. 00	2. 00		4. 00	5. 00	
(1) A - DEFAULT						
1.00	SPEECH PATHOLOGY		46. 00	0	265, 432	1. 00
2. 00	OCCUPATI ONAL THERAP	Υ	45.00	0	472, 397	2. 00
3. 00	PHYSICAL THERAPY		44. 00	0	296, 477	3. 00
4. 00	AMBULANCE		71. 00	0	445, 390	4. 00
5. 00	RADI OLOGY		40. 00	0	6, 225	5. 00
6. 00	LABORATORY		41. 00	0	10, 458	6. 00
7. 00	DRUGS CHARGED TO PA	TIENTS	49. 00	0	34, 573	7. 00
8. 00	LAUNDRY & LINEN SER	VICE	6. 00	0	584, 353	8. 00
9. 00	PHYSICIANS PRIVATE	OFFI CES	92.00	0	361, 327	9. 00
TOTALS						
100. 00	Total Reclassificat	ions (Sum		0	2, 476, 632	100. 00
	of columns 4 and 5	must				
	equal sum of column	s 8 and				
	9)					

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

Health Financial Systems	NEW JERSEY VETERANS HOME - VINELAND	In Lieu	ı of Form CMS-2540-10
RECLASSI FI CATI ONS	Provi der No.: 315496		Worksheet A-6
			Date/Time Prepared:
			10/17/2022 11 50 am
	Decreases		

				107 177 2022 11	OO CIII
		Decreases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	6.00	7. 00	8. 00	9. 00	
(1) A - DEFAULT					
1.00	SKILLED NURSING FACILITY	30.00	0	265, 432	1.00
2. 00	SKILLED NURSING FACILITY	30.00	0	472, 397	2. 00
3.00	SKILLED NURSING FACILITY	30.00	0	296, 477	3. 00
4.00	SKILLED NURSING FACILITY	30.00	0	445, 390	4.00
5. 00	SKILLED NURSING FACILITY	30.00	0	6, 225	5. 00
6.00	SKILLED NURSING FACILITY	30.00	0	10, 458	6. 00
7. 00	SKILLED NURSING FACILITY	30.00	0	34, 573	7. 00
8.00	HOUSEKEEPI NG	7.00	0	584, 353	8. 00
9. 00	SKILLED NURSING FACILITY	30.00	0	361, 327	9. 00
TOTALS					
100.00			0	2, 476, 632	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No.: 315496

				10	06/30/2022	10/17/2022 11	
				Acqui si ti ons		10/1//2022	00 am
	Description	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	'	Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	63, 260, 000	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	63, 260, 000	0	0	0	0	7.00
8.00	Reconciling Items	o	0	0	0	0	8. 00
9.00	Total (line 7 minus line 8)	63, 260, 000	0	0	0	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	S					
1. 00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	63, 260, 000	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	0	0				6.00
7.00	Subtotal (sum of lines 1-6)	63, 260, 000	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	63, 260, 000	0				9. 00

