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

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

Provider CCN: 315449
Period:
From 01/01/2022
From 01/01/2022
To 12/31/2021
Parts I, II & III
Date/Time Prepared:

					<u>5/30/2023 5</u>	:40 pm
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically prepared cost rep	ort		Date: 5/30/2023	3 Time:	5: 40 p
use only	2. [ ] Manually prepared cost report					
	3. [ 0 ] If this is an amended report ent	ter the numbe	r of times the provider	r resubmitted this	cost repor	t
	3.01 [ ] No Medicare Utilization. Enter '	Y" for yes o	r leave blank for no.			
Contractor	4. [ 1 ] Cost Report Status	6. Contractor	No.			
use only	(0) 0	7.[ N ] Firs	t Cost Report for this	Provider CCN		
		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.Contracto	r Vendor Code	4		
	5. Date Received:		care Utilization. Ente no utilization.	r "F" for full, "L	." for low,	or "N"
	1	ļ				

#### 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 ALARIS HEALTH AT WEST ORANGE ( 315449 ) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1		2	SI GNATURE STATEMENT	
1	Sa	am Stern	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Sam Stern			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-2, 461	3, 655	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	-2, 461	3, 655	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 ALARIS HEALTH AT WEST ORANGE In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315449 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/30/2023 5:40 pm 1.00 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 5 BROOK END DRIVE PO Box: 1.00 2.00 City: WEST ORANGE State: NJ Zi p Code: 07052 2.00 3.00 County: ESSEX CBSA Code: 35084 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 ALARIS HEALTH AT WEST 315449 09/02/1998 N Р Ν 4.00 ORANGE 5.00 Nursing Facility 5 00 ICF/IID 6.00 6.00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 SNF-Based FQHC 9.00 9.00 10.00 | SNF-Based CMHC 10.00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1.00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 14. 00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 | If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. Ν 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare N 19.01 utilization cost report, indicate with a "Y", for yes, or "N" for no. Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22 20.00 Straight Line 351, 980 20 00 21.00 Declining Balance 21.00 Sum of the Year's Digits 22.00 22.00 Sum of line 20 through 22 23.00 351, 980 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 0

Heal th	Financial Systems	ALARIS HEALTH AT WE	ST ORANGE	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSIN X INDENTIFICATION DATA	NG FACILITY HEALTH CARE	Provider No.: 315449	Period: From 01/01/2022 To 12/31/2022		
					5/30/2023 5: 4	
					Y/N	
					1.00	
	42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.					
43.00	Are there any home office costs as d	efined in CMS Pub. 15-1, Ch	apter 10?		N	43. 00
44.00	If line 43 is yes, enter the home of	fice chain number and enter	the name and address	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	organization, enter the nam	e and address of the	home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Contra	ictor's Number:		45. 00
46.00	Street:	PO Box:				46. 00
47.00	Ci ty:	State:	Zi p Co	ode:		47. 00

VI L	D NURSING FACILITY AND SKILLED NURSING FACILI	ALARIS HEALTH AT WE TY HEALTH CARE	_	No.: 315449	Peri od:	eu of Form CMS Worksheet S-	2
	X REIMBURSEMENT QUESTI ONNAI RE	THE THE THE			From 01/01/2022 To 12/31/2022	Part II	
						5/30/2023 5:	
					Y/N 1,00	Date	
	General Instruction: For all column 1 respons	ses enter in column	1, "Y" fo	r Yes or "N"	1.00 for No. For all	2.00 the date	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites						
00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the bed	i nni na of	the cost	N		1.
	reporting period? If column 1 is "Y", enter instructions)	the date of the cha	inge in col	umn 2. (see			
				1.00	2. 00	V/I 3. 00	
00	Has the provider terminated participation in			N			2.
	column 1 is yes, enter in column 2 the date 3, "V" for voluntary or "I" for involuntary.	of termination and	ın column				
00	Is the provider involved in business transac			Υ			3.
	contracts, with individuals or entities (e.g or medical supply companies) that are related	., chain home offic d to the provider o	es, drug rits				
	officers, medical staff, management personne						
	of directors through ownership, control, or	family and other si	milar				
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2.00	3. 00	
00	Financial Data and Reports  Column 1: Were the financial statements prep.	arod by a Cortific	l Dublic	Υ	С	1	4
00	Accountant? (Y/N) Column 2: If yes, enter "A			'			4
	Compiled, or "R" for Reviewed. Submit comple	te copy or enter da	ite				
00	available in column 3. (see instructions) If Are the cost report total expenses and total			l N			5
	those on the filed financial statements? If						
	reconciliation.				Y/N	Legal Oper.	
					1. 00	2. 00	
20	Approved Educational Activities	10 () (1) 0 1			N.		Ι,
00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	OOI? (Y/N) COLUMN 2	: IS the	provider the	N	N	6
00	Were costs claimed for Allied Health Program	s? (Y/N) see instru	ictions		N		7
						1	
00	Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) s	ng the cost reporti		for Nursing	N		
	Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s	ng the cost reporti		for Nursing	N	Y/N	
00	School and/or Allied Health Program? (Y/N) s	ng the cost reporti		for Nursing	N	Y/N 1.00	
	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba	ng the cost reporti ee instructions. d debts? (Y/N) see	ng period	ns.			8
00	Bad Debts Is the provider seeking reimbursement for balfine 9 is "Y", did the provider's bad deb	ng the cost reporti ee instructions. d debts? (Y/N) see	ng period	ns.		1. 00	9
00	Bad Debts Is the provider seeking reimbursement for ballfline 9 is "Y", did the provider's bad debperiod? If "Y", submit copy.	ng the cost reporti ee instructions.  d debts? (Y/N) see t collection policy	instruction change du	ns. ring this cos	t reporting	1. 00 Y	9
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.00	Bad Debts  Is the provider seeking reimbursement for ball fline 9 is "Y", did the provider's bad deb 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	d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du ived? If "Y	ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00	t reporting uctions. ctions. irt A Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9 10 11 12 13 13
.00	Bad Debts  Is the provider seeking reimbursement for bath of the provider seeking reimbursement for bath of the provider's bad debut 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.	d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du ived? If "Y	ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00  Y	t reporting uctions. ctions. irt A Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9 10 11 12 13 13
.00	Bad Debts  Is the provider seeking reimbursement for balf line 9 is "Y", did the provider's bad debperiod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles an 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.	d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du ived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00  N N	t reporting uctions. ctions. irt A Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9 10 11 12 13 13 14 15 16
.00	Bad Debts  Is the provider seeking reimbursement for ball fline 9 is "Y", did the provider's bad debperiod? 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.  If line 13 or 14 is "Y", then were	d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du ived? If "Y	ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00  Y	t reporting uctions. ctions. irt A Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9 10 11 12 13 13 14 15 16
000 000 000 000 000 000 000 000 000 00	Bad Debts  Is the provider seeking reimbursement for balf line 9 is "Y", did the provider's bad debperiod? If "Y", submit copy.  If line 9 is "Y", are patient deductibles an 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.	d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per	instruction change du ived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00  N N	t reporting uctions. ctions. irt A Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9, 10. 11. 12. 13.
00 00 0.00 .00 .00 2.00 3.00	Bad Debts  Is the provider seeking reimbursement for bath I line 9 is "Y", did the provider's bad deberoid? 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.  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.  If line 13 or 14 is "Y", then were adjustments made to PS&R data for Corrections of other PS&R data for Other?	d debts? (Y/N) see t collection policy d/or coinsurance was cost reporting per Description 0	instruction change du ived? If "Y	ns. ring this cos Y", see instru Pa Y/N 1.00  N N	t reporting uctions. ctions. irt A Date 2.00	1.00  Y N N N Part B Y/N 3.00  Y	9 10 11 12 13 13 14 15 16

Heal th	Financial Systems ALARIS	S HEALTH A	T WEST ORANGE		In Lie	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HE	ALTH CARE	Provi der		Period: From 01/01/2022	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE				To 12/31/2022	Date/Time Pre 5/30/2023 5:4	
			1.	00	2. (	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/posi	ition	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 repor-	t l	HEALTH CARE RE	SOURCES			20.00
	preparer.						
21.00	Enter the telephone number and email address of the	he cost	609-987-1440		CHRI S. GUI LBAULT	@HCRNJ. NET	21. 00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems ALARIS HEALTH AT SKILLED NURSING FACILITY HEALTH CARE ALARIS HEALTH AT WEST ORANGE

| Period: | Worksheet S-2 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315449 COMPLEX REIMBURSEMENT QUESTIONNAIRE

						o 12/31/202	22   Date/Time Pr 5/30/2023 5:	
		Part B					1070072020 0.	T p
		Date	1					
		4. 00						
	PS&R Data							
13. 00	Was the cost report prepared using the PS&R	03/17/2023						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
14.00	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",							
	see Instructions.							
16. 00	If line 13 or 14 is "Y", then were							16, 00
.0.00	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?							
40.00	Describe the other adjustments:							10.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.							18. 00
	provider s records? IT if see Histractions.							
				3.00		-		
	Cost Report Preparer Contact Information							
19. 00	Enter the first name, last name and the title		PREPAR	ER				19. 00
	held by the cost report preparer in columns 1	, 2, and 3,						
00.00	respectively.							00.00
20. 00	Enter the employer/company name of the cost r	eport						20. 00
21. 00	preparer. Enter the telephone number and email address	of the cost						21. 00
21.00	report preparer in columns 1 and 2, respective							21.00
	1. 1-1. 1 - 1-1-1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	,	1			1		1

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part | Date/Time Prepared: | 5/30/2023 5:40 pm | Propared: | P 
 Heal th Financial
 Systems
 ALARIS HEALTH AT WEST ORANGE

 SKILLED
 NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 Provider
 Provi der No.: 315449 COMPLEX STATISTICAL DATA

				Inpa	atient Days/Vis	si ts	<i>y</i>
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	120	43, 800	0	4, 864	25, 874	1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST						4.00
5.00	Other Long Term Care	0	0	1			5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPI CE	0	0	o	o	o	7. 00
8.00	Total (Sum of lines 1-7)	120	43, 800	1	4, 864	25, 874	8. 00
		Inpatient [			Di scharges	·	
		011	<b>.</b>	T' 11 1/	T: 11 \0.0111	T' 11 VIV	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
4 00	TOWALLED AND EASILY TV	6.00	7. 00	8.00	9. 00	10.00	
1.00	SKILLED NURSING FACILITY	7, 331	38, 069	1	124	142	1. 00
2.00	NURSING FACILITY	0	0	1		0	2. 00
3.00	ICF/IID	0	0	1		0	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5.00	Other Long Term Care	0	0	1			5. 00
6. 00	SNF-Based CMHC						6. 00
7.00	HOSPI CE	0	0	0	0	0	7. 00
8. 00	Total (Sum of lines 1-7)	7, 331	38, 069		124	142	8. 00
		Di sch	arges	Aver	age Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	SKILLED NURSING FACILITY	212	478		39. 23	182. 21	1. 00
2.00	NURSING FACILITY	1	0		07.20	0.00	2. 00
3.00	ICF/IID	0	0	0.00		0.00	3. 00
4. 00	HOME HEALTH AGENCY COST		0	1		0.00	4. 00
5. 00	Other Long Term Care	0	0				5. 00
6. 00	SNF-Based CMHC		0	1			6. 00
7. 00	HOSPI CE	0	0	0.00	0. 00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	212	478	1	39. 23	182. 21	8. 00
0.00	Total (Suil of Titles 1-7)	Average Length	470	Admi s		102. 21	0.00
		of Stay		Adilii 3	31 0113		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16. 00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	79. 64	0		83	227	1. 00
2.00	NURSING FACILITY	0.00	0		0	0	2. 00
3.00	ICF/IID	0. 00	_		0	o	3. 00
4. 00	HOME HEALTH AGENCY COST				-		4. 00
5. 00	Other Long Term Care	0.00				o	5. 00
6.00	SNF-Based CMHC						6. 00
7. 00	HOSPI CE	0. 00	0	o	0	o	7. 00
8.00	Total (Sum of lines 1-7)	79. 64	0	172	83	227	8. 00
		Admi ssi ons	Full Time				
	Component	Total	Employees on	Nonpai d			
	Component	TOTAL		Workers			
		21. 00	Payrol I 22. 00	23. 00			
1. 00	SKILLED NURSING FACILITY	482	31. 80				1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	0	0.00	1			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			4. 00 5. 00
6. 00	SNF-Based CMHC		0.00	0.00			6. 00
7. 00	HOSPI CE	0	0. 00	0.00			7. 00
8. 00	Total (Sum of lines 1-7)	482	31. 80	l l			8. 00
0.00	Total (Juli Of Titles 1-1)	1 402	31.00	0.00		l	0.00

