	I Systems required by Law (42 USC 1395g; 42 CFR 413.: since the beginning of the cost reporting po		re to report can resul	t in all interim	u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEAD EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315353	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I, II & III Date/Time Prepared: 5/19/2022 1:15 pm
PART I - COST I	REPORT STATUS				
Provi der use only	 [X] Electronically prepared cost rep [Manually prepared cost report [0] If this is an amended report ent 3.01 [No Medicare Utilization. Enter ' 	ter the numbe		Date: 5/19/20 er resubmitted thi	
Contractor use only	 4. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received:	6. Contractor 7.[N] Firs 8.[N] Last 9. NPR Date: 10.[0]IfI 11. Contracto 12.[F] Medi		Provider CCN Enter number of <u>4</u>	

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OF 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 CRANBURY CENTER (315353) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Dia	ne Morris	Y Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Diane Morris			2
3	Signatory Title	VP OF REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	-47, 727	1, 340	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
7.10	SNF - BASED CORF I	0		0		7.10
100.00	TOTAL	0	-47, 727	1, 340	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.

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI		NBURY CENTE		No.: 315353	Peri od:	n Lieu	of For Workshe		
	X INDENTIFICATION DATA					From 01/01 To 12/31		Part I Date/Ti		
	1.00	2	. 00		3.00			5/19/20	22 1:1	5 pm
	Skilled Nursing Facility and Skilled Nursing	Facility		dress:	5.00					
		PO Box:		7	00001					1.0
		State: NJ CBSA Code		Zip Code: Urban/Rur						2.0
)1		CBSA Code								3.
			Compon	ent Name	Provider CCN	Date Certified		nt Syst 0, or N		
					CCN		V			1
			1	. 00	2.00	3.00	4.00		6.00	
	SNF and SNF-Based Component Identification:		CRANBURY CE	NTED	315353	09/07/1996	N	Р	Р	4.
	Nursing Facility		SKANDUKT CL	NILK	315555			F		5.
00	ICF/IID									6.
	SNF-Based HHA									7.
	SNF-Based RHC SNF-Based FQHC									8.
	SNF-Based CMHC									10.
	SNF-Based OLTC									11.
	SNF-Based HOSPICE SNF-Based CORF									12.
00						From	:	To	:	10.
00	Cost Descriptions Descied (marked (mark))					1.00		2.0		14
	Cost Reporting Period (mm/dd/yyyy) Type of Control (See Enstructions)					01/01/2	4	12/31/	2021	14.
								Y/I		
	Type of Freestanding Skilled Nursing Facility	,						1.0	00	
00	Is this a distinct part skilled nursing facility section 483.5?		meets the r	requi remen	ts set forth	n in 42 CFR		N		16.
00	Is this a composite distinct part skilled nur	sing faci	lity that r	neets the	requirements	s set forth	in	Ν		17.
00	42 CFR section 483.5? Are there any costs included in Worksheet A t organizations as defined in CMS Pub. 15-1, ch							Y		18.
	Miscellaneous Cost Reporting Information									1
	If this is a low Medicare utilization cost re							N		19.
	If line 19 is yes, does this cost report meet utilization cost report, indicate with a "Y",				or filing a	I ow Medi car	e	N		19.
	Depreciation - Enter the amount of depreciati				he method in	ndicated on	Li nes	20 - 22		1
	Straight Line								38, 024	
	Declining Balance Sum of the Year's Digits								(21.
	Sum of line 20 through 22								38, 024	
	If depreciation is funded, enter the balance				0 ()(())				C	24.
	Were there any disposal of capital assets dur Was accelerated depreciation claimed on any a	5		51	. ,	porting per	Sho in	N N		25.
00	(Y/N)	33613 111	the current	. or any p	ITOI COST IE	por tring per	rou:	IN IN		20.
00	Did you cease to participate in the Medicare	program a	t end of th	ne period	to which thi	s cost repo	ort	Ν		27.
00	applies? (Y/N) Was there a substantial decrease in health in	surance p	roportion o	of allowab	le cost from	n prior cost	:	Ν		28.
	reports? (Y/N)						Part	APart B	Other	-
							1.00		3.00	1
	If this facility contains a public or non-pub								1	
	of the lower of the costs or charges enter "Y exemption.	for eac	in componen	t and type	e of service	that quall	Tes To	n the		
	Skilled Nursing Facility						N	N		29.
	Nursing Facility								N	30.
	ICF/IID SNF-Based HHA						N	N	N	31.
	SNF-Based RHC							N		33.
	SNF-Based FQHC							N		34.
	SNF-Based CMHC SNF-Based OLTC							N		35.
						Y/N		1	•	
00	Is the skilled nursing facility located in a	stato the	t contifier	the prov	ider ac a Ch	1.00)	2.0	00	27
00	regardless of the level of care given for Tit				iuei as a SN	VI Y				37.
	Are you legally-required to carry malpractice	i nsuranc	e? (Y/N)			N				38.
00	Is the malpractice a "claims-made" or "occurr			e policy i	S	1				39.
00						1				
00	<u>"claims-made" enter 1. If the policy is "occu</u>	rrenee ,			Premiums	Paid Los	sses S	elf Ins	urance	
	"claims-made" enter 1. If the policy is "occu List malpractice premiums and paid losses:	rrenee ,			Premiums 1.00 1	Paid Los 2.00		elfins 3.0 0		41.

Health Financial Systems	CRANBURY	CENTER		In Lie	eu of Form CMS	-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.:		Period:	Worksheet S-	2
COMPLEX INDENTIFICATION DATA				From 01/01/2021 To 12/31/2021		epared:
					5/19/2022 1:	
					Y/N	
					1.00	
42.00 Are malpractice premiums and paid losse	es reported in other 1	than the Administra	ative and	General cost	N	42.00
center? Enter Y or N. If yes, check box	x, and submit supporti	ng schedule listin	ng cost ce	enters and		
amounts.						
43.00 Are there any home office costs as defi					Y	43.00
44.00 If line 43 is yes, enter the home offic	ce chain number and er	nter the name and a	address of	f the home	HB0067	44.00
office on lines 45, 46 and 47.						
1.00	2.0	0		3.00		
If this facility is part of a chain org	ganization, enter the	name and address	of the ho	me office on the	e lines	
bel ow.						
45.00 Name: GENESIS HEALTHCARE	Contractor's Name: NO	VI TAS	Contracto	or's Number: 1200)1	45.00
46.00 Street: 101 EAST STATE STREET	PO Box:					46.00
47.00 City: KENNETT SQUARE	State: PA		Zip Code:	1934	18	47.00

	EX REIMBURSEMENT QUESTI ONNAI RE	TY HEALTH CARE	rovider No.	: 315353	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time P	
					Y/N	5/19/2022 1:	:15 pm
					1.00	Date 2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites	ses enter in column 1,	"Y" for Y	és or "N"			
~~	Provider Organization and Operation		- <u> </u>				
00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)	the date of the change	e in column	1 2. (see	N		1.
				Y/N	Date	V/I	_
00	Has the provider terminated participation in	the Medicare Program	2.1.f	1.00 N	2.00	3.00	2.
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and in	col umn				
00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offices, d to the provider or i l, or members of the b	drug ts poard	Y			3.
				Y/N	Туре	Date	
				1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepa	and by a Contified D	ublic 1	Y	С		4.
00	Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" for te copy or enter date	-	Ŷ	L.		4.
00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different fr	-om	Ν			5
					Y/N	Legal Oper.	
	Approved Educational Activities				1.00	2.00	_
00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2:	ls the nro	wider the	N	N	6
)0)0	legal operator of the program? (Y/N) Were costs claimed for Allied Health Program Were approvals and/or renewals obtained during	s? (Y/N) see instructi	ons.		N		7.
.0							
	School and/or Allied Health Program? (Y/N) se			5			0.
	School and/or Allied Health Program? (Y/N) se					Y/N	0.
						Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb	d debts? (Y/N) see ins	structions.		st reporting		9
00	Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	d debts? (Y/N) see ins t collection policy ch	structions. nange durir	ng this cos		1.00 Y	9.
00 00	Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	' structions. nange durir ed? If "Y",	ng this cos see instr see instru	ructions.	1.00 Y N N	9. 10. 11.
00 00	Bad Debts Is the provider seeking reimbursement for bar If line 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	d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	' structions. nange durir ed? If "Y",	ng this cos see instr see instru Pa	ructions.	1.00 Y N N Part B	9. 10. 11. 12.
00 00	Bad Debts Is the provider seeking reimbursement for bar If line 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	d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting perioc Description	' structions. nange durir ed? If "Y",	ng this cos see instru See instru Pa Y/N	art A	1.00 Y N N Part B Y/N	9.10.
00 00	Bad Debts Is the provider seeking reimbursement for bar If line 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	d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	' structions. nange durir ed? If "Y",	ng this cos see instr see instru Pa	ructions.	1.00 Y N N Part B	9 10 11
00	Bad Debts Is the provider seeking reimbursement for bad If line 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	d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting perioc Description	' structions. nange durir ed? If "Y",	ng this cos see instru See instru Pa Y/N	art A	1.00 Y N N Part B Y/N	9. 10. 11. 12.
00 00 00 00 00	Bad Debts Is the provider seeking reimbursement for bailf line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to	d debts? (Y/N) see instructions.	' structions. nange durir ed? If "Y",	ng this cos see instru see instru Pa Y/N 1.00	art A	1.00 Y N N Part B Y/N 3.00	9 10 11 12 13
	Bad Debts Is the provider seeking reimbursement for bar If line 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",	d debts? (Y/N) see instructions.	' structions. nange durir ed? If "Y",	ng this cos see instru Pa Y/N 1.00 N	actions.	1.00 Y N N Part B Y/N 3.00 N	9. 10. 11.
	Bad Debts Is the provider seeking reimbursement for bad If line 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 adjustments made to PS&R data for corrections of other PS&R Report	d debts? (Y/N) see instructions.	' structions. nange durir ed? If "Y",	ng this cos see instru see instru Pa Y/N 1.00 N	actions.	1.00 Y N N Part B Y/N 3.00 N	9. 10. 11. 12. 13. 14. 15.
	Bad Debts Is the provider seeking reimbursement for bailf line 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 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 instructions.	' structions. nange durir ed? If "Y",	ng this cos see instru Pa Y/N 1.00 N Y	actions.	1.00 Y N N Part B Y/N 3.00 N Y	9, 10. 11. 12. 13. 14.

Heal th	Financial Systems CRA	NBURY	CENT	ER			In Lieu	」of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH	CARE		Provi der	No.: 315353		eriod:	Worksheet S-2	2
COMPLE	X REIMBURSEMENT QUESTIONNAIRE					To	rom 01/01/2021 0 12/31/2021	Part II Date/Time Pre 5/19/2022 1:1	epared: 5 pm
				1.	00		2. (00	
	Cost Report Preparer Contact Information								
19.00	Enter the first name, last name and the title/position	n	JEAN			F	PRICE		19.00
	held by the cost report preparer in columns 1, 2, and	3,							
	respecti vel y.								
20.00	Enter the employer/company name of the cost report		GENES	SIS HEALTH	CARE				20.00
	preparer.								
21.00	Enter the telephone number and email address of the correport preparer in columns 1 and 2, respectively.	ost	41080	44481		-	JEAN. PRI CE@GENE	SI SHCC. COM	21.00

Heal th	Financial Systems	CRANBURY (CENTER	In Lie	u of Form CMS-2	540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provider No.: 315353	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prep 5/19/2022 1:15	pared:
		Part B Date 4.00				
	PS&R Data					
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	03/19/2022				14. 00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
			3.00			
	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		EIMBURSEMENT ANALYST			19.00
20.00	Enter the employer/company name of the cost r preparer.	report				20.00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems D NURSING FACILITY AND SKILLED NURSIN	CRANBURY		No.: 315353 Pe	eriod:	J of Form CMS-2 Worksheet S-3	
	X STATISTICAL DATA		TTOVIDEI		rom 01/01/2021	Part I Date/Time Prep	
						5/19/2022 1:1	
				Inpa	atient Days/Vis	its	
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
00	SKILLED NURSING FACILITY	154	56, 210	0	3, 218	24, 657	1.
00	NURSING FACILITY	0	0	0		0	2.
)())()		0	0	0	0	0	3. 4.
0	HOME HEALTH AGENCY COST Other Long Term Care	0	0	0	0	0	4. 5.
0	SNF-Based CMHC	0	0				6.
0	SNF-Based CORF						6.
00	HOSPI CE	0	0	0	О	0	7.
0	Total (Sum of lines 1-7)	154	56, 210	0	3, 218	24, 657	8.
		Inpatient D	ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	· · · · · · · · · · · · · · · · · · ·	6.00	7.00	8.00	9.00	10.00	
00	SKILLED NURSING FACILITY	7,744	35, 619	0	137	32	1.
0	NURSING FACILITY	0	0	0		0	2.
0	ICF/IID HOME HEALTH AGENCY COST	0	0			0	3
0	Other Long Term Care	0	0				5.
0	SNF-Based CMHC	, i i i i i i i i i i i i i i i i i i i	0				6.
0	SNF-Based CORF						6.
0	HOSPI CE	0	0	0	0	0	7.
0	Total (Sum of lines 1-7)	7,744	35, 619	0	137	32	8.
		Discha	arges	Aver	age Length of S	stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	- 1
)0)0	SKILLED NURSING FACILITY NURSING FACILITY	217	386 0	0.00 0.00	23.49	770. 53 0. 00	1. 2.
0		0	0	0.00		0.00	3.
0	HOME HEALTH AGENCY COST	, i i i i i i i i i i i i i i i i i i i	0			0100	4.
0	Other Long Term Care	0	0				5.
0	SNF-Based CMHC						6.
0	SNF-Based CORF						6.
0	HOSPICE	0	0	0.00	0.00	0.00	7.
0	Total (Sum of lines 1-7)	217 Average Length	386	0.00 Admis	23.49 si ons	770. 53	8.
		of Stay					
	Component	<u>Total</u> 16.00	<u>Title V</u> 17.00	Title XVIII 18.00	Title XIX 19.00	0ther 20.00	
0	SKILLED NURSING FACILITY	92. 28	0	18.00	19.00	20.00	1.
0	NURSING FACILITY	0.00	0		0	0	2.
0	ICF/IID	0.00			О	0	3.
0	HOME HEALTH AGENCY COST						4.
0	Other Long Term Care	0.00				0	5.
0	SNF-Based CMHC						6.
0 0	SNF-Based CORF HOSPICE	0.00	0	0	0	0	6. 7.
0	Total (Sum of lines 1-7)	92.28	0	150	13	227	8.
	· · · · · · · · · · · · · · · · · · ·	Admi ssi ons	Full Time	Equi val ent	k		
	Component	Total	Employees on	Nonpai d			
	component	Total	Payrol I	Workers			
0		21.00	22.00	23.00			4
0 0	SKILLED NURSING FACILITY NURSING FACILITY	390 0	83. 77 0. 00	0.00 0.00			1. 2.
0	ICF/IID	0	0.00	0.00			3.
0	HOME HEALTH AGENCY COST		0.00	0.00			4.
0	Other Long Term Care	0	0.00	0.00			5.
0	SNF-Based CMHC		0.00	0.00			6.
	SNF-Based CORF		0.00	0.00			6.
0			0.00	0.00			7.
0 00 00	HOSPICE Total (Sum of lines 1-7)	0 390	0. 00 83. 77	0.00 0.00			8.

