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

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

Provider CCN: 315353

Period:
From 01/01/2022
To 12/31/2022

Worksheet S
Parts I, II & III
Date/Time Prepared:
5/17/2023 2:33 pm

				3/1//	ZUZS Z.	. SS PIII
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared cost rep	ort		Date: 5/17/2023	Ti me:	2: 33 pr
use only	2. [] Manually prepared cost report					
	3. [0] If this is an amended report ent	er the number	of times the provider	resubmitted this cos	t repor	t
	3.01 [] No Medicare Utilization. Enter "	Y" for yes o	leave blank for no.			
Contractor	4. [1] Cost Report Status	6. Contractor	No	<u></u>		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provi der CCN		
	(2) Settled without audit	8.[N] Last	Cost Report for this F	Provider CCN		
	(3) Settled with audit	9. NPR Date:	•			
	(4) Reopened	10.[0] f	ne 4, column 1 is "4":	 Enter number of times	s reope	ned
	(5) Amended	11.Contracto	r Vendor Code	4	•	
	5. Date Received:	12.[F] Medi	care Utilization. Ente no utilization.		r low,	or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRANBURY CENTER (315353) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title XVIII			
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3. 00	4. 00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	24, 713	112	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	24, 713	112	0	100. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete and review the information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems CRANBURY CENTER In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315353 Peri od: Worksheet S-2 From 01/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2022 5/17/2023 2:33 pm 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 292 APPLEGARTH ROAD PO Box: 1.00 2.00 City: MONROE TOWNSHIP State: NJ Zi p Code: 08831 2.00 3.00 County: MI DDLESEX CBSA Code: 35154 Urban/Rural: U 3.00 3. 01 CBSA Code: 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: P 4.00 SNF CRANBURY CENTER 315353 09/07/1996 N Р 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2022 01/01/2022 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 140, 042 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 23 00 140, 042 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility N 30.00 31.00 | ICF/IID Ν 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC Ν 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38.00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 41 00

Heal th	Financial Systems	CRANBURY CENT	ER	In Lie	u of Form CMS-2	2540-10
SKI LLE	ED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 3153	Peri od:	Worksheet S-2	
COMPLE	EX INDENTIFICATION DATA			From 01/01/2022	Part I	
				To 12/31/2022	Date/Time Pre	
					5/17/2023 2: 3	3 pm
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid loss	es reported in other than	the Administrative	and General cost	N	42. 00
center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and						
	amounts.		9			
43.00	Are there any home office costs as def	ined in CMS Pub. 15-1, Cha	apter 10?		Υ	43.00
43.00 Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?					44. 00	
	office on lines 45, 46 and 47.					
	1.00	2.00		3. 00		
	If this facility is part of a chain or	ganization, enter the name	e and address of th	ne home office on the	lines	
	bel ow.					
45.00	Name: GENESIS HEALTHCARE	Contractor's Name: NOVITA	S Cont	ractor's Number: 1200	1	45. 00
46.00	Street: 101 EAST STATE STREET	PO Box:				46, 00
		State: PA	zi p	Code: 1934	8	47. 00
	or ty. Hemiel. Odorine	otato.	P	1701	•	1

	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI	CRANBURY CENT		No . 215252		eu of Form CMS-	
	D NORSING FACILITY AND SKILLED NORSING FACILI X REIMBURSEMENT QUESTIONNAIRE	IY HEALIH CARE	Provi der		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
					Y/N	5/17/2023 2:3 Date	33 pm
	General Instruction: For all column 1 respons	and onton in column	1 "V" fo	5 Voc. os "N"	1.00	2.00	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in corumn	1, 1 10	r res or in	TOT NO. FOT ALL	the date	
1.00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter				N		1.00
	instructions)			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Progra	am? If	1.00 N	2. 00	3. 00	2.00
2.00	column 1 is yes, enter in column 2 the date						2.00
3.00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider on I, or members of the	es, drug its e board	Y			3. 00
	(000 1.150. 450. 6.15)			Y/N	Type	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" t te copy or enter da	for te	Y	A	03/27/2023	4. 00
5.00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different	from	N			5. 00
	reconcritation.				Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
6. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	ool? (Y/N) Column 2:	Is the	provider the	N	N	6. 00
7. 00 8. 00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri	ng the cost reportin		for Nursing	N N		7. 00 8. 00
	School and/or Allied Health Program? (Y/N) s	ee Thstructions.				Y/N 1.00	
9. 00	Bad Debts Is the provider seeking reimbursement for ba	d dob+s2 (V/N) soo i	netruetio	nc		Υ	9. 00
10. 00	If line 9 is "Y", did the provider's bad debperiod? If "Y", submit copy.	t collection policy	change du	ring this cos	,	N N	10.00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wai	ved? If "	Y", see instr	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting peri	od? If "Y			N	12. 00
		Description	n	Y/N	rt A Date	Part B Y/N	
	looso o	0		1.00	2. 00	3.00	
13. 00	PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			N		N	13. 00
14. 00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			Y	03/15/2023	Y	14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.			N		N	15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.			N		N	16. 00
17. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:			N		N	17. 00
18. 00	Was the cost report prepared only using the			N		N	18. 00

Heal th	Financial Systems C	CRANBURY	CENTE	R			In Lieu	u of Form CMS-	2540-10
	ED NURSING FACILITY AND SKILLED NURSING FACILITY HEAL X REIMBURSEMENT QUESTIONNAIRE	TH CARE		Provi der	No.: 315353		eriod: rom 01/01/2022 o 12/31/2022	Worksheet S-2 Part II Date/Time Pro 5/17/2023 2:3	pared:
		-		1.	00		2.0	00	-
	Cost Report Preparer Contact Information							-	
19. 00	Enter the first name, last name and the title/positi held by the cost report preparer in columns 1, 2, at respectively.		JEAN				PRI CE		19. 00
20. 00	Enter the employer/company name of the cost report preparer.		GENES	IS HEALTH	CARE				20. 00
21. 00	Enter the telephone number and email address of the report preparer in columns 1 and 2, respectively.	cost	41080	44481		-	JEAN. PRI CE@GENE	ESI SHCC. COM	21. 00

Health Financial Systems CRANBURY CENTER In Lieu of Form CMS-2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
COMPLEX REIMBURSEMENT QUESTIONNAIRE

CRANBURY CENTER
Provider No.: 315353
Period: Worksheet S-2
From 01/01/2022 Part II

COMPLE	X KELMBOKSEMENT GOESTLONNALKE			To 12/31/2022	
		Part B			, , , , , , , , , , , , , , , , , , ,
		Date			
	PS&R Data	4. 00			
13. 00	Was the cost report prepared using the PS&R		I		13. 00
13.00	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to				13.00
	prepare this cost report in cols. 2 and				
14. 00	4. (see Instructions.) Was the cost report prepared using the PS&R	03/15/2023			14.00
14.00	for total and the provider's records for	037 137 2023			14.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00	, , , , , , , , , , , , , , , , , , , ,				15. 00
	made to PS&R data for additional claims that have been billed but are not included on the				
	PS&R used to file this cost report? If "Y",				
	see Instructions.				
16. 00					16.00
	adjustments made to PS&R data for				
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
10 00	Describe the other adjustments: Was the cost report prepared only using the				18. 00
10.00	provider's records? If "Y" see Instructions.				18.00
	1		3. 00		
	Cost Report Preparer Contact Information	/! ! !	DELMBURGEMENT ANALYST		10.00
19.00	Enter the first name, last name and the title held by the cost report preparer in columns 1		REIMBURSEMENT ANALYST		19. 00
	respectively.	, Z, allu 3,			
20.00	Enter the employer/company name of the cost r	report			20.00
_0.00	preparer.				20.00
21. 00	Enter the telephone number and email address	of the cost			21. 00
	report preparer in columns 1 and 2, respectiv	∕el y.			

In Lieu of Form CMS-2540-10 CRANBURY CENTER Provi der No.: 315353

 Heal th Financial
 Systems
 CRANBURY

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

						5/17/2023 2:33	
				I np	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	154	56, 210	0	4, 370		1. 00
2.00	NURSING FACILITY	0	0	0		0	2. 00
3.00	I CF/II D	0	0			0	3. 00
4. 00	HOME HEALTH AGENCY COST		0	0	0	0	4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	0	U				5. 00 6. 00
6. 10	SNF-Based CORF						6. 10
7. 00	HOSPI CE	0	0	0	0	ol	7. 00
8.00	Total (Sum of lines 1-7)	154	56, 210	Ō	4, 370		8. 00
		Inpatient [ays/Vi si ts		Di scharges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	Component	6. 00	7. 00	8.00	9. 00	10.00	
1. 00	SKILLED NURSING FACILITY	7, 142	41, 286	0			1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5. 00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6. 00
6. 10 7. 00	SNF-Based CORF HOSPI CE		0	0	0	ol	6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	7, 142	41, 286	0	114		8. 00
0.00	Total (Juli of Titles 1 7)	Di sch			rage Length of		0. 00
						·	
	Component	0ther	Total	Title V	Title XVIII	Title XIX	
1. 00	SKILLED NURSING FACILITY	11. 00	12. 00 339	13. 00 0. 00	14. 00 38. 33	15. 00 595. 48	1. 00
2. 00	NURSING FACILITY	1/5	339	0.00	30. 33	0.00	2. 00
3. 00	ICF/IID	0	0	0.00		0.00	3. 00
4. 00	HOME HEALTH AGENCY COST		J			0.00	4. 00
5.00	Other Long Term Care	0	0				5. 00
6.00	SNF-Based CMHC						6.00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0	0	0.00		l .	7. 00
8. 00	Total (Sum of lines 1-7)	175 Average Length	339	0.00 Admi s	38. 33 si ons	595. 48	8. 00
		of Stay		, rain s	31 0113		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1 00	CVILLED NUDCINO FACILLEY	16.00	17. 00	18. 00	19. 00	20.00	4.00
1.00	SKILLED NURSING FACILITY	121. 79	0	132	24 0	l	1.00
2. 00 3. 00	NURSING FACILITY	0. 00 0. 00	U		0	0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			0	Ĭ	4. 00
5. 00	Other Long Term Care	0.00				o	5. 00
6.00	SNF-Based CMHC						6.00
6. 10	SNF-Based CORF						6. 10
7.00	HOSPI CE	0.00					7. 00
8. 00	Total (Sum of lines 1-7)	121. 79 Admi ssi ons	0 Full Time		24	192	8. 00
		744111 331 0113	Tarr Trille				
	Component	Total	Employees on	Nonpai d			
		21. 00	Payrol I 22. 00	Workers 23.00			
1.00	SKILLED NURSING FACILITY	348	88. 41	0.00			1. 00
2.00	NURSING FACILITY	0	0. 00				2. 00
3.00	ICF/IID	0	0. 00	0.00			3. 00
4.00	HOME HEALTH AGENCY COST		0. 00				4. 00
5.00	Other Long Term Care	0	0.00				5. 00
6.00	SNF-Based CMHC		0.00				6.00
6. 10 7. 00	SNF-Based CORF HOSPI CE		0. 00 0. 00				6. 10 7. 00
8. 00	Total (Sum of lines 1-7)	348					8. 00
5. 55	(55 51 1155 1 7)	1 340	33. 41	0.00		1	5. 55