SNF WAGE INDEX INFORMATION

instructions)

Provi der No.: 315449

Period: Worksheet S-3 From 01/01/2022 Part II

12/31/2022 Date/Time Prepared: 5/30/2023 5:40 pm Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Wage (col. 3 Reported col . 4) Worksheet A-6  $1 \pm col. 2$ Salary in col 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 1, 275, 975 1, 275, 975 66, 066. 00 19.31 1.00 Physician salaries-Part A 0.00 2.00 2.00 0 0 0 0.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 3.00 Home office personnel 0 0 0 0.00 0.00 4.00 4.00 Sum of lines 2 through 4 0.00 5.00 0 0.00 5.00 0 0 1, 275, 975 6.00 Revised wages (line 1 minus line 5) 1, 275, 975 66, 066. 00 19.31 6.00 7.00 Other Long Term Care 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 8.00 9.00 CMHC 9.00 10.00 HOSPI CE 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0.00 0.00 11.00 Subtotal Excluded salary (Sum of lines 7 0 0 0.00 0.00 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 1, 275, 975 C 1, 275, 975 66, 066. 00 19.31 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 5, 570, 195 5, 570, 195 170, 821. 00 32. 61 14.00 15.00 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 247, 504 247, 504 17.00 18.00 Wage-related costs other (See Part IV) 0 18.00 Ω Wage related costs (excluded units) 0 0 19.00 0 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 21.00 0 22.00 Total Adjusted Wage Related cost (see 247, 504 0 247, 504 22.00

Health Financial Systems
SNF WAGE INDEX INFORMATION Provi der No.: 315449

						5/30/2023 5: 40	J pili
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						l
1.00	Employee Benefits	0	0	C	0.00	0.00	1. 00
2.00	Administrative & General	316, 189	0	316, 189	10, 034. 00	31. 51	2. 00
3.00	Plant Operation, Maintenance & Repairs	0	0	C	0.00	0.00	3. 00
4.00	Laundry & Linen Service	0	0	C	0.00	0.00	4. 00
5.00	Housekeepi ng	355, 041	0	355, 041	24, 027. 00	14. 78	5. 00
6.00	Di etary	495, 986	0	495, 986	29, 701. 00	16. 70	6. 00
7.00	Nursing Administration	0	0	C	0.00	0.00	7. 00
8.00	Central Services and Supply	0	0	C	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	C	0.00	0.00	10.00
11. 00	Soci al Servi ce	108, 759	0	108, 759	2, 303. 00	47. 22	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	0	0	C	0.00	0.00	13.00
14.00	Total (sum lines 1 thru 13)	1, 275, 975	0	1, 275, 975	66, 065. 00	19. 31	14. 00

Health Financial Systems	ALARIS HEALTH AT WEST ORANGE	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315449	Peri od: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

		То	12/31/2022	Date/Time Prep 5/30/2023 5:40	
				Amount	
				Reported	
				1. 00	
PAI	RT IV - WAGE RELATED COSTS				
Pai	rt A - Core List				
RE <sup>*</sup>	TI REMENT COST				
1.00 40	O1K Employer Contributions			0	1.00
2.00 Ta	ax Sheltered Annuity (TSA) Employer Contribution			0	2. 00
	ualified and Non-Qualified Pension Plan Cost			0	3. 00
4. 00 Pr	ior Year Pension Service Cost			0	4.00
	AN ADMINISTRATIVE COSTS (Paid to External Organization)				
	O1K/TSA Plan Administration fees			0	5.00
	egal/Accounting/Management Fees-Pension Plan			0	6. 00
	nployee Managed Care Program Administration Fees			0	7. 00
	ALTH AND INSURANCE COST			-	
	ealth Insurance (Purchased or Self Funded)			99, 592	8.00
	rescription Drug Plan			0	9. 00
	ental, Hearing and Vision Plan			1, 438	
	fe Insurance (If employee is owner or beneficiary)			0	11.00
	ccident Insurance (If employee is owner or beneficiary)			0	12.00
	sability Insurance (If employee is owner or beneficiary)			0	13.00
	ong-Term Care Insurance (If employee is owner or beneficiary)			0	14.00
	orkers' Compensation Insurance			32, 573	
	etirement Health Care Cost (Only current year, not the extraor	dinary accrual required by I	ASR 106	32, 373 0	16.00
	on cumulative portion)	urriary accruai required by i	A3D 100.	O	10.00
	XES				
	CA-Employers Portion Only			96, 370	17 00
	edicare Taxes - Employers Portion Only			70, 370	18.00
	nemployment Insurance			0	
	tate or Federal Unemployment Taxes			17, 531	
	HER			17, 551	20.00
	Recutive Deferred Compensation			0	21.00
	ay Care Cost and Allowances			0	22.00
	uition Reimbursement			0	23. 00
	otal Wage Related cost (Sum of lines 1 - 23)			247, 504	
24.00 10	rtal mage herated cost (Suill of Triles 1 - 25)			Amount	24.00
				Reported	
				1. 00	
Pa	rt B - Other than Core Related Cost			1.00	
	THER WAGE RELATED COSTS (SPECIFY)			0	25. 00
0.	,		ı	٥١	

Occupational Therapy Aides

Speech Therapists

26.00 Other Medical Staff

Respiratory Therapists

23.00 24.00

25.00

0.00

0.00

0.00

1, 202. 00

87, 839

0

0

0.00

73. 08

0.00

23.00

24.00

25.00

0.00 26.00

SNF REPORTING OF DIRECT CARE EXPENDITURES Provider No.: 315449 Peri od: Worksheet S-3 From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/30/2023 5:40 pm Occupational Category Amount Fri nge Adj usted Pai d Hours Average Hourly Benefits Salaries (col. Related to Wage (col. 3 Reported col . 4) 1 + col. 2Salary in col 1.00 2.00 5. 00 3.00 4.00 Direct Salaries Nursing Occupations 1.00 Registered Nurses (RNs) 0.00 0.00 1.00 0 0 Licensed Practical Nurses (LPNs) 0.00 0.00 2.00 2.00 0 3.00 Certified Nursing Assistant/Nursing 0 0 0.00 0.00 3.00 Assi stants/Ai des ̈ 4.00 Total Nursing (sum of lines 1 through 3) 00000000 0.00 0.00 4.00 5.00 Physical Therapists 0 0 0.00 5.00 0 00 Physical Therapy Assistants 0 0 0.00 6.00 0.00 6.00 7.00 Physical Therapy Aides 0 0.00 0.00 7.00 Occupational Therapists
Occupational Therapy Assistants 0 0 0.00 8.00 0.00 8.00 0 0 0.00 9.00 0.00 9.00 10.00 Occupational Therapy Aides 0 0 0.00 0.00 10.00 Speech Therapists 0 0 0.00 11.00 0.00 11.00 Respiratory Therapists 0 12.00 0 00 0 00 12 00 Ω 13.00 Other Medical Staff 0.00 0.00 13.00 Contract Labor Nursing Occupations 43, 259. 00 1, 793, 723 14 00 Registered Nurses (RNs) 1, 793, 723 41 46 14 00 15.00 Licensed Practical Nurses (LPNs) 547, 992 547, 992 17, 706. 00 30.95 15.00 Certified Nursing Assistant/Nursing 2, 407, 047 2, 407, 047 94, 112. 00 25.58 16.00 16.00 Assi stants/Ai des ̈ 17.00 Total Nursing (sum of lines 14 through 16) 4, 748, 762 4, 748, 762 155, 077. 00 30.62 17.00 18.00 Physical Therapists 358,008 358, 008 6, 494. 00 55.13 18.00 19.00 Physical Therapy Assistants 88, 310 88, 310 2, 253.00 39.20 19.00 Physical Therapy Aides 20.00 0.00 0.00 20.00 21.00 Occupational Therapists 193, 665 193, 665 3, 427. 00 56.51 21.00 Occupational Therapy Assistants 22.00 93, 611 93, 611 2, 369.00 39. 51 22.00

87, 839

0

0

Health Financial Systems	ALARIS HEALTH AT WEST ORANGE	In Lie	u of Form CMS-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der No.: 315449	From 01/01/2022	Date/Time Prepared:
			5/30/2023 5:40 pm

		5/30/2023 5: 40	O pm
	Group	Days	
	1. 00	2. 00	4 00
1.00	RUX		1.00
2.00	RUL		2.00
3. 00 4. 00	RVX RVL		3. 00 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
16. 00	RHC		16. 00
17. 00	RHB		17. 00
18. 00	RHA		18. 00
19. 00	RMC		19. 00
20. 00	RMB		20. 00
21. 00	RMA		21.00
22. 00	RLB		22. 00
23. 00	RLA		23. 00
24. 00	ES3		24. 00
25. 00	ES2		25. 00
26. 00 27. 00	ES1 HE2		26. 00 27. 00
28. 00	HE1		28.00
29. 00	HD2		29. 00
30.00	HD1		30.00
31. 00	HC2		31.00
32.00	HC1		32.00
33.00	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	CE1		44.00
45. 00	CD2		45. 00
46. 00	CD1		46. 00
47. 00	CC2		47. 00
48. 00 49. 00	CC1 CB2		48. 00 49. 00
50. 00	CB2		50.00
51. 00	CA2		51.00
52. 00	CA2		52.00
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	I B2		59. 00
60.00	I B1		60.00
61. 00	I A2		61. 00
62. 00	I A1		62. 00
63.00	BB2		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			
74. 00 75. 00	PB1 PA2		74. 00 75. 00

Health Financial Systems	ALARIS HEALTH AT WEST ORANGE		In Lie	u of Form CMS-	2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315449	Peri od:	Worksheet S-7	'
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 5:4	
			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 "With direct patient care and related expenses (See instructions)	xpected this increase to be used or in column 1 the amount of the of for each category to total SNF or yes or "N" for no if the s	l for direct pexpense for expense for expenue from spending refle	oatient care and each category. En Worksheet G-2, P ects increases as	related ter in art I, sociated	
101. 00  Staffi ng 102. 00  Recrui tment					101. 00 102. 00
103.00 Retention of employees					102.00
104. 00 Trai ni ng					104. 00
105. 00 OTHER (SPECIFY)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)				106. 00

Heal th	Financial Systems	ALARIS HEALTH AT N	WEST ORANGE		In Lie	eu of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2022		
					To 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col :	Reclassi fi cati	5/30/2023 5: 40 Reclassi fi ed	J DIII
	cost center bescription	Sai ai i es	other	+ col . 2)	ons	Trial Balance	
				+ (01. 2)	I ncrease/Decre		
					ase (Fr Wkst	col. 4)	
					A-6)	(01.4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		2, 982, 578	2, 982, 57	8 0	2, 982, 578	1. 00
3.00	00300 EMPLOYEE BENEFITS	o	256, 049			256, 049	3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	316, 189	1, 844, 556			2, 160, 745	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	537, 662			537, 662	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE		262, 599			262, 599	6. 00
7. 00	00700 HOUSEKEEPING	355, 041	91, 240			446, 281	7. 00
8. 00	00800 DI ETARY	495, 986	556, 899			1, 052, 885	8. 00
9. 00	00900 NURSING ADMINISTRATION	475, 760	345, 600			345, 600	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	343, 600	343, 60	0	345, 600	10.00
		0	0		0	1	
12.00	01200 MEDICAL RECORDS & LIBRARY	1 "	0	100 75	0	100.750	12.00
13.00	01300 SOCIAL SERVICE	108, 759	077 (54	108, 75		108, 759	13.00
15. 00	01500 PATIENT ACTIVITIES	0	277, 654	277, 65	4 0	277, 654	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		E 004 0E0	F 004 0F		5 004 050	00.00
30.00	03000 SKILLED NURSING FACILITY	0	5, 221, 350			-,,	30.00
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
32. 00	03200   CF/IID	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	0	7, 801	7, 80		.,	40. 00
41. 00	04100 LABORATORY	0	16, 161	16, 16			41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	23, 892			23, 892	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	977, 664	977, 66		977, 664	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	31, 091	31, 09		31, 091	45. 00
46.00	04600 SPEECH PATHOLOGY	0	24, 959	24, 95	9 0	24, 959	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENT	0	234, 605	234, 60	5 0	234, 605	49. 00
51.00	05100 SUPPORT SURFACES	0	42, 736	42, 73	6 0	42, 736	51.00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	50, 892	50, 89	2 0	50, 892	71. 00
	SPECIAL PURPOSE COST CENTERS				_		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0		80.00
81. 00	08100 I NTEREST EXPENSE		0		0	0	81. 00
82.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0		0	0	82. 00
83.00	08300 H0SPI CE	0	0		0 0	0	83.00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 275, 975	13, 785, 988	15, 061, 96	3 0	15, 061, 963	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	o	0		0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES		0		0 0	0	92.00
93.00	09300 NONPALD WORKERS		0		0 0	0	93. 00
94.00	09400 PATIENTS LAUNDRY		0		0 0	0	94.00
100.00	TOTAL	1, 275, 975	13, 785, 988	15, 061, 96	3 0	15, 061, 963	100.00
		,	,			•	