	Financial Systems	CRANBURY	CENTER		In Li€	eu of Form CMS-2	2540-10
	GE INDEX INFORMATION		Provi der		Period: From 01/01/2021 To 12/31/2021		
		Amount	Reclass. of	Adj usted		Average Hourly	
			Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	4, 820, 709	C	4, 820, 70	9 174, 245. 00	27.67	1.00
2.00	Physician salaries-Part A	0	C		0.00	0.00	2.00
3.00	Physician salaries-Part B	0	C		0 0.00	0.00	3.00
4.00	Home office personnel	0	C		0 0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	C		0 0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	4, 820, 709	C	4, 820, 70	9 174, 245. 00	27.67	6.00
7.00	Other Long Term Care	0	C		0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	C)	0 0.00	0.00	8.00
9.00	СМНС	0	C)	0 0.00	0.00	9.00
9.10	CORF						9.10
10.00	HOSPI CE	0	C)	0 0.00	0.00	10.00
11.00	Other excluded areas	0	C)	0 0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	C)	0 0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line	4, 820, 709	C	4, 820, 70	9 174, 245. 00	27.67	13.00
	12)						
	OTHER WAGES & RELATED COSTS				_	-	
14.00	Contract Labor: Patient Related & Mgmt	2, 359, 809	C	2, 359, 80			14.00
15.00	Contract Labor: Physician services-Part A	28, 512	C	28, 51			15.00
	Home office salaries & wage related costs	512, 260	C	512, 26	0 9, 563. 00	53.57	16.00
	WAGE-RELATED COSTS			1	_		
17.00	Wage-related costs core (See Part IV)	1, 158, 192	C	1, 158, 19	2		17.00
18.00	Wage-related costs other (See Part IV)	0	C		0		18.00
19.00	Wage related costs (excluded units)	0	C		0		19.00
20.00	Physician Part A - WRC	0	C		0		20.00
21.00	Physician Part B - WRC	0	C		0		21.00
22.00	Total Adjusted Wage Related cost (see	1, 158, 192	C	1, 158, 19	2		22.00
	instructions)						

Amount Reported Reclass. of Salaries from Worksheet A-6 Adjusted Salaries (col. 1 ± col. 2) Part III Date/Time Pr Salaries (col. Salary in col. 3 Average Hourl Wage (col. 3 col. 4) PART 111 - OVERHEAD COST - DI RECT SALARI ES 0 <th>2540-10</th> <th>eu of Form CMS-2</th> <th>In Lie</th> <th></th> <th>CENTER</th> <th>CRANBURY</th> <th>Financial Systems</th> <th>Heal th</th>	2540-10	eu of Form CMS-2	In Lie		CENTER	CRANBURY	Financial Systems	Heal th
PART 111 - OVERHEAD COST - DI RECT SALARI ES Amount Reported Recl ass. of Sal ari es from Worksheet A-6 Adj usted Sal ari es (col. 1 ± col. 2) Paid Hours Rel ated to Sal ari es (col. 1 ± col. 2) Paid Hours Rel ated to Sal ari es (col. 3 Average Hourl Rel ated to Sal ari es (col. 1 ± col. 2) Paid Hours Rel ated to Sal ari es (col. 3 Paid Hours Rel ated to Sal ary in col. 3 Average Hourl Rel ated to Sal ary in col. 3 1.00 2.00 3.00 4.00 5.00 2.00 Admini strati ve & General 407, 850 0 0 0.00 0.00 2.00 Admini strati ve & General 407, 850 0 407, 850 12, 950.00 31.4 3.00 Plant Operation, Maintenance & Repairs 117, 150 0 117, 150 4, 268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0.00 0.00 0.00 5.00 Housekeepi ng 0 0 0 0.00 0.00 0.00 0.00 6.00 Di etary 0 35, 984 35, 984 1, 552.00 23.1 9.00 Pharmacy 0			rom 01/01/2021	F	Provi der		AGE INDEX INFORMATION	SNF WAG
PART 111 - OVERHEAD COST - DIRECT SALARIES 0		5/19/2022 1:15						
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$		Average Hourly				Amount		
PART 111 - OVERHEAD COST - DIRECT SALARIES 1.00 2.00 3.00 4.00 5.00 1.00 Employee Benefits 0 0 0.00 0.00 2.00 Administrative & General 407,850 0 0.00 0.00 3.14 3.00 Plant Operation, Maintenance & Repairs 117,150 0 117,150 4,268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0.00 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 0.00 0.00 0.00 6.00 Dietary 0 0 0 0.00 <td< td=""><td>+</td><td>Wage (col. 3 ÷</td><td></td><td></td><td></td><td>Reported</td><td></td><td></td></td<>	+	Wage (col. 3 ÷				Reported		
PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0 0 0.00 0.00 2.00 Administrative & General 407,850 0 407,850 12,950.00 31.4 3.00 Plant Operation, Maintenance & Repairs 117,150 0 117,150 4,268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 6.00 Dietary 0 0 0 0.00 0.00 7.00 Nursing Administration 553,726 -72,375 481,351 11,046.00 43.5 8.00 Central Services and Supply 0 35,984 35,984 15,52.00 23.1 9.00 Pharmacy 0 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8		col. 4)	Salary in col.	1 ± col. 2)	Worksheet A-6			
PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0 0 0.00 0.00 2.00 Administrative & General 407,850 0 407,850 12,950.00 31.4 3.00 Plant Operation, Maintenance & Repairs 117,150 0 117,150 4,268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 6.00 Dietary 0 0 0 0.00 0.00 7.00 Nursing Administration 553,726 -72,375 481,351 11,046.00 43.5 8.00 Central Services and Supply 0 35,984 35,984 15,52.00 23.1 9.00 Pharmacy 0 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8			3					
1.00 Employee Benefits 0 0 0 0.00 0.00 2.00 Administrative & General 407,850 0 407,850 12,950.00 31.4 3.00 Plant Operation, Maintenance & Repairs 117,150 0 117,150 4,268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 6.00 Dietary 0 0 0.00 0.00 0.00 7.00 Nursing Administration 553,726 -72,375 481,351 11,046.00 43.5 8.00 Central Services and Supply 0 35,984 35,984 1,552.00 23.1 9.00 Pharmacy 0 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8	_	5.00	4.00	3.00	2.00	1.00		
2.00 Administrative & General 407,850 0 407,850 12,950.00 31.4 3.00 Plant Operation, Maintenance & Repairs 117,150 0 117,150 4,268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 0.00 6.00 Dietary 0 0 0 0.00 0.00 0.00 7.00 Nursing Administration 553,726 -72,375 481,351 11,046.00 43.5 8.00 Central Services and Supply 0 35,984 35,984 1,552.00 23.1 9.00 Pharmacy 0 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8					i			1
3.00 Plant Operation, Maintenance & Repairs 117,150 0 117,150 4,268.00 27.4 4.00 Laundry & Linen Service 0 0 0 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 0.00 6.00 Dietary 0 0 0 0.00 0.00 0.00 7.00 Nursing Administration 553,726 -72,375 481,351 11,046.00 43.5 8.00 Central Services and Supply 0 35,984 35,984 1,552.00 23.1 9.00 Pharmacy 0 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8	0 1.00			0	0	C		
4.00 Laundry & Linen Service 0 0 0 0.00 0.00 5.00 Housekeeping 0 0 0 0.00 0.00 6.00 Dietary 0 0 0 0.00 0.00 7.00 Nursing Administration 553,726 -72,375 481,351 11,046.00 43.5 8.00 Central Services and Supply 0 35,984 35,984 15,52.00 23.1 9.00 Pharmacy 0 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8								
5.00 Housekeeping 0 0 0.00 <	5 3.00	27.45	4, 268. 00	117, 150	0	117, 150	Plant Operation, Maintenance & Repairs	3.00
6.00 Di etary 0 0 0.00 43.5 35.00 Central Services and Supply 0 35,984 35,984 1,552.00 23.1 9.00 Pharmacy 0 0 0 0.00 <th< td=""><td>4.00</td><td>0.00</td><td>0.00</td><td>0</td><td>0</td><td>C</td><td>Laundry & Linen Service</td><td>4.00</td></th<>	4.00	0.00	0.00	0	0	C	Laundry & Linen Service	4.00
7.00Nursing Administration553,726-72,375481,35111,046.0043.58.00Central Services and Supply035,98435,9841,552.0023.19.00Pharmacy0000.000.0010.00Medical Records & Medical Records Library036,39136,3911,745.0020.8	5.00	0.00	0.00	0	0	C	Housekeepi ng	5.00
8.00 Central Services and Supply 0 35,984 35,984 1,552.00 23.1 9.00 Pharmacy 0 0 0 0 0.00	6.00	0.00	0.00	0	0	C	Dietary	6.00
9.00 Pharmacy 0 0 0.00 0.00 10.00 Medical Records & Medical Records Library 0 36,391 36,391 1,745.00 20.8	3 7.00	43.58	11, 046. 00	481, 351	-72, 375	553, 726	Nursing Administration	7.00
10. 00 Medi cal Records & Medi cal Records Li brary 0 36, 391 36, 391 1, 745. 00 20. 8	8.00	23.19	1, 552. 00	35, 984	35, 984	C	Central Services and Supply	8.00
	9.00	0.00	0.00	0	0	C	Pharmacy	9.00
11. 00 Social Service 148, 860 0 148, 860 30. 7	5 10.00	20.85	1, 745. 00	36, 391	36, 391	C	Medical Records & Medical Records Library	10.00
	0 11.00	30. 70	4, 849. 00	148, 860	0	148, 860	Social Service	11.00
12.00 Nursing and Allied Health Ed. Act.	12.00						Nursing and Allied Health Ed. Act.	12.00
13. 00 Other General Service 125, 854 0 125, 854 6, 058. 00 20. 7	7 13.00	20.77	6, 058. 00	125, 854	0	125, 854	Other General Service	13.00
14.00 Total (sum lines 1 thru 13) 1,353,440 0 1,353,440 42,468.00 31.8	7 14.00	31.87	42, 468. 00	1, 353, 440	0	1, 353, 440	Total (sum lines 1 thru 13)	14.00

Heal th	Financial Systems	CRANBURY CENTER	In Lie	u of Form CMS-2	2540-10
SNF WA	GE RELATED COSTS	Provi der No.: 31535	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prep 5/19/2022 1:1	
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS			1100	
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			45, 734	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contri	bution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Co	ost		0	3.00
4.00	Prior Year Pension Service Cost			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)			
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension PI	an		0	6.00
7.00	Employee Managed Care Program Administratic	on Fees		0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded))		473, 478	8.00
9.00	Prescription Drug Plan			0	9.00
10.00	Dental, Hearing and Vision Plan			0	10.00
11.00	Life Insurance (If employee is owner or ber	nefi ci ary)		0	11.00
12.00	Accident Insurance (If employee is owner or			0	12.0
13.00	Disability Insurance (If employee is owner			0	13.0
14.00	Long-Term Care Insurance (If employee is ow	wner or beneficiary)		0	14.0
15.00	Workers' Compensation Insurance			206, 578	15.0
16.00	Retirement Health Care Cost (Only current y	year, not the extraordinary accrual requi	red by FASB 106.	0	16.0
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			356, 499	
	Medicare Taxes - Employers Portion Only			0	18.00
	Unemployment Insurance			0	19.00
20.00	State or Federal Unemployment Taxes			62, 961	20.00
21 00	OTHER			0	21 0
	Executive Deferred Compensation			0	21.00
22.00	Day Care Cost and Allowances Tuition Reimbursement			0 12, 942	22.00 23.00
23.00		22)		12, 942	
∠4.00	Tiotal waye Related Cost (Sum of Times I - 2	23)		1, 158, 192 Amount	24.00
				Reported	
				1.00	
	Part B - Other than Core Related Cost			1.00	
25 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	CRANBURY	CENTER		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES				Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adj usted Sal ari es (col 1 + col. 2)	. Related to	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	565, 709	209, 650				1.00
2.00	Licensed Practical Nurses (LPNs)	1, 212, 087	260, 717				2.00
3.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	1, 689, 473	501, 906	2, 191, 37	9 36, 668. 00	59.76	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3, 467, 269	972, 273	4, 439, 54			4.00
5.00	Physical Therapists	0	C		0 0.00		
6.00	Physical Therapy Assistants	0	0		0 0.00		
7.00	Physical Therapy Aides	0	0		0 0.00	0.00	7.00
8.00	Occupational Therapists	0	C		0 0.00		8.00
9.00	Occupational Therapy Assistants	0	C		0 0.00		
10.00	Occupational Therapy Aides	0	0		0 0.00		
11.00	Speech Therapists	0	0		0 0.00		
12.00	Respiratory Therapists	0	0		0 0.00		
13.00	Other Medical Staff	0	0		0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations			1		1	
14.00	Registered Nurses (RNs)	165, 587		165, 58			
15.00	Licensed Practical Nurses (LPNs)	168, 399		168, 39			•
16.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	189, 118		189, 11	8 4, 028. 82	46.94	16.00
17.00	Total Nursing (sum of lines 14 through 16)	523, 104		523, 10			
18.00	Physical Therapists	101, 490		101, 49	0 2, 109. 00	48.12	18.00
19.00	Physical Therapy Assistants	68, 363		68, 36	3 1, 866.00	36.64	19.00
20.00	Physical Therapy Aides	0			0.00	0.00	20.00
21.00	Occupational Therapists	168, 612		168, 61			
22.00	Occupational Therapy Assistants	64, 748		64, 74	8 1, 914.00	33.83	22.00
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapists	94, 262		94, 26			
25.00	Respiratory Therapists	1, 585		1, 58			
26.00	Other Medical Staff	28, 512		28, 51	2 335.00	85.11	26.00

lealth Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	CRANBURY CENTER Provider No.: 315353	Peri od:	worksheet S-	
		From 01/01/2021 To 12/31/2021	Date/Time Pr 5/19/2022 1:	repared:
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00		RVX		3.00
4. 00 5. 00		RVL RHX		4.00
5.00		RHL		6.00
7.00		RMX		7.00
3. 00		RML		8.00
9. 00 10. 00		RLX RUC		9.00
11.00		RUB		11.00
12.00		RUA		12.00
13.00		RVC		13.00
14.00 15.00		RVB RVA		14.00
16.00		RHC		16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00 20.00		RMC RMB		19.00
21.00		RMA		20.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00 25.00		ES3 ES2		24.00 25.00
26.00		ES1		26.00
27. 00		HE2		27.00
28.00		HE1		28.00
99.00 30.00		HD2 HD1		29.00
81.00		HC2		31.00
32.00		HC1		32.00
33.00		HB2		33.00
34. 00 35. 00		HB1 LE2		34.00
36.00		LE1		36.00
37. 00		LD2		37.00
38.00		LD1		38.00
39. 00 10. 00		LC2 LC1		39.00 40.00
11.00		LB2		41.00
12.00		LB1		42.00
3.00		CE2		43.00
.4. 00 .5. 00		CE1 CD2		44.00 45.00
6.00		CD1		46.00
7.00		CC2		47.00
8.00		CC1		48.00
9.00 0.00		CB2 CB1		49. 0 50. 0
1.00		CA2		51.0
2.00		CA1		52.0
3. 00 4. 00		SE3 SE2		53.0 54.0
5. 00		SE1		54.0
6. 00		SSC		56.0
7.00		SSB		57.0
3. 00 9. 00		SSA I B2		58.0 59.0
9.00 D.00		I B2		60.0
1.00		I A2		61.0
2.00		I A1		62.0
3. 00 4. 00		BB2 BB1		63. 0 64. 0
5.00		BA2		65.0
6. 00		BA1		66.0
7.00		PE2		67.0
8. 00 9. 00		PE1 PD2		68.0
9.00		PD2 PD1		69. 0 70. 0
1.00		PC2		71.0
2.00		PC1		72.00
3.00		PB2		73.0
4. 00 5. 00		PB1 PA2		74.0 75.0

Health Financial Systems CRANBURY CEN	NTER		In Lieu of Form CMS-2540-10					
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315353	Period:	Worksheet S	-7			
			From 01/01/2021 To 12/31/2021	Date/Time P 5/19/2022 1				
			Group	Days				
			1.00	2.00				
76.00			PA1		76.00			
99.00			AAA		99.00			
100. 00 TOTAL					100.00			
		Expenses	Percentage	Y/N				
		1.00	2.00	3.00				
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)								
101.00 Staffing 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00			