Provi der No.: 315353

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

Amount Reported Reported Reported Salaries From Salaries (col. Worksheet A-6 1 ± col. 2) Salaries (col. 3) Wage (col. 3 + col. 4) Wage (col. 4) Wage (col. 3 + col. 4) Wage (col. 4) Wage (col. 3 + col. 4) Wage (col.					1	0 12/31/2022	5/17/2023 2:3	
Reported Salaries From Salaries (col. 2) Salaries (col. 2) Salaries (col. 3) Col. 4)			Amount	Reclass. of	Adj usted	Paid Hours		
PART II - DIRECT SALARIES			Reported	Salaries from	Salaries (col.			
PART II - DIRECT SALARIES SAL			·	Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
PART II - DIRECT SALARIES SAL					·	3		
SALARIES			1. 00	2. 00	3.00	4. 00	5. 00	
1.00 Total salaries (See Instructions) 5, 132, 424 0 5, 132, 424 183, 886. 00 27.91 1.00 2.00 Physician salaries-Part A 0 0 0 0 0.00 0.00 0.00 3.00 A.00 Physician salaries-Part B 0 0 0 0 0.00 0.00 3.00 A.00 Home office personnel 0 0 0 0 0.00								
2.00 Physician salaries-Part A								
3.00 Physician salaries-Part B		1	5, 132, 424	0	5, 132, 424	· ·		
4.00 Home office personnel 0 0 0 0 0 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0 0 0 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 5, 132, 424 0 5, 132, 424 183, 886. 00 27, 91 6.00 0 0.00 0.00 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 0.00 8.00 9.00 CMHC 0 0 0 0 0.00 0.00 0.00 9.00 9.10 CORF 0 0 0 0 0 0.00 0.00 0.00 9.10 10.00 HOSPICE 0 0 0 0 0 0 0.00 0.00 11.00 11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00 11.00 Other excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 0.00 11.00 12.00 13.00 14.00 14.00 15.00 Contract Labor: Patient Related & Might 3,075,099 0 3,075,099 74,024.41 41.54 14.54 15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 15.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 49.02 16.00 Wage-related costs core (See Part IV) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0			
5.00 Sum of lines 2 through 4 0 0 0 0 0 0 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 5,132,424 0 5,132,424 183,886.00 27.91 6.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			0	0	0			
6.00 Revised wages (line 1 minus line 5) 5,132,424 0 5,132,424 183,886.00 27.91 6.00 7.00 Other Long Term Care 0 0 0 0 0 0 0.00 0.00 7.00 9.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0 0.00 0.00 9.00 9.00 9.10 CORF 0 0 0 0 0 0.00 0.00 9.00 9.10 CORF 0 0 0 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12.00 12.00 12.00 There wages & RELATED COSTS 0 0 0 0 0 0.00 0.00 12.00 12.00 Contract Labor: Patient Related & Mgmt 0.00 0.00 0.00 16.			0	0	0			
7. 00 Other Long Term Care 0 0 0 0 0 0.00 0.00 7. 00 8. 00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8. 00 9. 00 0 0.00 0.0			0	0	0			
8.00 HOME HEALTH AGENCY COST 0 0 0 0 0.00 0.00 8.00 9.00 9.00 CMHC 0 0 0 0 0 0.00 0.00 9.00 9.00 9.00 9.0			5, 132, 424	0	5, 132, 424			
9.00 CMHC CORF			0	0	0			
9. 10 10. 00 HOSPICE 0 0 0 0 0 0.00 0.00 10.00 11. 00 Other excluded areas 0 0 0 0 0 0.00 0.00 11. 00 12. 00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12. 00 13. 00 Total Adjusted Salaries (line 6 minus line 5, 132, 424 0 5, 132, 424 183, 886. 00 27. 91 13. 00 Total Adjusted Salaries (line 6 minus line 12) Total Adjusted Salaries (line 6 minus line 12) Total Adjusted Salaries (line 6 minus line 13, 075, 099 0 3, 075, 099 74, 024. 41 41. 54 14. 00 15. 00 Contract Labor: Patient Related & Mgmt 30, 840 0 30, 840 363. 00 84. 96 15. 00 16. 00 Home office salaries & wage related costs 436, 995 0 436, 995 8, 914. 00 49. 02 MAGE-RELATED COSTS 17. 00 Wage-related costs core (See Part IV) 1, 181, 565 0 1, 181, 565 19. 00 18. 00 Wage-related costs other (See Part IV) 0 0 0 0 18. 00 19. 00 Wage related costs (excluded units) 0 0 0 0 19. 00 20. 00 Physician Part A - WRC 0 0 0 0 20. 00 21. 00 Physician Part B - WRC 0 0 0 0 22. 00 22. 00 Total Adjusted Wage Related cost (see 1, 181, 565) 0 1, 181, 565 0 22. 00			0	0	0			
10.00 HOSPICE 0 0 0 0 0 0 0 0 10.00 10.00 11.00 11.00 12.00 12.00 12.00 13.00 13.00 13.00 14.00 13.00 15.00 14.00 15.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 17			0	0	0	0.00	0.00	
11.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12.00 12.00 13.00 Total Adjusted Salaries (line 6 minus line 12) 0 5, 132, 424 183, 886.00 27.91 13.00 12.00 1								
12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0 0.00 0.00 12.00 through 11) 13.00 Total Adjusted Salaries (line 6 minus line 5, 132, 424 0 5, 132, 424 183, 886.00 27.91 13.00 0THER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 3,075,099 0 3,075,099 74,024.41 41.54 14.00 15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 15.00 16.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 49.02 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,181,565 0 1,181,565 0 19.00 19.00 Wage related costs (excluded units) 0 0 0 0 19.00 19.00 Physician Part A - WRC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	HOSPI CE	0	0	0			10.00
through 11) Total Adjusted Salaries (line 6 minus line 5, 132, 424 0 5, 132, 424 183, 886.00 27.91 13.00 OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 3,075,099 0 3,075,099 74,024.41 41.54 14.00 15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 15.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 49.02 17.00 Wage-related costs core (See Part IV) 1,181,565 0 1,181,565 17.00 18.00 Wage related costs (excluded units) 0 0 0 19.00 Wage related costs (excluded units) 0 0 20.00 Physician Part A - WRC 0 0 21.00 Physician Part B - WRC 0 0 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0	11. 00	Other excluded areas	0	0	0	0.00		
13.00 Total Adjusted Salaries (line 6 minus line 12) 12.00 13.00 143,886.00 27.91 13.00 14.00 27.91 13.00 27.91 13.00 27.91 27.9	12.00		0	0	0	0.00	0.00	12.00
12 OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 3,075,099 0 3,075,099 74,024.41 41.54 14.00 15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 15.00 16.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 49.02 16.00 WAGE-RELATED COSTS								
OTHER WAGES & RELATED COSTS 14.00 Contract Labor: Patient Related & Mgmt 3,075,099 0 3,075,099 74,024.41 41.54 14.00 15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 15.00 16.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 49.02 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,181,565 0 1,181,565 17.00 18.00 Wage-related costs other (See Part IV) 0 0 0 18.00 19.00 Wage related costs (excluded units) 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 22.00	13. 00	`	5, 132, 424	0	5, 132, 424	183, 886. 00	27. 91	13. 00
14.00 Contract Labor: Patient Related & Mgmt 3,075,099 0 3,075,099 74,024.41 41.54 15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 16.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 49.02 17.00 Wage-related costs core (See Part IV) 1,181,565 0 1,181,565 17.00 18.00 Wage related costs other (See Part IV) 0 0 0 18.00 19.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 0								
15.00 Contract Labor: Physician services-Part A 30,840 0 30,840 363.00 84.96 15.00 16.00 Home office salaries & wage related costs 436,995 0 436,995 8,914.00 16.00 16.00 17.00 Mage-related costs core (See Part IV) 1,181,565 0 1,181,565 17.00 18.00 19.00 Wage related costs other (See Part IV) 0 0 0 0 18.00 19.00				1				
16.00 Home office salaries & wage related costs		9						
WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,181,565 0 1,181,565 17.00 18.00 Wage-related costs other (See Part IV) 0 0 0 18.00 19.00 Wage related costs (excluded units) 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 22.00			· ·					
17. 00 Wage-related costs core (See Part IV) 1, 181, 565 0 1, 181, 565 17. 00 18. 00 Wage-related costs other (See Part IV) 0 0 0 0 18. 00 19. 00 Wage related costs (excluded units) 0 0 0 0 19. 00 20. 00 Physician Part A - WRC 0 0 0 0 20. 00 21. 00 Physician Part B - WRC 0 0 0 0 21. 00 22. 00 Total Adjusted Wage Related cost (see 1, 181, 565 0 1, 181, 565 0	16. 00		436, 995	0	436, 995	8, 914. 00	49. 02	16. 00
18.00 Wage-related costs other (See Part IV) 0 0 0 19.00 Wage related costs (excluded units) 0 0 0 20.00 Physician Part A - WRC 0 0 0 21.00 Physician Part B - WRC 0 0 0 22.00 Total Adjusted Wage Related cost (see 1, 181, 565 0 1, 181, 565				_		I		
19.00 Wage related costs (excluded units) 0 0 0 20.00 Physician Part A - WRC 0 0 0 21.00 Physician Part B - WRC 0 0 0 22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565		, ,	1, 181, 565	0	1, 181, 565			
20.00 Physician Part A - WRC 0 0 0 0 21.00 Physician Part B - WRC 0 0 0 0 22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 22.00			0	0	0			
21.00 Physician Part B - WRC 0 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 22.00		, ,	0	0	0			
22.00 Total Adjusted Wage Related cost (see 1,181,565 0 1,181,565 22.00			0	0	0			
		1 3	0	0	0			
Instructions)	22. 00		1, 181, 565	0	1, 181, 565			22. 00
		Instructions)		l				

Health Financial Systems
SNF WAGE INDEX INFORMATION CRANBURY CENTER

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | Part Provi der No.: 315353

				'	0 12/31/2022	5/17/2023 2: 3	
	·	Amount	Reclass. of	Adj usted	Paid Hours	Average Hourly	
		Reported		Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0.00	1. 00
2.00	Administrative & General	400, 319	0	400, 319	12, 811. 00	31. 25	2. 00
3.00	Plant Operation, Maintenance & Repairs	115, 925	0	115, 925	4, 139. 00	28. 01	3. 00
4.00	Laundry & Linen Service	0	0	0	0.00	0.00	4. 00
5.00	Housekeepi ng	0	0	0	0.00	0.00	5. 00
6.00	Di etary	0	0	0	0.00	0.00	6. 00
7.00	Nursing Administration	592, 575	-79, 363	513, 212	11, 821. 00	43. 42	7. 00
8.00	Central Services and Supply	0	41, 034	41, 034	1, 706. 00	24. 05	8. 00
9.00	Pharmacy	0	0	0	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	38, 329	38, 329	1, 837. 00	20. 86	10. 00
11. 00	Soci al Servi ce	134, 266	0	134, 266	4, 296. 00	31. 25	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	114, 611	0	114, 611	5, 689. 00	20. 15	13. 00
14. 00	Total (sum lines 1 thru 13)	1, 357, 696	o	1, 357, 696	42, 299. 00	32. 10	14. 00

Health Financial Systems	CRANBURY CENTER	In Lieu of Form CMS-2540-10
SNF WAGE RELATED COSTS		Peri od: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared:

Amount Reported Re			То	12/31/2022	Date/Time Prep 5/17/2023 2:3	
PART IV - WAGE RELATED COSTS						
PART IV - WAGE RELATED COSTS Part A - Core List						
Part A - Core List RETIREMENT COST State State						
RETIREMENT COST		PART IV - WAGE RELATED COSTS				
1.00	Ī	Part A - Core List				
Tax Shel tered Annui ty (TSA) Employer Contribution 0 2 . 00	Ī	RETIREMENT COST				
Qualified and Non-Qualified Pension Plan Cost	1.00	401K Employer Contributions			55, 345	1. 00
Prior Year Pension Service Cost 0 4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	3.00	Qualified and Non-Qualified Pension Plan Cost		I	0	3. 00
\$ 0.00 401K/TSA Plan Administration fees 0 5.00 6.00 1.00	4.00	Prior Year Pension Service Cost			0	4. 00
Legal / Accounting / Management Fees-Pension Plan Demployee Managed Care Program Administration Fees Demployee Section Plan De	Ì	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
Employee Managed Care Program Administration Fees 0 7.00	5.00	401K/TSA Plan Administration fees			0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan			0	6. 00
Heal th Insurance (Purchased or Self Funded) Funder Funded Funded Funded Funder Funded	7.00	Employee Managed Care Program Administration Fees			0	7. 00
Prescription Drug Plan	Ī	HEALTH AND INSURANCE COST				
Prescription Drug Plan	8.00	Heal th Insurance (Purchased or Self Funded)			522, 932	8.00
10. 00 Dental, Hearing and Vision Plan 0 10. 00 11. 00				İ	0	9. 00
11. 00					0	10.00
12.00					0	11. 00
13. 00 Disability Insurance (If employee is owner or beneficiary) 0 13. 00 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00 15. 00 Workers' Compensation Insurance 133, 199 15. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16. 00 Non cumulative portion) TAXES 17. 00 17. 00 FICA-Employers Portion Only 382, 526 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 0 19. 00 19. 00 State or Federal Unemployment Taxes 55, 737 OTHER 21. 00 Executive Deferred Compensation 0 21. 00 22. 00 Day Care Cost and Allowances 31, 826 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1, 181, 565 24. 00 Part B - Other than Core Related Cost 10. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00 Part B - Other than Core Related Cost 1. 0					0	12.00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00 15. 00 Workers' Compensation Insurance 133, 199 15. 00 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16. 00 Non cumulative portion					0	13. 00
15. 00 Workers' Compensation Insurance 133, 199 15. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16. 00 Non cumulative portion TAXES					0	14. 00
16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost					-	
Non cumulative portion TAXES TAX			dinary accrual required by F	ASB 106.		
TAXES 17. 00 FI CA-Empl oyers Portion Only 382, 526 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19.					_	
18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 0 19. 00 20. 00 State or Federal Unemployment Taxes 55, 737 20. 00 OTHER 0 21. 00 21. 00 Executive Deferred Compensation 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 31, 826 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1, 181, 565 24. 00 Amount Reported 1. 00 1. 00				<u>'</u>		
18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 0 19. 00 20. 00 State or Federal Unemployment Taxes 55, 737 20. 00 OTHER 0 21. 00 21. 00 Executive Deferred Compensation 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 31, 826 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1, 181, 565 24. 00 Amount Reported 1. 00 1. 00	17. 00	FICA-Employers Portion Only			382, 526	17. 00
19. 00 Unemployment Insurance 0 19. 00 20. 00 State or Federal Unemployment Taxes 55, 737 20. 00 OTHER 21. 00 Executive Deferred Compensation 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 31, 826 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1, 181, 565 24. 00 Amount Reported 1. 00 Part B - Other than Core Related Cost 1. 00 1. 00					0	18. 00
20. 00 State or Federal Unemployment Taxes 55, 737 20. 00 OTHER 21. 00 Executive Deferred Compensation 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 Tuition Reimbursement 31, 826 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 1, 181, 565 24. 00 Amount Reported 1. 00 Part B - Other than Core Related Cost					0	19. 00
OTHER 21.00 Executive Deferred Compensation					55, 737	20.00
22.00 Day Care Cost and Allowances 0 22.00						
22.00 Day Care Cost and Allowances 0 22.00					0	21. 00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost					0	22. 00
Amount Reported 1.00 Part B - Other than Core Related Cost					31, 826	23. 00
Amount Reported 1.00 Part B - Other than Core Related Cost						
Part B - Other than Core Related Cost		, ,				
Part B - Other than Core Related Cost					Reported	
					1. 00	
25.00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25.00		Part B - Other than Core Related Cost				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