 
 Heal th Financial
 Systems
 ALARIS HEAD

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provi der No.: 315449 

				То	12/31/2022	Date/Time Prepared: 5/30/2023 5:40 pm
	Cost Center Description	Adjustments to	Net Expenses			9, 39, 2323 31 16 5
	·	Expenses (Fr	For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	-1, 763, 993	1	1		1. 00
3.00	00300 EMPLOYEE BENEFITS	0	256, 049	1		3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-294, 330	1	1		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	537, 662	1		5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	262, 599	1		6. 00
7.00	00700 HOUSEKEEPI NG	0	446, 281	1		7. 00
8.00	00800 DI ETARY	0	1, 052, 885	1		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	345, 600	1		9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	1		10.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	100.750	1		12.00
13.00	01300 SOCIAL SERVICE	0	108, 759	•		13.00
15. 00	01500 PATIENT ACTIVITIES	0	277, 654			15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	42.447	F 2/2 017	T		20.00
31.00	03100 NURSING FACILITY	42, 467	5, 263, 817 0	1		30. 00 31. 00
32. 00	03200   CF/IID	0		•		32.00
33. 00	03300 OTHER LONG TERM CARE	0		•		33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	0				33.00
40. 00	04000 RADI OLOGY	0	7, 801			40.00
41. 00	04100 LABORATORY	0	16, 161	•		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	23, 892			42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	•		43.00
44. 00	04400 PHYSI CAL THERAPY	-531, 346	1	1		44.00
45. 00	04500 OCCUPATI ONAL THERAPY	256, 185		1		45. 00
46. 00	04600 SPEECH PATHOLOGY	62, 880	1	1		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	1		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENT	0	234, 605			49. 00
51.00	05100 SUPPORT SURFACES	0	42, 736			51. 00
	OTHER REIMBURSABLE COST CENTERS					
71.00	07100 AMBULANCE	0	50, 892			71.00
	SPECIAL PURPOSE COST CENTERS					
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	0			80.00
81.00	08100 I NTEREST EXPENSE	0	0			81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0			82.00
83.00	08300 H0SPI CE	0	0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-2, 228, 137	12, 833, 826			89. 00
	NONREI MBURSABLE COST CENTERS					
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	•		90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0			91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0			92. 00
93. 00	09300 NONPAI D WORKERS	0	0			93. 00
94.00	09400 PATIENTS LAUNDRY	0	0			94.00
100.00	TOTAL	-2, 228, 137	12, 833, 826			100.00

Health Financial Systems	ALARIS HEALTH AT WES	T ORANGE		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	,
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 5:4	
			Increases			
	Cost Center	•	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4. 00	5. 00	
TOTALS						
100.00	Total Reclassificati	ons (Sum		0	0	100.00
	of columns 4 and 5 r	nust				
	equal sum of columns	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	ALARIS HEALTH AT WES	T ORANGE		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315449	Peri od:	Worksheet A-6	)
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	epared:
					5/30/2023 5: 4	
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7.00	8. 00	9. 00	
TOTALS						
100. 00				0	0	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
RECONCILIATION OF CAPITAL COSTS CENTERS ALARIS HEALTH AT WEST ORANGE In Lieu of Form CMS-2540-10

Provi der No.: 315449 

				10	12/31/2022	5/30/2023 5: 40	
			<b>'</b>	Acqui si ti ons			
	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	3					
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	813, 803	78, 051	0	78, 051	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	1, 957, 005	3, 956		3, 956		6. 00
7.00	Subtotal (sum of lines 1-6)	2, 770, 808	82, 007	0	82, 007	44, 624	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	2, 770, 808		0	82, 007	44, 624	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	5		T			
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	891, 854	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	1, 916, 337	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	2, 808, 191	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	2, 808, 191	0				9. 00

Provi der No.: 315449

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

				To 12/31/2022	Date/Time Prep 5/30/2023 5:40	
				Expense Classification on		J pili
				To/From Which the Amount is		
				Toy I Tom Will cit the Amount 13	to be maj astea	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
	boser per on (1)	Adjustment	ranoarre		Erric No.	
		1.00	2. 00	3.00	4. 00	
1. 00	Investment income on restricted funds	В		CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)	_	,	FIXTURES		
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	Tel ephone 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	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0		0.00	8. 00
0.00	physician adjustment		· ·			0.00
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	11. 00
	Capi tal expendi tures (chapter 24)		· ·		0.00	
12.00	Adjustment resulting from transactions with	A-8-1	-1, 818, 943	3		12. 00
	related organizations (chapter 10)		., ,			
13.00	Laundry and linen service		0		0.00	13. 00
14. 00	Revenue - Employee meals		0			14. 00
15. 00	Cost of meals - Guests		0		0.00	15. 00
16. 00	Sale of medical supplies to other than		0		0.00	16. 00
	patients		· ·		0.00	
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	
19. 00	Vending machines		0		0.00	19. 00
20. 00	Income from imposition of interest, finance		0		0.00	20. 00
20.00	or penalty charges (chapter 21)		Č		0.00	20.00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
200	and borrowings to repay Medicare		· ·		0.00	21100
	overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)		_			
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
	φ			FIXTURES		
24.00	Depreciationmovable equipment		0	*** Cost Center Deleted ***	2. 00	24. 00
25. 00	Other adjustment (specify)		n		0.00	25. 00
25. 01	OFFICE EXPENSE	A	-6. 853	ADMINISTRATIVE & GENERAL	4.00	
25. 03	CONTRI BUTI ONS	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	PENALTI ES	A		ADMINISTRATIVE & GENERAL	4.00	25. 04
25. 04	BAD DEBTS	A		ADMINISTRATIVE & GENERAL	4.00	25. 04
	Total (sum of lines 1 through 99) (Transfer	, ,	-2, 228, 137	l .	4.00	100.00
100.00	to Worksheet A, col. 6, line 100)		2, 220, 137			100.00
(4) 5	11	ı	0110 5 1 45 4		ı	ļi

<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.

ALARIS HEALTH AT WEST ORANGE

 
 Heal th Financial
 Systems
 ALARIS
 HEALTH AT

 STATEMENT OF COSTS
 OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
 Provi der No.: 315449 OFFICE COSTS

			1	o 12/31/2022	Date/Time Prep. 5/30/2023 5:40	
	Li ne No.	Cost (		Expense	Items	
	1.00	2.		3.0		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR	
1.00		CAP REL COSTS FLXTURES	- BLDGS &	RENT		1. 00
2. 00	1	ADMI NI STRATI VE	& GENERAL	RENT		2. 00
3. 00	44. 00	PHYSICAL THERA	PY	PT		3. 00
4. 00	45. 00	OCCUPATI ONAL TI	HERAPY	OT		4. 00
5. 00	46. 00	SPEECH PATHOLO	GY	ST	1	5.00
6. 00	30.00	SKILLED NURSIN	G FACILITY	TRANSPORTERS		6.00
7. 00	4. 00	ADMI NI STRATI VE	& GENERAL	OFFI CE		7.00
3. 00	0.00					8. 00
9. 00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.			1			
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col. 5	col . 5)			
	4.00	5. 00	6. 00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI				D ORGANIZATIONS	OR	
CLAIMED HOME OFFICE COSTS:		01 110 110 10 10 11 0		.5 011071111 27111 0110		
1. 00	565, 524	2, 318, 548	-1, 753, 024	Į.		1.00
2. 00	2, 622	0	2, 622	2		2. 00
3. 00	446, 318	977, 664	-531, 346			3.00
4. 00	287, 276	31, 091	256, 185	5		4.00
5. 00	87, 839	24, 959	62, 880	)		5. 00
6. 00	42, 467	0	42, 467	7		6.00
7. 00	101, 273	0	101, 273	3		7. 00
3. 00	0	0	(	)		8. 00
9. 00	0	0	(			9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 533, 319	3, 352, 262	-1, 818, 943	3		10. 00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315449 Peri od: Worksheet A-8-1 From 01/01/2022 OFFICE COSTS Parts I-II 12/31/2022 Date/Time Prepared:

				5/30/2023 5: 40	) pm
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/O	R HOME OFFICE:			

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

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

1.00		Α	AVERY ELSENRELCH	99.00	1.00
2. 00		Α	RIVKA JACOBOWITZ	1.00	2.00
3.00		A	AVERY EISENREICH	99.00	3.00
4.00		A	RIVKA JACOBOWITZ	1.00	4.00
5.00				0.00	5. 00
6.00				0.00	6.00
7. 00				0.00	7. 00
8.00				0.00	8.00
9. 00				0.00	9.00
10. 00				0.00	10.00
100.00 G. Other (fina	ncial or non-financial)			0.00	100.00
speci fy:					

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

·	Rel ated Organization(s) and/or Home Office				
	Name	Percentage of	Type of Business		
		Ownershi p	3.		
	4.00	5. 00	6.00	1	
DADT II. INTERDELATIONSHIP TO BELATER ORGANIE	14T1 011 (0) 411D (0D 11011E 0EEL 0E			_	

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

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

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

1.00		ST CLOUD REALTY	99.00	REALTY	1.00
2.00		ST CLOUD REALTY	1.00	REALTY	2.00
3.00		ADVANTAGE REHAB	99.00	REHAB	3. 00
4.00		ADVANTAGE REHAB	1.00	REHAB	4. 00
5.00			0.00		5. 00
6.00			0.00		6. 00
7.00			0.00		7. 00
8.00			0.00		8. 00
9.00			0.00		9. 00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	speci fy:				

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

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

| Peri od: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315449

					To	12/31/2022	Date/Time Prep 5/30/2023 5:40	pared:
				CAPI TAL			37 307 2023 3. 40	Э рііі
				RELATED COSTS				
		Cost Center Description	Net Expenses	BLDGS &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
			for Cost Allocation	FI XTURES	BENEFITS		& GENERAL	
			(from Wkst A					
			col . 7)					
			0	1. 00	3. 00	3A	4. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS - BLDGS & FIXTURES	1, 218, 585	1, 218, 585				1. 00
3. 00	1	EMPLOYEE BENEFITS	256, 049	0				3. 00
4.00	1	ADMINISTRATIVE & GENERAL	1, 866, 415	79, 825		2, 009, 689	2, 009, 689	4. 00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	537, 662 262, 599	145, 450 30, 104		683, 112 292, 703	126, 831	5. 00 6. 00
7. 00	1	HOUSEKEEPING	446, 281	30, 104		549, 024	54, 345 101, 936	7. 00
8. 00		DI ETARY	1, 052, 885	156, 555		1, 308, 969	243, 032	8. 00
9. 00	1	NURSING ADMINISTRATION	345, 600	6, 384		351, 984	65, 352	9. 00
10.00	1	CENTRAL SERVICES & SUPPLY	0	0,001		0	0	10. 00
12. 00		MEDICAL RECORDS & LIBRARY	0	3, 676		3, 676	683	12. 00
13.00		SOCIAL SERVICE	108, 759	8, 667	21, 825	139, 251	25, 854	13. 00
15.00	01500	PATIENT ACTIVITIES	277, 654	40, 938	0	318, 592	59, 152	15.00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00		SKILLED NURSING FACILITY	5, 263, 817	662, 865		5, 926, 682	1, 100, 394	30. 00
31.00	1	NURSING FACILITY	0	0		0	0	31. 00
32. 00	1	I CF/IID	0	0		0	0	32. 00
33. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	U U	0	0	0	U	33. 00
40. 00		RADI OLOGY	7, 801	0	0	7, 801	1, 448	40. 00
41. 00		LABORATORY	16, 161	0		16, 161	3, 001	41. 00
42.00	04200	INTRAVENOUS THERAPY	23, 892	0	0	23, 892	4, 436	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00		PHYSI CAL THERAPY	446, 318	28, 130		474, 448	88, 089	44. 00
45. 00		OCCUPATIONAL THERAPY	287, 276	22, 791	0	310, 067	57, 569	45. 00
46.00		SPEECH PATHOLOGY	87, 839	1, 703		89, 542	16, 625	
47. 00		ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENT	234, 605	0		234, 605	0 43, 558	48. 00 49. 00
51.00		SUPPORT SURFACES	42, 736	0		42, 736	7, 935	51. 00
31.00		REIMBURSABLE COST CENTERS	42,730	0	0	42, 730	7, 733	31.00
71. 00		AMBULANCE	50, 892	0	0	50, 892	9, 449	71. 00
		AL PURPOSE COST CENTERS				·		
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		I NTEREST EXPENSE						81. 00
82. 00		UTILIZATION REVIEW - SNF						82. 00
83. 00	08300	HOSPI CE	0	0		0	0	83. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	12, 833, 826	1, 218, 585	256, 049	12, 833, 826	2, 009, 689	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0	O	0	0	90. 00
91. 00		BARBER AND BEAUTY SHOP	0	0		0	0	91. 00
92. 00		PHYSICIANS PRIVATE OFFICES		0	_	0	0	92.00
93. 00		NONPALD WORKERS	l ől	0		0	Ö	93. 00
94.00		PATIENTS LAUNDRY		0	Ö	0	0	94. 00
98. 00		Cross Foot Adjustments	o	0	0	0	0	98. 00
99. 00		Negative Cost Centers	0	0	0	0	0	99. 00
100.00	)	TOTAL	12, 833, 826	1, 218, 585	256, 049	12, 833, 826	2, 009, 689	100. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der No.: 315449 | Peri od: | Worksheet B | From 01/01/2022 | Part / I ma D