Heal th	Financial Systems	CRANBURY CE	NTER		In Lie	u of Form CMS-2	2540-10
	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF				eriod:	Worksheet A	
				F T	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/19/2022 1:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons Increase/Decre ase (Fr Wkst	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	A-6) 4.00	5.00	
	GENERAL SERVICE COST CENTERS		2.00	0,00		0100	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		1, 975, 286		0	1, 975, 286	1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		0	-	0	0	2.00
3.00 4.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	0 407, 850	1, 149, 792 1, 873, 591	1, 149, 792 2, 281, 441	0	1, 149, 792 2, 281, 441	3.00 4.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	117, 150	421, 848		0	538, 998	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	260, 318		0	260, 318	6.00
7.00	00700 HOUSEKEEPI NG	0	327, 389	327, 389	0	327, 389	7.00
8.00	00800 DI ETARY	0	958, 924		0	958, 924	8.00
9.00	00900 NURSING ADMINISTRATION	553, 726	14, 615		-72, 375	495, 966	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	28, 584 0	28, 584	35, 984 0	64, 568 0	10. 00 11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	390	-	36, 391	36, 781	12.00
13.00	01300 SOCIAL SERVICE	148, 860	611	149, 471	00,071	149, 471	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	125, 854	30, 042	155, 896	0	155, 896	15.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	3, 467, 269	693, 944	4, 161, 213 0	0	4, 161, 213 0	30. 00 31. 00
31.00	03200 I CF/I I D	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	Ő	0	0	0	0	33.00
	ANCI LLARY SERVI CE COST CENTERS	· · · · ·	-				
40.00	04000 RADI OLOGY	0	15, 455		0	15, 455	40.00
41.00	04100 LABORATORY	0	45, 190		0	45, 190	41.00
42.00	04200 INTRAVENOUS THERAPY	0	28, 077		0	28,077	42.00
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0	25, 051 186, 110	25, 051 186, 110	0	25, 051 186, 110	43.00 44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	160, 665		0	160, 665	45.00
46.00	04600 SPEECH PATHOLOGY	0	159, 528		0	159, 528	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	246, 751	246, 751	0	246, 751	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	13, 208	13, 208	0	0 13, 208	50. 00 51. 00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	Ő	13, 200		0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
60.00	06000 CLI NI C	0	0		0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 63.00	06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	62.00 63.00
03.00	OTHER REI MBURSABLE COST CENTERS	<u> </u>	0	0	0	0	03.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100 AMBULANCE	0	0	0	0	0	71.00
72.00	07200 CORF	0	0	0	0	0	72.00
73.00 74.00	07300 CMHC 07400 OTHER REI MBURSABLE COST	0	0	0	0	0	73.00
74.00	SPECIAL PURPOSE COST CENTERS	U	0	0	0	0	74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0	0	0	0	80.00
81.00	08100 INTEREST EXPENSE		0	0	0	0	81.00
82.00	08200 UTI LI ZATI ON REVI EW	0	0	0	0	0	82.00
83.00		0	0	0	0	0	83.00
84.00 89.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	4 820 700	0 415 240	0 12 424 079	0	12 426 079	84.00 89.00
69.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	4, 820, 709	8, 615, 369	13, 436, 078	0	13, 436, 078	69.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	2, 875	2, 875	0	2, 875	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
	09300 NONPAID WORKERS	0	0	0	0	0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	94.00 95.00
95.00 100.00		4, 820, 709	8, 618, 244	13, 438, 953	0	13, 438, 953	
		., 520, 707	0,010,211	1	0	, 100, 700	

CLASSI FI CA	TION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES	Provi der	No.: 315353	Peri od:	Worksheet A
					From 01/01/2021 To 12/31/2021	Date/Time Prepa
	Cost Center Description	Adjustments to	Net Expenses			5/19/2022 1:15
		5	For Allocation	n		
		Wkst A-8)	(col. 5 +-			
		6.00	col. 6)	-		
GENERA	AL SERVICE COST CENTERS	0.00	7.00		<u>.</u>	
	CAP REL COSTS - BLDGS & FIXTURES	0	1, 975, 286	ó		
0 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0				
	EMPLOYEE BENEFITS	2, 303		1		
	ADMINISTRATIVE & GENERAL	-587, 829		1		
	PLANT OPERATION, MAINT. & REPAIRS	0		1		
	LAUNDRY & LINEN SERVICE	0	260, 318	1		
	HOUSEKEEPI NG DI ETARY	0	327, 389	1		
	NURSI NG ADMI NI STRATI ON		958, 924 495, 966	1		
	CENTRAL SERVICES & SUPPLY		64, 568	1		
	PHARMACY		04, 500	1		
	MEDICAL RECORDS & LIBRARY		36, 781			
	SOCIAL SERVICE	0		•		
	NURSING AND ALLIED HEALTH EDUCATION	0	(1		
	ACTI VI TI ES	-28, 512	127, 384	1		
I NPATI	ENT ROUTINE SERVICE COST CENTERS					
00 03000	SKILLED NURSING FACILITY	956	4, 162, 169	9		:
	NURSING FACILITY	0		D		
	ICF/IID	0				
	OTHER LONG TERM CARE	0	(0		
	ARY SERVICE COST CENTERS	-		-		
	RADI OLOGY	0		1		
		0				
	INTRAVENOUS THERAPY	0		1		
	OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY		25, 051 186, 110	1		
	OCCUPATIONAL THERAPY		160, 665	1		
	SPEECH PATHOLOGY	0	159, 528	1		
	ELECTROCARDI OLOGY	0	(0),020	1		
	MEDICAL SUPPLIES CHARGED TO PATIENTS					
	DRUGS CHARGED TO PATIENTS	0	246, 751			
	DENTAL CARE - TITLE XIX ONLY	0		1		
00 05100	SUPPORT SURFACES	0	13, 208	3		
	OTHER ANCILLARY SERVICE COST CENTERS	0	(
	FIENT SERVICE COST CENTERS		1	1		
	CLINIC	0				
	RURAL HEALTH CLINIC	0	0	D		
00 06200						
	OTHER OUTPATIENT SERVICE COST CENTER	0	(ון		
	REI MBURSABLE COST CENTERS HOME HEALTH AGENCY COST	0)		
	AMBULANCE			Ś		
00 07200				á		
00 07200						
	OTHER REIMBURSABLE COST	0				
	AL PURPOSE COST CENTERS			1		
	MALPRACTICE PREMIUMS & PAID LOSSES	0	(
	INTEREST EXPENSE	0	C C			
00 08200	UTILIZATION REVIEW	0	0	p		
	HOSPI CE	0	0	D		
	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0		
	SUBTOTALS (sum of lines 1-84)	-613, 082	12, 822, 996	b		
	MBURSABLE COST CENTERS		1	1		
	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0		
	BARBER AND BEAUTY SHOP	0	2, 875			
	PHYSICIANS PRIVATE OFFICES	0	0			
	NONPAID WORKERS	0		2		
	PATIENTS LAUNDRY	0		2		
	OTHER NONREI MBURSABLE COST CENTERS	0	() I		
. 00	TOTAL	-613, 082	12, 825, 871	l]		10

Health Financial Systems	CRANBURY CENTER			In Lieu of Form CMS-2540-10		
RECLASSI FI CATI ONS		Provi der	No.: 315353	Period: From 01/01/2021	Worksheet A-6	
				To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
			Increases		5/19/2022 1:1	
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
(1) A - DEFAULT						
1.00	CENTRAL SERVICES &	SUPPLY	10. (35, 984	0	1.00
2.00	MEDICAL RECORDS & L	I BRARY	12. (36, 391	0	2.00
TOTALS						
100.00	Total Reclassificat			72, 375	0	100.00
	of columns 4 and 5					
		equal sum of columns 8 and				
	9)					

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

Health Financial Systems CRANBURY CENTER					In Lieu of Form CMS-2540-10			
RECLASSI FI CATI ONS			No.: 315353	Period: From 01/01/2021	Worksheet A-6			
				To 12/31/2021	Date/Time Pre 5/19/2022 1:1			
	Decreases							
	Cost Cente	r	Line #	Sal ary	Non Salary			
	6.00		7.00	8.00	9.00			
(1) A - DEFAULT								
1.00	NURSING ADMINISTRAT	I ON	9. (00 35, 984	0	1.00		
2.00	NURSING ADMINISTRATION 9		9. (36, 391	0	2.00		
TOTALS								
100. 00				72, 375	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.

Heal th	Financial Systems	CRANBURY	CENTER		In Lie	eu of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315353	Period: From 01/01/2021	Worksheet A-7	
					To 12/31/2021	Date/Time Prep 5/19/2022 1:15	
				Acqui si ti on	S		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	<u>S</u>					
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	101, 175	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	66, 525	130, 713		0 130, 713		4.00
5.00	Fixed Equipment	0	11, 179		0 11, 179		5.00
6.00	Movable Equipment	102, 275	49, 072		0 49, 072	0	6.00
7.00	Subtotal (sum of lines 1-6)	269, 975	190, 964		0 190, 964	0	7.00
8.00	Reconciling Items	0	0		0 0	0	8.00
9.00	Total (line 7 minus line 8)	269, 975	190, 964		0 190, 964	0	9.00
	Description	Endi ng Bal ance	Fully				
		-	Depreciated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	S					
1.00	Land	0	0				1.00
2.00	Land Improvements	101, 175	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	197, 238	0				4.00
5.00	Fixed Equipment	11, 179	0				5.00
6.00	Movable Equipment	151, 347	0				6.00
7.00	Subtotal (sum of lines 1-6)	460, 939	0				7.00
8.00	Reconciling Items	0	0				8.00
9.00	Total (line 7 minus line 8)	460, 939	0				9.00

	Financial Systems MENTS TO EXPENSES	CRANBURY C		No . 215252	Period:	u of Form CMS-2	
ADJUS I	MENTS TO EXPENSES		Provi der	No.: 315353	From 01/01/2021 To 12/31/2021	Worksheet A-8 Date/Time Pre 5/19/2022 1:1	pared
				Expense C	lassification on		
					ch the Amount is		
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Adjustment 1.00	2.00		3.00	4.00	
. 00	Investment income on restricted funds	1.00	0		0.00	0.00	1. (
	(chapter 2)						
. 00	Trade, quantity, and time discounts (chapter		0			0.00	2.0
. 00	8) Refunds and rebates of expenses (chapter 8)		0			0,00	3.0
. 00	Rental of provider space by suppliers		0			0.00	
	(chapter 8)		-				
5.00	Telephone services (pay stations excluded)		0			0.00	5.0
00	(chapter 21)		20 512			15.00	
. 00 . 00	Television and radio service (chapter 21) Parking lot (chapter 21)	A	-28, 512	ACTI VI TI ES		15.00 0.00	6. 7.
. 00	Remuneration applicable to provider-based	A-8-2	0			0.00	8.
. 00	physician adjustment	N 0 2	0				0.
. 00	Home office cost (chapter 21)		0			0.00	9.
0. 00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
1. 00	Nonal lowable costs related to certain		0			0.00	11.
2.00	Capital expenditures (chapter 24) Adjustment resulting from transactions with	A-8-1	217, 888				12.
2.00	related organizations (chapter 10)		217,000				
3.00	Laundry and linen service		0			0.00	13.
4.00	Revenue - Employee meals		0			0.00	
5.00	Cost of meals - Guests		0			0.00	
6.00	Sale of medical supplies to other than patients		0			0.00	16.
7.00	Sale of drugs to other than patients		0			0.00	17.
B. 00	Sale of medical records and abstracts		0			0.00	
9.00	Vending machines		0			0.00	19.
0.00	Income from imposition of interest, finance		0			0.00	20.
1 00	or penalty charges (chapter 21)		0			0.00	21
1.00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21.
	overpayments						
2.00	Utilization reviewphysicians' compensation		0	UTI LI ZATI ON	REVIEW	82.00	22.
	(chapter 21)						
3.00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23.
4.00	Depreciationmovable equipment		0	FIXTURES CAP REL COST		2.00	24
4.00			0	EQUI PMENT	5 - WOVADLL	2.00	24.
5.00	MI SC I NCOME	В	-4, 419	ADMI NI STRATI	VE & GENERAL	4.00	25.
5. 01	UNALLOWED A & G	A	-801, 298	ADMI NI STRATI	VE & GENERAL	4.00	
	WORKERS COMPENSATION	A		EMPLOYEE BEN		3.00	
	HEP/SALINE	A			ING FACILITY	30.00	
00.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-613, 082				100.

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

Health Financial Systems	CRANBURY	CENTER		In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS				Period: From 01/01/2021 To 12/31/2021	Worksheet A- Parts I-II Date/Time Pr 5/19/2022 1:	epared:
	Line No.		Center	Expense	e Items	
	1.00		00	3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	S OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE A&C	G	1.00
2.00	4.00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE CAN	PI TAL	2.00
3.00		PHYSICAL THERA		PT		3.00
4.00		OCCUPATI ONAL T		OT		4.00
5.00		SPEECH PATHOLO		ST		5.00
6.00		SKILLED NURSIN		NURSING PURCHAS	SED SERVICES	6.00
7.00		OXYGEN (INHALA				7.00
8.00	4.00	ADMI NI STRATI VE	& GENERAL	MEDICAL DIRECTO	OR	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.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	s		
	Cost	Wkst. A, col.	col. 5)			
		5				
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI CLAIMED HOME OFFICE COSTS:			-		S OR	
1.00	664, 613					1.00
2.00	40, 926		1 10/ /2	26		2.00
3.00	184, 251			0		3.00
4.00	158, 896			0		4.00
5.00	159, 528			0		5.00
6.00	523, 104			0		6.00
7.00	14, 268			0		7.00
8.00	28, 512	28, 512		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 774, 098	1, 556, 210	217, 88	38		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.	1					I

Health Financial Systems	CRANBURY	CENTER	In Lieu of Form CMS-2540-10			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ROM RELATED ORGANIZATIONS AND HOME		From 01/01/2021	Worksheet A-8- Parts I-II Date/Time Prep 5/19/2022 1:15	bared:	
	Symbol (1)	Name	Percentage of Ownership			
	1.00	2.00	3.00			

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

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

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

1.00	В	0.00	1.00
2.00	В	0.00	2.00
3.00	В	0.00	3.00
4.00	В	0.00	4.00
5.00	В	0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in

related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Rel ated Organi	zation(s) and/	or Home Office	
	Name	Percentage of	Type of Business	1
		Ownership		
	4.00	5.00	6.00	1
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(S) AND/OR HOME OFFICE:			

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

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

1.00	GENESIS HEALTHCARE	100.00 MANAGEMENT COMPANY	1.00
2.00	GRS	100.00PT 0T ST	2.00
3.00	GSS	100.00 NURSING PURCHASED SERVICES	3.00
4.00	RHS	100.00 RT	4.00
5.00	GPS	100.00 MEDI CAL DI RECTOR	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.