Peri od: Worksheet A-8 From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

11. 00 Nonallowable costs related to certain Capital expenditures (chapter 24)  12. 00 Adjustment resulting from transactions with related organizations (chapter 10)  13. 00 Laundry and linen service  14. 00 Revenue - Employee meals  15. 00 Cost of meals - Guests  16. 00 Sale of medical supplies to other than patients  17. 00 Sale of drugs to other than patients  18. 00 Sale of medical records and abstracts  19. 00 Vending machines  10. 00  11. 00 Vending machines  12. 00 Octobro transactions with A-8-1  13. 00 Laundry and linen service  14. 00 Octobro meals - Guests  15. 00 Octobro medical supplies to other than patients  16. 00 Sale of medical records and abstracts  17. 00 Sale of medical records and abstracts  18. 00 Sale of medical records and abstracts  19. 00 Vending machines  19. 00 Octobro from imposition of interest, finance or penalty charges (chapter 21)	
Description (1)	
Description (1)   (2)   Basis For   Amount   Cost Center   Line No.	
Adjustment   1.00	
1.00   2.00   3.00   4.00	
1.00	
(chapter 2) Trade, quantity, and time discounts (chapter 8) 3.00 Refunds and rebates of expenses (chapter 8) 4.00 Rental of provider space by suppliers (chapter 8) 5.00 Tel ephone services (pay stations excluded) (chapter 21) 6.00 Tel evision and radio service (chapter 21) 7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 21) 9.00 Home office cost (chapter 23) 11.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meal s 15.00 Cost of meals - Guests 17.00 Sale of drugs to other than patients 18.00 Sale of forgis to other than patients 19.00 Coult of the supplies to the	1. 00
2.00   Trade, quantity, and time discounts (chapter 8)	1.00
8) 3.00 Refunds and rebates of expenses (chapter 8) 4.00 Rental of provider space by suppliers (chapter 8) 5.00 Telephone services (pay stations excluded) (chapter 21) 6.00 Television and radio service (chapter 21) 7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 21) 9.00 Sale of scrap, waste, etc. (chapter 23) 10.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonallowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meal s 15.00 Cost of meals - Guests 16.00 Sale of drugs to other than patients 17.00 Sale of medical supplies to other than patients 18.00 Sale of medical records and abstracts 19.00 Vending machines 19.00 Vending machines 10.00 Ocoul Interest, enable or penalty charges (chapter 21) 11.10 Interest expense on Medicare overpayments	2. 00
3.00 Refunds and rebates of expenses (chapter 8) 4.00 Rental of provider space by suppliers (chapter 8) 5.00 Tel ephone services (pay stations excluded) (chapter 21) 6.00 Tel evision and radio service (chapter 21) 7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 21) 9.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonallowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Remense Employee meal s 15.00 Cost of meals - Guests 16.00 Sale of medical supplies to other than patients 17.00 Sale of medical records and abstracts 18.00 Vending machines 19.00 Vending machines 19.00 Vending machines 19.00 Interest expense on Medicare overpayments	2.00
4.00 Rental of provider space by suppliers (Chapter 8)  5.00 Telephone services (pay stations excluded) (Chapter 21)  6.00 Television and radio service (chapter 21)  8.00 Remuneration applicable to provider-based physician adjustment  9.00 Home office cost (chapter 21)  10.00 Nonal lowable costs related to certain capital expenditures (chapter 24)  12.00 Adjustment resulting from transactions with related organizations (chapter 10)  13.00 Laundry and linen service  14.00 Revenue - Employee meals  15.00 Cost of meals - Guests  16.00 Sale of drugs to other than patients  17.00 Sale of drugs to other than patients  18.00 Sale of medical records and abstracts  19.00 Vending machines  19.00 Unone from imposition of interest, finance or penalty charges (chapter 24)  19.00 Interest expense on Medicare overpayments	3. 00
(chapter 8)  5.00 Tel ephone services (pay stations excluded) (chapter 21)  6.00 Tel evision and radio service (chapter 21)  7.00 Parking lot (chapter 21)  8.00 Remuneration applicable to provider-based physician adjustment  9.00 Home office cost (chapter 21)  9.00 Nonal lowable costs related to certain Capital expenditures (chapter 24)  12.00 Adjustment resulting from transactions with related organizations (chapter 10)  13.00 Laundry and linen service  15.00 Cost of meals - Guests  16.00 Sale of medical supplies to other than patients  17.00 Sale of medical records and abstracts  18.00 Sale of medical records and abstracts  19.00 Vending machines  10.00 Cool of meals - Guester (chapter 24)  10.00 Cool of meals - Guester  10.00 Cool of medical supplies to other than patients  10.00 Cool of medical records and abstracts  10.00 Cool of medical records and abstracts  10.00 Cool of meals - Guester  10.00 Cool of medical records and abstracts  10.00 Cool of meals - Guester  11.00 Income from imposition of interest, finance or penalty charges (chapter 21)  11.00 Interest expense on Medicare overpayments	4. 00
5.00 Telephone services (pay stations excluded) (chapter 21) 6.00 Television and radio service (chapter 21) 7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 23) 10.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonallowable costs related to certain capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meals 15.00 Cost of meals - Guests 16.00 Sale of medical supplies to other than patients 17.00 Sale of medical records and abstracts 18.00 Sale of medical records and abstracts 19.00 Vending machines 10.00 Cost of men service 10.00 Cost of medical records and abstracts 10.00 Cost of medical records and abs	1. 00
(chapter 21) 6. 00 Tel evision and radio service (chapter 21) 7. 00 Parking lot (chapter 21) 8. 00 Remuneration applicable to provider-based physician adjustment 9. 00 Home office cost (chapter 21) 10. 00 Sale of scrap, waste, etc. (chapter 23) 11. 00 Nonallowable costs related to certain Capital expenditures (chapter 24) 12. 00 Adjustment resulting from transactions with related organizations (chapter 10) 13. 00 Laundry and linen service 14. 00 Revenue - Employee meal s 15. 00 Cost of meals - Guests 17. 00 Sale of drugs to other than patients 18. 00 Sale of medical records and abstracts 19. 00 Vending machines 19. 00 Vending machines 19. 00 Unone from imposition of interest, finance or penalty charges (chapter 21) 11. 11. 11. 12. 12. 13. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	5. 00
6.00 Television and radio service (chapter 21) 7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 21) 9.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonal lowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meals 15.00 Cost of meals - Guests 16.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of medical records and abstracts 17.00 Sale of medical records and abstracts 17.00 Sale of medical records and abstracts 17.00 Coome from imposition of interest, finance or penal ty charges (chapter 21) 21.00 Interest expense on Medicare overpayments	
7.00 Parking lot (chapter 21) 8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 21) 10.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonal lowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meals 15.00 Cost of meals - Guests 10.00 16.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of medical records and abstracts 10.00 18.00 Sale of medical records and abstracts 10.00 10.00 11.00 Vending machines 10.00 Ve	6.00
8.00 Remuneration applicable to provider-based physician adjustment 9.00 Home office cost (chapter 21) 10.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonal lowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 13.00 Revenue - Employee meals 15.00 Cost of meals - Guests 17.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of medical records and abstracts 18.00 Sale of medical records and abstracts 19.00 Vending machines 10.00 Sale of medical records and abstracts 10.00 Sale of medical rec	7. 00
physician adjustment  9.00 Home office cost (chapter 21)  10.00 Sale of scrap, waste, etc. (chapter 23)  11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)  12.00 Adjustment resulting from transactions with related organizations (chapter 10)  13.00 Laundry and linen service  14.00 Revenue - Employee meals  0 Cost of meals - Guests  15.00 Cost of meals - Guests  17.00 Sale of drugs to other than patients  17.00 Sale of drugs to other than patients  17.00 Sale of medical records and abstracts  17.00 Sale of medical records and abstracts  17.00 Solution of interest, finance or penalty charges (chapter 21)  18.00 Income from imposition of interest, finance or penalty charges (chapter 21)  21.00 Interest expense on Medicare overpayments	8. 00
9.00 Home office cost (chapter 21) 10.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonal lowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meals 15.00 Cost of meals - Guests 16.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of medical records and abstracts 17.00 Sale of medical records and abstracts 17.00 Urncome from imposition of interest, finance or penal ty charges (chapter 21) 10.00 Interest expense on Medicare overpayments	
10.00 Sale of scrap, waste, etc. (chapter 23) 11.00 Nonallowable costs related to certain Capital expenditures (chapter 24) 12.00 Adjustment resulting from transactions with related organizations (chapter 10) 13.00 Laundry and linen service 14.00 Revenue - Employee meals 15.00 Cost of meals - Guests 16.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Vending machi nes 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments	9.00
11. 00 Nonallowable costs related to certain Capital expenditures (chapter 24)  12. 00 Adjustment resulting from transactions with related organizations (chapter 10)  13. 00 Laundry and linen service 14. 00 Revenue - Employee meals 15. 00 Cost of meals - Guests 16. 00 Sale of medical supplies to other than patients 17. 00 Sale of drugs to other than patients 17. 00 Sale of medical records and abstracts 19. 00 Vending machi nes 10. 00 11. 00 Income from imposition of interest, finance or penalty charges (chapter 21)  21. 00 Interest expense on Medicare overpayments	10.00
Capital expenditures (chapter 24)  12.00 Adjustment resulting from transactions with related organizations (chapter 10)  13.00 Laundry and linen service  14.00 Revenue - Employee meals  15.00 Cost of meals - Guests  16.00 Sale of medical supplies to other than patients  17.00 Sale of drugs to other than patients  18.00 Sale of medical records and abstracts  19.00 Vending machines  10.00  11.00 Income from imposition of interest, finance or penalty charges (chapter 21)  21.00 Interest expense on Medicare overpayments	11. 00
related organizations (chapter 10)  13.00 Laundry and Linen service  0 0.00  14.00 Revenue - Employee meals  0 0.00  15.00 Cost of meals - Guests  16.00 Sale of medical supplies to other than patients  17.00 Sale of drugs to other than patients  17.00 Sale of medical records and abstracts  17.00 Vending machines  17.00 Income from imposition of interest, finance or penalty charges (chapter 21)  21.00 Interest expense on Medicare overpayments	
13.00 Laundry and Linen service  14.00 Revenue - Employee meals  15.00 Cost of meals - Guests  16.00 Sale of medical supplies to other than patients  17.00 Sale of drugs to other than patients  18.00 Sale of medical records and abstracts  19.00 Vending machines  20.00 Income from imposition of interest, finance or penalty charges (chapter 21)  21.00 Interest expense on Medicare overpayments  0 0.00  0.00  0.00  0.00  0.00  0.00  0.00	12.00
14.00 Revenue - Employee meals  Cost of meals - Guests  O 0.00  15.00 Sale of medical supplies to other than patients  Tr.00 Sale of drugs to other than patients  Sale of medical records and abstracts  O 0.00  Sale of medical records and abstracts  O 0.00  Income from imposition of interest, finance or penalty charges (chapter 21)  Interest expense on Medicare overpayments	
15.00 Cost of meals - Guests  16.00 Sale of medical supplies to other than patients  17.00 Sale of drugs to other than patients  18.00 Sale of medical records and abstracts  19.00 Vending machines  20.00 Income from imposition of interest, finance or penalty charges (chapter 21)  21.00 Interest expense on Medicare overpayments  0 0.00  0.00  0.00  0.00  0.00	13.00
16.00 Sale of medical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments  0 0 0.00 0 0.00 0 0.00	14.00
patients  17.00 Sale of drugs to other than patients  18.00 Sale of medical records and abstracts  19.00 Vending machines  20.00 Income from imposition of interest, finance or penalty charges (chapter 21)  21.00 Interest expense on Medicare overpayments  0 0 0.00  0.00	15.00
17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments 0 0.00 0.00 0.00 0.00	16.00
18.00 Sale of medical records and abstracts 19.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments 0 0.00 0.00 0.00	
18.00 Sale of medical records and abstracts 19.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments 0 0.00 0.00 0.00	17.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments 0 0.00	18.00
or penalty charges (chapter 21) 21.00 Interest expense on Medicare overpayments 0 0.00	19.00
21.00   Interest expense on Medicare overpayments   0 0.00	20.00
and borrowings to repay Medicare	21.00
overpayments	
	22. 00
(chapter 21)	
23.00 Depreciationbuildings and fixtures 0CAP REL COSTS - BLDGS & 1.00	23.00
FI XTURES	
24.00 Depreciationmovable equipment 0CAP REL COSTS - MOVABLE 2.00	24. 00
EQUI PMENT	
	25. 00
25. 01 CENTRAL OFFICE SALARIES A 358, 667 ADMINISTRATIVE & GENERAL 4. 00	25. 01
25. 02 CENTRAL OFFICE FRINGE BENEFITS A 218, 966 ADMINISTRATIVE & GENERAL 4. 00	25. 02
	25. 03
FI XTURES	05.01
	25. 04
FIXTURES	00.00
	00. 00
to Worksheet A, col. 6, line 100)	