Date/Time Prepared: 12/31/2022 5/30/2023 5:40 pm Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATI ON, LINEN SERVICE ADMI NI STRATI ON MAINT. & REPAI RS 6.00 9. 00 7.00 8.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 3.00 00300 EMPLOYEE BENEFITS 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4 00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 809, 943 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 24, 547 371, 595 6.00 00700 HOUSEKEEPI NG 7.00 25,682 676, 642 7.00 00800 DI ETARY 8.00 127, 655 113, 696 1, 793, 352 8.00 9.00 00900 NURSING ADMINISTRATION 5, 206 4,637 427, 179 9.00 01000 CENTRAL SERVICES & SUPPLY 0 0 10.00 10.00 2, 997 01200 MEDICAL RECORDS & LIBRARY 12 00 0 2.670 0 Λ 12.00 13.00 01300 SOCIAL SERVICE 7,067 C 6, 295 0 0 13.00 15.00 01500 PATIENT ACTIVITIES 33, 381 29, 731 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 427, 179 30.00 03000 SKILLED NURSING FACILITY 540, 500 371, 595 481, 397 30.00 1, 793, 352 31.00 03100 NURSING FACILITY 0 31.00 03200 | CF/IID 0 0 0 32.00 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 33.00 33 00 0 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 0 0 0 40.00 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42.00 0 42 00 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 43.00 04400 PHYSI CAL THERAPY 44.00 22, 937 20, 429 0 44.00 04500 OCCUPATIONAL THERAPY 45 00 18.583 Ω 16 551 45.00 0 04600 SPEECH PATHOLOGY 46.00 1,388 C 1, 236 0 46.00 0 47.00 04700 ELECTROCARDI OLOGY 0 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 0 0 0 48.00 04900 DRUGS CHARGED TO PATIENT 49 00 0 Ω O 0 49 00 05100 SUPPORT SURFACES 51.00 0 0 51.00 OTHER REIMBURSABLE COST CENTERS 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 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 08300 H0SPI CF 83.00 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 809, 943 371, 595 676, 642 1, 793, 352 427, 179 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 09100 BARBER AND BEAUTY SHOP 0 0 91.00 C 0 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 93.00 09300 NONPALD WORKERS 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 94.00 0 94.00 0 0 98.00 Cross Foot Adjustments 0 C 0 0 0 98.00 99.00 Negative Cost Centers 99.00 100.00 809, 943 371, 595 676, 642 1, 793, 352 427, 179 100. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315449

				10	5 12/31/2022	5/30/2023 5:4	
					OTHER GENERAL	0,00,2020 0. 1	, p
					SERVI CE		
	Cost Center Description	CENTRAL	MEDI CAL	SOCIAL SERVICE	PATI ENT	Subtotal	
		SERVICES &	RECORDS &		ACTI VI TI ES		
		SUPPLY	LI BRARY				
	DENIEDAL DERIVLOS DOOT DENIEDO	10. 00	12. 00	13. 00	15. 00	16. 00	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING				+		6. 00 7. 00
8. 00	00800 DI ETARY				-		8.00
9. 00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0					10.00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	10, 026				12.00
13. 00	01300 SOCIAL SERVICE	0	10, 020				13.00
15. 00	1 1	0	0		440, 856		15. 00
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			440, 030		13.00
30. 00		O	10, 026	178, 467	440, 856	11, 270, 448	30. 00
31. 00	1 1	0	.0,020		0	0	31.00
32. 00		Ö	Ö		o	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0	0		0	0	33. 00
00.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>			<u> </u>		00.00
40.00		o	0	0	0	9, 249	40.00
41.00	1 1	o	0	0	0	19, 162	41.00
42.00	04200 I NTRAVENOUS THERAPY	o	0	0	0	28, 328	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	o	O	0	o	0	43.00
44.00	04400 PHYSI CAL THERAPY	o	0	0	o	605, 903	44.00
45.00	04500 OCCUPATI ONAL THERAPY	o	0	0	0	402, 770	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0	0	0	108, 791	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 PATIENT	0	0	0	0	278, 163	49. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	50, 671	51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00		0	0	0	0	60, 341	71. 00
	SPECIAL PURPOSE COST CENTERS						
80. 00	1						80. 00
81. 00							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)	0	10, 026	178, 467	440, 856	12, 833, 826	89. 00
	NONREI MBURSABLE COST CENTERS	_1		_			
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	_	0	0	91.00
92.00		0	0	0	0	0	92.00
93.00	09300 NONPALD WORKERS	0	0	9	0	0	93. 00
94.00		0	0	9	0	0	94.00
98.00	Cross Foot Adjustments	0			0	0	98. 00
99.00	Negative Cost Centers	0	10.007	170 4/7	140.05	0	99.00
100.00	0   TOTAL	이	10, 026	178, 467	440, 856	12, 833, 826	1100.00

Provi der No.: 315449

In Lieu of Form CMS-2540-10

Period:	Worksheet B
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/30/2023 5:40 pm	

				5/30/2023 5: 4	lO pm
	Cost Center Description	Post Stepdown	Total		
		Adjustments			
		17. 00	18. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
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				10.00
12.00	01200 MEDICAL RECORDS & LIBRARY				12. 00
13.00	01300 SOCIAL SERVICE				13.00
15.00	01500 PATIENT ACTIVITIES				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	0	11, 270, 448		30.00
31.00		0	o		31. 00
32.00	03200   CF/IID	0	o		32.00
33.00	03300 OTHER LONG TERM CARE	0	o		33. 00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	0	9, 249		40.00
41.00	04100 LABORATORY	0	19, 162		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	28, 328		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		43.00
44.00	04400 PHYSI CAL THERAPY	0	605, 903		44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	402, 770		45.00
46.00	04600 SPEECH PATHOLOGY	0	108, 791		46. 00
47.00	04700 ELECTROCARDI OLOGY	0	o		47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o		48. 00
49.00	04900 DRUGS CHARGED TO PATIENT	0	278, 163		49. 00
51.00	05100 SUPPORT SURFACES	0	50, 671		51.00
	OTHER REIMBURSABLE COST CENTERS				
71. 00		0	60, 341		71. 00
	SPECIAL PURPOSE COST CENTERS				
80.00					80.00
81. 00					81. 00
82. 00					82. 00
83.00	08300 H0SPI CE	0	0		83. 00
89. 00		0	12, 833, 826		89. 00
	NONREI MBURSABLE COST CENTERS				
90. 00		0	0		90.00
91. 00		0	0		91. 00
92.00		0	0		92.00
93. 00		0	0		93. 00
94. 00		0	0		94. 00
98. 00	1 1	0	0		98. 00
99. 00	1 1 3	0	0		99. 00
100.0	O TOTAL	0	12, 833, 826		100.00

In Lieu of Form CMS-2540-10 ALLOCATION OF CAPITAL RELATED COSTS Provider No.: 315449 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/30/2023 5:40 pm CAPI TAL RELATED COSTS Directly **EMPLOYEE** ADMI NI STRATI VE Cost Center Description BLDGS & Subtotal Assigned New **FIXTURES** BENEFITS & GENERAL Capi tal Related Costs 0 1.00 2A 3.00 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 00300 EMPLOYEE BENEFITS 3.00 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 0 79, 825 79, 825 0 79, 825 4 00 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 0 0 0 145, 450 145, 450 0 5,038 5.00 00600 LAUNDRY & LINEN SERVICE 30, 104 2, 159 6.00 30, 104 6 00 7.00 00700 HOUSEKEEPI NG 31, 497 31, 497 4,049 7.00 0 8.00 00800 DI ETARY 156, 555 156, 555 9, 654 8.00 6, 384 0 9.00 00900 NURSING ADMINISTRATION 0 0 6.384 2.596 9.00 01000 CENTRAL SERVICES & SUPPLY 10.00 0 10.00 12.00 01200 MEDICAL RECORDS & LIBRARY 3, 676 3,676 0 27 12.00 01300 SOCIAL SERVICE 0 0 13.00 8, 667 8,667 1,027 13.00 01500 PATIENT ACTIVITIES 0 40, 938 2, 350 15.00 40.938 0 15 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 0 662, 865 662, 865 0 43, 706 30.00 31.00 03100 NURSING FACILITY 0 0 31.00 C 0 0 o 0 32.00 03200 | CF/IID Ω 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 0 58 40.00 0000000000 0 04100 LABORATORY 0 119 41.00 0 41 00 42.00 04200 I NTRAVENOUS THERAPY 0 176 42.00 04300 OXYGEN (INHALATION) THERAPY 43.00 0 0 0 43.00 04400 PHYSI CAL THERAPY 3, 499 44.00 28, 130 28. 130 44.00 04500 OCCUPATIONAL THERAPY 2, 287 45.00 22, 791 22, 791 45 00 46.00 04600 SPEECH PATHOLOGY 1,703 1,703 0 660 46.00 04700 ELECTROCARDI OLOGY 47.00 0 47.00 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 48.00 0 0 04900 DRUGS CHARGED TO PATIENT 0 0 49 00 C 0 1,730 49.00 05100 SUPPORT SURFACES 51.00 0 315 51.00 OTHER REIMBURSABLE COST CENTERS 07100 AMBULANCE 0 0 0 375 71.00 71.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 83.00 89.00 SUBTOTALS (sum of lines 1-84) 0 1, 218, 585 1, 218, 585 0 79, 825 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 0 0 0 0 0 91.00

0

0

0

0

0

0

1, 218, 585

0

0

92.00

93.00

98.00

0

0

0 94.00

0 99.00

79, 825 100.00

0

C

C

1, 218, 585

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

09300 NONPALD WORKERS

TOTAL

09400 PATIENTS LAUNDRY

92.00

93.00

94.00

98.00

99 00

100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ALARIS HEALTH AT WEST ORANGE Provi der No.: 315449

				То	12/31/2022		
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/30/2023 5: 4 NURSI NG	O pili
	cost center bescription	OPERATION,	LINEN SERVICE	HOUSEKEELLING	DILIANI	ADMI NI STRATI ON	
		MAINT. &	LINEN SERVICE			ADMINI STRATTON	
		REPAI RS					
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	150, 488	8				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	4, 561	36, 824				6. 00
7.00	00700 HOUSEKEEPI NG	4, 772	2	40, 318			7. 00
8.00	00800 DI ETARY	23, 718	0	6, 775	196, 702		8. 00
9.00	00900 NURSING ADMINISTRATION	967	0	276	0	10, 223	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	557	0	159	0	0	12. 00
13.00	01300 SOCIAL SERVICE	1, 313	0	375	0	0	13.00
15.00	01500 PATIENT ACTIVITIES	6, 202	0	1, 772	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	100, 425	36, 824	28, 684	196, 702		30. 00
31. 00	03100 NURSING FACILITY	0	1	-	0	0	31. 00
32. 00	03200   I CF/I I D	0		0	0	1	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS					1	
40.00	04000 RADI OLOGY	0	1	_	0	1	40.00
41. 00	04100 LABORATORY	0	-	0	0		41.00
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	4, 262	1	1, 217	0	0	44.00
45. 00	04500 OCCUPATIONAL THERAPY	3, 453		986	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	258	l .	74	0	0	46.00
48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		1	0	0	0	47. 00 48. 00
48.00	04900 DRUGS CHARGED TO PATIENTS		_	0	0	0	48.00
51. 00	05100 SUPPORT SURFACES		1	0	0	0	51.00
31.00	OTHER REIMBURSABLE COST CENTERS		,	<u> </u>	0		31.00
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
	SPECIAL PURPOSE COST CENTERS		-	-1	-		
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	O	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	150, 488	36, 824	40, 318	196, 702	10, 223	89. 00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	1	0	0	1	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATI ENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments		0	0	0	0	98. 00
99. 00	Negative Cost Centers	0	0	0	0	0	99. 00
100.00	D TOTAL	150, 488	36, 824	40, 318	196, 702	10, 223	100.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315449