 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.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

2:00 00200 02AP CCSTS - MOVABLE EQUIPMENT 0 2 0 0:00 00300 AUM POVEL BINNET IVE & CENERAL 1, 693, 612 645, 772 0 99, 795 2, 248, 179 4, 00 0:00 00000 AUM OPERTARY, MAINT & REPAIRS 288, 996 99, 705 22, 248, 179 4, 00 0:00000 LANNEY & LINEN SERVICE 200, 318 69, 777 0 0 26, 662, 662, 662, 662, 662, 662, 662,	Health Financial Systems	CRANBURY	CENTER		_	In Lie	u of Form CMS-2	2540-10
Cost Eenter Rescription Net Function All cost in (ring mission) Provide FixTures Provide FixTures <td>COST ALLOCATION - GENERAL SERVICE COSTS</td> <td></td> <td>Provi der</td> <td>No.: 315353</td> <td>Fro</td> <td>om 01/01/2021</td> <td>Part I Date/Time Pre</td> <td></td>	COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315353	Fro	om 01/01/2021	Part I Date/Time Pre	
TOP COST ALL CONTON (From WAST A D FEXTURES D FEXTURES FEXTURES FEXTURES FEXTURES FEXTURES FEXTURES 1:00 0 1:00 2:00 3:00 30 1:00 0 0:000 (CAP REL COSTS - REAS & FEXTURES FEXTURES 1:975:286 1:975:286 1:975:286 1:975:286 1:00 0:0000 (CAP REL COSTS - REAS & FEXTURES FEXTURES 1:975:286 1:975:286 1:975:286 1:975:286 1:00 0:0000 (CAP REL COSTS - REAS FEXTURES 1:975:286 1:975:286 1:975:286 1:975:286 1:00 0:0000 (FAMT OPERATON, WAINTS A FEXTURES FEXTURES 1:975:286 1:977:00 0:0000 (CAR REL COSTS - REAS FEXTURES FEXTURES 1:975:273,000 1:0.00 1:0.00 0:000 (CAR REL COSTS - REAS FEXTURES FEXTURES 0:000 (CAR REL COSTS - REAS FEXTURES FEXTURES 0:000 (CAR REL COSTS - REAS FEXTURES FEXTURES COST - CAR REAS FEXTURES 0:000 (CAR REL COSTS - REAS FEXTURES FEXTURES COST - CAR REAS FEXTURES			CAPI TAL REL	ATED COSTS			5/19/2022 1:1	5 pm
O 1.00 2.00 3.00 3.4 1.00 00100 (AP RL CGSTS - BLIKS & FLATURES 00000 (AP RL CGSTS - BLIKS & FLATURES 000000 (AP RL CGSTS - BLIKS & FLATURES 000000 (APR NC GSTS - BLIKS & FLATURES 00000 (APR NC GSTS - BLIKS & FLATURES 00000 (APR NC GSTS - BLIKS & FLATURES 00000 (APR NC GSTS - BLIKS & FLATURES 000000 (APR NC GSTS - BLIKS & FLATURES 00000 (APR NC GSTS - BLIKS & FLATURES 00000 (APR NC GST CST ESTERS 00000 (APR NC GST CST ESTERS 00000 (APR NC GST CST ESTERS 000000 (APR NC GST CST ESTERS 000000 (APR NC GST CST ESTERS 000000 (APR NC GST CST ESTERS 00000 (APR NC GST CST ESTERS 00000 (APR NC GST CST ESTERS 000000 (APR NC GST CST ESTERS 000000 (APR NC GST CST ESTERS 000000 (APR NC GST CST CST ESTERS 0000000 (APR NC GST CST CST ESTERS 0000000 (APR NC GST CST CST ESTERS 0000000000 (APR NC GST CST CST ESTERS 0000000 (APR NC GST CST	Cost Center Description	for Cost Allocation					Subtotal	
DECREMAL SERVICE COST CONTERS 1, V75, 286 1, V75, V75 V77 0 0, 00000 V77 0 0, 000000 V77 0			1 00	2 00		3.00	30	
2.00 00200 (AP RFL COSTS - MOVABLE FOULPRENT 0	GENERAL SERVICE COST CENTERS	0	1.00	2.00		3.00	38	
6.00 00600 (LAUNDRY & LINEN SERVICE 260.318 69.777 0 0 330.095 6.00 0.00 00900 (DITARY 966.924 94.697 0 0 1.053.621 8.00 0.00 00900 (DITARY 969.924 94.697 0 0 1.000 0.01003 (CHITAL SERVICES & SUPPLY 64.568 27.369 0 0.0000 0.01003 (CHITAL SERVICES & SUPPLY 64.568 27.600 0 0.0000 0.01003 (CHITAL SERVICES & SUPPLY 64.568 27.600 0 0.000 0.0000 0.01007 10.00	2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT 3.00 00300 EMPLOYEE BENEFITS -	0 1, 152, 095 1, 693, 612	27, 459 454, 772		0 0	99, 795		1.00 2.00 3.00 4.00
11.00 01100 PINARAKY 0 0 0 0 0 0 0 11.10 12.00 01300 SCI.AL SERVICE 149,471 5,642 0 3,042 17,137 13.00 14.00 01400 NURSING AND ALLED HEALTH EDUCATION 0	6.00 00600 LAUNDRY & LI NEN SERVICE 7.00 00700 HOUSEKEEPING 8.00 00800 DI ETARY 9.00 00900 NURSING ADMINISTRATION	260, 318 327, 389 958, 924 495, 966	69, 777 6, 771 94, 697 37, 098		0 0 0 0	0 0 117, 779	330, 095 334, 160 1, 053, 621 650, 843	6.00 7.00 8.00 9.00
INPATI ENT ROUTINE SERVICE COST CENTERS 00 03000 SKILLED NURS FACILITY 4, 162, 169 1, 041, 623 0 848, 387 6, 052, 179 30 03100 00 NURSING FACILITY 0 0 0 0 0 0 31, 00 03200 OTHER LONG TERM CARE 0 0 0 0 0 0 33, 00 04000 RADIOLOGY 15, 455 0 0 0 0 28, 077 0 0 28, 077 0 0 28, 077 20 0 28, 077 0 0 28, 077 0 0 28, 077 0 0 28, 077 0 0 28, 077 20 0 264, 550 44, 00 0 244, 50 44, 00 0 244, 50 44, 00 0 244, 50 44, 00 0 244, 50 44, 00 0 45, 50 44, 00 0 45, 50 44, 00 0 45, 50 46, 00 0 0 47, 50 46, 00 0 0 46, 00 <td< td=""><td>11. 00 01100 PHARMACY 12. 00 01200 MEDICAL RECORDS & LIBRARY 13. 00 01300 SOCIAL SERVICE</td><td>0 36, 781 149, 471</td><td>0 8, 416 5, 642</td><td></td><td>0 0 0</td><td>0 8, 904</td><td>0 54, 101 191, 537</td><td>11.00</td></td<>	11. 00 01100 PHARMACY 12. 00 01200 MEDICAL RECORDS & LIBRARY 13. 00 01300 SOCIAL SERVICE	0 36, 781 149, 471	0 8, 416 5, 642		0 0 0	0 8, 904	0 54, 101 191, 537	11.00
31.00 03100 NURSING FACILITY 0 <td>I NPATI ENT ROUTI NE SERVI CE COST CENTERS</td> <td>· · ·</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>[</td>	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	· · ·						[
40 00 0000 RADIOLOGY 15, 455 0 0 0 15, 455 0, 0 0 15, 455 0, 0 0 15, 455 0, 0 0 0 15, 455 0, 0 0 0 15, 455 0 0 0 0 28, 077 0 0 0 28, 077 0 0 0 25, 051 0 0 0 25, 051 0 0 0 25, 051 0 0 0 0 0 25, 051 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 164, 512 46, 00 46, 00 0	31.00 03100 NURSING FACILITY 32.00 03200 ICF/IID 33.00 03300 OTHER LONG TERM CARE	0	0 0		0 0	0	0 0	31.00 32.00
41.00 04100 LABORATORY 45, 190 0 0 45, 190 7, 20 42.00 04200 INTRAVENOUS THERAPY 25, 051 0 0 25, 051 43, 00 44.00 04400 PHYSI CAL, THERAPY 186, 110 78, 240 0 0 264, 350 44, 00 45.00 04500 OCUPATI ONAL, THERAPY 186, 110 78, 240 0 0 1215, 302 45, 00 46.00 04600 SPEECH PATHOLOGY 159, 528 4, 984 0 0 1215, 302 45, 00 47.00 04700 DELECTROCARGED TO PATI ENTS 0 3, 715 0 0 247, 533 49, 00 50.00 DOBUSCS CHARGED TO PATI ENTS 246, 751 752 0 0 0 0 0 50, 00 0 0 0 0 0 0 50, 00 0		15 455	0		0	0	15 455	40 00
45.00 04500 0CCUPATIONAL THERAPY 160, 665 54, 637 0 0 215, 302 45, 00 46.00 04000 SPECET PATHOLOGY 159, 528 4, 984 0 0 164, 512 46, 00 47.00 04700 ELECTROCARDIOLOGY 0 3, 715 0 0 3, 715 0 0 0 0 0 3, 715 0 0 0 0 0 0 3, 715 0 <t< td=""><td>41.00 04100 LABORATORY 42.00 04200 INTRAVENOUS THERAPY 43.00 04300 OXYGEN (INHALATION) THERAPY</td><td>45, 190 28, 077 25, 051</td><td>0 0 0</td><td></td><td>0 0 0</td><td>-</td><td>45, 190 28, 077 25, 051</td><td>41.00 42.00 43.00</td></t<>	41.00 04100 LABORATORY 42.00 04200 INTRAVENOUS THERAPY 43.00 04300 OXYGEN (INHALATION) THERAPY	45, 190 28, 077 25, 051	0 0 0		0 0 0	-	45, 190 28, 077 25, 051	41.00 42.00 43.00
49:00 04:00 DRUGS CHARGE TO PATIENTS 246,751 752 0 0 247,503 49.00 50:00 05:00 DENTAL CARE - TITLE XIX ONLY 0	45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	160, 665 159, 528 0	54, 637 4, 984 0		0	000000000000000000000000000000000000000	215, 302 164, 512 0	45.00 46.00 47.00
OUTPATI ENT SERVICE COST CENTERS 60.00 00000 CLINIC 0<	49.00 04900 DRUGS CHARGED TO PATIENTS 50.00 05000 DENTAL CARE - TITLE XIX ONLY 51.00 05100 SUPPORT SURFACES	246, 751 0 13, 208	752 0 0		0	-	247, 503 0 13, 208	49.00 50.00 51.00
62.00 06200 FOHC 62.00 63.00 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 0 63.00 0 63.00 0 0 0 63.00 0 63.00 0 63.00 0 0 0 63.00 0 63.00 0 63.00 0 0 0 63.00 0 63.00 0 63.00 0 0 63.00 0 63.00 0 0 0 63.00 <	OUTPATIENT SERVICE COST CENTERS		0		-	- 1		
OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY OST O <td< td=""><td>62.00 06200 FQHC</td><td></td><td>-</td><td></td><td></td><td></td><td></td><td>62.00</td></td<>	62.00 06200 FQHC		-					62.00
71.00 07100 AMBULANCE 0 0 0 0 71.00 72.00 C7200 CORF 0 0 0 0 72.00 73.00 O7300 CMHC 0 0 0 0 72.00 73.00 O7300 CMHC 0 0 0 0 0 72.00 74.00 O7400 OTHER REIMBURSABLE COST 0 0 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 81.00 81.00 81.00 82.00 0 0 0 0 81.00 81.00 81.00 82.00 0 0 0 83.00 83.00 84.00 <td>OTHER REIMBURSABLE COST CENTERS</td> <td>1 9</td> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td>00.00</td>	OTHER REIMBURSABLE COST CENTERS	1 9	5					00.00
74.00 07400 0THER REIMBURSABLE COST 0	71. 00 07100 AMBULANCE 72. 00 07200 CORF	0	0		0	0 0 0	0	71.00 72.00
80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTI LI ZATI ON REVI EW 82.00 83.00 08300 HOSPI CE 0 0 83.00 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 83.00 89.00 SUBTOTALS (sum of Lines 1-84) 12,822,996 1,975,286 0 1,179,554 12,822,996 89.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 90.00 990.00	74.00 07400 OTHER REIMBURSABLE COST	0 0	0 0			0 0		
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 84.00 84.00 84.00 SUBTOTALS (sum of lines 1-84) 12,822,996 1,975,286 0 1,179,554 12,822,996 89.00 89.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0	80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81. 00 08100 I NTEREST EXPENSE 82. 00 08200 UTI LI ZATI ON REVI EW							80.00 81.00 82.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 2,875 0 0 0 2,875 91.00 92.00 09200 PHYSI CLANS PRI VATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAI D WORKERS 0 0 0 0 93.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 94.00 95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 94.00 98.00 Cross Foot Adj ustments 0 0 0 0 98.00 99.00 Negati ve Cost Centers 0 0 0 0 99.00	84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 89.00 SUBTOTALS (sum of lines 1-84)	0 0 12, 822, 996	0 0 1, 975, 286		-	0 0 1, 179, 554	0	84.00
95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00	90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91. 00 09100 BARBER AND BEAUTY SHOP 92. 00 09200 PHYSI CLANS PRI VATE OFFI CES 93. 00 09300 NONPAI D WORKERS		0 0 0 0			0 0 0 0	2, 875 0 0	92.00 93.00
	95.0009500OTHER NONREI MBURSABLE COST CENTERS98.00Cross Foot Adjustments99.00Negative Cost Centers	0 0 0 12, 825, 871	0 0 0 1, 975, 286		-	0 0 0 1, 179, 554	0 0 0	95.00 98.00 99.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	CRANBURY		No.: 315353 F	Period:	u of Form CMS-: Worksheet B	2340-10
5551 7				F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/19/2022 1:1	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS			1	1		1 1 00
1.00 2.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	2, 248, 179 133, 213	759, 979	,			1.00 2.00 3.00 4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE	70, 158	36, 981				6.00
7.00	00700 HOUSEKEEPI NG	71, 022	3, 588				7.00
8.00	00800 DI ETARY	223, 937	50, 188			1, 356, 263	
9.00	00900 NURSING ADMINISTRATION	138, 330	19, 662			0	9.00
10.00 11.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	21, 461	14, 628 0			0	10.00
12.00	01200 MEDICAL RECORDS & LIBRARY	11, 499	4, 461		, i	0	12.00
13.00	01300 SOCI AL SERVICE	40, 709	2, 990		_,	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	2, , , 0			0	14.00
15.00	01500 ACTI VI TI ES	33, 619	C		0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	1, 286, 328	552, 048	437, 234	313, 674	1, 356, 263	30.00
31.00	03100 NURSING FACILITY	0	C		-	0	31.00
32.00	03200 I CF/I I D	0	0			0	
33.00	03300 OTHER LONG TERM CARE	0	0	C	0 0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	3, 285	C		0	0	40.00
41.00	04100 LABORATORY	9,605	C			0	41.00
42.00	04200 I NTRAVENOUS THERAPY	5,967	0			0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	5, 324	0		0	0	43.00
44.00	04400 PHYSI CAL THERAPY	56, 185	41, 467	' C	23, 561	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	45, 760	28, 957	' C	16, 453	0	45.00
46.00	04600 SPEECH PATHOLOGY	34, 965	2, 641			0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	-	, v	0	47.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	790	1, 969 399		.,	0	48.00
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	52, 604	399 0		227 0 0	0	49.00
50.00	05100 SUPPORT SURFACES	2,807	0		-	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	2,007	C		-	0	52.00
	OUTPATIENT SERVICE COST CENTERS		-	-	-		
60.00	06000 CLINIC	0	C) C	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	C	0 0	0 0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C) C	0 0	0	63.00
70 00	OTHER REIMBURSABLE COST CENTERS	0	0			0	70.00
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0				0	70.00
72.00	07200 CORF	0	0			0	
73.00	07300 CMHC	0	0		o o	0	
74.00		0	C) C	0 0	0	
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVI EW		~			~	82.00
83.00 84.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0			0	83.00 84.00
84.00 89.00	SUBTOTALS (sum of lines 1-84)	2, 247, 568	759, 979	437, 234	408, 770	1, 356, 263	
57.00	NONREI MBURSABLE COST CENTERS	2,247,300	137, 117	437,234	400,770	1, 550, 205	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0) C	0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	611	0		-	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C	0 0	0	0	92.00
93.00	09300 NONPAI D WORKERS	0	0) C	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	C) C	0	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0	95.00
98.00	Cross Foot Adjustments	0	0		0	0	98.00
99.00 100.00	Negative Cost Centers TOTAL	0 2 240 170	0 759, 979			0 1 356 263	99.00
100.00		2, 248, 179	124, 414	437, 234	408, 770	1, 356, 263	100.00