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315496

				o 06/30/2022	Date/Time Pre	
		CAPI TAL REL	_ATED COSTS		10/17/2022 11	:50 am
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	col. 7)	1. 00	2.00	3. 00	3A	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES	1, 594, 479	1, 594, 479	_			1.00
2. 00   00200   CAP REL COSTS - MOVABLE EQUI PMENT	0	0	C	14 050 350		2.00
3.00   00300 EMPLOYEE BENEFITS 4.00   00400 ADMINISTRATIVE & GENERAL	14, 959, 259 2, 665, 991	173, 888		14, 959, 259 868, 538	3, 708, 417	3. 00 4. 00
5. 00   00500 PLANT OPERATION, MAINT. & REPAIRS	6, 720, 367	232, 859		837, 394	7, 790, 620	5.00
6. 00 00600 LAUNDRY & LINEN SERVICE	611, 934	14, 365	Č	0	626, 299	6.00
7. 00 00700 HOUSEKEEPI NG	2, 490, 624	41, 582	c	1, 097, 860	3, 630, 066	7. 00
8. 00   00800   DI ETARY	4, 422, 274	94, 504	C	1, 728, 240	6, 245, 018	8. 00
9.00 00900 NURSING ADMINISTRATION	0	0	C	0	0	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	591, 506	60, 483	C	0	651, 989	10.00
11. 00   01100   PHARMACY	425 000	11 241		240 011	(07.350	11.00
13.00   O1300   SOCIAL SERVICE 14.00   O1400   NURSING AND ALLIED HEALTH EDUCATION	425, 898	11, 341	) (	260, 011	697, 250 0	13. 00 14. 00
15. 00 01500 RECREATION	946, 536	89, 212		1 1	1, 613, 608	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	710,000	07,212		, 377,000	1,010,000	10.00
30.00 03000 SKILLED NURSING FACILITY	16, 654, 268	835, 419	C	9, 368, 766	26, 858, 453	30.00
31.00 03100 NURSING FACILITY	O	0	C	0	0	31. 00
32. 00   03200   I CF/I I D	0	0	C	7	0	32. 00
33. 00 03300 OTHER LONG TERM CARE	0	0	C	0	0	33. 00
ANCI LLARY SERVI CE COST CENTERS  40. 00 O4000 RADI OLOGY	6, 225	0		ol ol	6, 225	40. 00
41. 00   04100   LABORATORY	10, 458	0			10, 458	41.00
42. 00 04200 I NTRAVENOUS THERAPY	10, 430	0			10, 430	42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	o	0	ď	ol ol	0	43. 00
44. 00 04400 PHYSI CAL THERAPY	319, 480	37, 802	c	0	357, 282	44. 00
45. 00 04500 OCCUPATIONAL THERAPY	472, 397	0	C	0	472, 397	45. 00
46. 00 04600 SPEECH PATHOLOGY	265, 432	0	C	0	265, 432	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	04 524	0			04 534	48. 00
49. 00   04900   DRUGS CHARGED TO PATIENTS 50. 00   05000   DENTAL CARE - TITLE XIX ONLY	84, 524	0		1	84, 524 0	49. 00 50. 00
51. 00 05100 SUPPORT SURFACES	0	0		1	0	51.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		,,		01.00
60. 00 06000 CLI NI C	0	0	C	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	O	0	C	o	0	61.00
62. 00 06200 FQHC						62.00
OTHER REIMBURSABLE COST CENTERS  70, 00 07000 HOME HEALTH AGENCY COST		0			0	70.00
70.00   07000   HOME HEALTH AGENCY COST 71.00   07100   AMBULANCE	0 445, 390	0			0 445, 390	70. 00 71. 00
73. 00 07300 CMHC	443, 340	0			445, 390	73.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		·1		70.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00 08100 INTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00   08300   HOSPI CE	0	0	C		0	83. 00
89.00 SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	53, 687, 042	1, 591, 455	C	14, 738, 669	53, 463, 428	89. 00
90. 00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	C		0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP		3, 024			3, 024	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	361, 327	0	d	220, 590	581, 917	92.00
93. 00 09300 NONPALD WORKERS	0	0	c	0	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	0	c	0	0	94. 00
98.00 Cross Foot Adjustments	0	0	С	7	0	98. 00
99.00 Negative Cost Centers	0	0	C	-	0	99. 00
100. 00   T0TAL	54, 048, 369	1, 594, 479	[ C	14, 959, 259	54, 048, 369	1100.00

| Peri od: | Worksheet B | From 07/01/2021 | Part I | To 06/30/2022 | Date/Time Prepared:

				T	06/30/2022		
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	10/17/2022 11 DI ETARY	: 50 am
	cost center bescription	& GENERAL	OPERATION,	LINEN SERVICE	11003EREEL TING	DILIAKI	
			MAINT. &				
			REPAI RS				
	I	4.00	5. 00	6. 00	7. 00	8. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2. 00 3. 00	OO200   CAP REL COSTS - MOVABLE EQUIPMENT   OO300   EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	3, 708, 417					4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	573, 912	8, 364, 532	,			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	46, 138	101, 162	1			6. 00
7. 00	00700 HOUSEKEEPI NG	267, 416	292, 838		4, 190, 320		7. 00
8.00	00800 DI ETARY	460, 052	665, 542	1	349, 893	7, 720, 505	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	48, 030	425, 947	0	223, 932	0	10.00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
13. 00	01300 SOCIAL SERVICE	51, 364	79, 865	0	41, 987	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14. 00
15. 00	01500 RECREATION	118, 870	628, 272	2 0	330, 299	0	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 070 (00	F 000 000	770 500	2 202 255	7 700 505	00.00
30.00	03000 SKILLED NURSING FACILITY	1, 978, 603	5, 883, 392	773, 599	3, 093, 055	7, 720, 505	30.00
31. 00 32. 00	03100   NURSING FACILITY   03200   CF/IID	0	0		0	0	31. 00 32. 00
32.00	03300 OTHER LONG TERM CARE	0	0		0	0	33.00
33.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		0	9	0	33.00
40. 00	04000 RADI OLOGY	459	0	0	0	0	40. 00
41. 00	04100 LABORATORY	770	0	1	0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	o o	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
44.00	04400 PHYSI CAL THERAPY	26, 320	266, 217	0	139, 957	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	34, 800	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	19, 554	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	6, 227	0	0	0	0	49. 00
50. 00 51. 00	O5000   DENTAL CARE - TITLE XIX ONLY   O5100   SUPPORT SURFACES	0	0		0	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	l U	0	<u> </u>	U <sub>I</sub>	0	31.00
60.00	06000 CLINIC	0	0	0	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	1	0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	32, 811	0	0	0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100   I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW - SNF		0			0	82.00
89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	3, 665, 326	8, 343, 235	773, 599	4, 179, 123	0 7, 720, 505	•
67.00	NONREI MBURSABLE COST CENTERS	3,003,320	0, 343, 233	173,377	4, 177, 123	7, 720, 505	09.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		n	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	223	21, 297	0	11, 197	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	42, 868	0	o o	0	0	92.00
93. 00	09300 NONPAI D WORKERS	0	0	o o	o	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	TOTAL	3, 708, 417	8, 364, 532	773, 599	4, 190, 320	7, 720, 505	100. 00

In Lieu of Form CMS-2540-10

| Period: | Worksheet B |
| From 07/01/2021 | Part |
| To 06/30/2022 | Date/Time Prepared: | 10/17/2022 11:50 am

					10 00/30/2022	10/17/2022 11	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	SOCIAL SERVICE		
	•	ADMI NI STRATI ON	SERVICES &			ALLIED HEALTH	
			SUPPLY			EDUCATI ON	
		9. 00	10.00	11.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSING ADMINISTRATION						9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	1, 349, 898				10.00
11. 00	01100 PHARMACY	0	1, 349, 696				11.00
	i i	0	0		070 444		1
13.00	01300 SOCIAL SERVICE	0	0		0 870, 466		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	
15. 00	01500 RECREATION	0	Ü		0 0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			ı		_	
30. 00	03000 SKILLED NURSING FACILITY	0	1, 349, 898		0 870, 466	0	1
31. 00	03100 NURSING FACILITY	0	0		0	0	
32. 00	03200   I CF/I I D	0	0	1	0	0	1
33. 00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33. 00
	ANCILLARY SERVICE COST CENTERS				_		
40. 00	04000 RADI OLOGY	0	0		0	0	
41. 00	04100 LABORATORY	0	0		0	0	
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0		0 0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		o o	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	o	0		0 0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	o	0		o o	0	50.00
51. 00	05100 SUPPORT SURFACES	o	0		o o	0	
	OUTPATIENT SERVICE COST CENTERS	-1					
60.00	06000 CLI NI C	0	0		0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	1
62. 00	06200 FQHC		J			Ĭ	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70. 00	07000 HOME HEALTH AGENCY COST	O	0		0 0	0	70. 00
71. 00	07100 AMBULANCE	o	0	1	o o		
73. 00	07300 CMHC	0	0	1	0	0	
70.00	SPECIAL PURPOSE COST CENTERS	٩	J		<u> </u>		70.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			1			80.00
81. 00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF			•			82.00
83. 00	08300 HOSPI CE		0			0	1
89. 00	SUBTOTALS (sum of lines 1-84)		1, 349, 898		0 870, 466		
89.00		l d	1, 349, 898		0 870, 466		89.00
00 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0	I			00 00
90.00		0	0		0	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	
92.00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	0	
93.00	09300 NONPALD WORKERS	0	0		0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		니 이	0	
98. 00	Cross Foot Adjustments	0	0		_	0	
99. 00	Negative Cost Centers	0	0	1	0	0	
100.00	TOTAL	0	1, 349, 898		0 870, 466	0	100. 00