Provider No.: 315353 | Period: | Worksheet S-3 | From 01/01/2022 | Part V |

				Ť	o 12/31/2022	Date/Time Prep 5/17/2023 2:3	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	У Ріп
	g ,	Reported		Salaries (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				<u> </u>	3	ĺ	
		1.00	2. 00	3.00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	764, 538	105, 949		,		1. 00
2.00	Licensed Practical Nurses (LPNs)	1, 097, 921	259, 401				2. 00
3.00	Certified Nursing Assistant/Nursing	1, 912, 269	570, 004	2, 482, 273	91, 554. 17	27. 11	3. 00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	3, 774, 728	935, 354	4, 710, 082	· ·		4. 00
5.00	Physical Therapists	0	0	0	0.00		5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		6. 00
7.00	Physical Therapy Aides	0	0	0	0.00		7. 00
8.00	Occupational Therapists	0	0	0	0. 00		8. 00
9.00	Occupational Therapy Assistants	0	0	0	0. 00		9. 00
10.00	Occupational Therapy Aides	0	0	0	0. 00		10.00
11. 00	Speech Therapists	0	0	0	0.00		11. 00
12. 00	Respi ratory Therapi sts	0	0	0	0. 00		12.00
13. 00	Other Medical Staff	0	0	0	0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	1		1		1	
14.00	Registered Nurses (RNs)	98, 232		98, 232			14.00
15. 00	Li censed Practical Nurses (LPNs)	528, 221		528, 221	· ·		15.00
16. 00	Certified Nursing Assistant/Nursing	87, 726		87, 726	2, 363. 90	37. 11	16. 00
17. 00	Assistants/Aides Total Nursing (sum of lines 14 through 16)	714, 179		714, 179	11, 619. 94	(1.4)	17. 00
17. 00	Physical Therapists	241, 955		241, 955	· ·		17.00
19. 00	'				i i		18.00
	Physical Therapy Assistants	96, 866		96, 866	· ·		20.00
20. 00 21. 00	Physical Therapy Aides Occupational Therapists	184, 850		184, 850	0. 00 2, 809. 00		
21.00	Occupational Therapy Assistants	95, 525		95, 525	· ·		21.00
23. 00	Occupational Therapy Assistants	95, 525		95, 525	0.00		23. 00
24. 00	Speech Therapists	129, 785		129, 785			24. 00
25. 00	Respi ratory Therapi sts	1, 403		1, 403	· ·		25. 00
26. 00		30, 840		30, 840			
20.00	Tother wedical Stall	30, 640		J 30, 640	30.00	000.07	20.00

Peri od: Worksheet S-7 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/17/2023 2:33 pm

	10 12/31/2022	5/17/2023 2:33 pm
	Group	Days
	1.00	2. 00
1.00	RUX	1.00
2. 00 3. 00	RUL RVX	2.00
4.00	RVL	4.00
5. 00	RHX	5. 00
6.00	RHL	6. 00
7. 00	RMX	7.00
8. 00	RML	8.00
9.00	RLX	9.00
10. 00 11. 00	RUC RUB	10.00
12.00	RUA	12. 00
13. 00	RVC	13. 00
14. 00	RVB	14. 00
15. 00	RVA	15. 00
16. 00	RHC	16.00
17. 00	RHB	17. 00
18. 00 19. 00	RHA RMC	18. 00 19. 00
20. 00	RMB	20.00
21. 00	RMA	21. 00
22. 00	RLB	22. 00
23. 00	RLA	23. 00
24.00	ES3	24.00
25. 00 26. 00	ES2 ES1	25. 00 26. 00
27. 00	HE2	27. 00
28. 00	HE1	28. 00
29. 00	HD2	29. 00
30. 00	HD1	30.00
31.00	HC2	31.00
32. 00 33. 00	HC1 HB2	32. 00 33. 00
34. 00	HB1	34.00
35. 00	LE2	35. 00
36. 00	LE1	36.00
37. 00	LD2	37. 00
38.00	LD1	38.00
39. 00 40. 00	LC2 LC1	39. 00 40. 00
41.00	LB2	41. 00
42. 00	LB1	42. 00
43. 00	CE2	43. 00
44.00	CE1	44. 00
45. 00	CD2	45. 00
46. 00 47. 00	CD1 CC2	46. 00 47. 00
48. 00	CC1	48. 00
49. 00	CB2	49. 00
50. 00	CB1	50.00
51. 00	CA2	51.00
52. 00	CA1	52.00
53. 00 54. 00	SE3 SE2	53. 00 54. 00
55. 00	SE1	55. 00
56. 00	SSC	56. 00
57. 00	SSB	57. 00
58. 00	SSA	58. 00
59. 00	I B2	59.00
60. 00 61. 00	I B1 I A2	60. 00 61. 00
62. 00	I A1	62.00
63. 00	BB2	63. 00
64. 00	BB1	64. 00
65. 00	BA2	65. 00
66.00	BA1	66.00
67. 00 68. 00	PE2 PE1	67. 00 68. 00
69. 00	PD2	69.00
70. 00	PD1	70.00
71. 00	PC2	71.00
72. 00	PC1	72.00
73.00	PB2	73.00
74. 00 75. 00	PB1 PA2	74. 00 75. 00
10.00	I AZ	1 73.00

Health Financial Systems	CRANBURY CENTER		In Lie	u of Form CMS	-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der		Peri od:	Worksheet S-	7
			From 01/01/2022 To 12/31/2022		
			Group	Days	
			1. 00	2. 00	
76. 00			PA1		76. 00
99. 00			AAA		99. 00
100. 00 TOTAL		_			100. 00
		Expenses	Percentage	Y/N	
		1.00	2. 00	3. 00	
A notice published in the Federal Register payments beginning 10/01/2003. Congress ex expenses. For lines 101 through 106: Enter column 2 the percentage of total expenses line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expen (See instructions)	pected this increase to be used in column 1 the amount of the for each category to total SNF for yes or "N" for no if the	d for direct p expense for e revenue from spending refle	atient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101. 00 Staffi ng					101. 00
102.00 Recruitment					102. 00
103.00 Retention of employees					103. 00
104. 00 Trai ni ng					104. 00
105. 00 OTHER (SPECIFY)					105. 00
106.00 Total SNF revenue (Worksheet G-2, Part I,	line 1, column 3)	1			106. 00

Heal th	Financial Systems	CRANBURY C	ENTER		In Lie	u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
					10 12/31/2022	5/17/2023 2:3	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	, , , , , , , , , , , , , , , , , , ,			+ col . 2)	ons	Trial Balance	
				,	Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col . 4)	
					A-6)		
	CENIEDAL CEDVICE COST CENTEDS	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FLXTURES		2, 067, 062	2, 067, 06	2 0	2, 067, 062	1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		22, 452			22, 452	2.00
3. 00	00300 EMPLOYEE BENEFITS	0	1, 166, 864			1, 166, 864	3. 00
4. 00	00400 ADMINISTRATIVE & GENERAL	400, 319	2, 088, 556			2, 488, 875	4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	115, 925	483, 154			599, 079	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	298, 452			298, 452	6.00
7. 00	00700 HOUSEKEEPI NG	o	381, 654			381, 654	ł
8.00	00800 DI ETARY	O	1, 095, 790			1, 095, 790	1
9.00	00900 NURSING ADMINISTRATION	592, 575	106, 862	699, 43	7 -79, 363	620, 074	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	34, 050	34, 05	0 41, 034	75, 084	10.00
11.00	01100 PHARMACY	0	0		0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0 38, 329	38, 329	12.00
13.00	01300 SOCIAL SERVICE	134, 266	12, 385	146, 65	1 0	146, 651	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14. 00
15. 00	01500 ACTIVITIES	114, 611	32, 215	146, 82	6 0	146, 826	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	3, 774, 728	905, 112	4, 679, 84	0	4, 679, 840	1
31. 00	03100 NURSING FACILITY	0	0		0	0	31. 00
	03200 CF/ D	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		44.047	14.04		44.044	40.00
40.00	04000 RADI OLOGY	0	14, 216				1
41.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	30, 258 23, 993			30, 258	
42. 00 43. 00	04300 OXYGEN (INHALATION) THERAPY	0					1
44. 00	04400 PHYSI CAL THERAPY	0	16, 258 287, 410			16, 258 287, 410	1
45. 00	04500 OCCUPATI ONAL THERAPY		325, 911			325, 911	1
46. 00	04600 SPEECH PATHOLOGY		139, 709			139, 709	ł
47. 00	04700 ELECTROCARDI OLOGY		137, 707	137, 70	n o	0	1
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	0		0 0	Ö	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	o	152, 158	152, 15	8 0	152, 158	ł
50.00	05000 DENTAL CARE - TITLE XIX ONLY	O	0	,	0	0	1
51.00	05100 SUPPORT SURFACES	0	19, 849	19, 84	9 0	19, 849	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	52.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0		0		
61. 00	06100 RURAL HEALTH CLINIC	0	0		0	0	
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			1	0 0	0	70.00
	07000 HOME HEALTH AGENCY COST	0	0		0		70.00
	07100 AMBULANCE	0	0		0	0	71. 00 72. 00
72.00	07300 CMHC	0	0			0	73.00
	07400 OTHER REIMBURSABLE COST	0	0			0	1
74.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	0	0	74.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES		0		0 0	0	80. 00
	08100 NTEREST EXPENSE		0		0	0	1
82.00	08200 UTILIZATION REVIEW	O	0		0 0	0	1
83.00	08300 HOSPI CE	O	0		0	0	83. 00
84.00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	0		0	0	84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	5, 132, 424	9, 704, 370	14, 836, 79	4 0	14, 836, 794	89. 00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0		90.00
	09100 BARBER AND BEAUTY SHOP	0	6, 338	6, 33	8 0		91.00
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	
	09300 NONPAI D WORKERS	0	0		0	0	
	09400 PATIENTS LAUNDRY		0			0	
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST CENTERS TOTAL	5, 132, 424	9, 710, 708	14, 843, 13	0	0 14, 843, 132	
100.00	TI TIVIAL	5, 132, 424	7, 110, 100	1 14,043,13	۷	14,043,132	1100.00

Health Financial Systems CRAN RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315353