Heal t	n Financial Systems	CRANBURY	CENTER			In Lie	u of Form CMS-2	2540-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315353		riod: om 01/01/2021 12/31/2021	Worksheet B Part I Date/Time Prep 5/19/2022 1:1	pared: 5 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		RECORDS & LI BRARY	SOCIAL SERVICE	
	CENEDAL SEDVICE COST CENTEDS	9.00	10.00	11.00		12.00	13.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	820, 007 0 0 0 0 0 0	145, 374 0 0 0		00000	72, 596 0 0	236, 935 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00 \end{array}$
15.00	01500 ACTI VI TI ES	0	0		0	0	0	15.00
30. 00 31. 00 32. 00 33. 00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	820, 007 0 0 0	145, 374 0 0 0		0 0 0 0	61, 555 0 0 0	236, 935 0 0 0	30. 00 31. 00 32. 00 33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	[0	202	0	40 00
40.00 41.00 42.00 43.00 44.00 45.00 45.00 46.00 47.00 48.00 49.00 50.00 51.00 52.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TI TLE XI X ONLY 05100 SUPPORT SURFACES					202 324 128 3, 354 3, 217 2, 537 0 0 1, 268 0 3 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 42.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 45.\ 00\\ 46.\ 00\\ 47.\ 00\\ 48.\ 00\\ 49.\ 00\\ 50.\ 00\\ 51.\ 00\\ 52.\ 00 \end{array}$
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	0 0		0 0	0 0	0 0	60. 00 61. 00 62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		0	0	0	63.00
70.00 71.00 72.00 73.00 74.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF 07300 CMHC 07400 OTHER REIMBURSABLE COST	0 0 0 0	0 0 0 0 0		0 0 0 0	0 0 0 0	0 0 0 0	71.00 72.00 73.00
80.00 81.00 82.00 83.00 84.00 89.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0 0 820,007	0 0 145, 374		0 0 0	0 0 72, 596	0 0 236, 935	80. 00 81. 00 82. 00 83. 00 84. 00 89. 00
90.00 91.00 92.00 93.00 94.00 95.00 98.00 99.00 100.0	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0 820,007	0 0 0 0 0 0 0 145, 374		0 0 0 0 0 0 0 0	0 0 0 0 0 0 72, 596	0 0 0 0 0 0 236, 935	90. 00 91. 00 92. 00 93. 00 94. 00 95. 00 98. 00 99. 00 100. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CRANBURY			Period: From 01/01/2021	wof Form CMS- Worksheet B Part I	
					To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
			OTHER GENERAL			371772022 1.1	
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	SERVICE ACTIVITIES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5.00
8.00 7.00	00700 HOUSEKEEPING						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSING ADMINISTRATION						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
13.00	01300 SOCIAL SERVICE						13.00
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	191, 798				14.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	191,790	2			15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	0	191, 798	3 11, 453, 39	5 0	11, 453, 395	30.00
31.00	03100 NURSING FACILITY	0			0 0	0	
32.00	03200 CF/I D	0			0 0	0	
33.00	03300 OTHER LONG TERM CARE	0	0)	0 0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS			10.04	2 0	10.042	40.00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	0) 18, 94) 55, 11		18, 942 55, 119	1
41.00	04200 INTRAVENOUS THERAPY	0		34, 17		34, 172	
43.00	04300 OXYGEN (INHALATION) THERAPY	0		30, 38		30, 383	
44.00	04400 PHYSI CAL THERAPY	0	(C	388, 91	7 0	388, 917	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	C	309, 68		309, 689	1
46.00	04600 SPEECH PATHOLOGY	0	0	206, 15		206, 156	1
47.00 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0 3 0	0 7, 593	
48.00	04900 DRUGS CHARGED TO PATIENTS	0) 7, 59) 302, 00		302, 001	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			0 0	0	
51.00	05100 SUPPORT SURFACES	0	0	16, 01	8 0	16, 018	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	52.00
	OUTPATIENT SERVICE COST CENTERS	-	-			-	
60.00 61.00		0			0 0	0	
62.00	06100 RURAL HEALTH CLINIC 06200 F0HC	0	C		0 0	0	61.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0 0	0	1
	OTHER REIMBURSABLE COST CENTERS			-			1
70.00	07000 HOME HEALTH AGENCY COST	0	C)	0 0	0	1
71.00	07100 AMBULANCE	0	C	D	0 0	0	
72.00	07200 CORF	0	0		0 0	0	
73.00 74.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0			0 0 0 0	0	1
74.00	SPECIAL PURPOSE COST CENTERS	0		<u>и</u>	0 0	0	74.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW						82.00
83.00	08300 HOSPI CE	0	C		0 0	0	1
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	101 700		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	191, 798	3 12, 822, 38	5 0	12, 822, 385	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	(0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		3, 48		3, 486	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	C		0 0	0	92.00
	09300 NONPAI D WORKERS	0	C		0 0	0	1
93.00				1	0		0 1 00
93.00 94.00	09400 PATIENTS LAUNDRY	0			0 0	0	
93.00 94.00 95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0				0	95.00
93.00 94.00						-	95.00 98.00

	Financial Systems	CRANBURY					u of Form CMS-2	2540-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315353		d: 01/01/2021 12/31/2021	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS			5/19/2022 1:1	5 pm
	Cast Conton Description	Dimonthy		MOVADLE		ubtotol		
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	5	ubtotal	EMPLOYEE BENEFI TS	
		Capi tal						
		Related Costs	1.00	2.00		2A	3.00	
	GENERAL SERVICE COST CENTERS		1.00	2.00		20	3.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	27, 459		0	27, 459	27, 459	2.00 3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	454, 772		Ö	454, 772	2, 323	•
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	59, 103		0	59, 103	667	5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	0	69, 777 6, 771		0	69, 777 6, 771	0	6.00 7.00
7.00 8.00	00800 DI ETARY	0	6, 771 94, 697		0	94, 697	0	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	37, 098		0	37, 098	2, 742	
10.00	01000 CENTRAL SERVICES & SUPPLY	0	27, 600		0	27,600	205	•
11.00		0	0		0	0	0	11.00
12.00 13.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0	8, 416 5, 642		0	8, 416 5, 642	207 848	12.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0,012		0	0	0	14.00
15.00	01500 ACTI VI TI ES	0	0		0	0	717	15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	0	1,041,623	1	0	1,041,623	19, 750	30.00
30.00	03100 NURSING FACILITY	0	1, 041, 023		0	1, 041, 023	19,750	30.00
32.00	03200 CF/I D	0	0		0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	0	40.00
40.00	04100 LABORATORY	0	0		0	0	0	40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	0	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	78, 240 54, 637		0	78, 240 54, 637	0	44.00
46.00	04600 SPEECH PATHOLOGY	0	4, 984		Ö	4, 984	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	3, 715 752		0	3, 715 752	0	48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	/ 52		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	52.00
60.00	OUTPATI ENT SERVICE COST CENTERS	0	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62.00	06200 FQHC							62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0		0	0	0	63.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70.00
71.00	07100 AMBULANCE	0	0		0	0	0	
72.00	07200 CORF	0	0		0	0	0	•
73.00 74.00	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0		0	0	0	•
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0	0	0	/ 4.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81.00	08100 I NTEREST EXPENSE							81.00
82.00 83.00	08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	0		0	0	0	82.00 83.00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	1
89.00	SUBTOTALS (sum of lines 1-84)	0	1, 975, 286		0	1, 975, 286	27, 459	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN				0	0	0	90.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	90.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0	0	0	92.00
93.00	09300 NONPAID WORKERS	0	0		0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0	0	0	94.00
95.00 98.00	09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0		U	0	0	95.00 98.00
99.00	Negative Cost Centers		0		0	0	0	99.00
	TOTAL	0	1, 975, 286	1	0	1, 975, 286	27, 459	1

	Financial Systems	CRANBURY				u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2021 p 12/31/2021	Worksheet B Part II Date/Time Pre 5/19/2022 1:1	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	<u> </u>
		4.00	5.00	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1 1					1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - BEDGS & TEXTORES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY	457, 095 27, 084 14, 264 14, 440 45, 530	86, 854 4, 226 410 5, 736	88, 267 0	21, 621 1, 508	147, 471	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	28, 125	2, 247	0	591	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	4, 363	1, 672	0	440	0	10.00
11.00 12.00 13.00 14.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0 2, 338 8, 277 0	0 510 342 0	0	0 134 90 0	0 0 0 0	11.00 12.00 13.00 14.00
15.00	01500 ACTI VI TI ES	6, 835	0		0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 SKILLED NURSING FACILITY	261, 535	63, 090		16, 592	147, 471	30.00
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0		0	0	31.00 32.00
32.00	03300 OTHER LONG TERM CARE	0	0		0	0	
00.00	ANCI LLARY SERVICE COST CENTERS				0		00.00
40.00	04000 RADI OLOGY	668	0	0	0	0	40.00
41.00	04100 LABORATORY	1, 953	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	1, 213	0	-	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1, 083	0		0	0	43.00
44.00	04400 PHYSI CAL THERAPY	11, 423	4, 739	1	1, 246	0	44.00
45.00 46.00	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	9, 304 7, 109	3, 309 302		870 79	0	45.00 46.00
47.00	04700 ELECTROCARDI OLOGY	0	0	1	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	161	225		59	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	10, 695	46	0	12	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50.00
51.00	05100 SUPPORT SURFACES	571	0	1	0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
60.00	OUTPATI ENT SERVICE COST CENTERS	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	•
62.00	06200 FQHC		J. J	, i i i i i i i i i i i i i i i i i i i	Ū.	Ū	62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	0	0	0	0	•
72.00 73.00	07200 CORF 07300 CMHC	0	0	0	0	0	
	07400 OTHER REIMBURSABLE COST	0	0		0	0	•
7 11 00	SPECIAL PURPOSE COST CENTERS						1
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW		_			_	82.00
83.00		0	0	0	0	0	83.00
84.00 89.00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	456, 971	86, 854	88, 267	21, 621	0 147 471	84.00 89.00
07.00	NONREIMBURSABLE COST CENTERS	400, 971	00, 854	00, 207	21,021	147, 471	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	124	0		Ō	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00	09300 NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	95.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers		Ω		0	0	98.00 99.00
100. OC		457,095	86, 854	88, 267	21, 621	147, 471	•
	1 1	,.,.,	00,001	00,207	2., 32.1	,	1 00