From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 10/17/2022 11:50 am OTHER GENERAL SERVI CE Cost Center Description RECREATI ON Subtotal Post Stepdown Total Adjustments 15.00 18.00 16.00 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFITS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 11.00 01100 PHARMACY 11.00 13.00 01300 SOCIAL SERVICE 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 14.00 01500 RECREATION 15.00 2, 691, 049 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 2, 691, 049 51, 219, 020 0 51, 219, 020 30.00 03100 NURSING FACILITY 0 31 00 31 00 32.00 03200 | CF/IID 0 0 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40 00 04000 RADI OLOGY 40 00 6.684 O 6.684 41.00 04100 LABORATORY 0 11, 228 0 11, 228 41.00 04200 I NTRAVENOUS THERAPY 42.00 0000000 0 42.00 0 43 00 04300 OXYGEN (INHALATION) THERAPY 0 43 00 O 0 44.00 04400 PHYSI CAL THERAPY 789, 776 789, 776 44.00 45.00 04500 OCCUPATIONAL THERAPY 507, 197 507, 197 45.00 46.00 04600 SPEECH PATHOLOGY 284, 986 0 284, 986 46.00 04700 ELECTROCARDI OLOGY 47 00 0 47 00 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 90, 751 0 90, 751 49.00 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 05100 SUPPORT SURFACES 51.00 0 51.00 Ω 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 07100 AMBULANCE 0 478, 201 0 478, 201 71.00 71.00 0 07300 CMHC 73.00 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 83.00 SUBTOTALS (sum of lines 1-84) 2, 691, 049 53, 387, 843 0 53, 387, 843 89.00 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 0 91.00 09100 BARBER AND BEAUTY SHOP 0 0 35, 741 35, 741 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 92.00 624, 785 624, 785 92.00 93.00 09300 NONPALD WORKERS r 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 C 0 0 94.00 Cross Foot Adjustments 0 98.00 0 0 98.00 C 0 99.00 Negative Cost Centers 99 00 100.00 TOTAL 2, 691, 049 54, 048, 369 54, 048, 369 100.00

Health Financial Systems NEW JERSEY VETERANS HOME - VINELAND In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315496 Peri od: Worksheet B From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 10/17/2022 11:50 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDGS & MOVABLE Subtotal Assigned New **FLXTURES FOUL PMENT BENEFITS** Capi tal Related Costs 0 1.00 2.00 2A 3.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 3.00 00300 EMPLOYEE BENEFITS 0 00400 ADMINISTRATIVE & GENERAL 4.00 0 0 0 173,888 173, 888 00500 PLANT OPERATION, MAINT. & REPAIRS 0 5 00 232 859 232 859 0 00600 LAUNDRY & LINEN SERVICE 0 6.00 14, 365 14, 365 0 7.00 00700 HOUSEKEEPI NG 41, 582 41, 582 0 00800 DI ETARY 00000 0 94, 504 8 00 94, 504 0 00900 NURSING ADMINISTRATION 0 9.00 0 10.00 01000 CENTRAL SERVICES & SUPPLY 60, 483 60, 483 0 01100 PHARMACY 11.00 0 0 0 01300 SOCIAL SERVICE 13 00 11, 341 11.341 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 01500 RECREATION 89, 212 0 89, 212 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 SKILLED NURSING FACILITY 835, 419 0 835, 419 0 31.00 03100 NURSING FACILITY 0 0 0 03200 | CF/IID 0 0 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 0 0 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 04100 LABORATORY 0 0 0 41.00 0 0 04200 I NTRAVENOUS THERAPY 0 42.00 0 0 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 0 37, 802 04400 PHYSI CAL THERAPY 37, 802 44.00 0 04500 OCCUPATIONAL THERAPY 45.00 0 04600 SPEECH PATHOLOGY 0 0 46,00 0 0 0 47.00 04700 ELECTROCARDI OLOGY C 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 0 0 50.00 Λ

Health Financial Systems NEW JERSEY VETERANS HOME - VINELAND In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315496 Peri od: Worksheet B From 07/01/2021 Part II Date/Time Prepared: 06/30/2022 10/17/2022 11:50 am Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, & GENERAL LINEN SERVICE MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 173,888 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 26, 909 259, 768 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 3, 142 2, 163 19,670 6.00 00700 HOUSEKEEPI NG 7.00 12,538 9, 094 C 63.214 7.00 8.00 00800 DI ETARY 21,570 20, 669 0 5, 278 142, 021 8.00 9.00 00900 NURSING ADMINISTRATION 0 9.00 0 10.00 01000 CENTRAL SERVICES & SUPPLY 0 10.00 2, 252 13, 228 3.378 Ω 11.00 01100 PHARMACY 0 0 11.00 13.00 01300 SOCIAL SERVICE 2,408 2, 480 0 633 0 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 14.00 0 01500 RECREATION 5, 573 19, 512 4, 983 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 92, 784 182, 714 19, 670 46, 662 142, 021 30.00 03100 NURSING FACILITY 31 00 0 0 0 31 00 03200 | CF/IID 32.00 0 0 0 0 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40 00 04000 RADI OLOGY 40 00 22 O 0 0 41.00 04100 LABORATORY 36 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 42.00 0 0 0 0 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 C 0 0 04400 PHYSI CAL THERAPY 0 44.00 1, 234 8, 268 2, 111 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 1,632 0 45.00 0 04600 SPEECH PATHOLOGY 0 46.00 917 0 0 46.00 0 04700 ELECTROCARDI OLOGY 47 00 Ω 47 00 0 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 0 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 292 0 0 0 49.00 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 o 0 50.00 05100 SUPPORT SURFACES 0 51.00 0 Ω 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 ol 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 70.00 07100 AMBULANCE 1, 538 0 71.00 0 0 0 71.00 07300 CMHC 0 73.00 Ω 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82 00 83.00 08300 H0SPI CE 83.00 89.00 SUBTOTALS (sum of lines 1-84) 171, 868 259, 107 19, 670 63, 045 142, 021 89.00 NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 09100 BARBER AND BEAUTY SHOP 0 91.00 10 169 0 91.00 661

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09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

09300 NONPALD WORKERS

09400 PATIENTS LAUNDRY

TOTAL

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315496

In Lieu of Form CMS-2540-10

| Period: | Worksheet B | From 07/01/2021 | Part II |
| To 06/30/2022 | Date/Time Prepared: 10/17/2022 11:50 am

					10 00/30/2022	10/17/2022 11	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	SOCIAL SERVICE		
	•	ADMI NI STRATI ON	SERVICES &			ALLIED HEALTH	
			SUPPLY			EDUCATI ON	
		9. 00	10.00	11. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8.00
9. 00	00900 NURSI NG ADMI NI STRATI ON						9.00
		0	70 241				1
10.00	01000 CENTRAL SERVICES & SUPPLY	0	79, 341				10.00
11.00	01100 PHARMACY	0	0		0		11.00
13. 00	01300 SOCIAL SERVICE	0	0		0 16, 862	_	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	
15. 00	01500 RECREATION	0	0		0 0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	0	79, 341		0 16, 862	0	30. 00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
32.00	03200   CF/IID	0	0		0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0		0	0	40. 00
41.00	04100 LABORATORY	0	0		0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	o	0		0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	o	0		0	0	43.00
44.00	04400 PHYSI CAL THERAPY	o	0		0	0	
45. 00	04500 OCCUPATI ONAL THERAPY	0	0		0	Ö	
46. 00	04600 SPEECH PATHOLOGY	0	0		0	Ö	
47. 00	04700 ELECTROCARDI OLOGY		0			0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	1
49. 00	04900 DRUGS CHARGED TO PATTENTS	0	0		0	0	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0		1
			0		0		
51. 00	05100 SUPPORT SURFACES	l U	U		0	0	51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS		0				/
60.00	06000 CLINIC	0	0		0	0	
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	
62. 00	06200 FOHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS					_	70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	
71. 00	07100 AMBULANCE	0	0		0		1
73. 00	07300 CMHC	0	0		0 0	0	73. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0		0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	79, 341		0 16, 862	0	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	o	0		0	0	92.00
93.00	09300 NONPALD WORKERS	o	0		0	0	
94.00	09400 PATIENTS LAUNDRY	0	0		o o	0	
98. 00	Cross Foot Adjustments	O	0		0	0	
99. 00	Negative Cost Centers	o	n		ol ol	0	
100.00		o	79, 341		0 16, 862		100.00
	The state of the s	, 9	, = ,	'	,, 502	,	

Peri od:

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100.00

From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 10/17/2022 11:50 am OTHER GENERAL SERVI CE Cost Center Description RECREATI ON Subtotal Post Step-Down Total Adjustments 16.00 15.00 18.00 17.00 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 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 00700 HOUSEKEEPI NG 7.00 7.00 8.00 00800 DI ETARY 8.00 9.00 00900 NURSING ADMINISTRATION 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 10.00 11.00 01100 PHARMACY 11.00 13.00 01300 SOCIAL SERVICE 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 14.00 01500 RECREATION 15.00 119, 280 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 30.00 119, 280 1, 534, 753 0 1, 534, 753 30.00 03100 NURSING FACILITY 0 31 00 31 00 32.00 03200 | CF/IID 0 C 0 0 32.00 33.00 03300 OTHER LONG TERM CARE 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40 00 04000 RADI OLOGY 40 00 0 22 O 22 41.00 04100 LABORATORY 0 36 0 36 41.00 04200 I NTRAVENOUS THERAPY 42.00 00000000 C 0 0 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY C 0 0 43 00 04400 PHYSI CAL THERAPY 0 44.00 49, 415 49, 415 44.00 45.00 04500 OCCUPATIONAL THERAPY 1,632 1, 632 45.00 04600 SPEECH PATHOLOGY 0 46.00 917 917 46.00 04700 ELECTROCARDI OLOGY 47 00 0 47 00 C 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48.00 0 48.00 04900 DRUGS CHARGED TO PATIENTS 292 0 292 49.00 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 0 50.00 05100 SUPPORT SURFACES 0 0 51.00 51.00 Ω 0 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 06200 FQHC 62.00 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 70.00 07100 AMBULANCE 1, 538 0 0 1, 538 71.00 71.00 0 07300 CMHC 73.00 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 H0SPI CE 83.00 89.00 SUBTOTALS (sum of lines 1-84) 119, 280 1, 588, 605 0 1, 588, 605 89.00 NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 0 3, 864 3, 864 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 2,010 2,010 92.00 93.00 09300 NONPALD WORKERS r 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 C 0 0 94.00 Cross Foot Adjustments 0 0 98.00 0 98.00 C Negative Cost Centers 0 99.00 0 99 00

119, 280

1, 594, 479

100.00

TOTAL

COST ALLOCATION - STATISTICAL BASIS Provider No.: 315496 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 10/17/2022 11:50 am CAPITAL RELATED COSTS BLDGS & MOVABLE **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description **EQUI PMENT FLXTURES** BENEFITS & GENERAL (SQUARE FEET) (COSTED (ACCUM COST) (GROSS REQUIS) SALARI ES) 1.00 2.00 4A 4.00 3.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 210, 900 1.00 1.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 24, 503, 291 3.00 0 4.00 00400 ADMINISTRATIVE & GENERAL 23,000 1, 422, 667 -3, 708, 417 50, 339, 952 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 7, 790, 620 5 00 30 800 1, 371, 653 5 00 00600 LAUNDRY & LINEN SERVICE 6.00 1,900 626, 299 6.00 7.00 00700 HOUSEKEEPI NG 5,500 1, 798, 296 3, 630, 066 7.00 00800 DI ETARY 2, 830, 860 0 6, 245, 018 8.00 8 00 12 500 00900 NURSING ADMINISTRATION 9.00 C 9.00 10.00 01000 CENTRAL SERVICES & SUPPLY 8,000 651, 989 10.00 0 11.00 01100 PHARMACY C 11.00 0 01300 SOCIAL SERVICE 697, 250 13 00 1.500 Ω 425, 898 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00  $\cap$ 01500 RECREATION 15.00 11,800 946, 536 1, 613, 608 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 110, 500 n 30.00 03000 SKILLED NURSING FACILITY 15, 346, 054 0 26, 858, 453 30.00 31.00 03100 NURSING FACILITY 0 0 0 31.00 03200 | CF/IID 0 0 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 0 33.00 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 6, 225 40.00 C 04100 LABORATORY 0 0 0 41.00 0 10, 458 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 0 0 0 42.00 0 04300 OXYGEN (INHALATION) THERAPY 0 43.00 0 Ω 0 43 00 04400 PHYSI CAL THERAPY 0 357, 282 44.00 5,000 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 472, 397 45.00 04600 SPEECH PATHOLOGY 0 0 265, 432 46,00 0 46,00 47.00 04700 ELECTROCARDI OLOGY 0 C 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 48.00 0 0 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 84, 524 49.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 50.00 C Ω 50.00 51.00 05100 SUPPORT SURFACES 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 0 0 06100 RURAL HEALTH CLINIC 0 61.00 0 C 0 0 61.00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST 70 00 0 Ω 0 0 Λ 70 00 71.00 07100 AMBULANCE 0 C 0 0 445, 390 71.00 73.00 07300 CMHC 0 73.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83 00 08300 H0SPLCE 83 00 0 89.00 SUBTOTALS (sum of lines 1-84) 210,500 0 24, 141, 964 -3, 708, 417 49, 755, 011 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 90.00 400 0 09100 BARBER AND BEAUTY SHOP 3 024 91 00 91 00 Ω 0 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 361, 327 0 581, 917 92.00 09300 NONPALD WORKERS 0 93.00 93.00 94.00 09400 PATIENTS LAUNDRY 0 C 94.00 0 98 00 Cross Foot Adjustments 98 00 99.00 Negative Cost Centers 99.00 3, 708, 417 102.00 Cost to be allocated (per Wkst. B, 1, 594, 479 14, 959, 259 102.00 Part I) 0.073667 103.00 103.00 Unit cost multiplier (Wkst. B, Part I) 7. 560356 0.000000 0.610500 104.00 Cost to be allocated (per Wkst. B, 173, 888 104. 00 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.003454 105.00

II)

| Peri od: | From 07/01/2021 | To 06/30/2022 | Date/Ti me Prepared:

			Т	o 06/30/2022	Date/Time Pre 10/17/2022 11	
Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	. 50 am
	OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
	MAINT. & REPAIRS	(POUNDS OF			(DI RECT	
	(SQUARE FEET)	LAUNDRY)			NURSING)	
	5. 00	6.00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00   00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3. 00   00300   EMPLOYEE BENEFITS 4. 00   00400   ADMINISTRATIVE & GENERAL		•				3. 00 4. 00
5. 00   00500 PLANT OPERATION, MAINT. & REPAIRS	157, 100		•			5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	1, 900	l .				6.00
7. 00 00700 HOUSEKEEPI NG	5, 500	1	1			7. 00
8. 00   00800   DI ETARY	12, 500	0	12, 500	272, 253		8. 00
9.00 00900 NURSING ADMINISTRATION	C	1	C	0	0	9. 00
10. 00 01000 CENTRAL SERVI CES & SUPPLY	8,000	0	8, 000	0	0	10.00
11. 00   01100   PHARMACY 13. 00   01300   SOCI AL   SERVI CE	1, 500		1, 500	0	0	11. 00 13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	1, 300		1, 300	0	0	14. 00
15. 00 01500 RECREATION	11, 800	Ö	11, 800	0	0	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	110, 500	1	110, 500	272, 253	0	
31. 00   03100   NURSI NG FACILI TY	C		C	_	0	31.00
32. 00   03200   1CF/IID	C		C	0	0	32.00
33. 00 03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	C	0		U	0	33.00
40. 00 04000 RADI OLOGY		0	0	0	0	40. 00
41. 00   04100   LABORATORY	C	Ö	o c	0	0	41.00
42.00 04200 I NTRAVENOUS THERAPY	C	0	o c	0	0	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	C	0	C	0	0	43. 00
44. 00   04400   PHYSI CAL THERAPY	5,000	i .	5, 000	0	0	44. 00
45. 00   04500   OCCUPATI ONAL THERAPY 46. 00   04600   SPEECH PATHOLOGY	C	0		0	0	45. 00 46. 00
47. 00   04700   ELECTROCARDI OLOGY				0	0	47.00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		j ő		0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	C	0	C	0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	C	0	C	0	0	50.00
51. 00 05100 SUPPORT SURFACES	C	0	<u>C</u>	0	0	51.00
OUTPATIENT SERVICE COST CENTERS  60. 00 06000 CLINIC	T C	0	l c		0	60.00
61. 00   06100   RURAL HEALTH CLINIC		1	-		0	61.00
62. 00   06200   FQHC		,				62.00
OTHER REIMBURSABLE COST CENTERS	,	,	'			
70.00 07000 HOME HEALTH AGENCY COST	C		C	0	0	70. 00
71. 00   07100   AMBULANCE	C	l .		0	_	71. 00
73. 00 07300 CMHC	C	0	<u> </u>	0	0	73. 00
SPECIAL PURPOSE COST CENTERS  80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 08100 I NTEREST EXPENSE						81.00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00   08300   HOSPI CE	C	0	C	0	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	156, 700	90, 751	149, 300	272, 253	0	89. 00
NONREI MBURSABLE COST CENTERS	1		J	0	0	00 00
90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00   09100   BARBER AND BEAUTY SHOP	400		400	_	_	
92. 00 09200 PHYSICIANS PRIVATE OFFICES	400	l e	400	0	0	
93. 00 09300 NONPALD WORKERS	C	Ō	o c	0	0	
94.00 09400 PATIENTS LAUNDRY	C	0	C	0	0	94. 00
98.00 Cross Foot Adjustments						98. 00
99.00 Negative Cost Centers	0.2/4.522	772 500	4 100 220	7 700 505		99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	8, 364, 532	773, 599	4, 190, 320	7, 720, 505	0	102. 00
103.00 Unit cost multiplier (Wkst. B, Part I)	53. 243361	8. 524413	27. 991450	28. 357833	0. 000000	103. 00
104.00 Cost to be allocated (per Wkst. B,	259, 768	1	1			104. 00
Part II)						
105.00 Unit cost multiplier (Wkst. B, Part	1. 653520	0. 216747	0. 422271	0. 521651	0. 000000	105. 00
1 )	I	I	I		I	I