			1	0 12/31/2022	5/30/2023 5:4	
		-		OTHER GENERAL SERVI CE		у рііі
Cost Center Description	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	ACTI VI TI ES	Subtotal	
	10.00	12.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES						1. 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 O0900 NURSING ADMINISTRATION						9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	0					10. 00
12.00 01200 MEDICAL RECORDS & LIBRARY	0	4, 419	1			12.00
13. 00   01300   SOCIAL SERVICE	0	C	11, 382	!		13.00
15.00 01500 PATIENT ACTIVITIES	0	C	0	51, 262		15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	0	4, 419	11, 382	51, 262	1, 146, 492	30.00
31.00 03100 NURSING FACILITY	0	C	٦	1 1	0	31. 00
32. 00   03200   1 CF/1 I D	0	C	1		0	32. 00
33.00 O3300 OTHER LONG TERM CARE	0	C	0	0	0	33. 00
ANCILLARY SERVICE COST CENTERS						
40. 00   04000   RADI OLOGY	0	C	1		58	40. 00
41. 00   04100   LABORATORY	0	C	1		119	41. 00
42. 00   04200   I NTRAVENOUS THERAPY	0	C	0	0	176	42. 00
43. 00   04300   0XYGEN (I NHALATION) THERAPY	0	C		0	0	43.00
44. 00   04400   PHYSI CAL THERAPY	0	C		1 4	37, 108	44. 00
45. 00   04500   OCCUPATI ONAL THERAPY	0	C		0	29, 517	45. 00
46. 00   04600   SPEECH PATHOLOGY	0	C			2, 695	46. 00
47. 00 04700 ELECTROCARDI OLOGY	U <sub>I</sub>	C			0	47. 00
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   49.00   04900   DRUGS CHARGED TO PATIENT	0			1 1	0 1, 730	48. 00 49. 00
51. 00   05100   SUPPORT SURFACES	0	C	1	-	315	51. 00
OTHER REIMBURSABLE COST CENTERS	U		)	ų U	313	51.00
71. 00 07100 AMBULANCE	0	C		O	375	71. 00
SPECIAL PURPOSE COST CENTERS	O <sub>I</sub>		71 0	١	373	71.00
80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81. 00 08100 I NTEREST EXPENSE						81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF						82. 00
83. 00   08300   HOSPI CE	o	C	ol o	ol	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	0	4, 419	11, 382	51, 262	1, 218, 585	89. 00
NONREI MBURSABLE COST CENTERS						
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C	0	0	0	90.00
91.00 09100 BARBER AND BEAUTY SHOP	0	C	0	0	0	91.00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0	C	0	0	0	92.00
93. 00   09300   NONPAI D   WORKERS	0	C	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	C	) C	0	0	94. 00
98.00 Cross Foot Adjustments	0			0	0	98. 00
99.00 Negative Cost Centers	0	C	0	0	0	99. 00
100. 00 TOTAL	0	4, 419	11, 382	51, 262	1, 218, 585	100. 00

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

				To 12/31/2022 Date/Ti me 5/30/2023	
	Cost Center Description	Post Step-Down	Total	37 307 2023	3. 40 pm
	·	Adjustments			
		17. 00	18. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1. 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				10.00
12.00	01200 MEDICAL RECORDS & LIBRARY				12. 00
13.00	01300 SOCIAL SERVICE				13. 00
15.00	01500 PATIENT ACTIVITIES				15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 SKILLED NURSING FACILITY	0	1, 146, 492		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	O	O		33. 00
	ANCILLARY SERVICE COST CENTERS				
40.00	04000 RADI OLOGY	0	58		40. 00
41.00	04100 LABORATORY	0	119		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	176		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		43. 00
44.00	04400 PHYSI CAL THERAPY	0	37, 108		44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	29, 517		45. 00
46.00	04600 SPEECH PATHOLOGY	0	2, 695		46. 00
47.00	04700 ELECTROCARDI OLOGY	0	0		47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00
49.00	04900 DRUGS CHARGED TO PATIENT	0	1, 730		49. 00
51.00	05100 SUPPORT SURFACES	0	315		51.00
	OTHER REIMBURSABLE COST CENTERS				
71. 00	07100 AMBULANCE	0	375		71. 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  H0SPI CE	0	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 218, 585		89. 00
	NONREI MBURSABLE COST CENTERS				
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90. 00
91. 00	09100 BARBER AND BEAUTY SHOP	0	0		91. 00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0		92. 00
93.00	09300 NONPALD WORKERS	0	0		93. 00
94.00	09400 PATIENTS LAUNDRY	0	0		94. 00
98. 00	Cross Foot Adjustments	0	0		98. 00
99. 00	Negative Cost Centers	0	0		99. 00
100.00	O TOTAL	0	1, 218, 585		100. 00

Heal th	Financial Systems	ALARIS HEALTH AT	WEST ORANGE		In Lie	u of Form CMS-2	2540-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
					rom 01/01/2022	D 1 (T' D	
				T	o 12/31/2022	Date/Time Pre 5/30/2023 5:4	parea:
		CAPI TAL				5/30/2023 5: 4	U pili
		RELATED COSTS					
	Coat Cantan Dagarintian		EMDL OVEE	Dogganailiation	ADMINI CTDATIVE	DI ANT	
	Cost Center Description	BLDGS & FLXTURES	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON,	
						· · · · · · · · · · · · · · · · · · ·	
		(SQUARE FEET)	(GROSS		(ACCUM COST)	MAINT. &	
			SALARI ES)			REPAI RS	
		1.00	2.00	4.0	4.00	(SQUARE FEET)	
	CENEDAL CEDIU CE COCT CENTEDO	1.00	3. 00	4A	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS	21 402			1		1 00
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	31, 493	4 075 075				1.00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 275, 975	1			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 063	316, 189	1			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	3, 759	0	0	683, 112	25, 671	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	778	0	0	292, 703	778	6. 00
7.00	00700 HOUSEKEEPI NG	814	355, 041	0	549, 024	814	7. 00
8.00	00800  DI ETARY	4, 046	495, 986	0	1, 308, 969	4, 046	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	165	0	0	351, 984	165	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	95	0	0	3, 676	95	12.00
13.00	01300 SOCIAL SERVICE	224	108, 759	0	139, 251	224	13. 00
15.00	01500 PATIENT ACTIVITIES	1, 058	0	0	318, 592	1, 058	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 SKILLED NURSING FACILITY	17, 131	0	0	5, 926, 682	17, 131	30.00
31.00	03100 NURSING FACILITY	ol	0	0		0	31.00
	03200   CF/IID	o	0	0	0	0	32.00
	03300 OTHER LONG TERM CARE	0	0		_	0	33. 00
00.00	ANCI LLARY SERVI CE COST CENTERS	9			٩		00.00
40.00	04000 RADI OLOGY	0	0	0	7, 801	0	40. 00
41. 00	04100 LABORATORY	0	0			0	1
	04200 I NTRAVENOUS THERAPY	0	0	0	23, 892	0	42. 00
	04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43. 00
	04400 PHYSI CAL THERAPY	727	0		474, 448	727	44. 00
	04500 OCCUPATI ONAL THERAPY	589	0		310, 067	589	45. 00
	04600 SPEECH PATHOLOGY	44	0		89, 542	44	46. 00
	04700 ELECTROCARDI OLOGY	0	0		07, 0.12	0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0	48. 00
	04900 DRUGS CHARGED TO PATIENT		0	Ö	234, 605	0	49. 00
	05100 SUPPORT SURFACES		0				
31.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1	42, 730	0	31.00
71 00	07100 AMBULANCE	0	0	0	50, 892	0	71. 00
71.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		· · · · · · · · ·	30, 072		71.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100   NTEREST EXPENSE						81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
	08300 H0SPI CE	0	0		٥	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	31, 493	1, 275, 975	-2, 009, 689	10, 824, 137		89. 00
07.00	NONREI MBURSABLE COST CENTERS	31,473	1, 273, 773	-2,007,007	10, 024, 137	25, 071	07.00
90 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	O	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	1		0	
	09200 PHYSICIANS PRIVATE OFFICES		0	l .		0	
	09300 NONPAI D WORKERS		0		_	0	93. 00
	09400 PATIENTS LAUNDRY		0	_		0	94.00
98. 00	Cross Foot Adjustments	٩	0	Ĭ	Ĭ	O	98. 00
99. 00	Negative Cost Centers						99.00
102.00		1, 218, 585	256, 049		2, 009, 689	809, 943	1
102.00	Part I)	1, 210, 303	230, 049		2,007,007	007, 743	102.00
103.00		38. 693837	0. 200669		0. 185667	31. 550894	103 00
103.00		33.073037	0. 200007 N		79, 825	150, 488	
10 1.00	Part II)		0		, ,, 023	150, 400	
105.00			0. 000000		0. 007375	5. 862179	105. 00
		. '		•	, '		•

Provider No.: 315449 | Period: From 01/01/2022 | Provider No.: 315449 | Period: From 01/01/2022 | Provider No.: 315449 | Period: Provider No.: 315449 | Per Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

				Ť	0 12/31/2022	Date/Time Pre 5/30/2023 5:4	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	, jui
		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	SERVICES &	
		(PATIENT			(DI DECT NUDS	SUPPLY	
		CENSUS)			(DI RECT NURS HRS)	(COSTED REQUIS.)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
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	38, 069					6. 00
7.00	00700 HOUSEKEEPI NG	0	,	•			7. 00
8.00	00800 DI ETARY	0	4, 046		155 077		8.00
9. 00 10. 00	OO9OO   NURSI NG ADMI NI STRATI ON   O10OO   CENTRAL SERVI CES & SUPPLY	0	165 0	0	155, 077	0	9. 00 10. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		95	1 0	0	0	12. 00
13. 00	01300 SOCIAL SERVICE	0	224	0	0	0	13. 00
	01500 PATIENT ACTIVITIES	0		Ö	o	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	_	.,,,,,,	-	-1		
30.00	03000 SKILLED NURSING FACILITY	38, 069	17, 131	114, 207	155, 077	0	30. 00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200   CF/IID	0	0	0	0	0	32. 00
33.00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
	ANCI LLARY SERVI CE COST CENTERS		1	1			
40.00	04000 RADI OLOGY	0	1		0	0	1
41. 00	04100 LABORATORY	0	0	0	0	0	
42. 00 43. 00	04200   INTRAVENOUS THERAPY   04300   OXYGEN (INHALATION) THERAPY	0	0	0	0	0	
44. 00	04400 PHYSI CAL THERAPY	0	727		0	0	1
45. 00	04500 OCCUPATIONAL THERAPY		589	•		0	1
46. 00	04600 SPEECH PATHOLOGY	0	44	0	o	0	1
47. 00	04700 ELECTROCARDI OLOGY	0	0	Ō	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 PATIENT	0	0	0	0	0	49. 00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
	OTHER REIMBURSABLE COST CENTERS						
71. 00	07100 AMBULANCE	0	0	0	0	0	71. 00
00.00	SPECIAL PURPOSE COST CENTERS	I	I	I			00.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	08100   INTEREST EXPENSE   08200   UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	0	0	_		0	
89. 00	SUBTOTALS (sum of lines 1-84)	38, 069	24, 079	114, 207	155, 077	0	1
07.00	NONREI MBURSABLE COST CENTERS	30,007	21,077	111,207	100,011		07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93.00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers	074 505		4 700 050	407 470		99. 00
102.00		371, 595	676, 642	1, 793, 352	427, 179	0	102. 00
102.00	Part I)   Unit cost multiplier (Wkst. B, Part I)	9. 761092	20 100010	15 702445	2 754425	0. 000000	102 00
103.00 104.00		9. 761092 36, 824					103.00
104.00	Part II)	30, 824	40, 310	170, 702	10, 223	U	104.00
105.00	1 1 ,	0. 967296	1. 674405	1. 722329	0. 065922	0. 000000	105. 00