2: 00 00200 CAP REL COSTS - MOVABLE FOULPHENT 4: 00 00400 ADMUNS INTRATIVE & GEBLEAL 5: 00 00500 LAWINEY ALL THE SERVICE 6: 00 00500 LAWINEY ALL THE SERVICE 6: 00 00500 CHERKL SERVICE & SUPPLY 0: 00 00500 CHERKL SERVICE & SUPPLY 0: 00 00500 CHERKL SERVICE & SUPPLY 0: 00 00500 CHERKL SERVICE S & SUPPLY 0: 00 00500 CHERKL SERVICE OST CHERES 0: 00 00500 CHERKL SERVICE OST CHERES 0: 00 00500 CHERKL SERVICE 0: 00 00 00 00 00 00 00 0: 00 00 00 00 0: 00 00 00 0: 00 00 00 0: 00 00		Financial Systems	CRANBURY				In Lie	u of Form CMS-2	2540-10
M2M IN STRATION SERVICES & PERCENS & 100 GOTOD CAP RL COST CENTERS 9.00 10.00 11.00 12.00 13.00 2.00 GOTOD CAP RL COST S - MOXALL FOULPRINT 7 7 7 7 3.00 GOTOD CAP RL COST S - MOXALL FOULPRINT 7 8 7 7 7 8 7 7 7 7 8 7 7 7 7 7 7 7 7 7 7 7 7 7 7 <th>ALLOCA</th> <th>ATION OF CAPITAL RELATED COSTS</th> <th></th> <th>Provi der</th> <th>No.: 315353</th> <th>Fro</th> <th>m 01/01/2021</th> <th>Part II Date/Time Pre</th> <th>pared: 5 pm</th>	ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315353	Fro	m 01/01/2021	Part II Date/Time Pre	pared: 5 pm
CENERAL SERVICE COST CONTERS 1 0.000000 CAP REL COSTS - MOXABLE EQUITIENT 2 0.00000000000000000000000000000000000		Cost Center Description	ADMI NI STRATI ON	SERVI CES & SUPPLY			RECORDS & LI BRARY		
1.00 00100 CAP REL COSTS - BLOCS & FIXTURES 000200 (ADMORENCE) MOVABLE CONTENTS 000200 (ADMORENCE) MOV			9.00	10.00	11.00		12.00	13.00	
7. 00 00700 HOUSEKEEPING 7 8.00 008000 INTERN 7 9.00 00900 INTERN 7 9.00 00900 INTERN 7 9.00 00900 INTERN 5 9.0100 INTERN 5 1 9.00 00900 INTERN 5 9.00 00900 INTERN 5 9.00 00900 INTERN 5 9.00 00900 INTERN 5 9.00 0000 INTERN 6 9.00 0000 INTERN 6 9.00 0000 INTERN 7 9.00 0000 INTERN 6 9.00 0000 INTERN 6 9.00 0000 INTERN <t< td=""><td>2.00 3.00 4.00 5.00</td><td>00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS</td><td></td><td></td><td></td><td></td><td></td><td></td><td>1.00 2.00 3.00 4.00 5.00 6.00</td></t<>	2.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS							1.00 2.00 3.00 4.00 5.00 6.00
10.00 01000 CENTRAL SERVICES & SUPPLY 0 34.280 11 11.00 01100 PHARMACY 0 0 0 11 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 0 11 13.00 01300 MEDICAL RECORDS & LIBRARY 0	7.00 8.00	00700 HOUSEKEEPING 00800 DI ETARY	70, 803						7.00 8.00 9.00
13.00 01200 SOCIAL SERVICE 0 </td <td>10. 00 11. 00</td> <td>01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY</td> <td>0</td> <td>34, 280 0</td> <td></td> <td>0</td> <td>11 605</td> <td></td> <td>10.00 11.00 12.00</td>	10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	34, 280 0		0	11 605		10.00 11.00 12.00
30:00 03000 SKILLED NURSING FACILITY 70,803 34,280 0 9,841 15,199 33 31:00 03100 (3100) UNESING FACILITY 0 0 0 0 33 32:00 03200 (TCFLID 0 0 0 0 33 30:00 03300 (THER LONG TERM CARE 0 0 0 32 0 40:00 04000 (TABILLORY SERVICE COST CENTERS 0 0 0 32 0 44 41:00 0400 (ADDI LARGY ENDIS THERAPY 0 0 0 20 04 42:00 04200 (INTRAVENUS THERAPY 0 0 0 1 0 43 44:00 04400 (PHYSICAL THERAPY 0 0 0 514 0 44 45:00 04500 (DEURAL NEARED TO PATIENTS 0 0 0 0 0 44 46:00 04500 (DEURAL CARSE TO PATIENTS 0 0 0 0 0 52 50:00 05000 DEURAL CARSE TO PATIENTS 0 0 0 0 52 52 52 52 <td>13.00 14.00</td> <td>01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION</td> <td>0</td> <td>0 0 0 0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>13.00 14.00 15.00</td>	13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0 0 0 0			0 0	0	13.00 14.00 15.00
31.00 03100 NUES ING FACILITY 0<					1				
12 00 0					1				30.00
ANCI LLARY SERVICE COST CENTERS Image: Cost C	32.00	03200 CF/I D	0	0		0	О	0	31.00 32.00 33.00
11.00 04100 LABORATORY 0 0 52 0 41 42.00 04300 INTRAVENDUS THERAPY 0 0 0 1 0 42 43.00 04300 INTRAVENDUS THERAPY 0 0 0 1 0 43 44.00 04400 PHYSICAL THERAPY 0 0 0 536 0 44 45.00 04500 COLPATI DUAL THERAPY 0 0 0 514 0 45 46.00 04600 SPEECH PATHOLOGY 0 0 0 0 0 1 47 47.00 04700 ELECTROCARGED TO PATI ENTS 0									
42.00 042001 INTRAVENOUS THERAPY 0 0 20 0 43 43.00 04300 OVECEN INHALATION THERAPY 0 0 0 336 44.00 OLAGOO NYCEN INHALATION THERAPY 0 0 0 536 0 44.00 OLAGOO NYCEN INHALATIONAL THERAPY 0 0 0 3514 0 45.00 OAGOO SPECCH PATHOLOGY 0 0 0 0 0 0 466 46.00 OAGOO BEDICAL CARRED TO PATIENTS 0 0 0 0 0 0 67 47.00 OAGOO DENTAL CARRED TO PATIENTS 0			0	0					40.00
43.00 Q4300 QVQEN (INHALATION) THERAPY 0 0 1 0 43 44.00 Q4400 PHYSICAL THERAPY 0 0 0 536 0 44 45.00 Q4500 QCCUPATIONAL THERAPY 0 0 0 536 0 44 46.00 Q4600 PHYSICAL THERAPY 0 0 0 406 0 406 0 406 0 406 0 406 0 406 46 46 46 0 400 400 0			0	0		0		-	41.00 42.00
44.00 0 0 0 536 0 44 45.00 04500 CCUPATIONAL THERAPY 0 0 0 406 0 46.00 04600 SPEECH PATHOLOGY 0 0 0 0 406 44 46.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 47 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 44 49.00 04900 DRUSS CHARGE TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 45 51.00 05200 DENTAL CARE - TITLEX XLX 0NLY 0 <			0	0		0			43.00
46.00 0 0 0 0 0 0 0 400 47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 47 48.00 04900 REDICAL SUPPLIES 0 0 0 0 48 49.00 04900 REDICAL SUPPLIES 0 0 0 0 48 60.00 05000 DENTAL CARE - TITLEX IX ONLY 0 0 0 0 0 55 00 05000 DENTAL CARE - TITLEX IX ONLY 0 0 0 0 0 52 00 05000 DUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 63 63.00			0	0)	0	536	0	44.00
47.00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0	45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	514	0	45.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 49.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 49.00 60.00 DS000 DEWTAL CARE - TITLE XIX ONLY 0			0	0		0			46.00
49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 203 0 45 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 50 51.00 05100 SUPPORT SURFACES 0 0 0 0 50 0 05100 SUPPORT SURFACES 0 0 0 0 0 50 0 0000 COUTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 60 0 06000 CINIC 0 0 0 0 0 0 60 61.00 06200 FORT 0 0 0 0 0 66 63.00 06300 OTHER REINBURSABLE COST CENTERS 0 0 0 0 70 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70 70 71.00 07000 CORF 0 0 0 0 0 73 74.00 7400 OTHER REINBURSABLE COST			0	0		0			47.00
50.00 DS000 DENTAL CARE - TITLE XIX ONLY 0			0	0		0	-	0	48.00 49.00
51.00 DS100 SUPPORT SURFACES 0 0 0 0 0 52 0 05200 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 52 00 00 0 0 0 0 0 0 0 52 00 00 0 0 0 0 0 0 0 52 00 00 0 0 0 0 0 0 52 00 00 0 0 0 0 0 0 52 00 00 0 0 0 0 0 0 52 00 00 0 0 0 0 0 0 62 00 00 0 0 0 0 0 0 62 62 00 00 0 0 0 0 0 0 0 72 70 0700 0 0 0 0 0 0 <			0	0		0		0	50.00
OUTPATIENT SERVICE COST CENTERS O <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>51.00</td></t<>			0	0		0		0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61 62.00 06200 FOHC 0 0 0 0 63 63.00 07400 THER VUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 63 07000 HOME HEALTH AGENCY COST 0		05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0				-1		52.00
62.00 06200 FOHC 0 0 62 63.00 07HER REI MBURSABLE COST CENTERS 0 0 0 62 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 70 71.00 07100 AMBULANCE 0 0 0 0 70 72.00 07200 CORF 0 0 0 0 73 74.00 07400 OTHER REI MBURSABLE COST 0 0 0 0 74 74.00 07400 OTHER SET MBURSABLE COST 0 0 0 0 74 75.00 08000 MALPRACTI CE PREMI UMS & PAID LOSSES 81 81 81 81 81 81 81 82 81 82 81 82 81 82 81 82 83 83 8300 8300 91 11 nes 1-84 70, 803 34, 280 11, 605 15, 199 84 89.00 SUBTOTALS (sum of 1 i nes 1-84) 70, 803 34, 280 11, 605 15, 199 84			0		1				60.00
63.00 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 OTHER REIMBURSABLE COST CENTERS			0	0		0	0	0	61.00 62.00
OTHER REI MBURSABLE COST CENTERS 70.00 O7000 HOME HEALTH AGENCY COST 0 0 0 0 70 71.00 O7100 AMBULANCE 0 0 0 0 0 71 0 07200 CORF 0 0 0 0 72 0 07200 CORF 0 0 0 0 72 0 074.00 OTHER REI MBURSABLE COST 0 0 0 0 74 0 07400 OTHER REI MBURSABLE COST 0 0 0 0 74 0 07400 OTHER REI MBURSABLE COST 0 0 0 0 74 80.00 08100 INTEREST EXPENSE 8 8 81 82 0 80 82 0 0 0 0 82 81.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>63.00</td></td<>			0	0		0	0	0	63.00
71.00 07100 AMBULANCE 0 0 0 0 71 72.00 07200 CORF 0 0 0 0 72 73.00 07300 CMHC 0 0 0 0 73 74.00 07400 OTHER REI MBURSABLE COST 0 0 0 0 73 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81 0 81.00 08100 INTEREST EXPENSE 81 81 81.00 08100 INTEREST EXPENSE 82.00 0 0 0 0 83 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 83 84.00 0 11,605 15,199 83 84.00 0 11,605 15,199 84 90.00 11,605 15,199 84 90.00 11,605 15,199 91 92.00 92.00 94.00 0 0 0 0 92.00 92.00 94.00 0 0 0 92.00 92.				-			-1	-	
72.00 07200 CORF 0 0 0 72 73.00 07300 CMHC 0 0 0 0 73 74.00 07400 OT400 OT400 0 0 0 0 73 74.00 07400 OT4PR REIMBURSABLE COST 0 0 0 0 0 74 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 0 0 0 0 0 0 74 81.00 08100 INTEREST EXPENSE 0 0 0 0 81 82 82.00 08200 UTI LI ZATI ON REVIEW 0 0 0 83 83 0 8300 HORST EXPENSE 0 0 0 83 84.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 83 90.00 SUBTOTALS (sum of Lines 1-84) 70, 803 34, 280 0 11, 605 15, 199 89 91.00 O9000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 <									70.00
73.00 07300 CMHC 0 0 0 0 73 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 0 74 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81 <td< td=""><td>71.00</td><td>07100 AMBULANCE</td><td>0</td><td>0</td><td></td><td>0</td><td>Ű</td><td></td><td>71.00</td></td<>	71.00	07100 AMBULANCE	0	0		0	Ű		71.00
74.00 07400 0THER REIMBURSABLE COST 0 0 0 0 0 74 SPECIAL PURPOSE COST CENTERS 80.00 08100 NALPRACTICE PREMI UMS & PAID LOSSES 80 80 80 80 80 81.00 08100 INTEREST EXPENSE 80 81.00 08100 UTI LI ZATI ON REVIEW 81 81.00 80.00 00 0 0 81.00 8300 HOSPI CE 0 0 0 0 81.00 8300 HOSPI CE 0 0 0 0 83.00 83.00 08400 OTHER SPECI AL PURPOSE COST CENTERS 0 0 0 0 84.80 90.00 SUBTOTALS (sum of lines 1-84) 70,803 34,280 0 11,605 15,199 89 NONRET MBURSABLE COST CENTERS 0 0 0 0 0 0 90 91.00 9100 BARBER AND BEAUTY SHOP 0 0 0 92.00 92.00 92.00 93.00 0 0 0			0	0		0	-		72.00 73.00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81 82.00 08200 UTI LI ZATI ON REVI EW 81 83.00 08300 HOSPI CE 0 0 82 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 84 89.00 SUBTOTALS (sum of lines 1-84) 70,803 34,280 0 11,605 15,199 89 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 90 0 91.00 9100 BARBER AND BEAUTY SHOP 0 0 0 91.00 9100 BARBER AND BEAUTY SHOP 0 0 0 92.00 9200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 92.00 9300 NONREI MBURSABLE COST CENTERS 0 0 0 92.00 93.00 93.00 93.00 93.00 0 0 0 0 92.00 94.00 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>-</td> <td></td> <td>74.00</td>			0	0		-	-		74.00
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 8000 INTEREST EXPENSE 81 81.00 08100 INTEREST EXPENSE 81 81 81 82.00 08200 UTILIZATION REVIEW 82 81 82 83.00 08200 UTILIZATION REVIEW 82 81 82 83.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 82 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 84 89.00 SUBTOTALS (sum of lines 1-84) 70,803 34,280 0 11,605 15,199 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92 93.00 09300 NONREI MBURSABLE COST CENTERS 0 0	/ 1. 00			0			0		/ 1.00
82.00 08200 UTILIZATION REVIEW 82 83.00 08300 HOSPICE 0 0 0 0 83 84 0 08300 HOSPICE 0 0 0 0 0 83 84 00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 83 84 00 11,605 15,199 84 84 00 11,605 15,199 84 89 0 11,605 15,199 84 84 89 0 11,605 15,199 84 84 84 84 84 90 0 10 15,199 84		08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
83.00 08300 HOSPICE 0 0 0 0 83.3 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 84.4 89.00 SUBTOTALS (sum of lines 1-84) 70,803 34,280 0 11,605 15,199 89.4 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 90.00 09100 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0									81.00 82.00
84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 84.00 SUBTOTALS (sum of lines 1-84) 70,803 34,280 0 11,605 15,199 84.00 NONREI MBURSABLE COST CENTERS			0	0		0	0	0	82.00
89.00 SUBTOTALS (sum of lines 1-84) 70,803 34,280 0 11,605 15,199 89 NORRE IMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90 91 0 00 0 0 0 91 91 0 9100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 91 92 0 9200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 92 93.00 09300 NONPAI D WORKERS 0 0 0 0 94 0 94.00 0 0 0 0 94 94.00 09400 PATI ENTS LAUNDRY 0 0 0 0 94 95.00 09500 THER MONREI MBURSABLE COST CENTERS 0 0 0 0 94 97 98.00 0 0 0 0 0 94 99 99 0 0			0	0			0		84.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90 91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92 93.00 09300 NONPAID WORKERS 0 0 0 92 94.00 09400 PATIENTS LAUNDRY 0 0 0 94 95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95 98.00 Cross Foot Adj ustments 0 0 0 94 99 90 0 0 0 94		SUBTOTALS (sum of lines 1-84)	70, 803	34, 280			11, 605		89.00
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92 93.00 09300 NONPAI D WORKERS 0 0 0 0 93 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94 95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95 98.00 Cross Foot Adj ustments 0 0 0 98 99.00 Negative Cost Centers 0 0 0 0 99	90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
93.00 09300 NONPAI D WORKERS 0 0 0 93.00 9300 Second Patterns 93.00 94.00 94.00 94.00 94.00 90.00 0 0 0 94.00 94.00 94.00 90.00 94.00 90.00 97.00 90.00 97.00 90.00 0 0 0 97.00			0	0		0	0		91.00
94.00 09400 PATIENTS LAUNDRY 0 0 0 94 95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 95 98.00 Cross Foot Adjustments 0 0 0 98 99 0 0 0 98 99 0 0 0 98 99 0 0 0 0 98 99 0 0 0 0 99 99 90 0 0 0 0 0 99 99 90 0 0 0 0 99 99 90 0 0 0 0 99 99 90 0 0 0 0 0 99 99 90 90 90 90 0 0 0 99 99 90 90 90 90 90 90 99 90 90 90 90 90 90 90 90			0	0		0	0		92.00
95.00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 98.00 0 98.00 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 99.00 0 0 0 0 99.00 0 0 0 0 0 0 0 99.00 0 0 0 0 0 0 0 99.00 99.00 0			0	0		0	0		93.00
98.00 Cross Foot Adjustments 0 0 98.00 98.00 0 0 98.00 98.00 98.00 98.00 0 0 98.00 99.00<			0	0		0	0		94.00 95.00
99.00 Negative Cost Centers 0 0 0 0 0 99			0	0		0	0	0	98.00
			0	0		0	о	0	
100. 00 TOTAL 70, 803 34, 280 0 11, 605 15, 199 100	100.00	DITOTAL	70, 803	34, 280		0	11, 605	15, 199	100. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	CRANBURY	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/19/2022 1:1	pared:
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	18.00	
12.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - BLDGS & FIXTURES 00200 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	7, 552	2			15.00
31. 00 32. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0	7, 552 C C		3 0 0 0 0 0 0 0 0 0	1, 776, 003 0 0 0	30. 00 31. 00 32. 00 33. 00
	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY 04100 LABORATORY	0	C C			700 2, 005	40.00
43.00 44.00 45.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0 0 0 0		1, 23 1, 08 96, 18 68, 63	4 0 4 0	1, 233 1, 084 96, 184 68, 634	43.00 44.00 45.00
47.00 48.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS) 12, 88) 4, 16) 11, 70	0 0 0 0	12, 880 0 4, 160 11, 708	47.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	000000000000000000000000000000000000000		57	0 0	0 571 0	50.00 51.00 52.00
	OUTPATI ENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	000			0 0 0 0	0	60.00 61.00 62.00
	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0			o <u>o</u>	0	63.00 70.00
71.00 72.00 73.00	07100 AMBULANCE 07200 CORF 07300 CMHC 07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	0 0 0 0			0 0 0 0 0 0 0 0 0 0	0 0 0 0	71.00 72.00 73.00
81. 00 82. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW 08300 HOSPI CE	0	C		0 0	0	80. 00 81. 00 82. 00 83. 00
89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	0		1	1	0 1, 975, 162	
91.00 92.00 93.00 94.00 95.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS	0 0 0 0 0 0		12	0 0 4 0 0 0 0 0 0 0 0 0	0 124 0 0 0 0 0	91.00 92.00 93.00 94.00 95.00
98.00 99.00 100.00	Cross Foot Adjustments Negative Cost Centers TOTAL	000000000000000000000000000000000000000	0 0 7, 552) 2 1, 975, 28	0 0 0 0 6 0	0 0 1, 975, 286	

	Financial Systems LOCATION - STATISTICAL BASIS	CRANBURY			Period: From 01/01/2021	eu of Form CMS-2 Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDGS & FI XTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	42 010		1	1	I	1 1 (
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 0. 00 1. 00 2. 00 3. 00 3. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	42, 010 584 9, 672 1, 257 1, 484 144 2, 014 789 587 0 179 120 0	42, 010 584 9, 672 1, 257 1, 484 144 2, 014 789 587 0 179 120	4, 820, 704 407, 850 117, 150 (481, 35 35, 98 (36, 39 148, 860	-2, 248, 179 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 577, 692 626, 766 330, 095 334, 160 1, 053, 621 650, 843 100, 973 0 54, 101 191, 537 0	5. (6. (7. (8. (9. (10. (11. (12. (13. (
	01500 ACTIVITIES	0				-	
0. 00 1. 00 2. 00 3. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	22, 153 0 0 0	22, 153 0	3, 467, 26		6, 052, 179	30. 0 31. 0 32. 0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 6.00 1.1.00	ANGLEART SERVICE COST CENTERS 04000 RADIOLOGY 04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY 04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04600 SPEECH PATHOLOGY 04600 SPEECH PATHOLOGY 04600 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0 0 1,664 1,162 106 0 79 16 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 1, 664 1, 162 106 0 79 16 0 0 0 0			15, 455 45, 190 28, 077 25, 051 264, 350 215, 302 164, 512 0 3, 715 247, 503 0 13, 208 0	41. 0 42. 0 43. 0 44. 0 45. 0 46. 0 47. 0 48. 0 49. 0 50. 0 51. 0
0. 00 1. 00 2. 00	OUTPATI ENT SERVICE COST CENTERS 06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	0	0	(0	60. 61. 62.
	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	63. (
0.00 1.00 2.00 3.00 4.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07200 CORF 07300 CMHC 07400 OTHER REIMBURSABLE COST	0 0 0 0 0			0 0 0 0 0 0 0 0 0 0	0 0 0 0	71. (72. (73. (
0.00 1.00 2.00 3.00 4.00 9.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW 08300 HOSPICE 08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS	0 0 42, 010	0 0 42, 010	((4, 820, 70	0 0 0 0 9 -2, 248, 179	0 0 10, 574, 817	84. (
0. 00 1. 00 2. 00 3. 00 4. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 0 0 1, 975, 286	0 0 0 0 0			0 2, 875 0 0 0 0 2, 248, 179	91. 92. 93. 94. 95. 98. 99.
03. 00 04. 00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	47. 019424			5	0. 212540 457, 095	103.
05.00	Unit cost multiplier (Wkst. B, Part)			0.005690	5	0. 043213	105.