				То	12/31/2022	Date/Time Prepared: 5/17/2023 2:33 pm
	Cost Center Description	Adjustments to	Net Expenses			37 177 2023 2. 33 piii
			For Allocation			
		Wkst A-8)	(col. 5 +- col. 6)			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FIXTURES OO200 CAP REL COSTS - MOVABLE EQUIPMENT	0	_, _,,	•		1.00
3. 00	00300 EMPLOYEE BENEFITS	41, 210	,	•		3.00
4. 00	00400 ADMINISTRATIVE & GENERAL	-789, 952		•		4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	599, 079	•		5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	298, 452	1		6. 00
7.00	00700 HOUSEKEEPI NG	0	381, 654	•		7.00
8. 00 9. 00	O0800 DI ETARY O0900 NURSI NG ADMI NI STRATI ON		1, 095, 790 620, 074	1		8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY		75, 084	•		10.00
11. 00	01100 PHARMACY	0	0	1		11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	38, 329	1		12.00
13.00	01300 SOCIAL SERVICE	0	146, 651 0			13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	-30, 967		•		14. 00 15. 00
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS	30,707	110,007			10.00
30.00	03000 SKILLED NURSING FACILITY	-30, 536		1		30.00
31. 00 32. 00	03100 NURSING FACILITY 03200 CF/IID	0	0	i e		31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE		0	i e		33. 00
	ANCILLARY SERVICE COST CENTERS	_				
	04000 RADI OLOGY	0	14, 216	1		40. 00
41. 00	04100 LABORATORY	0	30, 258			41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY		23, 993 16, 258	•		42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		287, 410			44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	325, 911			45. 00
46. 00	04600 SPEECH PATHOLOGY	0	139, 709	1		46. 00
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1		47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATTENTS		152, 158	1		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		50.00
51. 00	05100 SUPPORT SURFACES	0	19, 849	1		51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0			52. 00
60. 00	06000 CLINIC	T 0	0			60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0			61. 00
62.00	06200 FQHC	_	_			62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	0			63. 00
70. 00	07000 HOME HEALTH AGENCY COST	T 0	0			70.00
71. 00	07100 AMBULANCE	0	0			71. 00
72. 00	07200 CORF	0	0			72. 00
	07300 CMHC 07400 OTHER REI MBURSABLE COST	0	0	1		73. 00 74. 00
74.00	SPECIAL PURPOSE COST CENTERS		0			74.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	0			80.00
81. 00	08100 I NTEREST EXPENSE	0	0			81.00
82.00	08200 UTI LI ZATI ON REVI EW	0	0			82.00
83. 00 84. 00	08300 HOSPI CE 08400 OTHER SPECI AL PURPOSE COST CENTERS	0	0			83. 00 84. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-810, 245	14, 026, 549			89. 00
	NONREI MBURSABLE COST CENTERS					
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 6, 338	1		90.00
	09200 PHYSI CLANS PRI VATE OFFI CES	1 0	0, 338			92.00
93.00	09300 NONPAI D WORKERS		ő			93. 00
	09400 PATIENTS LAUNDRY	0	0			94.00
95. 00 100. 00	O9500 OTHER NONREIMBURSABLE COST CENTERS TOTAL	-810, 245	0 14, 032, 887			95. 00 100. 00
100.00	/ ITOTAL	-010, 245	14,032,087	I		1100.00

Health Financial Systems	CRANBURY CENTER			In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS	Pro	ovider No		Period: From 01/01/2022	Worksheet A-6	
			Т	To 12/31/2022	Date/Time Pre 5/17/2023 2:3	pared: 3 pm
			Increases			
	Cost Center		Li ne #	Sal ary	Non Salary	
	2. 00		3.00	4. 00	5. 00	
(1) A - DEFAULT						
1. 00	CENTRAL SERVICES & SUPF	PLY	10.00	41, 034	0	1. 00
2. 00	MEDICAL RECORDS & LIBRA	ARY	12.00	38, 329	0	2. 00
TOTALS						
100. 00	Total Reclassifications	ıs (Sum		79, 363	0	100. 00
	of columns 4 and 5 must	it				
	equal sum of columns 8	and				
	9)					

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

Health Financial Systems	CRANBURY CENT	ER		In Lie	u of Form CMS-	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 01/01/2022		
				To 12/31/2022		
					5/17/2023 2:3	3 pm
			Decreases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
(1) A - DEFAULT	_					
1.00	NURSING ADMINISTRAT	ION	9. 0	00 41, 034	0	1. 00
2. 00	NURSING ADMINISTRAT	ION	9. C	00 38, 329	0	2. 00
TOTALS						
100. 00				79, 363	0	100. 00

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

Provider No.: 315353 | Period: From 01/01/2022 | Worksheet A-7 Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS CRANBURY CENTER

					To 12/31/2022	Date/Time Prep 5/17/2023 2:33	
				Acqui si ti ons	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 BALANCES	5					
1.00	Land	0	0		0	0	1. 00
2.00	Land Improvements	101, 175	4, 622		0 4, 622	0	2. 00
3.00	Buildings and Fixtures	0	0		0	0	3. 00
4.00	Building Improvements	197, 238	79, 046		0 79, 046	0	4. 00
5.00	Fi xed Equi pment	11, 179	23, 390		0 23, 390	0	5. 00
6.00	Movable Equipment	151, 347	0		0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	460, 939	107, 058		0 107, 058		7. 00
8.00	Reconciling Items	0	0		0	0	8. 00
9.00	Total (line 7 minus line 8)	460, 939			0 107, 058	0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
	TANAL YOU OF SUMMORS IN SARITAL ASSET BALANCE	6.00	7. 00				
4 00	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		0				4 00
1.00	Land	105 707	0				1.00
2.00	Land Improvements	105, 797	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	276, 284	0				4. 00
5.00	Fi xed Equi pment	34, 569	0				5. 00
6.00	Movable Equipment	151, 347	0				6. 00
7.00	Subtotal (sum of lines 1-6)	567, 997	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9.00	Total (line 7 minus line 8)	567, 997	0			l	9. 00

Provi der No.: 315353

Peri od: Worksheet A-8 Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: <u>5/17/2023</u> 2:33 pm

					5/17/2023 2: 3	3 pm
				Expense Classification on	Worksheet A	
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Line No.	
	Description (1)	` '	Alliourt	Cost center	Little No.	
		Adjustment	2.00	2.00	4.00	
4 00	1	1.00	2.00	3. 00	4.00	1 00
1. 00	Investment income on restricted funds		0	1	0.00	1. 00
0.00	(chapter 2)				0.00	0.00
2.00	Trade, quantity, and time discounts (chapter		0)	0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	
4.00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)	A	-30, 967	ACTI VI TI ES	15.00	6. 00
7.00	Parking Lot (chapter 21)		0)	0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0)		8. 00
	physician adjustment					
9.00	Home office cost (chapter 21)		0		0.00	9. 00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11. 00	Nonallowable costs related to certain		0		0.00	
	Capital expenditures (chapter 24)					
12.00	Adjustment resulting from transactions with	A-8-1	178, 228			12.00
	related organizations (chapter 10)		,			
13.00	Laundry and linen service		О		0.00	13. 00
14. 00	Revenue - Employee meals		0	II	•	14. 00
15. 00	Cost of meals - Guests		Ö	1		15. 00
16. 00	Sale of medical supplies to other than		0	1	1	16. 00
10.00	pati ents			1	0.00	10.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0	1	0.00	
19. 00	Vending machines		0		0.00	
20. 00	Income from imposition of interest, finance		0		0.00	
20.00	or penalty charges (chapter 21)		0	1	0.00	20.00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
21.00	and borrowings to repay Medicare		0	1	0.00	21.00
	. ,					
22.00	overpayments			NUTLI I ZATI ONI DEVILEW	00.00	22.00
22. 00	Utilization reviewphysicians' compensation		U	UTILIZATION REVIEW	82.00	22. 00
22.00	(chapter 21)		,	CAD DEL COSTS DI DOS A	1 00	22.00
23. 00	Depreciationbuildings and fixtures		U	CAP REL COSTS - BLDGS &	1.00	23. 00
04.00				FI XTURES	0.00	04.00
24. 00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
	Lu oo Luoous	_		EQUI PMENT		
25. 00	MI SC I NCOME	В		ADMINISTRATIVE & GENERAL	4. 00	
25. 01	UNALLOWED A & G	A		ADMINISTRATIVE & GENERAL	4. 00	
25. 02	WORKERS COMPENSATION	A		EMPLOYEE BENEFITS	3.00	
25. 03	HEPARI N/SALI NE	A		SKILLED NURSING FACILITY	30.00	
100.00	Total (sum of lines 1 through 99) (Transfer		-810, 245			100. 00
	to Worksheet A, col. 6, line 100)				1	
(1) D-		transport and the second and the second	CMC D. L 1F 1	i		

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

⁽²⁾ Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

Health Financial Systems CRANBURY COSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME CRANBURY CENTER

Provi der No.: 315353 OFFICE COSTS

				Т	To 12/31/2022 Date/Time Pro 5/17/2023 2:3	epared: 33 pm
	·	Li ne No.	Cost (Center	Expense I tems	
		1. 00		00	3. 00	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIFICALAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS OR	
1.00		4. 00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE A&G	1.00
2.00			ADMI NI STRATI VE		HOME OFFICE CAPITAL	2.00
3.00			PHYSICAL THERA		PT	3.00
4.00			OCCUPATIONAL T		ОТ	4.00
5.00			SPEECH PATHOLO		ST	5.00
6.00			SKILLED NURSIN		NURSING PURCHASED SERVICES	6.00
7.00			OXYGEN (INHALA	,	RT	7.00
8.00			ADMI NI STRATI VE		MEDICAL DIRECTOR	8.00
9.00			CAP REL COSTS	- BLDGS &	LEASE	9. 00
			FI XTURES			
10. 00	TOTALS (sum of lines 1-9). Transfer column					10.00
	6, line 100 to Worksheet A-8, column 3, line					
	12.			1		1
		Amount	Amount	Adjustments		
		Allowable In	Included in	(col. 4 minus		
		Cost	Wkst. A, col.	col. 5)		
		4.00	5 5. 00	6.00	-	
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF				D ODCANI ZATI ONE OD	_
	CLAIMED HOME OFFICE COSTS:					
1.00		695, 003				1. 00
2.00		79, 969		79, 969		2. 00
3.00		284, 140				3. 00
4.00		324, 242	324, 242	(4. 00
5.00		139, 668	139, 668	(5. 00
6.00		683, 113	714, 180	-31, 067	7	6. 00
7.00		8, 726	8, 726	(7. 00
8.00		30, 840	30, 840	(8. 00
9.00		1, 672, 882	1, 672, 882	(9. 00
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	3, 918, 583	3, 740, 355	178, 228	8	10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315353 Peri od: Worksheet A-8-1 From 01/01/2022 Parts I-II Date/Time Prepared: OFFICE COSTS 12/31/2022 5/17/2023 2:33 pm

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00 PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

1.00	В	0.00	1.00
2.00	В	0.00	2.00
3.00	В	0.00	3.00
4.00	В	0.00	4.00
5. 00	В	0.00	5. 00
6.00	В	0.00	6.00
7. 00		0.00	7. 00
8.00		0.00	8.00
9. 00		0.00	9.00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

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

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

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

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

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

1.00		GENESIS HEALTHCARE	100.00	MANAGEMENT COMPANY	1.00
2.00		POWERBACK	100.00	PT OT ST	2.00
3.00		CAREER STAFF UNLIMITED	100.00	NURSING PURCHASED SERVICES	3.00
4.00		POWERBACK RESPIRATORY	100.00	RT	4.00
5.00		GENESIS PHYSICIAN SERVICES	100.00	MEDICAL DIRECTOR	5.00
6.00		NEXT HC	46. 40	LEASE	6. 00
7.00			0.00		7.00
8.00			0.00		8.00
9. 00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial)		0.00		100. 00
	speci fy:				