Provi der No.: 315449

				10	5/30/2023 5:4	
				OTHER GENERAL		
				SERVI CE		
	Cost Center Description		SOCIAL SERVICE			
		RECORDS &		ACTI VI TI ES		
		LI BRARY	(PATI ENT	(PATIENT DAYS)		
		(PATI ENT	CENSUS)			
		CENSUS)	40.00	45.00		
CENE	ERAL SERVICE COST CENTERS	12.00	13. 00	15. 00		
	00 CAP REL COSTS - BLDGS & FIXTURES					1.00
	00 EMPLOYEE BENEFITS					3.00
	DO ADMINISTRATIVE & GENERAL					4.00
	DO PLANT OPERATION, MAINT. & REPAIRS					5.00
	00 LAUNDRY & LINEN SERVICE					6.00
	DO HOUSEKEEPING					7. 00
	DO DI ETARY					8.00
	OO NURSING ADMINISTRATION					9. 00
	00 CENTRAL SERVICES & SUPPLY					10.00
	DO MEDICAL RECORDS & LIBRARY	38, 069				12. 00
•	00 SOCIAL SERVICE	0	38, 069			13. 00
•	DO PATIENT ACTIVITIES	o o	00,007			15. 00
	ATIENT ROUTINE SERVICE COST CENTERS		-	, ,,,,,,,		1
	OO SKILLED NURSING FACILITY	38, 069	38, 069	38, 069		30.00
	NURSING FACILITY	0	0	0		31.00
32.00 0320	DO I CF/IID	0	0	o		32. 00
33.00 0330	OO OTHER LONG TERM CARE	0	0	o		33. 00
	LLARY SERVICE COST CENTERS					
40.00 0400	OO RADI OLOGY	0	0	0		40. 00
41.00 0410	DO LABORATORY	0	0	o		41.00
42.00 0420	00 INTRAVENOUS THERAPY	0	0	0		42.00
43.00 0430	OO OXYGEN (INHALATION) THERAPY	0	0	0		43.00
44.00 0440	DO PHYSI CAL THERAPY	0	0	0		44.00
45.00 0450	OO OCCUPATI ONAL THERAPY	0	0	0		45.00
46.00 0460	OO SPEECH PATHOLOGY	0	0	0		46. 00
47.00 0470	00 ELECTROCARDI OLOGY	0	0	0		47. 00
48. 00 0480	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		48. 00
49.00 0490	DO DRUGS CHARGED TO PATIENT	0	0	0		49. 00
51.00 0510	00 SUPPORT SURFACES	0	0	0		51. 00
	R REIMBURSABLE COST CENTERS					
	DO AMBULANCE	0	0	0		71. 00
	CIAL PURPOSE COST CENTERS			1		
	DO MALPRACTICE PREMIUMS & PAID LOSSES					80.00
1	DO I NTEREST EXPENSE					81.00
	DO UTILIZATION REVIEW - SNF		•			82.00
	OO HOSPI CE	0	0 00	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	38, 069	38, 069	38, 069		89. 00
	REIMBURSABLE COST CENTERS DO GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	O		90.00
•	DO BARBER AND BEAUTY SHOP	0	0	0		91.00
	00 PHYSICIANS PRIVATE OFFICES	0	0	0		92.00
	OO NONPALD WORKERS	0	0			93.00
	00 PATIENTS LAUNDRY	0	0	1		94. 00
98. 00	Cross Foot Adjustments	0	0			98. 00
99. 00	Negative Cost Centers			•		99.00
102.00	Cost to be allocated (per Wkst. B,	10, 026	178, 467	440, 856		102.00
102.00	Part I)	10,020	170, 407	440, 650		102.00
103. 00	Unit cost multiplier (Wkst. B, Part I)	0. 263364	4. 687988	11. 580446		103. 00
104. 00	Cost to be allocated (per Wkst. B,	4, 419	11, 382			104. 00
	Part II)	', 11/	11,302	31, 202		1.51.55
105. 00	Unit cost multiplier (Wkst. B, Part	0. 116079	0. 298983	1. 346555		105. 00
	11)					
•	·					

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS   Provider No.: 315449   Peri od: From 01/01/2022   To 12/31/2022   To 12/31/202   To 12/31/20	Heal th	Financial Systems	ALARIS HEALTH AT WE	ST ODANGE		In Li	eu of Form CMS-2	2540_10
To   12/31/2022   Date/Time Prepared:   5/30/2023 5: 40 pm				_		Peri od:	Worksheet C	2340-10
Wkst. B, Pt I, col. 18)							Date/Time Pre	
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00		Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
ANCILLARY SERVICE COST CENTERS					Wkst. B, Pt I	,	di vi ded by	
ANCI LLARY SERVI CE COST CENTERS   40. 00   04000   RADI OLOGY   9, 249   0   0. 000000   40. 00					col . 18)		col. 2	
40. 00       04000 RADI OLOGY       9, 249       0       0.000000       40.00         41. 00       04100 LABORATORY       19, 162       0       0.000000       41.00         42. 00       04200 I NTRAVENOUS THERAPY       28, 328       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       605, 903       644, 295       0.940412       44.00         45. 00       04500 OCCUPATI ONAL THERAPY       402, 770       566, 194       0.711364       45.00         46. 00       04600 SPEECH PATHOLOGY       108, 791       202, 057       0.538417       46.00         47. 00       04700 ELECTROCARDI OLOGY       0       0       0.000000       47.00         48. 00       04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0.000000       48.00         49. 00       04900 DRUGS CHARGED TO PATI ENT       278, 163       234, 605       1.185665       49.00         51. 00       00TPATI ENT SERVI CE COST CENTERS       50, 671       0       0.000000       71.00         71. 00       07100 AMBULANCE       60, 341       0       0.000000       71.00 <td></td> <td></td> <td></td> <td></td> <td>1. 00</td> <td>2. 00</td> <td>3. 00</td> <td></td>					1. 00	2. 00	3. 00	
41. 00       04100 LABORATORY       19, 162       0       0.000000       41. 00         42. 00       04200 INTRAVENOUS THERAPY       28, 328       0       0.000000       42. 00         43. 00       04300 OXYGEN (INHALATION) THERAPY       0       0       0.000000       43. 00         44. 00       04400 PHYSI CAL THERAPY       605, 903       644, 295       0. 940412       44. 00         45. 00       04500 OCCUPATI ONAL THERAPY       402, 770       566, 194       0. 711364       45. 00         46. 00       04600 SPEECH PATHOLOGY       108, 791       202, 057       0. 538417       46. 00         47. 00       04700 ELECTROCARDI OLOGY       0       0       0. 000000       47. 00         48. 00       04900 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0. 000000       47. 00         49. 00       04900 DRUGS CHARGED TO PATI ENT       278, 163       234, 605       1. 185665       49. 00         51. 00       05100 SUPPORT SURFACES       50, 671       0       0. 000000       51. 00         0UTPATI ENT SERVI CE COST CENTERS       60, 341       0       0. 000000       71. 00								
42.00   04200   INTRAVENOUS THERAPY   28, 328   0   0.000000   42.00   43.00   04300   0XYGEN (INHALATION) THERAPY   0   0.000000   43.00   44.00   04400   PHYSI CAL THERAPY   605, 903   644, 295   0.940412   44.00   45.00   04500   0CCUPATIONAL THERAPY   402, 770   566, 194   0.711364   45.00   46.00   04600   SPEECH PATHOLOGY   108, 791   202, 057   0.538417   46.00   47.00   04700   ELECTROCARDIOLOGY   0   0   0.000000   47.00   48.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0.000000   47.00   49.00   DRUGS CHARGED TO PATIENT   278, 163   234, 605   1.185665   49.00   51.00   0010000   51.00   00100000   51.00   001000000   51.00   001000000   51.00   001000000   51.00   001000000   51.00   0010000000   51.00   001000000   51.00   001000000000000000000000000000000	40.00	04000 RADI OLOGY			9, 24	9	0.000000	40.00
43. 00	41.00	04100 LABORATORY			19, 16	2	0.000000	41. 00
44. 00       04400 PHYSI CAL THERAPY       605, 903       644, 295       0. 940412       44. 00         45. 00       04500 OCCUPATI ONAL THERAPY       402, 770       566, 194       0. 711364       45. 00         46. 00       04600 SPEECH PATHOLOGY       108, 791       202, 057       0. 538417       46. 00         47. 00       04700 ELECTROCARDI OLOGY       0       0       0. 000000       47. 00         48. 00       04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0. 000000       48. 00         49. 00       04900 DRUGS CHARGED TO PATI ENT       278, 163       234, 605       1. 185665       49. 00         51. 00       05100 SUPPORT SURFACES       50, 671       0       0. 000000       51. 00         0UTPATI ENT SERVI CE COST CENTERS       60, 341       0       0. 000000       71. 00	42.00	04200 I NTRAVENOUS THERAPY			28, 32	8	0.000000	42. 00
45. 00	43.00	04300 OXYGEN (INHALATION) THERAPY				0	0.000000	43.00
46. 00	44.00	04400 PHYSI CAL THERAPY			605, 90	3 644, 29	0. 940412	44. 00
47. 00   04700   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0	45.00	04500 OCCUPATI ONAL THERAPY			402, 77	0 566, 19	0. 711364	45. 00
48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0.000000   48. 00   49. 00   0.000000   51. 00   0.0000000   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000	46.00	04600 SPEECH PATHOLOGY			108, 79	1 202, 05	0. 538417	46. 00
49. 00   04900   DRUGS CHARGED TO PATIENT   278, 163   234, 605   1. 185665   49. 00   05100   SUPPORT SURFACES   50, 671   0   0. 0000000   51. 00   00000000000000000000000000000000	47.00	04700 ELECTROCARDI OLOGY				0	0.000000	47. 00
51. 00 05100 SUPPORT SURFACES 50, 671 0 0. 000000 51. 00 0UTPATIENT SERVICE COST CENTERS  71. 00 07100 AMBULANCE 60, 341 0 0. 000000 71. 00	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS				o	0.000000	48. 00
OUTPATI ENT SERVI CE COST CENTERS           71. 00         07100         AMBULANCE         60, 341         0         0.000000         71. 00	49.00	04900 DRUGS CHARGED TO PATIENT			278, 16	3 234, 60	1. 185665	49. 00
71. 00 07100 AMBULANCE 60, 341 0 0. 000000 71. 00	51.00	05100 SUPPORT SURFACES			50, 67	1	0. 000000	51.00
		OUTPATIENT SERVICE COST CENTERS				•	•	
100 00 Total 1 563 378 1 647 151 100 00	71.00	07100 AMBULANCE			60, 34	1	0.000000	71. 00
1,00,00	100.00	Total			1, 563, 37	1, 647, 15	1	100. 00

Health Financial Systems	ALARIS HEALTH A	AT WEST ORANGE		In Li€	eu of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 5:4	pared: O pm
		Title	XVIII (1)	Skilled Nursing Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2.00	3.00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					1
ANCI LLARY SERVI CE COST CENTERS  40. 00 04000 RADI OLOGY	0.000000				0	40.00
41. 00   04100   LABORATORY	0. 000000			0	0	
42. 00   04200   NTRAVENOUS THERAPY	0. 000000				0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
44. 00   04400 PHYSI CAL THERAPY	0. 940412			0 268, 995	-	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	0. 711364			0 181, 176		45. 00
46. 00 04600 SPEECH PATHOLOGY	0. 538417			0 46, 956	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000	o		0 0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	o		0 0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENT	1. 185665	0		0 0	0	49.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
71.00   07100   AMBULANCE (2)	0. 000000			0		71. 00
100.00   Total (Sum of lines 40 - 71)		627, 939		0 497, 127	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.					