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	CRANBURY			eriod:	u of Form CMS-2 Worksheet B-1	
				T	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/19/2022 1:1	
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS (SQUARE FEET)	LINEN SERVICE (TOTAL PATIENT DAYS)		DI ETARY (MEALS SERVED)	NURSI NG	
	1	5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMI NI STRATI VE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LI NEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMI NI STRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LI BRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	30, 497 1, 484 144 2, 014 789 587 C 179 120 C C	35, 619 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28, 869 2, 014 789 587 0 179 120 0 0	106, 857 0 0 0 0 0 0 0 0 0	35, 619 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	22, 153				35, 619	30.00
31.00 32.00	03100 NURSING FACILITY 03200 I CF/I I D			0	0	0	31.00 32.00
33.00	O3300 OTHER LONG TERM CARE	C C		0	0	0	33.00
40.00	ANCI LLARY SERVICE COST CENTERS			0		0	40.00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY					0	40.00
42.00	04200 I NTRAVENOUS THERAPY	C		0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	C	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 664		1, 664		0	44.00
45.00	04500 OCCUPATIONAL THERAPY	1, 162		1, 162		0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	106		106 0	0	0	46.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	79		79	0	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	16		16		0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	C	0	0	0	0	50.00
51.00	05100 SUPPORT SURFACES	C		0	0	0	51.00
52.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	C	0	0	0	0	52.00
60.00	06000 CLINIC	C	0	0		0	60.00
61.00	06100 RURAL HEALTH CLINIC	C	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	C	0	0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	C	0	0	0	0	70.00
71.00	07100 AMBULANCE			0		0	71.00
72.00	07200 CORF	C	0	0	0	0	72.00
73.00	07300 CMHC	C	-	0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	74.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW						82.00
83.00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS		0	0	0	0	83.00
84.00 89.00	SUBTOTALS (sum of lines 1-84)	30, 497	35, 619	28, 869	0 106, 857	35, 619	84.00 89.00
07.00	NONREI MBURSABLE COST CENTERS	30,477	33, 017	20,007	100, 007	33, 017	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	C	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	C	0	0	0	0	91.00
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	0	0	0	92.00 93.00
93.00 94.00	09400 PATIENTS LAUNDRY		0	0	0	0	93.00
95.00	09500 OTHER NONREI MBURSABLE COST CENTERS		0	0	0	0	95.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	759, 979	437, 234	408, 770	1, 356, 263	820, 007	102.00
103.00		24. 919795					
104.00	Cost to be allocated (per Wkst. B, Part II)	86, 854	88, 267	21, 621	147, 471	70, 803	104.00
		1	1	1	1		1
105.00		2.847952	2. 478088	0. 748935	1. 380078	1. 987787	105.0

	Financial Systems LLOCATION - STATISTICAL BASIS	CRANBURY		No.: 315353 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2540-10
0001 /				F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/19/2022 1:1	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 10.00	PHARMACY (COSTED REQUI S.) 11.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 12.00	SOCI AL SERVI CE (TOTAL PATI ENT DAYS) 13.00	NURSI NG AND ALLI ED HEALTH EDUCATI ON (ASSI GNED TI ME) 14.00	
	GENERAL SERVICE COST CENTERS			1			
12.00 13.00 14.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	46, 013 0 0 0 0 0	0 0 0 0 0 0 0		35, 619 0 0	0 0	
30.00	03000 SKILLED NURSING FACILITY	46, 013	0	13, 836, 900	35, 619	0	30.00
32.00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0	0 0 0	0	0 0 0	0 0 0	31.00 32.00 33.00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	45, 477	o	0	40.00
	04100 LABORATORY	0	0		0	0	40.00
	04200 I NTRAVENOUS THERAPY	0	0	28, 770		0	42.00
	04300 OXYGEN (INHALATION) THERAPY	0	0	1, 769		0	43.00
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0	754, 075 723, 339		0	44.00 45.00
	04600 SPEECH PATHOLOGY	0	0	570, 475		0	46.00
47.00	04700 ELECTROCARDI OLOGY	О	0	0	0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	285, 166		0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
	05100 SUPPORT SURFACES 05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	671 0	0	0	51.00 52.00
52.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	η <u></u> υ	<u> </u>	0	52.00
60.00	06000 CLINIC	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200 FQHC						62.00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
70.00	OTHER REIMBURSABLE COST CENTERS		0	0	o	0	70 00
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			0	70.00 71.00
	07200 CORF	0	0	0	-	0	
	07300 CMHC	О	0	0	0	0	73.00
74.00	07400 OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
00.00	SPECIAL PURPOSE COST CENTERS			1			
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE						80.00 81.00
	08200 UTI LI ZATI ON REVI EW						82.00
	08300 HOSPI CE	о	0	0	0	0	
	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	46, 013	0	16, 319, 509	35, 619	0	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
	09300 NONPAID WORKERS	0	0	0	0	0	93.00
	09400 PATIENTS LAUNDRY	0	0	0	0	0	
	09500 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	95.00 98.00
98.00 99.00	Cross Foot Adjustments Negative Cost Centers						98.00 99.00
102.00	Cost to be allocated (per Wkst. B,	145, 374	0	72, 596	236, 935	0	102.00
	Part I)		Ū	_, _, _,			
103.00	Unit cost multiplier (Wkst. B, Part I)	3. 159411	0. 000000			0.000000	
104.00	Cost to be allocated (per Wkst. B,	34, 280	0	11, 605	15, 199	0	104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 745007	0. 000000	0.000711	0. 426710	0.000000	105 00
105.00)	0. 745007	0.00000	, 0.000711	0. 4207 10	0.00000	105.00

	Financial Systems LLLOCATION - STATISTICAL BASIS	CRANBURY CE	Provi der No.: 315353	Period: From 01/01/2021	u of Form CMS- Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/19/2022 1:1	
		OTHER GENERAL		I	571772022 1.1	
	Cost Contor Description	SERVI CE ACTI VI TI ES				
	Cost Center Description	(TOTAL PATIENT				
		DAYS)				
		15.00				
	GENERAL SERVICE COST CENTERS					
. 00	00100 CAP REL COSTS - BLDGS & FIXTURES					1.00
. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT					2.00
. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL					3.00
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS					4.0
. 00	00600 LAUNDRY & LINEN SERVICE					6.0
. 00	00700 HOUSEKEEPI NG					7.0
. 00	00800 DI ETARY					8.0
. 00	00900 NURSI NG ADMI NI STRATI ON					9.0
0.00	01000 CENTRAL SERVICES & SUPPLY					10.0
1.00	01100 PHARMACY					11.0
2.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE					12.0
	01400 NURSING AND ALLIED HEALTH EDUCATION					13.0
5.00	01500 ACTIVITIES	35, 619				15.0
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	00,017				10.0
0.00	03000 SKILLED NURSING FACILITY	35, 619				30. 00
1.00	03100 NURSING FACILITY	0				31.00
2.00	03200 CF/I D	0				32.00
3.00	O3300 OTHER LONG TERM CARE	0				33.00
0 00	ANCI LLARY SERVICE COST CENTERS	0				1 40 0
1.00	04000 RADI OLOGY 04100 LABORATORY	0				40.00
	04200 I NTRAVENOUS THERAPY	0				41.0
3.00	04300 OXYGEN (INHALATION) THERAPY	Ő				43.00
4.00	04400 PHYSI CAL THERAPY	0				44.00
5.00	04500 OCCUPATI ONAL THERAPY	0				45.0
6.00	04600 SPEECH PATHOLOGY	0				46.00
7.00	04700 ELECTROCARDI OLOGY	0				47.00
8.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0				48.00
	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	o				49.00
1.00	05100 SUPPORT SURFACES	0				51.00
2.00	05200 OTHER ANCI LLARY SERVICE COST CENTERS	0				52.00
	OUTPATIENT SERVICE COST CENTERS					
0.00	06000 CLI NI C	0				60.00
1.00	06100 RURAL HEALTH CLINIC	0				61.00
2.00	06200 FQHC					62.00
3.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0				63.00
0 00	OTHER REIMBURSABLE COST CENTERS	0				70.00
	07100 AMBULANCE	0				71.00
	07200 CORF	Ő				72.00
3.00	07300 CMHC	0				73.00
4.00	07400 OTHER REIMBURSABLE COST	0				74.00
0 0-	SPECIAL PURPOSE COST CENTERS	1				
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES					80.00
1.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW					81.00
3.00	08200 HOSPI CE	0				82.00
4.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0				84.00
9.00	SUBTOTALS (sum of lines 1-84)	35, 619				89.00
	NONREI MBURSABLE COST CENTERS					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0				90.0
	09100 BARBER AND BEAUTY SHOP	0				91.0
	09200 PHYSI CI ANS PRI VATE OFFI CES	0				92.0
	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0				93.0 94.0
4.00	09500 OTHER NONREIMBURSABLE COST CENTERS					94.0
8.00	Cross Foot Adjustments					95.0
9.00	Negative Cost Centers					99.0
02.00	5	191, 798				102.0
	Part I)					
03.00		5. 384710				103.00
04.00		7, 552				104.0
	Part II) Unit cost multiplier (Wkst. B, Part	0 212022				105.0
05.00	I TOTEL COSLIMULTIDITEL LWKSL, B. PART	0. 212022				1100.0

Health Financial Systems	CRANBURY CENT	ER		In Li€	eu of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT C	COST CENTERS	Provi der		Peri od:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Data /Tima Dra	narad
				10 12/31/2021	Date/Time Pre 5/19/2022 1:1	pareu. 5 pm
Cost Center Description			Total (from	Total Charges		
· ·			Wkst. B, Pt I	,	di vi ded by	
			col. 18)		col. 2	
			1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS						
40. 00 04000 RADI OLOGY			18, 94			
41.00 04100 LABORATORY			55, 11			
42.00 04200 I NTRAVENOUS THERAPY			34, 17			
43.00 04300 OXYGEN (INHALATION) THERAPY			30, 38			
44.00 04400 PHYSI CAL THERAPY			388, 91			
45.00 04500 OCCUPATI ONAL THERAPY			309, 68			
46.00 04600 SPEECH PATHOLOGY			206, 15	56 570, 475		
47.00 04700 ELECTROCARDI OLOGY				0 0	0. 000000	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS			7, 59		0. 000000	
49.00 04900 DRUGS CHARGED TO PATIENTS			302, 00	01 285, 166		•
50.00 05000 DENTAL CARE - TITLE XIX ONLY				0 0	0. 000000	•
51.00 05100 SUPPORT SURFACES			16, 01	8 671		•
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS				0 0	0.00000	52.00
OUTPATIENT SERVICE COST CENTERS			1		1	
60. 00 06000 CLINIC				0 0	0.000000	
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER				0 0	0.000000	
71.00 07100 AMBULANCE				0 0	0.000000	•
100.00 Total			1, 368, 99	2, 482, 609		100. 00

Health Financial Systems	CRANBURY				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315353	Period: From 01/01/2021 To 12/31/2021		
		Title	XVIII (1)	Skilled Nursing	PPS	
		Health Care Pr	Charge	Facility	Program Cost	
Cost Center Description	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 OUTPA	FIENT COST					
ANCI LLARY SERVI CE COST CENTERS			1		1	
40. 00 04000 RADI OLOGY	0. 416518			0 3, 866		
41. 00 04100 LABORATORY	0. 756433			0 5, 969		
42. 00 04200 I NTRAVENOUS THERAPY	1. 187765			0 11, 121		
43. 00 04300 OXYGEN (INHALATION) THERAPY	17. 175240			0 9, 103		1 101 00
44. 00 04400 PHYSI CAL THERAPY	0. 515754			0 150, 559		1
45. 00 04500 OCCUPATIONAL THERAPY	0. 428138			0 122, 251		1 101 00
46. 00 04600 SPEECH PATHOLOGY	0. 361376			0 77, 181		
47.00 04700 ELECTROCARDI OLOGY 48.00 04800 MEDI CAL_SUPPLIES_CHARGED_TO_PATIENTS	0.00000			0 0	0	
	0.00000			0 05 020	0	
49.00 04900 DRUGS CHARGED TO PATIENTS 50.00 05000 DENTAL CARE - TITLE XIX ONLY	1. 059036 0. 000000			0 85, 028	0	50.00
51.00 05100 SUPPORT SURFACES	23. 871833			0 1 (47		
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 1,647		
OUTPATIENT SERVICE COST CENTERS	0.00000	0		0 0	0	52.00
60. 00 06000 CLINIC	0.00000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.000000	Ŭ		0	0	61.00
62. 00 06200 FQHC						62.00
63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0, 000000	0		0 0	0	
71.00 07100 AMBULANCE (2)	0.000000			0	0	
100.00 Total (Sum of Lines 40 - 71)	3. 000000	898, 458		0 466, 725	-	100.00
	ly.	1 0,0,400	1	100,720		1.00.00

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

Health Financial Systems	CRANBURY	CENTER		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315353	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/19/2022 1:1	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description						
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00Drugs charged to patients - ratio of c2.00Program vaccine charges (From your rec3.00Program costs (Line 1 x line 2) (Title	ords, or the PS	&R)			1. 059036 4, 467 4, 731	1.00 2.00 3.00
E, Part I, line 18) Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Dort A Nurcing	
cost center bescription	(From Wkst. B, Part I, Col.	Allied Health (From Wkst. B,	Nursing & Allied Healt	Cost (From h Wkst. D Part	& Allied Health Costs	
	18	Part I, Col. 14)	Costs to Tota Costs - Part (Col. 2 / Col	A	for Pass Through (Col. 3 x Col. 4)	
			1)			
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS ANCILLARY SERVICE COST CENTERS	FUR NURSING &	ALLIED HEALIH				
40. 00 04000 RADI OLOGY	18, 942		0.0000	3, 866	0	40.00
41. 00 04100 LABORATORY	55, 119		0.0000			41.00
42. 00 04200 INTRAVENOUS THERAPY	34, 172		0.0000		0	42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	30, 383		0.0000		-	43.00
44. 00 04400 PHYSI CAL THERAPY	388, 917		0.0000			44.00
45. 00 04500 OCCUPATI ONAL THERAPY	309, 689		0, 00000		0	45.00
46.00 04600 SPEECH PATHOLOGY	206, 156		0.0000		0	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	Ċ	0.0000		0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 593	C	0. 00000		0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	302,001	C	0. 00000		0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	C	0. 00000	0 00	0	50.00
51.00 05100 SUPPORT SURFACES	16, 018	C	0. 00000	1, 647	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0. 00000	0 0	0	52.00
100.00 Total (Sum of Lines 40 - 52)	1, 368, 990	C)	466, 725	0	100. 00

	Financial Systems	CRANBURY CENTER	In Lie	u of Form CMS-2	2540-1
COMPUT	ATION OF INPATIENT ROUTINE COSTS		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/19/2022 1:1	pared:
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				1
1.00	Inpatient days including private room days			35, 619	1.0
2.00	Private room days			87	2.0
3.00	Inpatient days including private room days appl	icable to the Program		3, 218	3.0
4.00	Medically necessary private room days applicabl	e to the Program		0	4. C
5.00	Total general inpatient routine service cost			11, 453, 395	5.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
o. 00	General inpatient routine service charges			13, 785, 423 0, 830834	6.0
. 00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)				7.0
3.00	Enter private room charges from your records			34, 539 397, 00	
. 00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)				9.
0.00	Enter semi-private room charges from your records				10.
1. 00	Average semi-private room per diem charge (Sem semi-private room days)	i-private room charges line 10, divided	by	387.00	11.
2.00	Average per diem private room charge differenti	al (Line 9 minus line 11)		10.00	12.
3.00	Average per diem private room cost differential	(Line 7 times line 12)		8.31	13.
4.00	Private room cost differential adjustment (Line	2 times line 13)		723	14.
5.00	General inpatient routine service cost net of p PROGRAM INPATIENT ROUTINE SERVICE COSTS	rivate room cost differential (Line 5	minus line 14)	11, 452, 672	15.
6.00	Adjusted general inpatient service cost per die	m (Line 15 divided by line 1)		321.53	16.
7.00	Program routine service cost (Line 3 times lin	ie 16)		1, 034, 684	17.
8.00	Medically necessary private room cost applicabl	e to program (line 4 times line 13)		0	18.
9.00	Total program general inpatient routine service	cost (Line 17 plus line 18)		1, 034, 684	19.
0. 00	Capital related cost allocated to inpatient rou line 30 for SNF; line 31 for NF, or line 32 for		ll column 18,	1, 776, 003	20.
1.00	Per diem capital related costs (Line 20 divide	d by line 1)		49.86	21.
2.00	Program capital related cost (Line 3 times lin			160, 449	
3.00	Inpatient routine service cost (Line 19 minus			874, 235	23.
4.00	Aggregate charges to beneficiaries for excess c			0	24.
	Total program routine service costs for compari	son to the cost limitation (Line 23 min	us line 24)	874, 235	
6. 00	Enter the per diem limitation (1)				26.
	Inpatient routine service cost limitation (Line				27.
28.00	Reimbursable inpatient routine service costs (L (Transfer to Worksheet E, Part II, line 4) (See		ine 27)		28.
1) 11	nes 26 and 27 are not applicable for title XVIII	but may be used for title V and or ti	tle XIX		

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	35, 619	1.00
2.00	Program inpatient days (see instructions)	3, 218	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 090345	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