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

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			To	12/31/2022	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/17/2023 2: 3:	3 PIII
	_					
Cost Center Description	Net Expenses for Cost	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Subtotal	
	Allocation	TIATURES	LQUIFWLINI	DENETTIS		
	(from Wkst A					
	col . 7)					
CENERAL CERVILCE COCT CENTERS	0	1. 00	2. 00	3. 00	3A	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS - BLDGS & FLXTURES	2, 067, 062	2, 067, 062				1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	22, 452	2,007,002	22, 452			2. 00
3.00 00300 EMPLOYEE BENEFITS	1, 208, 074	28, 735	312	1, 237, 121		3. 00
4.00 OO400 ADMINISTRATIVE & GENERAL	1, 698, 923	475, 902	5, 169	96, 493	2, 276, 487	4. 00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS	599, 079	61, 849	672	27, 943	689, 543	5. 00
6.00 00600 LAUNDRY & LI NEN SERVI CE 7.00 00700 HOUSEKEEPI NG	298, 452 381, 654	73, 019 7, 085	793 77	0	372, 264 388, 816	6. 00 7. 00
8. 00 00800 DI ETARY	1, 095, 790	99, 097	1, 076	0	1, 195, 963	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	620, 074	38, 822	422	123, 705	783, 023	9. 00
10.00 01000 CENTRAL SERVICES & SUPPLY	75, 084	28, 883	314	9, 891	114, 172	10.00
11. 00 01100 PHARMACY	0	0	0	0	0	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY	38, 329	8, 808	96	9, 239	56, 472	12.00
13. 00 01300 SOCIAL SERVICE	146, 651	5, 904	64	32, 363	184, 982	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 15.00 01500 ACTIVITIES	115, 859	0	0	27, 626	0 143, 485	14. 00 15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	113, 637	<u> </u>	O _I	27,020	143, 403	13.00
30.00 03000 SKILLED NURSING FACILITY	4, 649, 304	1, 090, 017	11, 839	909, 861	6, 661, 021	30. 00
31.00 03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00 03200 1 CF/1 D	0	0	0	0	0	32. 00
33.00 O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	33. 00
40. 00 04000 RADI OLOGY	14, 216	ol	0	0	14, 216	40. 00
41. 00 04100 LABORATORY	30, 258	o	Ö	o	30, 258	41. 00
42.00 04200 I NTRAVENOUS THERAPY	23, 993	O	Ō	O	23, 993	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	16, 258	0	0	0	16, 258	43.00
44. 00 O4400 PHYSI CAL THERAPY	287, 410	81, 876	889	0	370, 175	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	325, 911	57, 175	621	0	383, 707	45. 00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	139, 709	5, 216	57 0	0	144, 982 0	46. 00 47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 887	42	0	3, 929	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	152, 158	787	9	O	152, 954	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51. 00 05100 SUPPORT SURFACES	19, 849	0	0	0	19, 849	51.00
52. 00 05200 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	52. 00
60. 00 OCT CENTERS 60. 00 OCT CENTERS	O	O	0	0	0	60. 00
61. 00 06100 RURAL HEALTH CLINIC	o	o	Ö	o	0	61. 00
62. 00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63. 00
OTHER REIMBURSABLE COST CENTERS		al	- I	ما		70.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE 72. 00 07200 CORF	0	0	0	0	0	71. 00 72. 00
73. 00 07300 CMHC	o	o	Ö	o	0	73. 00
74.00 07400 OTHER REIMBURSABLE COST	O	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 08100 I NTEREST EXPENSE						81.00
82. 00 08200 UTI LI ZATI ON REVI EW 83. 00 08300 HOSPI CE	0	0	0	0	0	82. 00 83. 00
84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS	o	o	Ö	o	0	84. 00
89.00 SUBTOTALS (sum of lines 1-84)	14, 026, 549	2, 067, 062	22, 452	1, 237, 121	14, 026, 549	89. 00
NONREI MBURSABLE COST CENTERS						
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	6, 338	0	0	0	6, 338	91.00
92. 00 O9200 PHYSICIANS PRIVATE OFFICES 93. 00 O9300 NONPAID WORKERS		0	0	0	0	92. 00 93. 00
94. 00 09400 PATI ENTS LAUNDRY		0	0	0	0	94.00
95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS		o	Ö	o	0	95. 00
98.00 Cross Foot Adjustments	0	О	0	0	0	98. 00
99.00 Negative Cost Centers	0	0	0	0	0	99. 00
100. 00 TOTAL	14, 032, 887	2, 067, 062	22, 452	1, 237, 121	14, 032, 887	100. 00

Provi der No.: 315353

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

				T	0 12/31/2022	Date/Time Prep 5/17/2023 2:33	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	3 PIII
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS					,	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	2, 276, 487	222 215				4.00
5. 00 6. 00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	133, 522 72, 084	823, 065 40, 051				5. 00 6. 00
7. 00	00700 HOUSEKEEPING	75, 290	3, 886		467, 992		7. 00
8. 00	00800 DI ETARY	231, 584	54, 355		32, 649	1, 514, 551	8. 00
9.00	00900 NURSING ADMINISTRATION	151, 623	21, 294	1	12, 790	0	9. 00
10.00	1	22, 108	15, 842	0	9, 516	0	10. 00
11. 00	1	0	0	0	0	0	11. 00
12.00	1	10, 935	4, 831	0	2, 902	0	12.00
13. 00 14. 00		35, 820	3, 239	0	1, 945	0	13. 00 14. 00
15. 00		27, 784	0	0	0	0	15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	27,701			<u> </u>	0	10.00
30.00		1, 289, 827	597, 872	484, 399	359, 120	1, 514, 551	30. 00
31. 00		0	0	0	0	0	31. 00
32. 00		0	0	_	0	0	32. 00
33. 00		0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	2, 753	0	0	٥	0	40. 00
41. 00		5, 859	0	0	0	Ö	41. 00
42. 00		4, 646	0	Ō	Ō	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	3, 148	0	0	0	0	43.00
44. 00	l l	71, 680	44, 909	0	26, 975	0	44. 00
45. 00	1	74, 300	31, 361	0	18, 837	0	45. 00
46. 00 47. 00		28, 074	2, 861 0		1, 718	0	46. 00 47. 00
48. 00		761	2, 132	0	1, 281	0	48. 00
49. 00		29, 618	432		259	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	50. 00
51.00		3, 844	0	0	0	0	51. 00
52. 00		0	0	0	0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0	0	O	0	60.00
61. 00			0	0	0	0	61. 00
62. 00			O		Ŭ	,	62. 00
63.00		0	0	0	О	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00		0	0	0	0	0	70.00
71. 00 72. 00		0	0	0	0	0	71. 00 72. 00
73. 00		0	0	0	0	0	73. 00
	07400 OTHER REIMBURSABLE COST	O	0	ő	0		74. 00
	SPECIAL PURPOSE COST CENTERS						
80.00							80. 00
81. 00							81. 00
82.00			0		0		82.00
83. 00 84. 00		0	0	0	0	0	83. 00 84. 00
89. 00		2, 275, 260	823, 065	484, 399	467, 992	1, 514, 551	89. 00
	NONREI MBURSABLE COST CENTERS			10.7,011	,	.,	
90.00		0	0	0	0	0	90. 00
91.00	1	1, 227	0	0	0	0	91.00
92. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	92.00
93. 00 94. 00			0		0	0	93. 00 94. 00
95.00			0	0	0	0	95.00
98. 00			0	o o	o	0	98. 00
99. 00	Negative Cost Centers	0	0	0	О	0	99. 00
100.00	0 TOTAL	2, 276, 487	823, 065	484, 399	467, 992	1, 514, 551	100. 00

Provi der No.: 315353

					'	0 12/31/2022	5/17/2023 2:3	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
			ADMI NI STRATI ON	SERVICES &		RECORDS &		
				SUPPLY		LIBRARY		
	CENED	AL CEDILLOS COCT CENTEDO	9. 00	10. 00	11. 00	12. 00	13.00	
1.00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00		CAP REL COSTS - BEDGS & TEXTORES CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	1	EMPLOYEE BENEFITS						3. 00
4. 00	1	ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	1	LAUNDRY & LINEN SERVICE						6. 00
7. 00		HOUSEKEEPI NG						7. 00
8.00		DI ETARY						8. 00
9.00	00900	NURSING ADMINISTRATION	968, 730					9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	161, 638				10.00
11. 00	01100	PHARMACY	0	0	()		11. 00
12.00	1	MEDICAL RECORDS & LIBRARY	0	0	(75, 140		12. 00
13. 00	1	SOCIAL SERVICE	0	0	(0	225, 986	
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0	0	(0	14. 00
15. 00		ACTIVITIES	0	0	() 0	0	15. 00
20.00		ENT ROUTINE SERVICE COST CENTERS	0/0 720	1/1 /20		VE 227	225 004	20.00
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	968, 730	161, 638 0	(· ·	225, 986 0	30. 00 31. 00
32. 00	1	ICF/IID	0	0			0	32.00
33. 00		OTHER LONG TERM CARE		0			0	33. 00
00.00		_ARY SERVICE COST CENTERS	<u> </u>			,		00.00
40.00		RADI OLOGY	0	0	(91	0	40. 00
41.00	04100	LABORATORY	o	0	(250	0	41. 00
42.00	04200	INTRAVENOUS THERAPY	0	0	(95	0	42.00
43.00		OXYGEN (INHALATION) THERAPY	0	0	(2	0	43. 00
44. 00		PHYSI CAL THERAPY	0	0	(3, 314	0	44. 00
45. 00		OCCUPATI ONAL THERAPY	0	0	(3, 722	0	45. 00
46. 00		SPEECH PATHOLOGY	0	0	(1, 434	0	46. 00
47. 00	1	ELECTROCARDI OLOGY	0	0	(0	0	47. 00
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	48. 00
49. 00 50. 00		DRUGS CHARGED TO PATIENTS DENTAL CARE - TITLE XIX ONLY	0	0		895		49. 00 50. 00
51.00		SUPPORT SURFACES	0	0		1	0	51. 00
52. 00	1	OTHER ANCILLARY SERVICE COST CENTERS		0			Ö	52. 00
02.00		TIENT SERVICE COST CENTERS	<u> </u>	<u> </u>				02.00
60.00		CLINIC	0	0	(0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	o	0	(0	0	61. 00
62.00	06200	FQHC						62. 00
63. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	63. 00
		REIMBURSABLE COST CENTERS			Γ		г	
70.00		HOME HEALTH AGENCY COST	0	0			l	
71.00		AMBULANCE	0	0	(0	0	71.00
72. 00 73. 00	07200 07300		0	0		0	0	72. 00 73. 00
74.00	1	OTHER REIMBURSABLE COST		0				
74.00		AL PURPOSE COST CENTERS	<u> </u>	O) 0	0	74.00
80. 00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00		INTEREST EXPENSE						81. 00
82.00	1	UTILIZATION REVIEW						82. 00
83.00		HOSPI CE	О	0	(0	0	83. 00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	o	0	(0	0	84. 00
89. 00		SUBTOTALS (sum of lines 1-84)	968, 730	161, 638	(75, 140	225, 986	89. 00
		MBURSABLE COST CENTERS						
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	
91.00		BARBER AND BEAUTY SHOP	0	0	(0	0	91.00
92.00		PHYSICIANS PRIVATE OFFICES		0	,		0	92. 00 93. 00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY		0	'			93.00
95.00	1	OTHER NONREIMBURSABLE COST CENTERS		0				95.00
98. 00		Cross Foot Adjustments		0	(98. 00
99. 00	1	Negative Cost Centers		0	(0	0	99. 00
100.00		TOTAL	968, 730	161, 638		75, 140	225, 986	
			,	'				

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | Part | | Provi der No.: 315353

					To 12/31/2022	Date/Time Pre 5/17/2023 2:3	
			OTHER GENERAL			371772023 2.3	J piii
			SERVI CE				
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	Subtotal	Post Stepdown	Total	
		ALLI ED HEALTH			Adjustments		
		EDUCATION	15 00	14 00	17.00	10.00	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16.00	17. 00	18. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY						7. 00 8. 00
9. 00	00900 NURSING ADMINISTRATION						9.00
10. 00	01000 CENTRAL SERVI CES & SUPPLY						10.00
11. 00	01100 PHARMACY						11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13.00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	l				14. 00
15. 00	01500 ACTIVITIES	0	171, 269)			15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	0	171 240	12, 499, 750	ol ol	12 400 750	20.00
30.00	03100 NURSING FACILITY		171, 269	12, 499, 750		12, 499, 750 0	30. 00 31. 00
32. 00	03200 CF/11D	0	0	1	1	0	32.00
33. 00	03300 OTHER LONG TERM CARE	Ö	l e	1		0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	17, 060	0	17, 060	40. 00
41. 00	04100 LABORATORY	0	0	36, 367		36, 367	
42.00	04200 I NTRAVENOUS THERAPY	0	0	28, 734		28, 734	
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0	19, 408 517, 053		19, 408 517, 053	
45. 00	04500 OCCUPATIONAL THERAPY	0		517, 053		517, 053 511, 927	
46. 00	04600 SPEECH PATHOLOGY	0	0	179, 069		179, 069	
47. 00	04700 ELECTROCARDI OLOGY	Ö	Ö) .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	8, 103	0	8, 103	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	184, 158	0	184, 158	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0)	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	23, 693		23, 693	1
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	0	0) (0	0	52.00
60. 00	06000 CLINIC	0	0		ol o	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	l .	1		0	61.00
62. 00	06200 FQHC		_			_	62. 00
63.00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0) (0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	(0	0	70. 00
71.00	07100 AMBULANCE	0	0		0	0	
	07200 CORF 07300 CMHC	0	0			0	72. 00 73. 00
	07400 OTHER REIMBURSABLE COST					0	
7 1. 00	SPECIAL PURPOSE COST CENTERS			1	<u> </u>	<u> </u>	, 1. 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW						82. 00
83. 00	08300 HOSPI CE	0	0		0	0	83. 00
84. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	0	171 240	14 005 200		14 025 222	1
89. 00	SUBTOTALS (sum of lines 1-84) NONRELMBURSABLE COST CENTERS	0	171, 269	14, 025, 322	2 0	14, 025, 322	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	Ö		7, 565	0	7, 565	1
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	0) (o	0	ı
93. 00	09300 NONPALD WORKERS	0	0) (이	0	
94. 00	09400 PATIENTS LAUNDRY	0	0		이	0	
95. 00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0			0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0				0	
100.00				14, 032, 887	7 0	_	
. 55. 50	-1 1.5		1,1,207	, 552, 66	٦	, 552, 567	1.00.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315353