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

Health Financial Systems ALARIS HEALTH AT WEST ORANGE In Lieu of Form CMS-2540-10							
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315449	Peri od: From 01/01/2022 To 12/31/2022		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
	DART II ARRORTIONMENT OF MACCINE COST					1.00	
1. 00 2. 00 3. 00	PART II - APPORTIONMENT OF VACCINE COST  Drugs charged to patients - ratio of co Program vaccine charges (From your reco Program costs (Line 1 x line 2) (Title E, Part I, line 18)	ords, or the PS	&R)		•	1. 185665 18, 936 22, 452	1. 00 2. 00 3. 00
	Cost Center Description	Total Cost	Nursing &	Ratio of		Part A Nursing	
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col.	(From Wkst. B, Part I, Col.	Costs to Tota		Health Costs for Pass	
		18	14)	Costs - Part		Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		0 X 001. 1)	
		1, 00	2, 00	3.00	4, 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	9, 249	C	0.00000	00	0	40. 00
	04100 LABORATORY	19, 162	C	0.00000	00	0	41. 00
	04200 INTRAVENOUS THERAPY	28, 328	C	0.00000		0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	1	0.00000		0	43. 00
	04400 PHYSI CAL THERAPY	605, 903		0.00000		<b>l</b>	44. 00
	04500 OCCUPATI ONAL THERAPY	402, 770		0.00000		<b>l</b>	45. 00
	04600 SPEECH PATHOLOGY	108, 791	C	0.00000		l	46. 00
	04700 ELECTROCARDI OLOGY	0		0.00000		0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.00000		0	48. 00
	04900 DRUGS CHARGED TO PATIENT	278, 163		0.00000		0	49. 00
	O5100  SUPPORT SURFACES   Total (Sum of Lines 40 - 52)	50, 671 1, 503, 037		0.00000		0	51. 00 100. 00
100.00		1, 503, 037	1	'I	497, 127	l 0	100.00

MPUTA	TION OF INPATIENT ROUTINE COSTS	Provi der No.: 315449	Peri od:	Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Parts I-II Date/Time Prep 5/30/2023 5:40	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS NPATIENT DAYS				-
	Inpatient days including private room days			38, 069	1
	Private room days			0	
	Inpatient days including private room days applicable to the	Program		4, 864	
	Medically necessary private room days applicable to the Progra			0	
	Total general inpatient routine service cost			11, 270, 448	
F	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges			13, 276, 225	
	General inpatient routine service cost/charge ratio (Line 5 o	divided by line 6)		0. 848920	7
	Enter private room charges from your records			0	
	Average private room per diem charge (Private room charges li 2)	ne 8 divided by private	room days, line	0.00	9
	Enter semi-private room charges from your records			0	
	Average semi-private room per diem charge (Semi-private room semi-private room days)	charges line 10, divide	d by	0. 00	1
	Average per diem private room charge differential (Line 9 min	us line 11)		0.00	1:
	Average per diem private room cost differential (Line 7 times			0.00	13
00	00 Private room cost differential adjustment (Line 2 times line 13)			0	14
-	General inpatient routine service cost net of private room co PROGRAM INPATIENT ROUTINE SERVICE COSTS	st differential (Line 5	minus line 14)	11, 270, 448	15
	Adjusted general inpatient service cost per diem (Line 15 di	vided by line 1)		296. 05	16
00	Program routine service cost (Line 3 times line 16)	,		1, 439, 987	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	7 plus line 18)		1, 439, 987	19
	Capital related cost allocated to inpatient routine service on line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	1, 146, 492	20
	Per diem capital related costs (Line 20 divided by line 1)			30. 12	
	Program capital related cost (Line 3 times line 21)			146, 504	
	Inpatient routine service cost (Line 19 minus line 22)			1, 293, 483	
	Aggregate charges to beneficiaries for excess costs (From pro		1: 24)	1 202 402	
	Total program routine service costs for comparison to the cos	t limitation (Line 23 mi	nus line 24)	1, 293, 483	
	Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the p	or diam limitation line	24) (1)		26
	Reimbursable inpatient routine service costs (Line 22 plus -tl		, , ,		28
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		,		20
Li n	es 26 and 27 are not applicable for title XVIII, but may be u	sed for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH	1		
	Total SNF inpatient days			38, 069	
	Program inpatient days (see instructions)		VI V	4, 864	
	Total nursing & allied health costs. (see instructions) (Do no	t complete for titles V	or XIX)	0 127740	1 ~
00	Nursing & allied health ratio. (line 2 divided by line 1)			0. 127768	4

Health Financial Systems	ALARIS HEALTH AT W	EST ORANGE	In Lieu of Form CMS-2540-10			
CALCULATION OF REIMBURSEMENT SETTLEM	ENT FOR TITLE XVIII	Provi der No.: 315449	From 01/01/2022	Worksheet E Part I Date/Ti me Prepared: 5/30/2023 5:40 pm		
		Title XVIII	Skilled Nursing	PPS		

		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT		1.00	
1.00	Inpatient PPS amount (See Instructions)	LIVILINI		3, 280, 209	1. 00
2.00	Nursing and Allied Health Education Activities (pass through pa	vments)		3, 200, 207	
3.00	Subtotal (Sum of lines 1 and 2)	ymerres)		3, 280, 209	
4.00	Primary payor amounts			40, 032	4. 00
5. 00	Coinsurance			548, 101	5. 00
6.00	Allowable bad debts (From your records)			600, 548	
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		78, 240	
8.00	Adjusted reimbursable bad debts. (See instructions)			390, 356	
9. 00	Recovery of bad debts - for statistical records only			0	
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			3, 082, 432	
12. 00	Interim payments (See instructions)			3, 045, 855	
13.00	Tentati ve adjustment			0	1
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)			4, 919	14. 75
14. 99	9 Sequestration amount (see instructions)				14. 99
15.00	Balance due provider/program (see Instructions)			-2, 461	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 - T	TITLE XVIII ONLY		
17. 00	Ancillary services Part B				17. 00
18. 00	Vaccine cost (From Wkst D, Part II, line 3)			22, 452	
19. 00	Total reasonable costs (Sum of lines 17 and 18)			22, 452	
20. 00	Medicare Part B ancillary charges (See instructions)			18, 936	
21. 00	Cost of covered services (Lesser of line 19 or line 20)			18, 936	
22. 00	Primary payor amounts			0	
23. 00	Coinsurance and deductibles			0	
24. 00	Allowable bad debts (From your records)	-+!>		0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	CTIONS)		0	
24. 02	Adjusted reimbursable bad debts (see instructions)			- 1	24. 02 25. 00
25. 00 26. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			18, 936 15, 043	
27. 00	Interim payments (See instructions) Tentative adjustment			15, 043	
28. 00	Other Adjustments (See instructions) Specify			0	28.00
28. 50	Demonstration payment adjustment amount before sequestration			0	
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			238	
29. 00	Balance due provider/program (see instructions)			3, 655	
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2	section 115.2	3, 039	
55.50	1	00 . 0.0 0 2, 0		٥١	, 50. 00

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 5:40 pm PPS

Title XVIII Skilled Nursing

Inpatient Part A				9 ,	Facility		
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00			Inpatien	t Part A	Par	t B	
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero							
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero   Services rendered in the cost reporting period. If none, enter zero   Services rendered in the cost reporting period. If none, enter zero   Services rendered in the cost reporting period. If none, write "NONE" or enter a zero. (1)	1. 00	Total interim payments paid to provider		2, 973, 804		15, 043	1. 00
Services rendered in the cost reporting period. If none, enter zero   Services rendered in the cost reporting period. If none, enter zero   Services rendered in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Services reporting period. Also show date of each payment. If none, write "None and the payment services reporting period. Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Services reporting period. Also show date of each payment. If none, write "NONE" or least report services reporting period. Services report services reporting period. Services report. Servi	2.00	Interim payments payable on individual bills, either		0		0	2.00
Intervence of the properties of the intervence of the intervence of the cost reporting period. Also show date of each payment. If none, write in payment is graph and payment is payment in payment							
1.   1.   1.   1.   1.   1.   1.   1.		services rendered in the cost reporting period. If none,					
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 payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	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   3.02   3.03   3.04   3.05   3.03   3.04   3.05   3.03   3.04   3.05   3.03   3.04   3.05	2 01		00 /22 /2022	70.051			2 01
3.03   3.04   3.05   3.06		ADJUSTMENTS TO PROVIDER	09/22/2022	·		-	
3.04   0							
3.05   Provider to Program   0							
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50				-			
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     3.54   0   0   0   3.53     3.54   0   0   0   3.53     3.59   2.3.99   2.3.99     4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.045,855   15,043     4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.045,855   15,043     4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.045,855   15,043     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)   2.00   0   0   5.01     5.01   TENTATIVE TO PROVIDER   0   0   0   5.03     7.02   TENTATIVE TO PROGRAM   0   0   5.55     5.50   5.51   5.52   0   0   0   5.55     5.50   5.51   5.52   0   0   0   5.55     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0   3.655   6.01     6.01   PROGRAM   0   0   3.655   6.01     6.02   PROVIDER TO PROGRAM   2,461   0   6.02     7.00   Total Medicare program liability (see instructions)   3.043,394   18,698   7.00     7.00   Total Medicare program liability (see instructions)   2.00   Contractor Number   1.00   2.00   Contractor Number	3.05	Provider to Program		U		U	3. 03
3.51   3.52   3.53   0   0   0   3.51   3.52   3.53   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.54   0   0   0   3.54   0   0   0   3.54   0   0   0   3.54   0   0   0   0   0   0   0   0   0	3 50			0		0	3 50
3.52   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.53   3.54   3.99   3.54   3.99   3.98)   72,051   0   3.53   3.54   3.99   3.045,855   72,051   0   3.59   3.54   3.99   3.045,855   15,043   4.00   3.59   3.045,855		ADJUSTINIENTS TO TROURAIN					
3.53   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.59   3.54   3.59   3.045,855   3.54   3.							
3.54   3.99   Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   72,051   0   3.54   3.99   -3.98   3.045,855   15,043   4.00   70   72,051   72				_			
Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   72,051   0   3.99    -3.98				Ĭ			
- 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 0 0 0 5.02 5.03 0 0 0 5.03  Provider to Program  5.50 TENTATIVE TO PROGRAM  5.50 0 0 0 5.51 5.52 0 0 0 0 5.51 5.52 0 0 0 0 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 0 0 5.52 5.99 Letermined 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)  7.00 Total Medicare program liability (see instructions)  8.00 Contractor Name Contractor Number Number (Contractor Number Number)  1.00 2.00		Subtotal (Sum of Lines 3 01 - 3 49 minus sum of Lines 3 50		72 051			
A.00   Total interim payments (sum of lines 1, 2, and 3.99)   3,045,855   15,043   4.00	0. , ,	`		, 2, 00.			0. ,,
26 for Part B	4.00			3, 045, 855		15, 043	4.00
TO BE COMPLETED BY CONTRACTOR		(Transfer to Wkst. E, Part I line 12 for Part A, and line					
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   O		26 for Part B)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
Solution   Solution				_		_	
Description		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATIVE TO PROGRAM	5.03	Durani dan ta Dirangan		U		0	5. 03
5.51 5.52 5.99 Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 5.51 0 0 5.52 0 0 5.99 - 5.98) 0 0 5.99 - 5.98) 0 0 5.99 - 6.00 - 7.00 Total Medicare program liability (see instructions)  1.00 Contractor Name Contractor Name Contractor Number 1.00 2.00	E			0			E E0
Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		TENTATIVE TO PROGRAW					
5.99   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   3,655   6.01   6.02   PROVIDER TO PROGRAM   2,461   0   6.02   7.00   Total Medicare program liability (see instructions)   3,043,394   18,698   7.00   Contractor Name   Contractor Number   1.00   2.00							
- 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)  0		Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50)		0			
the cost report. (1) PROGRAM TO PROVIDER 6. 01 PROVIDER TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Name Contractor Number 1. 00 3, 655 6. 01 2, 461 0 6. 02 3, 043, 394 18, 698 7. 00  Contractor Number 1. 00 2. 00		- 5. 98)					
6. 01 PROGRAM TO PROVIDER 0 3, 655 6. 01 6. 02 PROVIDER TO PROGRAM 2, 461 0 6. 02 7. 00 Total Medicare program liability (see instructions) 3, 043, 394 18, 698 7. 00  Contractor Name Contractor Number 1. 00 2. 00	6. 00						6. 00
6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions)  2, 461 0 6.02 3, 043, 394 18, 698 7.00  Contractor Name Contractor Number 1.00 2.00	/ O1					2 /55	( 01
7.00         Total Medicare program liability (see instructions)         3,043,394         18,698         7.00           Contractor Name         Contractor Number           1.00         2.00				2 4/4		3, 655	
Contractor Name   Contractor   Number						10 400	
1.00 Number 2.00	7.00	Tiotal medicale program frability (see instructions)					7.00
1.00 2.00				Contract	IOI Name		
				1.	00		
	8. 00	Name of Contractor					8. 00

<sup>8.00 |</sup>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.