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Heal th	Financial Systems CRANBUE	RY CENTER	In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provi der No.: 315353	Period: From 01/01/2021	Worksheet E	
			To 12/31/2021	Part I Date/Time Prep 5/19/2022 1:15	
		Title XVIII	Skilled Nursing	PPS	<u> </u>
			Facility		
				1.00	
				1.00	
1.00	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF RE Inpatient PPS amount (See Instructions)	IMBURSEMENT		2, 338, 092	1.00
2.00	Nursing and Allied Health Education Activities (pass thro	ugh navments)		2, 330, 092	2.00
3.00	Subtotal (Sum of Lines 1 and 2)	ugir payments)		2, 338, 092	3.00
4.00	Primary payor amounts			2, 330, 072	4.00
5.00	Coinsurance			246, 358	5.00
6.00	Allowable bad debts (From your records)			42, 495	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See	instructions)		29, 115	
8.00	Adjusted reimbursable bad debts. (See instructions)	,		27, 622	8.00
9.00	Recovery of bad debts - for statistical records only			0	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			2, 119, 356	
12.00	Interim payments (See instructions)			2, 166, 117	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestrat	ci on		0	14.50
14.55	Demonstration payment adjustment amount after sequestrati	on		966	14.55
14.75	Sequestration for non-claims based amounts (see instructi	ons)		0	14.75
14.99	Sequestration amount (see instructions)			0	14.99
15.00	Balance due provider/program (see Instructions)			-47, 727	15.00
16.00	Protested amounts (Nonallowable cost report items in acco			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT L	ESSER OF COST OR CHARGES - T	ITLE XVIII ONLY		
17.00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			4, 731	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)			4, 731	19.00
20.00	Medicare Part B ancillary charges (See instructions)			4, 467	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)			4, 467	21.00
22.00	Primary payor amounts			0	22.00
23.00 24.00	Coinsurance and deductibles			0	23.00 24.00
24.00	Allowable bad debts (From your records) Allowable Bad debts for dual eligible beneficiaries (see	instructions)		0	24.00
24.01	Adjusted reimbursable bad debts (see instructions)	Thisti uctions)		0	24.01
24.02	Subtotal (Sum of Lines 21 and 24, minus Lines 22 and 23)			4, 467	24.02
26.00	Interim payments (See instructions)			3, 127	26.00
27.00	Tentati ve adjustment			3, 127	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestrat	ion		0	28.50
28.55	Demonstration payment adjustment amount after sequestrati			0	28.55
28.99	Sequestration amount (see instructions)			Ő	28.99
29.00	Balance due provider/program (see instructions)			1, 340	
30 00	Protested amounts (Nonallowable cost report items) in acc	cordance with CMS Pub.15-2. s	ection 115.2		30.00

	Financial Systems				u of Form CMS-	2540-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT TIT	LE V and TITLE XIX ONLY	Provider No.: 315353	Peri od:	Worksheet E	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
				10 12/31/2021	5/19/2022 1:1	
			Title XIX	Skilled Nursing	PPS	
				Facility		
					1.00	
	COMPUTATION OF NET COST OF COVERED S					1
1.00	Inpatient ancillary services (see In		->		0	
2.00	Nursing & Allied Health Cost (From	Norksheet D-1, Pt. II, Iin	e 5)		0	
3.00	Outpatient services				0	
4.00	Inpatient routine services (see inst				0	
5.00	Utilization reviewphysicians' comp		cords)		0	
6.00 7.00	Cost of covered services (Sum of Lin				0	
	Differential in charges between semi	private accommodations and	Tess than semi private	accommodations	-	1
8.00	SUBTOTAL (Line 6 minus line 7)				0	
9.00	Primary payor amounts				0	
10.00	Total Reasonable Cost (Line 8 minus REASONABLE CHARGES	inne 9)			0	10. C
11 00	Inpatient ancillary service charges				0	1 11. C
	Outpatient service charges				0	
	Inpatient routine service charges				0	
	Differential in charges between semi	orivate accommodations and	less than semi-nrivate	accommodations	0	
	Total reasonable charges		ress than sempirvate	accommodations	0	
15.00	CUSTOMARY CHARGES				0	10.0
16.00	Aggregate amount actually collected	from patients liable for p	avment for services on	a charge basis	0	16. C
17.00	Amounts that would have been realize				0	
	had such payment been made in accord			in a onargo baoro	0	
18.00	Ratio of line 16 to line 17 (not to				0.000000	18.0
19.00	Total customary charges (see instruc	tions)			0	19.0
	COMPUTATION OF REIMBURSEMENT SETTLEM	ENT				
20.00	Cost of covered services (see Instru	ctions)			0	20.0
	Deducti bl es				0	21.0
22.00	Subtotal (Line 20 minus line 21)				0	22.0
	Coinsurance				0	23.0
24.00	Subtotal (Line 22 minus line 23)				0	24.0
25.00	Allowable bad debts (from your recor	ds)			0	25.0
26.00	Subtotal (sum of lines 24 and 25)				0	26.0
27.00	Unrefunded charges to beneficiaries	for excess costs erroneous	ly collected based on c	orrection of	0	27.0
	cost limit					
28.00	Recovery of excess depreciation resu	lting from provider termin	ation or a decrease in	program	0	28.0
	utilization					
	Other Adjustments (see instructions)				0	
30.00	Amounts applicable to prior cost rep		rom disposition of depr	eciable assets (0	30. C
01 00	if minus, enter amount in parenthese		27		-	01 -
	Subtotal (Line 26 plus or minus lin	es 29, and 30, minus lines	27 and 28)		0	
	Interim payments		overnevment- is so i	haaaa) (c	0	
33.00	Balance due provider/program (Line 3	i minus line 32) (Indicate	overpayments in parent	neses) (see	0	33.0

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315353	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Date/Time Prep 5/19/2022 1:15	pared:
		Ti tl	e XVIII	Skilled Nursing Facility		5 pii
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider 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		2, 136, 5	59 0	3, 127 0	1.00 2.00
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER	06/03/2021	29, 5	58	0	3.0
02		00,00,2021	2.7,0	0	0	3.02
03				0	0	3.0
04				0	0	3.0
. 05				0	0	3.0
	Provider to Program					
. 50	ADJUSTMENTS TO PROGRAM			0	0	3.5
. 51				0	0	3.5
. 52				0	0	3.5
. 53				0	0	3.5
. 54				0	0	3.5
. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		29, 5	58	0	3.9
. 00	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)		2, 166, 1	17	3, 127	4.0
	TO BE COMPLETED BY CONTRACTOR					
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
	Program to Provider					
. 01	TENTATI VE TO PROVI DER			0	0	5.0
. 02				0	0	5.0
. 03				0	0	5.0
	Provider to Program					
. 50	TENTATI VE TO PROGRAM			0	0	5.5
51				0	0	5.5
. 52				0	0	5.5
. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5.9
. 00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	PROGRAM TO PROVIDER			0	1, 340	6.0
. 01	PROVIDER TO PROGRAM		47,7	-	1, 340	6.0
. 02	Total Medicare program liability (see instructions)		2, 118, 3		4, 467	7.0
	recar mean care program rrabitity (see thist detrons)			actor Name	Contractor	7.0
			Contra	actor nume	Number	
				1.00	2.00	
						8.0

 8.00
 Name of Contractor

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

	Financial Systems CRANBURY E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	F	eriod: rom 01/01/2021	J of Form CMS-2 Worksheet G	
y)				o 12/31/2021	Date/Time Pre 5/19/2022 1:1	
		General Fund	Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1.00	2.00	3.00	4.00	
	CURRENT ASSETS	T	P			
0	Cash on hand and in banks	1, 730			0	
0 0	Temporary investments Notes receivable	0	0	0	0	
0	Accounts receivable	1, 553, 831	0	0	0	
0	Other receivables	-48, 499	0	0	0	1 5
0	Less: allowances for uncollectible notes and accounts	-262, 792	0	0	0	1 6
0	recei vabl e I nventory	86, 051	0	0	0	
0	Prepai d expenses	282, 706	0	0	0	
0	Other current assets	0	0	0	0	
00	Due from other funds	0	0	-	0	
00	TOTAL CURRENT ASSETS (Sum of Lines 1 - 10) FIXED ASSETS	1, 613, 027	0	0	0	1
00	Land	0	0	0	0	12
00	Land improvements	101, 175			0	
00	Less: Accumulated depreciation	-9, 959	0	0	0	
00	Buildings	0		0	0	
00 00	Less Accumulated depreciation Leasehold improvements	197, 238	-	0	0	
00	Less: Accumulated Amortization	-11, 148		0	0	
00	Fixed equipment	11, 180		0	0	
00	Less: Accumulated depreciation	-2, 723		0	0	
00 00	Automobiles and trucks Less: Accumulated depreciation	0	0	0	0	
00	Major movable equipment	151, 347		0	0	
00	Less: Accumulated depreciation	-33, 571	0	0	0	
00	Minor equipment - Depreciable	0	0	0	0	
00	Minor equipment nondepreciable	0	0	0	0	1 -
00 00	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	403, 539	0	-	0	
00	OTHER ASSETS	100/007				1
00	Investments	0	0	-	0	
00	Deposits on Leases	10,225	0	0	0	
00 00	Due from owners/officers Other assets	-10, 335		0	0	
00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	-10, 335	0	0	0	
00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	2, 006, 231	0	0	0	34
	Liabilities and Fund Balances					+
00	CURRENT LI ABI LI TI ES Accounts payable	709, 139	0	0	0	3
00	Salaries, wages, and fees payable	0			0	
00	Payroll taxes payable	0	0	0	0	
00	Notes & Loans payable (Short term)	0	0	0	0	
00 00	Deferred income Accelerated payments		0	0	0	3 3 4
00	Due to other funds	332	0	0	0	
00	Other current liabilities	936, 962	0	0	0	4
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 646, 433	0	0	0	43
00	LONG TERM LIABILITIES Mortgage payable	0	0	0	0	4
00	Notes payable	0	0	0	0	
00	Unsecured Loans	0	0	0	0	4
00	Loans from owners:	0	0	0	0	
00 00	Other long term liabilities APIC DISTRIBUTIONS; R/E EARNINGS	0 1, 607, 487		0	0	
00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	1, 607, 487	0	0	0	
00	TOTAL LIABILITIES (Sum of lines 43 and 50)	3, 253, 920			0	
	CAPI TAL ACCOUNTS		1			4
00 00	General fund balance Specific purpose fund	-1, 247, 689	0			5
00	Donor created - endowment fund balance - restricted			0		5
00	Donor created - endowment fund balance - restricted			0		5
00	Governing body created - endowment fund balance			0		5
00	Plant fund balance - invested in plant				0	
00 00					0	58
00	Plant fund balance - reserve for plant improvement,				0	
00 00		-1, 247, 689	n	0	0	

Health Financial Systems	CRANBURY CE	ENTER		In Lie	eu of Form CMS-2	2540-10
STATEMENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315353	Peri od: From 01/01/2021 To 12/31/2021	Worksheet G-1 Date/Time Pre 5/19/2022 1:1	
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 31)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments)5.006.007.008.009.00Total additions (sum of line 5 - 9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments)13.0014.0015.0016.0017.00Total deductions (sum of lines 13 - 17)19.00Fund balance at end of period per balance		0 -1, 247, 689 -1, 247, 689 -1, 247, 689 -1, 247, 689 0 -1, 247, 689	3.00		0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 31)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments)5.006.007.008.00	0	000000000000000000000000000000000000000		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance	000	0 0 0 0 0 0		0 0 0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems CI	RANBURY CENTER				In Lie	u of Form CMS-2	2540-10		
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Pr	rovi der	No.: 315353		riod: om 01/01/2021 12/31/2021	Worksheet G-2 Parts I-II Date/Time Pre 5/19/2022 1:1			
	Cost Center Description			I npati ent		Outpati ent	Total			
				1.00		2.00	3.00			
	PART I - PATIENT REVENUES									
	General Inpatient Routine Care Services									
1.00	ILLED NURSING FACILITY		13, 836, 900		13, 836, 900	1.00				
2.00	RSING FACILITY			0		0	2.00			
3.00	ICF/IID				0		0	3.00		
4.00	OTHER LONG TERM CARE				0		0	4.00		
5.00	Total general inpatient care services (Sum of lines	1 - 4)		13, 836, 9	00		13, 836, 900	5.00		
	All Other Care Services	,								
6.00	ANCI LLARY SERVI CES			2, 490, 1	90	0	2, 490, 190	6,00		
7.00	CLINIC					0	0	7.00		
8.00	HOME HEALTH AGENCY COST					0	0	8.00		
9.00	AMBULANCE					0	0	9.00		
10.00	RURAL HEALTH CLINIC					0	0	10.00		
10.10	FQHC					0	0	10.10		
11.00	СМНС					0	0	11.00		
11. 10	CORF					0	0	11.10		
12.00	HOSPICE				0	0	0	12.00		
	OTHER (SPECIFY)				0	0	0	12.00		
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Transf	For column 2 to		16, 327, 0	00	0	16, 327, 090			
14.00	Worksheet G-3, Line 1)			10, 327, 0	90	0	10, 327, 090	14.00		
	Cost Center Description									
	cost center bescription				-	1.00	2.00			
	PART II - OPERATING EXPENSES					1.00	2.00			
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 10	20)					13, 438, 953	1.00		
2.00	Add (Specify)	50)				0	10, 100, 700	2.00		
3.00						0		3.00		
4.00						0		4.00		
5.00						0		5.00		
6.00						0		6.00		
7.00						0		7.00		
8.00	Total Additions (Sum of lines 2 - 7)					0	0	8.00		
8.00 9.00	Deduct (Specify)					_	0	9.00		
9.00 10.00						0		9.00 10.00		
10.00						0		10.00		
						0				
12.00						0		12.00		
13.00						0	-	13.00		
14.00	Total Deductions (Sum of Lines 9 - 13)						0	14.00		
15.00	Total Operating Expenses (Sum of lines 1 and 8, minu	us line 14)				I	13, 438, 953	15.00		

Heal th	Financial Systems	ncial Systems CRANBURY CENTER In L		Inlie	eu of Form CMS-2540-10		
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		OR ADDREED CENT	Provi der No. : 315353	Peri od: From 01/01/2021	Worksheet G-3		
	To 12/31/2021				Date/Time Prepared: 5/19/2022 1:15 pm		
					1.00		
1.00	Total patient revenues (From Wkst. G-2, Part I,	16, 327, 090	1.00				
2.00	Less: contractual allowances and discounts on pa-	4, 158, 644	2.00				
3.00	Net patient revenues (Line 1 minus line 2)	12, 168, 446	3.00				
4.00	Less: total operating expenses (From Worksheet G-	13, 438, 953	4.00				
5.00	Net income from service to patients (Line 3 minus	-1, 270, 507	5.00				
	Other income:						
6.00	Contributions, donations, bequests, etc				0	6.00	
7.00	Income from investments				0	7.00	
8.00	Revenues from communications (Telephone and Inte	ernet service)			0	8.00	
9.00	Revenue from television and radio service				0	9.00	
10.00	Purchase di scounts				0	10.00	
11.00	Rebates and refunds of expenses				0	11.00	
12.00	Parking lot receipts				0	12.00	
13.00	Revenue from Laundry and Linen service				0	13.00	
14.00	Revenue from meals sold to employees and guests				0	14.00	
15.00	Revenue from rental of living quarters				0	15.00	
16.00	Revenue from sale of medical and surgical supplie	es to other tha	n patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients	S			0	17.00	
18.00	Revenue from sale of medical records and abstrac	ts			0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.))			0	19.00	
20.00	Revenue from gifts, flower, coffee shops, canteer	n			0	20.00	
21.00	Rental of vending machines				0	21.00	
22.00	Rental of skilled nursing space				0	22.00	
23.00	Governmental appropriations				0	23.00	
24.00	MISCINCOME				22, 818	24.00	
24.50					0	24.50	
25.00	Total other income (Sum of lines 6 - 24)				22, 818	25.00	
26.00					-1, 247, 689		
27.00	Other expenses (specify)				0	27.00	
28.00					0	28.00	
29.00					0	29.00	
	Total other expenses (Sum of lines 27 - 29)				0		
	Net income (or loss) for the period (Line 26 minu	us line 30)			-1, 247, 689		
		/		, i			