					То	12/31/2022	Date/Time Prep 5/17/2023 2:3	pared:
				CAPI TAL REL	ATED COSTS		371772023 2.3	э рііі
		Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
		oost content beschiptron	Assigned New	FIXTURES	EQUI PMENT	Jubiotal	BENEFITS	
			Capi tal Related Costs					
			0	1. 00	2.00	2A	3. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						1. 00 2. 00
3. 00		EMPLOYEE BENEFITS	o	28, 735	312	29, 047	29, 047	3. 00
4.00		ADMINISTRATIVE & GENERAL	0	475, 902	5, 169	481, 071	2, 266	4. 00
5. 00 6. 00		PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	0	61, 849 73, 019	672 793	62, 521 73, 812	656 0	5. 00 6. 00
7. 00		HOUSEKEEPI NG	o o	7, 085	77	7, 162	0	7. 00
8.00		DI ETARY	0	99, 097	1, 076	100, 173	0	8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	38, 822 28, 883	422 314	39, 244 29, 197	2, 905 232	9. 00 10. 00
11. 00	01100	PHARMACY	0	20, 003	0	27, 177	0	11. 00
12. 00		MEDICAL RECORDS & LIBRARY	O	8, 808	96	8, 904	217	12. 00
13. 00 14. 00		SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION	0	5, 904 0	64	5, 968 0	760 0	13. 00 14. 00
15. 00		ACTIVITIES		0	0	o	649	15. 00
		IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	0	1, 090, 017 0	11, 839 0	1, 101, 856 0	21, 362 0	30. 00 31. 00
32. 00		ICF/IID		0	0	o	0	32. 00
33. 00		OTHER LONG TERM CARE	0	0	0	o	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	l ol	O	0	ol	0	40. 00
41. 00		LABORATORY		0	0	ő	0	41. 00
42.00	1	INTRAVENOUS THERAPY	0	0	0	o	0	42. 00
43. 00 44. 00		OXYGEN (INHALATION) THERAPY PHYSICAL THERAPY	0	0 81, 876	0 889	0 82, 765	0	43. 00 44. 00
45.00		OCCUPATIONAL THERAPY		57, 175	621	57, 796	0	45. 00
46.00	04600	SPEECH PATHOLOGY	O	5, 216	57	5, 273	0	46. 00
47. 00 48. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 3, 887	0 42	0 3, 929	0	47. 00 48. 00
49. 00		DRUGS CHARGED TO PATTENTS		3, 667 787	9	3, 929 796	0	49. 00
50.00		DENTAL CARE - TITLE XIX ONLY	0	0	0	o	0	50. 00
51. 00 52. 00	1	SUPPORT SURFACES OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	51. 00 52. 00
32.00		TIENT SERVICE COST CENTERS	ı o	Oj	U	U	0	32.00
60.00	06000	CLI NI C	0	0	0	0	0	60. 00
61. 00 62. 00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61. 00 62. 00
63.00		OTHER OUTPATIENT SERVICE COST CENTER	0	0	О	o	0	63. 00
	OTHER	REIMBURSABLE COST CENTERS						
70. 00 71. 00		HOME HEALTH AGENCY COST AMBULANCE	0	0	0	0	0	70. 00 71. 00
	07200	CORF	0	0	0	Ö	0	
73.00	07300		0	0	0	0	0	73. 00
74. 00		OTHER REIMBURSABLE COST AL PURPOSE COST CENTERS	0	0	0	0	0	74. 00
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00		INTEREST EXPENSE						81.00
82. 00 83. 00		UTILIZATION REVIEW HOSPICE		0	0	0	0	82. 00 83. 00
84. 00		OTHER SPECIAL PURPOSE COST CENTERS	o o	0	Ö	Ö	0	84. 00
89. 00	NONDE	SUBTOTALS (sum of lines 1-84)	0	2, 067, 062	22, 452	2, 089, 514	29, 047	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN	l ol	0	O	ol	0	90. 00
91. 00	09100	BARBER AND BEAUTY SHOP	Ö	0	0	ō	0	91. 00
92.00		PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY		0	0	0	0	93. 00 94. 00
95. 00		OTHER NONREIMBURSABLE COST CENTERS		0	ő	ő	Ö	95. 00
98.00		Cross Foot Adjustments		_		O	_	98.00
99. 00 100. 00		Negative Cost Centers TOTAL	0	0 2, 067, 062	0 22, 452	0 2, 089, 514	0 29, 047	
. 55. 50	-1		, 9	2, 307, 302	22, 102	2, 307, 514	27,047	

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315353

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

5/17/2023 2:33 pm Cost Center Description ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION, LINEN SERVICE & GENERAL MAINT. & REPAI RS 7. 00 4.00 8.00 5.00 6.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 1.00 1.00 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 00300 EMPLOYEE BENEFLTS 3.00 3 00 4.00 00400 ADMINISTRATIVE & GENERAL 483, 337 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 28, 349 91, 526 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 15.305 4, 454 93, 571 6.00 00700 HOUSEKEEPI NG 7.00 15, 985 432 C 23.579 7.00 8.00 00800 DI ETARY 49, 170 6,044 0 1,645 157, 032 8.00 9.00 00900 NURSING ADMINISTRATION 32, 192 2, 368 0 9.00 644 0 01000 CENTRAL SERVICES & SUPPLY 4,694 0 479 10.00 10.00 1, 762 Ω 11.00 01100 PHARMACY 0 0 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 2.322 537 146 0 12.00 01300 SOCIAL SERVICE 0 98 13.00 13.00 7.605 0 360 01400 NURSING AND ALLIED HEALTH EDUCATION 0 14.00 0 0 14.00 15.00 01500 ACTI VI TI ES 5,899 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 93. 571 157. 032 30.00 273 852 66, 485 18 094 31.00 03100 NURSING FACILITY C 0 31.00 32.00 03200 | CF/IID 0 0 0 0 32.00 C 03300 OTHER LONG TERM CARE 33.00 0 0 0 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 584 0 0 0 0 40.00 41.00 04100 LABORATORY 1, 244 0 0 0 41.00 42 00 04200 I NTRAVENOUS THERAPY 986 Ω 0 0 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 668 C 0 0 43.00 04400 PHYSI CAL THERAPY 15, 219 4, 994 1, 359 0 44.00 44.00 04500 OCCUPATIONAL THERAPY 45.00 15, 775 3, 487 0 949 0 45.00 04600 SPEECH PATHOLOGY 46 00 5, 961 0 87 46 00 318 0 04700 ELECTROCARDI OLOGY 0 47.00 0 0 47.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 237 0 65 48.00 48.00 162 0 49.00 04900 DRUGS CHARGED TO PATIENTS 6, 288 48 0 13 0 49.00 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 50.00 0 Ω 0 0 51.00 05100 SUPPORT SURFACES 816 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 60.00 06000 CLI NI C 0 0 0 0 0 06100 RURAL HEALTH CLINIC 61.00 0 0 0 0 0 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 63.00 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 0 0 07200 CORF 0 72.00 0 0 72.00 0 73.00 07300 CMHC 0 0 0 0 73.00 74.00 07400 OTHER REIMBURSABLE COST 0 0 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 08300 H0SPLCE 83.00 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 483, 076 91, 526 93, 571 23, 579 157, 032 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90 00 90.00 0 Λ 09100 BARBER AND BEAUTY SHOP 91.00 261 0 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 92.00 0 0 09300 NONPALD WORKERS 0 0 93.00 93.00 0 0 09400 PATIENTS LAUNDRY 0 0 94.00 0 C 0 94.00 95.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 95.00 98.00 Cross Foot Adjustments 0 0 0 98.00 99 00 Negative Cost Centers 99 00 0 0 100.00 **TOTAL** 483, 337 91, 526 93, 571 23, 579 157, 032 100. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der No.: 315353 Peri

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

5/17/2023 2:33 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE RECORDS & ADMI NI STRATI ON SERVICES & **SUPPLY** LI BRARY 9.00 11.00 13.00 10.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 3.00 00300 EMPLOYEE BENEFITS 3.00 4.00 00400 ADMINISTRATIVE & GENERAL 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 6.00 00700 HOUSEKEEPI NG 7.00 7 00 8.00 00800 DI ETARY 8.00 9 00 00900 NURSING ADMINISTRATION 77, 353 9 00 01000 CENTRAL SERVICES & SUPPLY 36, 364 10.00 10.00 01100 PHARMACY 11.00 0 11.00 12.00 01200 MEDICAL RECORDS & LIBRARY 0 0 0 12, 126 12.00 13.00 01300 SOCIAL SERVICE 0 14, 791 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 0 14.00 14.00 C 0 0 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 77, 353 36, 364 0 10, 543 14, 791 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 Λ 32.00 03200 | CF/IID 0 C 0 0 32.00 03300 OTHER LONG TERM CARE 0 0 0 33.00 0 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 0 15 Λ 40.00 41.00 04100 LABORATORY 0 0 0 40 0 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 0000000000 15 42.00 43 00 04300 OXYGEN (INHALATION) THERAPY 0 0 43 00 0 0 04400 PHYSI CAL THERAPY 0 44.00 0 535 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 601 0 45.00 04600 SPEECH PATHOLOGY 46.00 0 232 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 47.00 0 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 48.00 04900 DRUGS CHARGED TO PATIENTS 49.00 0 0 145 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY Ω 0 0 50.00 0 05100 SUPPORT SURFACES 0 51.00 0 0 0 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 0 n O 60 00 60 00 06000 CLI NI C 0 0 06100 RURAL HEALTH CLINIC 61.00 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 63.00 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 n 0 0 0 70.00 71.00 07100 AMBULANCE 0 0 0 0 0 71.00 07200 CORF 0 0 0 72.00 72.00 0 0 07300 CMHC 0 73.00 0 C 0 0 73 00 07400 OTHER REIMBURSABLE COST 74.00 0 0 74.00 SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 H0SPI CE 0 O 83.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 84.00 0 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 77, 353 36, 364 0 12, 126 14, 791 89.00 NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 90.00 90.00 0 0 0 91.00 09100 BARBER AND BEAUTY SHOP 0 C 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 92.00 0 09300 NONPALD WORKERS 0 o 93.00 0 93.00 0 0 94.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 95.00 0 C 0 0 95.00 98.00 Cross Foot Adjustments 0 98.00 99. 00 Negative Cost Centers 0 99.00 0 TOTAL 12, 126 14, 791 100. 00 100.00 77, 353 36, 364

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | Part | I | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315353

						Γο 12/31/2022	Date/Time Pre 5/17/2023 2:3	
				OTHER GENERAL			07 177 2020 2.0	J piii
				SERVI CE				
		Cost Center Description	NURSING AND	ACTI VI TI ES	Subtotal	Post Step-Down	Total	
			ALLIED HEALTH EDUCATION			Adjustments		
			14. 00	15. 00	16.00	17. 00	18. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS			-			2. 00 3. 00
4.00		ADMINISTRATIVE & GENERAL						4. 00
5. 00		PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600	LAUNDRY & LINEN SERVICE						6. 00
7. 00		HOUSEKEEPI NG						7. 00
8.00		DI ETARY						8. 00
9. 00 10. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						9. 00 10. 00
11. 00	1	PHARMACY						11. 00
12.00	1	MEDICAL RECORDS & LIBRARY						12.00
13. 00		SOCIAL SERVICE						13. 00
14. 00	1	NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00		ACTIVITIES LENT ROUTINE SERVICE COST CENTERS] 0	6, 548	3			15. 00
30. 00		SKILLED NURSING FACILITY	0	6, 548	1, 877, 85	1 0	1, 877, 851	30. 00
31. 00		NURSING FACILITY	Ö	0,010	1	0	0	1
32. 00		CF/IID	0	O	•	0	0	1
33. 00		OTHER LONG TERM CARE	0	0)	0	0	33. 00
40. 00		LARY SERVICE COST CENTERS RADIOLOGY	0	0	59	9 0	599	40. 00
41. 00	1	LABORATORY	0		•		1, 284	1
42.00		INTRAVENOUS THERAPY	0	O	1, 00		1, 001	1
43.00	1	OXYGEN (INHALATION) THERAPY	0	O	668		668	1
44.00	1	PHYSI CAL THERAPY	0	0	104, 87		104, 872	1
45. 00 46. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	78, 608 11, 87		78, 608 11, 871	1
47.00		ELECTROCARDI OLOGY	0		11, 67	0	0	1
48. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O	4, 39	3 0	4, 393	1
49. 00		DRUGS CHARGED TO PATIENTS	0	O	7, 29	0	7, 290	1
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		0	0	
51. 00 52. 00		SUPPORT SURFACES OTHER ANCILLARY SERVICE COST CENTERS	0	0			816 0	1
02.00		TIENT SERVICE COST CENTERS	, ,			<u> </u>		02.00
60.00	1	CLI NI C	0			0	0	
61. 00		RURAL HEALTH CLINIC	0	O		0	0	
62. 00 63. 00	06200	OTHER OUTPATIENT SERVICE COST CENTER	0	l o		o	0	62. 00 63. 00
00.00		REIMBURSABLE COST CENTERS			'	51 0		00.00
70. 00		HOME HEALTH AGENCY COST	0	C)	0	0	70. 00
71.00		AMBULANCE	0	0	1	0	0	
72. 00 73. 00	07200		0	0			0	
		OTHER REIMBURSABLE COST	0				0	
	SPECIA	AL PURPOSE COST CENTERS						
	1	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW						81. 00 82. 00
83. 00		HOSPI CE	0	0		0	0	1
84. 00		OTHER SPECIAL PURPOSE COST CENTERS	0	o		0	0	1
89. 00		SUBTOTALS (sum of lines 1-84)	0	6, 548	2, 089, 25	3 0	2, 089, 253	89. 00
90. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN		Ι ο) (0 0	0	90. 00
91.00	1	BARBER AND BEAUTY SHOP	0		1	-	261	1
92.00		PHYSICIANS PRIVATE OFFICES	0	O		0	0	1
93.00		NONPALD WORKERS	0	0		0	0	
94. 00 95. 00		PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST CENTERS	0				0	
98.00	07500	Cross Foot Adjustments	0	"			0	
99. 00		Negative Cost Centers	0	0		o o	0	99. 00
100.00)	TOTAL	0	6, 548	2, 089, 51	4 O	2, 089, 514	100. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der No.: 315353