Provider No.: 315496 | Period: From 07/01/2021 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					T	o 06/30/2022		
							10/17/2022 11 OTHER GENERAL	:50 am
							SERVI CE	
		Cost Center Description	CENTRAL	PHARMACY	SOCIAL SERVICE		RECREATI ON	
			SERVICES &	(COSTED			(PATIENT DAYS)	
			SUPPLY	REQUIS)	(PATIENT DAYS)			
			(COSTED REQUIS)			(ASSI GNED TIME)		
			10.00	11.00	13.00	14.00	15. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS						2. 00 3. 00
4. 00	1	ADMINISTRATIVE & GENERAL						4.00
5. 00	1	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00		LAUNDRY & LINEN SERVICE						6. 00
7.00	1	HOUSEKEEPI NG						7. 00
8.00		DI ETARY						8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	1, 530, 951					9. 00 10. 00
11. 00	1	PHARMACY	1, 530, 951	(				11.00
13. 00	1	SOCIAL SERVICE	0	C	90, 751			13. 00
14.00		NURSING AND ALLIED HEALTH EDUCATION	0	C	1	0		14. 00
15. 00		RECREATI ON	0	C	0	0	90, 751	15. 00
		IENT ROUTINE SERVICE COST CENTERS	4 500 054				00 754	
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	1, 530, 951	C	1	0	•	30.00
31.00		ICF/IID	0	C	1	_	_	31. 00 32. 00
33. 00	1	OTHER LONG TERM CARE	0	C	l .		-	33.00
		LARY SERVICE COST CENTERS	-).					
40.00		RADI OLOGY	0	C	0		-	40. 00
41. 00		LABORATORY	0	C	1	_	-	41. 00
42.00		I NTRAVENOUS THERAPY	0	C	0	_	0	42.00
43. 00 44. 00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0	(	0	_	0	43. 00 44. 00
45. 00		OCCUPATIONAL THERAPY	0	C	ol ö	0	o o	45. 00
46. 00	1	SPEECH PATHOLOGY	0	C	0	0	0	46. 00
47.00		ELECTROCARDI OLOGY	0	C	0	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	48. 00
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0	C	0	_	0	49. 00 50. 00
51. 00		SUPPORT SURFACES	0	C		_		51.00
01.00		TIENT SERVICE COST CENTERS	<u> </u>		,	<u> </u>		01.00
60.00		CLINIC	0		0	0	0	60. 00
61. 00		RURAL HEALTH CLINIC	0	C	0	0	0	61. 00
62. 00	06200							62. 00
70. 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0	C	0	0	0	70. 00
71. 00		AMBULANCE	0	C	1			71.00
73. 00	07300	l i	0	Č	1			1
		AL PURPOSE COST CENTERS						
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	1	INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00		HOSPICE	0	C	0	0	0	1
89. 00	00000	SUBTOTALS (sum of lines 1-84)	1, 530, 951	C				89. 00
	NONRE	IMBURSABLE COST CENTERS	,					
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	1			
91.00		BARBER AND BEAUTY SHOP	0	C	1		-	91.00
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0	C	0		0	92. 00 93. 00
94.00	1	PATIENTS LAUNDRY	0			0	0	94.00
98. 00	07400	Cross Foot Adjustments			)	J		98.00
99.00		Negative Cost Centers						99. 00
102.00	O	Cost to be allocated (per Wkst. B,	1, 349, 898	C	870, 466	0	2, 691, 049	102. 00
102.00		Part I)	0.001700	0.000000	0 501007	0.000000	20 (5210)	102 00
103. 00 104. 00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 881738 79, 341	0. 000000	9. 591806 16, 862		29. 653106 119, 280	
104.00	1	Part II)	77, 341		10, 302		117, 200	1.04.00
105.00	o	Unit cost multiplier (Wkst. B, Part	0. 051825	0. 000000	0. 185805	0. 000000	1. 314366	105. 00
		11)			1			

Health Financial Systems	NEW JERSEY VETERANS HOME - VINELAND	In Lieu of Form CMS-2540-10
DATIO OF COST TO CHARCES FOR A	NCLLLADY AND OUTDATIENT COST CENTEDS   Droy i don No - 215404   Dr	asiad. Waskabaat C

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	Provi der	No.: 315496	Peri od:	Worksheet C	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	nared·
			10 00/00/2022	10/17/2022 11	: 50 am
Cost Center Description		Total (from			
		Wkst. B, Pt I	,	di vi ded by	
		col . 18)		col. 2	
		1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS					
40. 00   04000   RADI OLOGY		6, 68			
41. 00   04100   LABORATORY		11, 22	10, 458		
42. 00   04200   I NTRAVENOUS THERAPY			0	0. 000000	
43.00 O4300 OXYGEN (INHALATION) THERAPY			0	0. 000000	
44. 00 O4400 PHYSI CAL THERAPY		789, 77	· ·		
45. 00   04500   0CCUPATI ONAL THERAPY		507, 19	· ·		45. 00
46. 00   04600   SPEECH PATHOLOGY		284, 98	634, 680		
47. 00   04700   ELECTROCARDI OLOGY			0	0. 000000	
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0. 000000	
49.00 O4900 DRUGS CHARGED TO PATIENTS		90, 75	34, 822	2. 606140	
50.00   05000   DENTAL CARE - TITLE XIX ONLY			0	0. 000000	
51. 00 O5100 SUPPORT SURFACES			0 0	0.000000	51.00
OUTPATIENT SERVICE COST CENTERS					
60. 00  06000  CLI NI C			0	0. 000000	60.00
61.00  06100   RURAL HEALTH CLINIC					61.00
62. 00  06200  FQHC					62. 00
71. 00   07100   AMBULANCE		478, 20	1 445, 390	1. 073668	71. 00
100. 00   Total		2, 168, 82	2, 195, 707		100. 00

		SERGE: VETERWAR	S HOME - VINELA			u of Form CMS-	2010 10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 07/01/2021	Worksheet D Part I	
						Date/Time Pre	nared.
					10 00/00/2022	10/17/2022 11	
			Title	XVIII (1)	Skilled Nursing	PPS	
					Facility		
			Heal th Care Pr	rogram Charges	s Health Care	Program Cost	
		D 11 C 0 1	D 1 A	D 1 D	D 1 4 ( 1 4	D 1 D ( 1 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 OUTPAT		2.00	3.00	4.00	3.00	
	ANCI LLARY SERVICE COST CENTERS	1 2111 0001					f
40.00	04000 RADI OLOGY	1. 073735	6, 225		0 6, 684	0	40.00
41.00	04100 LABORATORY	1. 073628	10, 458		0 11, 228	0	41.00
	04200 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	0. 000000	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	1. 404596	84, 312		0 118, 424	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	1. 010651	90, 534		0 91, 498	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0. 449023	99, 741		0 44, 786	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0. 000000	0		0	0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	2. 606140	34, 573		0 90, 102	0	1
	05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00	05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS						4
	06000 CLI NI C	0. 000000	0		0	0	
	06100 RURAL HEALTH CLINIC						61.00
	06200 FQHC				_	_	62.00
	07100 AMBULANCE (2)	1. 073668			0		71.00
100.00			325, 843		0 362, 722	0	100. 00
(1) Fo	r title V and XIX use columns 1, 2, and 4 onl	V.					