Heal th Financial Systems

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

Provi der No.: 315449

oni y)			0 16		5/30/2023 5: 4	O pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	la	1. 00	2.00	3. 00	4. 00	
	Assets CURRENT ASSETS					
1. 00	Cash on hand and in banks	333, 212	0	0	0	1.0
2.00	Temporary investments	0	0	o	0	
3.00	Notes receivable	0	0	0	0	1
4.00	Accounts receivable	2, 500, 446	1	0	0	
5.00	Other receivables	380, 957	0	0	0	1
6. 00	Less: allowances for uncollectible notes and accounts receivable	-388, 400	0	٥	U	6.0
7. 00	Inventory	0	0	0	0	7.0
8. 00	Prepai d expenses	156, 889	0	Ö	0	
9. 00	Other current assets	244, 964	0	o	0	9.0
10. 00	Due from other funds	0	0	0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	3, 228, 068	0	0	0	11. C
	FI XED ASSETS	1				
12.00	Land	0	0		0	
13. 00 14. 00	Land improvements Less: Accumulated depreciation	0			0	
15. 00	Buildings			0	0	
16. 00	Less Accumulated depreciation	0			0	
17. 00	Leasehold improvements	891, 854	l o	o	0	
18. 00	Less: Accumulated Amortization	0	0	O	0	
19. 00	Fi xed equipment	0	0	o	0	19.0
20. 00	Less: Accumulated depreciation	0	0	0	0	20.0
21. 00	Automobiles and trucks	0	0	0	0	21.0
22. 00	Less: Accumulated depreciation	0	0	0	0	1
23. 00	Major movable equipment	1, 916, 337	0	0	0	
24. 00	Less: Accumulated depreciation	-2, 477, 608	0	0	0	1
25. 00	Mi nor equi pment - Depreci abl e	0	0	0	0	
26. 00 27. 00	Minor equipment nondepreciable Other fixed assets	0	0		0	
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	330, 583		- 1	0	
20.00	OTHER ASSETS	330, 303		<u> </u>	0	J 20. C
29. 00	Investments	1, 078, 073	0	ol	0	29.0
30. 00	Deposits on Leases	609, 500	0	o	0	30.0
31. 00	Due from owners/officers	133, 580	0	О	0	31.0
32. 00	Other assets	0	0	O	0	32.0
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 821, 153	0	-	0	
34. 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	5, 379, 804	0	0	0	34.0
	Liabilities and Fund Balances					-
35. 00	CURRENT LIABILITIES Accounts payable	5, 753, 588	0		0	35. C
36. 00	Salaries, wages, and fees payable	172, 665		l ő	0	
37. 00	Payrol I taxes payable	347	Ö	o	0	1
38. 00	Notes & Loans payable (Short term)	368, 766	0	o	0	
39. 00	Deferred income	1, 669, 771	0	o	0	39. C
40. 00	Accel erated payments	0				40.0
41. 00	Due to other funds	0	0	0	0	
42. 00	Other current liabilities	-46, 592			0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	7, 918, 545	0	0	0	43. C
44.00	LONG TERM LIABILITIES				0	144.0
44. 00	Mortgage payable	0	0		0	1
45. 00 46. 00	Notes payable Unsecured Loans	0	1 0		0	
47. 00	Loans from owners:	0			0	
48. 00	Other long term liabilities	0			0	
49. 00	OTHER (SPECIFY)	0	Ö	o	0	
50. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0	0	O	0	
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	7, 918, 545	0	0	0	51. (
	CAPITAL ACCOUNTS					
52. 00	General fund balance	-2, 538, 741				52.0
53. 00	Specific purpose fund		0	_		53. 0
54.00	Donor created - endowment fund balance - restricted			0		54. (
55.00	Donor created - endowment fund balance - unrestricted			0		55. (
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			١	0	56. ( 57. (
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				O	] 50. (
	1 .	1 0 500 744	1		0	59. (
59. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-2, 538, 741	1 0	UI	()	
59. 00 60. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-2, 538, 741 5, 379, 804		o	0	

In Lieu of Form CMS-2540-10 Health Financial Systems ALARIS HEALTH AT WEST ORANGE STATEMENT OF CHANGES IN FUND BALANCES Provider No.: 315449 Peri od: Worksheet G-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 5:40 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period -730, 115 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -1, 536, 947 2.00 Total (sum of line 1 and line 2) 3.00 -2, 267, 062 0 3.00 Additions (credit adjustments) 4.00 4.00 CAPITAL CONTRIBUTIONS 5.00 300,000 0 5.00 6.00 ROUNDI NG 0 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 5 - 9) 300, 001 10.00 Subtotal (line 3 plus line 10) 11.00 -1, 967, 061 0 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 DI VI DENDS 571, 680 0 13.00 14.00 0 14.00 0 0 0 15.00 0 15.00 16.00 0 0 0 16.00 17.00 0 17.00 18.00 Total deductions (sum of lines 13 - 17) 571, 680 18.00 Fund balance at end of period per balance 19.00 -2, 538, 741 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 Additions (credit adjustments) 4.00 4.00 CAPITAL CONTRIBUTIONS 5.00 5.00 ROUNDI NG 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 0 0 11.00 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 12.00 13.00 DI VI DENDS 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

19.00

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

		RIS HEALTH AT WES				eu of Form CMS-	
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der		Peri od:	Worksheet G-2	
					From 01/01/2022 To 12/31/2022		narod:
					10 12/31/2022	5/30/2023 5: 4	0 pm
	Cost Center Description			Inpati ent	Outpati ent	Total	
	·			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY			13, 276, 22	5	13, 276, 225	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 I	ines 1 - 4)		13, 276, 22	:5	13, 276, 225	5. 00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES			1, 647, 15	1 0	1, 647, 151	6. 00
7.00	CLI NI C				0	0	7. 00
8.00	HOME HEALTH AGENCY COST				0	0	8. 00
9.00	AMBULANCE				0	0	9. 00
10.00	RURAL HEALTH CLINIC				0	0	10.00
10. 10	FQHC				0	0	10. 10
11. 00	CMHC				0	0	11. 00
12.00	HOSPI CE				0 0	0	12.00
13.00	ROUTINE CHARGES / BED HOLD			8, 40	11 0	8, 401	13. 00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (T	ransfer column 3	to	14, 931, 77	7 0	14, 931, 777	14. 00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES						
1.00	Operating Expenses (Per Worksheet A, Col. 3, Li	ne 100)				15, 061, 963	1. 00
2.00	Add (Specify)				0		2. 00
3.00					0		3. 00
4.00					0		4. 00
5.00					0		5. 00
6.00					0		6. 00
7.00					0		7. 00
0 00	T-+-1 A-1-1:+: (C£ 1: 2 7)				1		0 00

8.00

9. 00

10.00

11.00

12.00

13. 00 0 14. 00 15, 061, 963 15. 00

8.00

9.00

10.00

11.00

12.00

Total Additions (Sum of lines 2 - 7)

13.00 13.00 14.00 Total Deductions (Sum of lines 9 - 13) 15.00 Total Operating Expenses (Sum of lines 1 and 8, minus line 14)

Deduct (Specify)

Heal th	Financial Systems ALARIS HEALTH AT WES	ST ORANGE	In Lie	u of Form CMS-2	2540-10
STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315449	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 5:40	
				4 00	
1. 00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14	1)		1. 00 14, 931, 777	1. 00
2. 00	Less: contractual allowances and discounts on patients accounts	1)		1, 436, 613	2. 00
3. 00	Net patient revenues (Line 1 minus line 2)			13, 495, 164	
4. 00				15, 061, 963	
5. 00					5. 00
0.00	Other income:			-1, 566, 799	0.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			10, 969	7. 00
8.00	Revenues from communications (Telephone and Internet service)			0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
14 00	Doverno from cale of medical and auraical auralias to ather there	notionto		Λ.	14 00

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

Revenue from sale of drugs to other than patients

Revenue from gifts, flower, coffee shops, canteen

18.00 Revenue from sale of medical records and abstracts

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

Total other income (Sum of lines 6 - 24)

Total other expenses (Sum of lines 27 - 29)

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

Rental of vending machines

Governmental appropriations

Total (Line 5 plus line 25)

Other expenses (specify)

COVI D-19 PHE Funding

Rental of skilled nursing space

16.00

17.00

21.00

24.00

24. 50

25.00

26.00

27.00

28.00

0 18.00

0 19.00

0 20.00

0 22.00

0 23.00

0

Ωl 29.00

0 30.00

-1, 536, 947 31. 00

10, 383

8, 500

29, 852

-1, 536, 947

16.00

17.00

20.00

21.00

22.00

23.00

24.00

24. 50

25.00

26.00

27.00

28.00

29. 00

30.00

PRI OR YEAR

#### ST CLOUD OPERATIONS LLC D/B/A ALARIS HEALTH AT WEST ORANGE

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

ASSETS Current assets		
Cash and cash equivalents	\$	453,107
Cash - restricted (patient funds)	Ψ	125,070
Accounts receivable - net		2,112,045
Escrow deposits		609,500
Due from related entity		508,580
Prepaid expenses and other		156,889
Trepard expenses and other		130,007
Total current assets		3,965,191
Property and equipment - net		330,583
Escrow deposits		1,078,073
•	_	
TOTAL ASSETS	\$	5,373,847
LIABILITIES AND MEMBERS' DEFICIENCY		
Current liabilities		- 0.10 - 1.1
Accounts payable	\$	5,819,644
Accrued expenses		163,586
Accrued and withheld taxes		9,426
Patients' funds payable		120,148
Deposits payable		897,937
Due to landlord		-
Due to related entity		34,793
Due to third party payers	_	867,054
Total current liabilities		7,912,588
Members' deficiency		(2,538,741)

TOTAL LIABILITIES AND MEMBERS' DEFICIENCY

\$ 5,373,847

## ST CLOUD OPERATIONS LLC D/B/A ALARIS HEALTH AT WEST ORANGE

# (a limited liability company) STATEMENTS OF OPERATIONS AND MEMBERS' DEFICIENCY YEAR ENDED DECEMBER 31, 2022

Revenues	\$ 13,307,267
Operating expenses	 14,863,682
Loss from operations	(1,556,415)
Non-operating revenue Interest income Settlement of debt	10,969 -
Stimulus funds	 8,500
NET LOSS	(1,536,946)
Members' deficiency - beginning of year	 (730,115) (2,267,061)
Net members' equity contributed (distributed)	 (271,680)
MEMBERS' DEFICIENCY - END OF YEAR	\$ (2,538,741)

## ST CLOUD OPERATIONS LLC D/B/A ALARIS HEALTH AT WEST ORANGE

### (a limited liability company) STATEMENTS OF CASH FLOWS YEAR ENDED DECEMBER 31, 2022

Cash flows from operating activities	(4.70.50.45)
Net loss	\$ (1,536,946)
Adjustments to reconcile net loss	
to net cash used in operating activities	0.40
Depreciation	84,759
(Increase) decrease in assets	
Accounts receivable	(498,276)
Prepaid expenses and other	296,470
Increase (decrease) in liabilities	
Accounts payable	398,299
Accrued expenses and withheld taxes	1,638
Due to third party payers	302,434
Due from related party	29,262
Due to landlord	-
Patients' funds and deposits payable	 131,278
Net cash used in operating activities	 (791,082)
Cash flows from investing activities	
Purchase of equipment	 (37,383)
Net cash used in investing activities	 (37,383)
Cash flows from financing activities	
Members' equity contributed	300,000
Members' equity distributed	(571,680)
Loans from related entities	-
Medicare advance - loan repayment	 (751,805)
Net cash used in financing activities	 (1,023,485)
Net decrease in cash, restricted cash and cash equivalents	(1,851,950)
Cash, restricted cash and cash equivalents - beginning of year	 4,117,700
CASH, RESTRICTED CASH	
AND CASH EQUIVALENTS - END OF YEAR	\$ 2,265,750

## ST CLOUD OPERATIONS LLC D/B/A ALARIS HEALTH AT WEST ORANGE

### (a limited liability company)

# SUPPLEMENTARY INFORMATION REVENUES

#### YEAR ENDED DECEMBER 31, 2022

				Per Patient Day
Current year				
Medicaid	\$	536,584	\$	261.75
Medicaid - Managed Care		6,260,937		263.39
Private		351,188		422.10
Medicare - Part A		3,956,669		637.45
Medicare - Part A bad debts		(198,281)		(31.94)
HMO		1,733,152		440.45
Hospice	_	403,961		307.43
	_	13,044,210	\$_	342.29
Prior years				
Private		41,731		
Medicaid		(22,265)		
Hospice		(1,785)		
Medicare		(56,998)		
HMO	_	49,701		
	_	10,384		
Ancillary revenue	_	252,673		
Other revenue	_			
TOTAL REVENUES	\$_	13,307,267		