				Т	o 12/31/2022	Date/Time Pre 5/17/2023 2:3	
		CAPITAL REI	LATED COSTS				,
	Cost Center Description	BLDGS & FIXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2.00	3. 00	4A	4.00	
	GENERAL SERVICE COST CENTERS		ı		1	I	
	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	42, 010	42, 010				1. 00 2. 00
	00300 EMPLOYEE BENEFITS	584					3. 00
	00400 ADMINISTRATIVE & GENERAL	9, 672			1		4. 00
	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	1, 257 1, 484				,	5. 00 6. 00
	00700 HOUSEKEEPI NG	144			_	388, 816	7. 00
1	00800 DI ETARY	2, 014	2, 014		_	1, 1,0,,00	8. 00
1	00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY	789 587	789 587			783, 023 114, 172	9. 00 10. 00
	01100 PHARMACY	0				0	11. 00
	01200 MEDICAL RECORDS & LIBRARY	179				56, 472	12. 00
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	120	120 0	· ·		101,702	13. 00 14. 00
4	01500 ACTIVITIES	0	o o		_		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	00.450	00.450				
	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	22, 153	22, 153 0				30. 00 31. 00
1	03200 CF/IID	Ö	ő				32. 00
	03300 OTHER LONG TERM CARE	0	0	C	0	0	33. 00
	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY	0	0		0	14, 216	40. 00
	04100 LABORATORY	Ö	ő				41. 00
	04200 I NTRAVENOUS THERAPY	0	0	C	_	20,,,0	42.00
	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	1, 664	1, 664		_	16, 258 370, 175	43. 00 44. 00
	04500 OCCUPATI ONAL THERAPY	1, 162				383, 707	45. 00
	04600 SPEECH PATHOLOGY	106				1 , , , , , ,	46. 00
	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 79			_	0 3, 929	47. 00 48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	16	16				49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		_	0	50.00
	05100 SUPPORT SURFACES 05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0				51. 00 52. 00
	OUTPATIENT SERVICE COST CENTERS	_					
4	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0				60. 00 61. 00
4	06200 FQHC		0		0		62. 00
	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0	<u> </u>	0	0	63. 00
	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST		0		0	0	70. 00
1	07100 AMBULANCE	0	o o	Ö			71. 00
1	07200 CORF	0	0	C	0		72. 00
	07300 CMHC 07400 OTHER REIMBURSABLE COST	0	0				73. 00 74. 00
	SPECIAL PURPOSE COST CENTERS			,		<u> </u>	7 00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80. 00 81. 00
	08200 UTI LI ZATI ON REVI EW						82. 00
83. 00	08300 HOSPI CE	0	0	C	0		83. 00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84)	0 42, 010	0 42, 010	5, 132, 424	0 -2, 276, 487	0 11, 750, 062	84. 00 89. 00
	NONREI MBURSABLE COST CENTERS	42,010	42,010	J, 132, 424	-2, 270, 407	11, 750, 002	89.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90. 00
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	6, 338 0	91. 00 92. 00
	09300 NONPALD WORKERS	0	o o		Ö	0	93. 00
1	09400 PATIENTS LAUNDRY	0	0	C	0	0	94. 00
95. 00 98. 00	O9500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0	C	0	0	95. 00 98. 00
99. 00	Negative Cost Centers						99. 00
102. 00	Cost to be allocated (per Wkst. B,	2, 067, 062	22, 452	1, 237, 121		2, 276, 487	102. 00
103. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	49. 204047	0. 534444	0. 241040		0. 193638	103. 00
104. 00	Cost to be allocated (per Wkst. B,	201047	3.331177	29, 047		483, 337	
10F 00	Part II) Unit cost multiplier (Wkst. B, Part			0.005440		0.041112	105 00
105. 00	II)			0. 005660		0. 041113	105.00

Provi der No.: 315353

						5/17/2023 2: 3	3 pm
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(TOTAL PATIENT			CTOTAL DATIENT	
		REPAIRS (SQUARE FEET)	DAYS)			(TOTAL PATIENT DAYS)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7. 00	
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	30, 497					5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	1, 484	41, 286	,			6. 00
7.00	00700 HOUSEKEEPI NG	144	0	28, 869			7. 00
8.00	00800 DI ETARY	2, 014	0	2, 014	125, 103		8. 00
9.00	00900 NURSING ADMINISTRATION	789	0	789	0	41, 286	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	587	0	587	0	0	10. 00
11. 00	01100 PHARMACY	0		C	0	0	11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	179	l .	179	0	0	12.00
13.00	01300 SOCIAL SERVICE	120		120	0	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14.00
15. 00	O1500 ACTIVITIES	0	0	0	0	0	15. 00
30. 00	O3000 SKILLED NURSING FACILITY	22, 153	41, 286	22, 153	125, 103	41, 286	30.00
31. 00	03100 NURSING FACILITY	22, 153		22, 100	125, 103	41, 200	31.00
32. 00	03200 CF/11D		_		0	0	32.00
33. 00	03300 OTHER LONG TERM CARE	0			0	0	33.00
00.00	ANCI LLARY SERVI CE COST CENTERS			1			00.00
40.00	04000 RADI OLOGY	0	0	C	0	0	40. 00
41.00	04100 LABORATORY	0	O	d	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	d c	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	o c	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	1, 664	0	1, 664	0	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	1, 162	0	1, 162	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	106	0	106	0	0	46. 00
47.00	04700 ELECTROCARDI OLOGY	0	_	O C	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	79	1	79		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	16		16	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	_		0	0	50.00
51. 00	05100 SUPPORT SURFACES	0		0	0	0	51.00
52. 00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	<u> </u> C	0	0	52. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	1 0	0	C		0	60.00
61. 00	06100 RURAL HEALTH CLINIC					0	61.00
62. 00	06200 FQHC			1		· ·	62.00
63. 00	06300 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	63.00
	OTHER REIMBURSABLE COST CENTERS		_				
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71.00	07100 AMBULANCE	0	0	o c	0	0	71. 00
72.00	07200 CORF	0	0	C	0	0	72. 00
73.00	07300 CMHC	0	0	o c	0	0	73. 00
74.00	07400 OTHER REIMBURSABLE COST	0	0	C	0	0	74. 00
	SPECIAL PURPOSE COST CENTERS		1	1	1	1	
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 I NTEREST EXPENSE						81.00
82. 00	08200 UTI LI ZATI ON REVI EW						82.00
83. 00	08300 HOSPI CE	0	_		0	0	83.00
84. 00 89. 00	08400 OTHER SPECIAL PURPOSE COST CENTERS	30, 497	_	28, 869	125, 103	0	84. 00 89. 00
89.00	SUBTOTALS (sum of lines 1-84) NONRELMBURSABLE COST CENTERS	30, 497	41, 280	28, 809	125, 103	41, 286	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	T 0	0	0	0	0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		1		_	0	91.00
92. 00	09200 PHYSICIANS PRIVATE OFFICES	0	_		0	Ö	92.00
93. 00	09300 NONPALD WORKERS	0			0	Ö	93.00
94. 00	09400 PATIENTS LAUNDRY	Ö	Ö	i c	0	o o	94. 00
95.00	09500 OTHER NONREIMBURSABLE COST CENTERS	0	0	d	0	0	95.00
98. 00	Cross Foot Adjustments						98. 00
99. 00	Negative Cost Centers						99. 00
102.00		823, 065	484, 399	467, 992	1, 514, 551	968, 730	102. 00
	Part I)						
103.00		26. 988392	l .	i		l e	
104.00		91, 526	93, 571	23, 579	157, 032	77, 353	104. 00
40= :	Part II)	0.55			a ====···		405 55
105.00		3. 001148	2. 266410	0. 816758	1. 255222	1. 873589	105. 00
	1)	I	I	I	I	I	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2540-10
Worksheet B-1 CRANBURY CENTER Provider No.: 315353 | Period: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/17/2023 2:33 pm |

Cost Center Description | CENTRAL | PHARMACY | MEDICAL | SOCIAL SERVICE | NURSING AND |