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

Heal th	Financial Systems NEW .	JERSEY VETERANS	S HOME - VINELA	AND	In Lie	eu of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS			Provi der		Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Parts II-III Date/Time Pre 10/17/2022 11	
	Title XVIII Skilled Nursing Facility						
	Cost Center Description					1. 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	line 49)	2. 606140	1.00
2.00	Program vaccine charges (From your reco					230	
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	vi ders, transf	er this amoun	t to Worksheet	599	3. 00
	E, Part I, line 18)	Tatal Cost	Numai na 0	Dot: o of	Dragnom Dont A	Dont A Nuncina	
	Cost Center Description   Total Cost   Nursing & Ratio of   Program Part Al (From Wkst. B, Allied Health   Nursing & Cost (From					& Allied	
	Part I, Col. (From Wkst. B, Allied Health Wkst. D Part					Health Costs	
	18 Part I, Col. Costs to Total I, Col. 4)				for Pass		
	14) Costs - Part A					Through (Col.	
				(Col . 2 / Col 1)		3 x Col . 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS			0.00		0.00	
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	6, 684	l e	0.00000			
41. 00	04100 LABORATORY	11, 228	0	0.00000		l	
42.00	04200 I NTRAVENOUS THERAPY	0	0	0.00000		0	
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	789, 776		0.00000 0.00000		0	43. 00 44. 00
45.00	04500 OCCUPATIONAL THERAPY	789, 776 507, 197		0.00000			45.00
46. 00	04600 SPEECH PATHOLOGY	284, 986		0.00000			46.00
47. 00	04700 ELECTROCARDI OLOGY	201, 700		0.00000		0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	0.00000		Ö	
49.00	04900 DRUGS CHARGED TO PATIENTS	90, 751	0	0. 00000	90, 102	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C	0.00000		0	00.00
	05100 SUPPORT SURFACES	0	0	0.00000		0	0 00
100.00	Total (Sum of lines 40 - 52)	1, 690, 622	0	Pl	362, 722	J 0	100. 00

Hoal th	Financial Systems NEW JERSEY VETERANS HC	ME VINELAND	Inlio	u of Form CMS-2	0540 10
	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315496	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Parts I-II	pared:
-		Title XVIII	Skilled Nursing Facility	PPS	. 00 a
			, agrici	1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days including private room days			90, 751	1. 00
2.00	Private room days			0	2. 00
3.00	Inpatient days including private room days applicable to the P			2, 032 0	3. 00 4. 00
4. 00 5. 00	Medically necessary private room days applicable to the Progra Total general inpatient routine service cost	III		51, 219, 020	
3.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			31, 217, 020	3.00
6.00	General inpatient routine service charges			15, 988, 332	6. 00
7.00	General inpatient routine service cost/charge ratio (Line 5 d	ivided by line 6)		3. 203525	7. 00
8.00	Enter private room charges from your records			0	8. 00
9.00	Average private room per diem charge (Private room charges lin	e 8 divided by private	room days, line	0. 00	9. 00
10. 00	2) Enter semi-private room charges from your records			0	10. 00
11. 00	Average semi-private room per diem charge (Semi-private room	charges Line 10. divide	d by		11.00
	semi-private room days)	g,			
12.00	Average per diem private room charge differential (Line 9 minu	s line 11)		0.00	12.00
13.00					13. 00
	14.00 Private room cost differential adjustment (Line 2 times line 13)			0	14.00
15.00	General inpatient routine service cost net of private room cos PROGRAM INPATIENT ROUTINE SERVICE COSTS	t differential (Line 5	minus iine 14)	51, 219, 020	15.00
16.00	Adjusted general inpatient service cost per diem (Line 15 div	ided by line 1)		564. 39	16. 00
17. 00	Program routine service cost (Line 3 times line 16)			1, 146, 840	
18.00	Medically necessary private room cost applicable to program (			0	18.00
20. 00	Total program general inpatient routine service cost (Line 17 Capital related cost allocated to inpatient routine service co		t II column 10	1, 146, 840 1, 534, 753	
20.00	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	SIS (FIUII WKSL. B, PAI	t II COTUIIII 16,	1, 554, 755	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)			16. 91	21.00
22. 00	Program capital related cost (Line 3 times line 21)			34, 361	
23. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 112, 479	
24. 00 25. 00	Aggregate charges to beneficiaries for excess costs (From pro		nua lina 24)	1 112 470	
26. 00	Total program routine service costs for comparison to the cost Enter the per diem limitation (1)	limitation (Line 23 mi	nus iine 24)	1, 112, 479	26.00
	Inpatient routine service cost limitation (Line 3 times the pe	r diem limitation line	26) (1)		27.00
	Reimbursable inpatient routine service costs (Line 22 plus th				28. 00
	(Transfer to Worksheet E, Part II, line 4) (See instructions)				
(1) Li	nes 26 and 27 are not applicable for title XVIII, but may be us	ed for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH			
1.00	Total SNF inpatient days			90, 751	
2.00	Program inpatient days (see instructions)			2, 032	2. 00
3.00	Total nursing & allied health costs. (see instructions) (Do not	complete for titles V	or XIX)	0 022224	3.00
4. 00 5. 00	Nursing & allied health ratio. (line 2 divided by line 1) Program nursing & allied health costs for pass-through. (line	3 times line 4)		0. 022391 0	4. 00 5. 00
3.00	program nursing a arried hearth costs for pass-through. (Title	J TIMES TITLE 4)	ı	ΟĮ	J 5.00

Health Financial Systems	NEW JERSEY VETERANS HOMI	E - VINELAND	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEME	ENT FOR TITLE XVIII	Provi der No.: 315496	From 07/01/2021 To 06/30/2022	Worksheet E Part I Date/Time Prepared: 10/17/2022 11:50 am
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENI		1 000 (00	
1.00	Inpatient PPS amount (See Instructions)			1, 280, 692	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	iyments)		0	2.00
3.00	Subtotal (Sum of lines 1 and 2)			1, 280, 692	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			161, 271	5. 00
6.00	Allowable bad debts (From your records)			13, 390	
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	icti ons)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			8, 704	
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)			1, 128, 125	
12. 00	Interim payments (See instructions)			1, 116, 992	
13. 00	Tentati ve adj ustment			0	
14.00	OTHER adjustment (See instructions)			0	
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55				0	14. 55
14. 75	· · · · · · · · · · · · · · · · · · ·			22	
14. 99				2, 429	
	5.00 Balance due provider/program (see Instructions)			8, 682	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	UF CUST UR CHARGES -	TITLE XVIII UNLY		47.00
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			599	
19.00	Total reasonable costs (Sum of lines 17 and 18)			599	
20.00	Medicare Part B ancillary charges (See instructions)			230	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			230	
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ictions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			230	
26. 00	Interim payments (See instructions)			230	
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			1	28. 99
29. 00	Balance due provider/program (see instructions)	o with CMC Dub 15 0	continu 11F 2	-1	
30.00	Protested amounts (Nonallowable cost report items) in accordance	e with two Pub. 15-2,	Section 115. 2	0	30. 00

Health Financial Systems	NEW JERSEY	VETERANS HOW	IE - VINELAND	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT TIT	LE V and TITLE	XIX ONLY	Provi der No.: 315496	From 07/01/2021	Worksheet E Part II Date/Time Prepared: 10/17/2022 11:50 am
			Title XIX	Skilled Nursing	Cost

		Title XIX	Skilled Nursing	Cost	
			Facility		
			-	1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00	
1.00	Inpatient ancillary services (see Instructions)			0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	
3.00	Outpatient services	3)		0	1
4. 00	Inpatient routine services (see instructions)			0	
5. 00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	
6.00	Cost of covered services (Sum of lines 1 - 5)			0	
7. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	1
8.00	SUBTOTAL (Line 6 minus line 7)			0	
9.00	Primary payor amounts			0	9, 00
10.00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
	REASONABLE CHARGES		,		
11. 00	Inpatient ancillary service charges			0	11. 00
12.00	Outpati ent servi ce charges			0	12. 00
13.00	Inpatient routine service charges			0	13. 00
14.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14.00
15.00				0	15. 00
	CUSTOMARY CHARGES				
16.00	Aggregate amount actually collected from patients liable for pa			0	16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services o	n 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	1
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20. 00	Cost of covered services (see Instructions)			0	
21. 00	Deducti bl es			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	y collected based on c	orrection of	0	27. 00
28. 00	cost limit Recovery of excess depreciation resulting from provider termina	tion or a docreace in	nrogram	0	28. 00
26.00	lutilization	tron or a decrease in	pi ogi alli	U	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of denr	aciahla assats (	0	
30.00	if minus, enter amount in parentheses)	on disposition of depi	eciable assets (	O	30.00
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments	2, and 20)		0	32.00
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overnavments in parent	heses) (see	0	
55. 55	Instructions)	pajoto in partin		O	55.00
	,		ı		'

Health Financial Systems NEW JERSE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315496 Peri od: From 07/01/2021 To 06/30/2022 Worksheet E-1 Date/Time Prepared: 10/17/2022 11:50 am Title XVIII Skilled Nursing PPS

				Facility		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 116, 992		230	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	enter zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provi der to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51 3. 52			0		0	3. 51 3. 52
3. 52			0		0	3. 52
3. 54			0		0	3. 54
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		0		o o	3. 99
0. ,,	- 3.98)		Ü		Ĭ	0. ,,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 116, 992		230	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	TERMINE TO THOMPSEN		0		o l	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50   - 5.98)		0		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		8, 682		o	6. 01
6. 02	PROVI DER TO PROGRAM		0		1	6. 02
7.00	Total Medicare program liability (see instructions)		1, 125, 674		229	7. 00
			Contract	or Name	Contractor	
					Number	
2.00	lu co i		1.	00	2. 00	
	Name of Contractor				l	8. 00
(1) Or	lines 3, 5, and 6, where an amount is due provider to progra	am, show the a	mount and date	on which the p	orovi der	

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

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

Provi der No.: 315496 | Peri od: From 07/01/2021 To 06/30/2022

Peri od: From 07/01/2021 To 06/30/2022 Worksheet G Date/Time Prepared: 10/17/2022 11:50 am

onl y)				10 00/30/2022	10/17/2022 11	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
	Assets					-
1. 00	CURRENT ASSETS  Cash on hand and in banks	1 0		ol ol	0	1.00
2.00	Temporary investments			o o	Ö	
3.00	Notes receivable	c		o o	0	3.00
4.00	Accounts receivable	C		0 0	0	
5.00	Other receivables	C		0	0	
6. 00	Less: allowances for uncollectible notes and accounts receivable		)		0	6. 00
7. 00	Inventory			0	0	7.00
8. 00	Prepaid expenses			o o	0	
9.00	Other current assets	C		o o	0	9.00
10.00	Due from other funds	C		0 0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	C	)	0 0	0	11.00
12. 00	FI XED ASSETS Land	1 0	N .	ol ol	0	12.00
13. 00	Land improvements		1		0	
14. 00	Less: Accumulated depreciation		1	o o	Ö	
15.00	Bui I di ngs	C		o o	0	15.00
16. 00	Less Accumulated depreciation	C		0 0	0	
17. 00	Leasehold improvements	C		0 0	0	
18.00	Less: Accumulated Amortization			0	0	
19. 00 20. 00	Fixed equipment Less: Accumulated depreciation		1	0 0	0	
21. 00	Automobiles and trucks				0	
22. 00	Less: Accumulated depreciation			o o	Ö	
23. 00	Maj or movable equipment	C		o o	0	23. 00
24. 00	Less: Accumulated depreciation	C		0 0	0	
25. 00	Mi nor equipment - Depreciable	C		0	0	
26. 00	Mi nor equipment nondepreciable		1	0 0	0	1
27. 00 28. 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)		1	0 0 0	0	
20.00	OTHER ASSETS		′1	0  0	0	20.00
29. 00	Investments	C		0 0	0	29. 00
30.00	Deposits on Leases	C		o o	0	30.00
31. 00	Due from owners/officers	C		0 0	0	
32.00	Other assets	C	1	0	0	
33. 00 34. 00	TOTAL OTHER ASSETS (Sum of Lines 29 - 32)		1	0 0	0	
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	1	ή	0  0	0	34.00
	CURRENT LIABILITIES					1
35. 00	Accounts payable	C		0 0	0	35.00
36. 00	Salaries, wages, and fees payable	C		0 0	0	
37. 00	Payrol I taxes payable	C		0	0	
38. 00	Notes & Loans payable (Short term) Deferred income			0	0	
39. 00 40. 00	Accel erated payments				0	39. 00 40. 00
41. 00	Due to other funds		ó	ol ol	0	
42.00	Other current liabilities	C		0 0	0	
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	C		0 0	0	43.00
	LONG TERM LIABILITIES	1	,	ما ما		
44.00	Mortgage payable			0 0	0	
45. 00 46. 00	Notes payable Unsecured Loans		S)	0 0	0	
47. 00	Loans from owners:		6		0	
48. 00	Other long term liabilities			o o	0	
49.00	OTHER (SPECIFY)	C		o o	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	C		0 0	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	C	)	0 0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	1	<u>,                                      </u>			52.00
53. 00	Specific purpose fund		ή			53.00
54. 00	Donor created - endowment fund balance - restricted			-   0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
59. 00	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)				0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and		ó		0	
	[59]			]		
	[54]	I	I			

12. 00 13. 00

14.00

15.00

16.00

17.00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315496 Peri od: Worksheet G-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 10/17/2022 11:50 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 16, 128, 228 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -16, 128, 229 2.00 3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 ROUNDI NG 0 5.00 6.00 0 0 0 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 13.00 0000 14.00 0 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 ROUNDI NG 5.00 0 6.00 6.00 7. 00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00

0

0

0

0

12.00

13. 00 14. 00

15.00

16.00

17.00

18.00

19.00

Deductions (debit adjustments)

sheet (Line 11 - line 18)

Total deductions (sum of lines 13 - 17)

Fund balance at end of period per balance

Health Financial Systems	NEW JERSEY VETERANS HOM	E - VINELAND	In Lie	u of Form CMS-2540-10
STATEMENT OF DATIENT DEVENUES /	AND ODEDATING EVDENCES	Drovi don No : 21E404	Dori od:	Workshoot C 2

Heal th	Financial Systems NEW JERSEY VETERANS HOM	ME - VINEL	AND	In Li€	eu of Form CMS-2	2540-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 07/01/2021 To 06/30/2022		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1. 00	SKILLED NURSING FACILITY		15, 988, 33	2	15, 988, 332	1. 00
2. 00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		15, 988, 33	2	15, 988, 332	5. 00
	All Other Care Services			_		
6. 00	ANCI LLARY SERVI CES		2, 195, 70		_,,	6. 00
7. 00	CLINIC			0	1	7. 00
8. 00	HOME HEALTH AGENCY COST			0	0	8. 00
9.00	AMBULANCE			0	0	9. 00
10.00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
	HOSPI CE			0	0	12.00
13. 00	OTHER (SPECIFY)		40.404.00	0	0	13.00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 Worksheet G-3, Line 1)	to	18, 184, 03	8 0	18, 184, 038	14. 00
	Cost Center Description					
				1. 00	2. 00	
	PART II - OPERATING EXPENSES					
1. 00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				36, 925, 551	1. 00
2.00	Add (Specify)			0	1	2. 00
3.00				0	)	3. 00
4.00				0	)	4. 00
5.00				0	)	5. 00
6.00				0	)	6. 00
7.00				0	)	7. 00
8. 00	Total Additions (Sum of lines 2 - 7)				0	8. 00
9.00	Deduct (Specify)			0	)	9. 00
10.00				0	)	10.00
11. 00				0	)	11. 00
12. 00				0	)	12. 00
13. 00				0		13. 00
	Total Deductions (Sum of lines 9 - 13)				0	
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				36, 925, 551	15. 00

Health Financial Systems	NEW JERSEY VETERANS HOM	E - V	I NELAND			In Lie	u of Form CMS-2540-10
OTATEMENT OF BATHERIT BEHINDS AND	ODEDATI NO EVOENOSO	_		045404	n		

Health Financial Systems NEW JERSEY VETERANS HOME - VINELAND In Lieu				u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider No.: 315496 Period:			Worksheet G-3		
			From 07/01/2021	D-+- /T: D	
			To 06/30/2022	Date/Time Pre 10/17/2022 11	
				10/1//2022 11	00 4111
				1. 00	
1.00	I.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			18, 184, 038	1. 00
2.00	Less: contractual allowances and discounts on patients accounts			0	2. 00
3.00	Net patient revenues (Line 1 minus line 2)			18, 184, 038	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, I	ine 15)		36, 925, 551	4. 00
5.00	Net income from service to patients (Line 3 minus 4)	•		-18, 741, 513	5. 00
	Other income:				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from communications (Telephone and Internet service)	)		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other th	nan patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of skilled nursing space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	Other miscellaneous revenue (specify)			0	24. 00
24. 50	COVI D-19 PHE Funding			2, 613, 284	24. 50
25.00	Total other income (Sum of lines 6 - 24)			2, 613, 284	25. 00
26.00	Total (Line 5 plus line 25)			-16, 128, 229	26. 00
27.00	Other expenses (specify)			0	27. 00
28.00				0	28. 00
29. 00				0	29. 00
30.00	Total other expenses (Sum of Lines 27 - 29)			0	30. 00
31. 00	Net income (or loss) for the period (Line 26 minus line 30)			-16, 128, 229	31. 00