A		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG AND	, j
COSTED CHAPTER CONT CENTERS 10.00 11.00 12.00 13.00 14.00 11.00 12.00 13.00 14.00 11.00 12.00 13.00 14								
				REQUIS.)				
BURNAL STRUCT COST CINTIES			,			DAYS)	,	
CERNISMAN SENDITE COST CENTERS 1.00 0.000 CAP NEL COSTS - MONABLE CONTENTS CONTENTS 0.0000 CAP NEL COSTS - MONABLE CONTENTS CHEEN 2.000 CAP NEL COSTS - MONABLE CONTENTS 0.0000 CAP NEL COSTS - MONABLE COST				11. 00		13. 00		
2.00 0.000 CAP REL COSTS - MOVABLE COUPRIENTS 2.00 3.00 0.000 CAPUNCTE SHEPT 3.00		GENERAL SERVICE COST CENTERS			12.00			
0.0000 DEMILOYEE SERIETTS	1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
4.00 DOSOPO JAMEN STRATTUR A GENERAL 4.00 5.0		1						1
0.000 0.00								ł
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00								ł
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00		1 1						ł
8 00 00000 DETARY 00 00000 DETARY 10 00 0000 DETARY 10 00 0000 DETARY 10 00 0000 DETARY 10 00 0000 DETARY 10 00 00 0000 DETARY 10 00 00 00 00 00 00 00 00 00 00 00 00 0								1
9.00 0.0900 MURSING AMIN NISTRATION 47,764 0 11,000 1000 CENTRAL SERVICES & SUPPLY 47,764 0 18,930,681 11,000 11,0							•	
10.00 10000 CFNTRAL SERVICES & SUPPLY 47,764 11.00								1
11.00 10100 PHASMACY 0 0 18,930.683 11.00 12.0			17 761					ł
12.00 1200 MEDICAL RECORDS & LIBRARY 0 0 18,930,683 12,00 1300 1310 0310		1 1	47, 704	0				ł
13.00 01300 SOCIAL SERVICE 0 0 0 0 41,286 13.00			0	0	18, 930, 683			•
14.00 0 1400 MURSI ING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 0 0			o	0	0			•
INANTI ENT BOUTH N. SERVICE COST CENTERS 31.00 03.00 0			0	0	0	0		•
30.00	15.00	01500 ACTI VI TI ES	O	0	0	0	0	15. 00
31.00 03100 NURSING FACILITY		INPATIENT ROUTINE SERVICE COST CENTERS						
32 00 03200 THEFL ION TERM CARE			47, 764	0	16, 460, 765	41, 286	0	•
33 0.0 03300 OTHER LONG TERM CARE O O O O O O O O O			0	0	0	0		•
MODI LARY SERVICE COST CENTERS		1 1	0	0	0	0		1
10. 00 04000 04000 04000 04000 0	33. 00		0	0	0	0	0	33.00
11.00 04100 LABORATORY 0 0 0 23,824 0 0 0 42.00	40.00				22.020			1 40 00
42.00 04200 INTRAVENOUS THERAPY 0 0 23.824 0 0 42.00			0	0	1			•
43. 00 04300 0XYGEN (INHALATION) THERAPY			0	0	1	0		1
44.00 04400 PHYSI CAL THERAPY			0	0	1	0	_	
45. 00 04500 04500 05000			0	0		0		
46. 00 04600 SPEECH PATHOLOGY		1 1	o	0				1
AB. 00 OABOO MEDIC CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0	0	1	0	0	1
49.00 04900 DRUGS CHARGED TO PATIENTS	47.00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 50.00	48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48. 00
51.00 OSTOO SUPPORT SURFACES O O O O O O O O O	49. 00		0	0	225, 498	0	0	49. 00
S2.00 OS200 OTHER ANCILLARY SERVICE COST CENTERS O O O O O O O O O O O O O O O O O O			0	0	0	0	0	•
OUTPATIENT SERVICE COST CENTERS O			0	0	1	0		ł
60.00 06000 CLINIC 0 0 0 0 0 0 0 0 0	52. 00		0	0	0	0	0	52. 00
61.00 06200 FOHC COLOR	(0.00				1 0			/ 0 00
62. 00 06200 OHC OBJORNIC			0	0		0	_	
63. 00				Ü	1	0		•
OTHER REI MBURSABLE COST CENTERS			0	0	0	0	0	•
70. 00	00.00		<u> </u>					00.00
71. 00 071000 071000 07100 071000 071000 07100 071000 071000 071000 071000 071000 071000 071000 071000 071000 071000 071000 071000 071000 0710000 071000 071000 0710000 071000 0710000 0710000 0	70. 00		0	0	0	0	0	70.00
73. 00 07300 CMHC 0 0 0 0 0 0 0 0 0			0	0	Ó	0	0	1
74. 00 07400 OTHER REIMBURSABLE COST O O O O O O O O O	72.00	07200 CORF	0	0	0	0	0	72. 00
SPECIAL PURPOSE COST CENTERS 80.00 0000 MALPRACTI CE PREMI WINS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 82.00 82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 HOSPICE 0 0 0 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0	73.00	07300 CMHC	0	0	0	0	0	73. 00
80. 00	74.00		0	0	0	0	0	74. 00
81.00			1		1	Г	1	
82.00 08200 UTILIZATION REVIEW 82.00 83.00 08300 HOSPICE 0 0 0 0 0 0 0 0 83.00 84.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 84.00 89.00 NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 90.00 9								•
83.00 08300 HOSPICE 0 0 0 0 0 0 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 89.00 SUBTOTALS (sum of lines 1-84) 47,764 0 18,930,683 41,286 0 89.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 90.00 OFFICE SHOPS & CANTEEN 0 0 0 0 0 91.00 OFFICE SHOPS & CANTEEN 0 0 0 0 0 92.00 OFFICE SHOPS & CANTEEN 0 0 0 0 0 93.00 OFFICE SHOPS & CANTEEN 0 0 0 0 94.00 OFFICE SHOPS & CANTEEN 0 0 0 0 95.00 OFFICE SHOPS & CANTEEN 0 0 0 0 96.00 OFFICE SHOPS & CANTEEN 0 0 0 0 97.00 OFFICE SHOPS & CANTEEN 0 0 0 0 98.00 OFFICE SHOPS & CANTEEN 0 0 0 99.00 OFFICE SHOPS & CANTEEN 0 0 0 99.00 OFFICE SHOPS & CANTEEN 0 0 0 99.00 OFFICE SHOPS & CANTEEN 0								
84. 00				0		0		
89. 00 SUBTOTALS (sum of lines 1-84) 47,764 0 18,930,683 41,286 0 89.00			0	0		0		
NONRE MBURSABLE COST CENTERS		1	47 764	0	18 930 683	41 286		•
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 91. 00 92. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 92. 00 93. 00 93. 00 93. 00 93. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 94. 00 95. 00 09500 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 95. 00 98. 00 00 00 00 00 00 00 00	07.00		17,701		10, 700, 000	11, 200		07.00
91. 00	90.00		0	0	0	0	0	90.00
93. 00 09300 NONPAID WORKERS 0 0 0 0 0 93. 00 94. 00 95. 00 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 95. 00 98. 00 0 0 0 0 95. 00 98. 00 0 0 0 0 0 0 0 0 0	91.00		O	0	0	0	0	91. 00
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94. 00 95. 00 98. 00 99. 00 0 0 0 0 0 98. 00 99. 00 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0	92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
95. 00 95. 00 95. 00 07HER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 95. 00 98. 00 99. 00 0 0 0 0 98. 00 99. 00 0 0 0 0 0 0 0 0 0		l l	0	0	0	0	0	
98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 0. 000000 0. 003969 12, 126 14, 791 0. 000000 103.00 0. 003969 12, 126 14, 791 0. 000000 105. 00 0. 000041 0. 358257 0. 000000 0. 000001 0. 000001			0	0	0	0		•
99. 00 102. 00 103. 00 104. 00 105. 00 105. 00 1075, 140 108. 00 1099. 00 1		1 1	0	0	0	0	0	•
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 3.384097 0.000000 0.003969 5.473671 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.761327 0.000000 0.000641 0.358257 0.000000 105.00 1								1
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Discool Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			1/1 /20	^	75 440	225 027	_	•
103.00 Unit cost multiplier (Wkst. B, Part I) 3.384097 0.000000 0.003969 5.473671 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 36,364 0 12,126 14,791 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 0.761327 0.000000 0.000641 0.358257 0.000000 105.00	102.00	***	101,038	0	75, 140	225, 986		102.00
104.00 Cost to be allocated (per Wkst. B, Part 0.761327 0.000000 0.000641 0.358257 0.000000 105.00	103 00		3 384097	0 000000	0 003080	5 473671	0 000000	103 00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.761327 0.000000 0.000641 0.358257 0.000000 105.00			1	0. 000000 N	1		l .	
105.00 Unit cost multiplier (Wkst. B, Part 0.761327 0.000000 0.000641 0.358257 0.000000 105.00	. 5 1. 50		35, 554	O	12, 120			55
	105.00	Unit cost multiplier (Wkst. B, Part	0. 761327	0. 000000	0. 000641	0. 358257	0. 000000	105. 00
		1)	l l		I		I	l

CRANBURY CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/17/2023 2:33 pm Provi der No.: 315353

				5/17/2023 2:3	3 pm
			OTHER GENERAL		
			SERVI CE		
		Cost Center Description	ACTI VI TI ES		
			(TOTAL PATIENT		
			DAYS)		
			15. 00		
		AL SERVICE COST CENTERS	,		
1.00	1	CAP REL COSTS - BLDGS & FLXTURES			1. 00
2.00		CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300	EMPLOYEE BENEFITS			3. 00
4.00	00400	ADMINISTRATIVE & GENERAL			4. 00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600	LAUNDRY & LINEN SERVICE			6. 00
7.00	00700	HOUSEKEEPI NG			7. 00
8.00	00800	DIETARY			8. 00
9.00	00900	NURSING ADMINISTRATION			9. 00
10.00		CENTRAL SERVICES & SUPPLY			10.00
11. 00	1	PHARMACY			11.00
12. 00	1	MEDICAL RECORDS & LIBRARY			12.00
13. 00	1	SOCIAL SERVICE			13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	1	ACTI VI TI ES	41, 286		15. 00
10.00		IENT ROUTINE SERVICE COST CENTERS	11, 200		10.00
30. 00		SKILLED NURSING FACILITY	41, 286		30.00
31. 00	1	NURSING FACILITY	0		31. 00
32. 00		ICF/IID			32. 00
33. 00	1	OTHER LONG TERM CARE			33. 00
33.00		LARY SERVICE COST CENTERS	U U		33.00
40. 00		RADI OLOGY	O		40. 00
41. 00		LABORATORY			41. 00
42. 00		I NTRAVENOUS THERAPY			42. 00
43. 00		OXYGEN (INHALATION) THERAPY			43. 00
44. 00	1	PHYSI CAL THERAPY			44. 00
45. 00		OCCUPATIONAL THERAPY			45. 00
46. 00	1	SPEECH PATHOLOGY			46. 00
47. 00	1	ELECTROCARDI OLOGY			47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS			48. 00
		DRUGS CHARGED TO PATIENTS			49. 00
50. 00		DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00		SUPPORT SURFACES			51.00
52. 00		OTHER ANCILLARY SERVICE COST CENTERS	o		52.00
		TIENT SERVICE COST CENTERS			
60.00		CLINIC	0		60.00
61.00	06100	RURAL HEALTH CLINIC	O		61.00
62.00	06200	FQHC			62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0		63. 00
		REIMBURSABLE COST CENTERS			
70.00	07000	HOME HEALTH AGENCY COST	0		70. 00
71.00	07100	AMBULANCE	0		71. 00
72.00	07200	CORF	0		72. 00
73.00	07300	CMHC	0		73. 00
74.00	07400	OTHER REIMBURSABLE COST	0		74. 00
	SPECI	AL PURPOSE COST CENTERS			
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00	08100	I NTEREST EXPENSE			81. 00
82. 00		UTILIZATION REVIEW			82. 00
83. 00		HOSPI CE	0		83. 00
84. 00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0		84. 00
89. 00		SUBTOTALS (sum of lines 1-84)	41, 286		89. 00
		IMBURSABLE COST CENTERS			
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0		90. 00
91. 00		BARBER AND BEAUTY SHOP	0		91. 00
92.00		PHYSICIANS PRIVATE OFFICES	0		92. 00
93.00		NONPALD WORKERS	0		93. 00
94. 00		PATIENTS LAUNDRY	0		94. 00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0		95. 00
98. 00		Cross Foot Adjustments			98. 00
99.00	J	Negative Cost Centers	171 0/0		99.00
102.00	Ί	Cost to be allocated (per Wkst. B,	171, 269		102. 00
103.00		Part Unit cost multiplier (Wkst. B, Part)	4. 148355		103. 00
103.00	1	Cost to be allocated (per Wkst. B,	6, 548		104. 00
104. UL	Ί	Part II)	0, 348		104.00
105.00		Unit cost multiplier (Wkst. B, Part	0. 158601		105. 00
. 55. 50			0. 100001		. 55. 50
	•				-

Health Financial Systems CRANBURY CENTER			In Lieu of Form CMS-2540-10
RATIO OF COST TO CHARGES FOR AND	CILLARY AND OUTPATIENT COST CENTERS Provider No.: 3	15353 Peri od:	Worksheet C

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/17/2023 2:33 pm Ratio (col. 1 Cost Center Description Total (from Total Charges Ratio (col. Wkst. B, Pt I, di vi ded by col. 2 3. 00 1.00 2. 00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 17, 060 22, 828 0. 747328 40.00 04100 LABORATORY 36, 367 62, 965 0.577575 41.00 41.00 23, 824 42.00 04200 I NTRAVENOUS THERAPY 28, 734 1. 206095 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 19, 408 592 32. 783784 43.00 44. 00 04400 PHYSI CAL THERAPY 517, 053 834, 999 0.619226 44.00 04500 OCCUPATIONAL THERAPY 45.00 511, 927 937, 748 0.545911 45.00 04600 SPEECH PATHOLOGY 0.495505 46.00 179, 069 361, 387 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 103 0.000000 48.00 04900 DRUGS CHARGED TO PATIENTS 0.816672 49.00 49.00 225, 498 184, 158 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 50.00 51.00 05100 SUPPORT SURFACES 23, 693 77 307.701299 51.00 52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 52.00 OUTPATIENT SERVICE COST CENTERS 0.000000 60.00 06000 CLI NI C 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FQHC 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 63.00 63.00 0.000000 0 0 71. 00 | 07100 | AMBULANCE 0.000000 71.00

1, 525, 572

2, 469, 918

100.00

100.00

Total

lealth Financial Systems	CRANBURY				u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narod:
				10 12/31/2022	5/17/2023 2: 3:	3 pm
		Title	XVIII (1)	Skilled Nursing	PPS	о р
			,	Facility		
		Heal th Care Pr	ogram Charges	Heal th Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)	0.00	0.00	4.00	F 00	
DADT I CALCULATION OF ANOLILIADY AND OUTDAT	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPATI ANCILLARY SERVICE COST CENTERS	LENI CUSI					-
40. 00 04000 RADI OLOGY	0. 747328	4, 958		3, 705	0	40.00
41. 00 04100 KABI OLOGI 41. 00 04100 LABORATORY	0. 747328			1, 528	0	
42. 00 04200 NTRAVENOUS THERAPY	1. 206095			9, 473	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	32. 783784	288		9, 442	0	
44. 00 04400 PHYSI CAL THERAPY	0. 619226			204, 475	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 545911	369, 807		201, 882	0	
46. 00 04600 SPEECH PATHOLOGY	0. 495505	141, 766	ì	70, 246	0	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000		,	0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		,		0	
49.00 04900 DRUGS CHARGED TO PATIENTS	0. 816672	87, 863	(71, 755	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		o	·	50.00
51. 00 05100 SUPPORT SURFACES	307. 701299	22	(6, 769	0	51.00
52.00 05200 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000		(o o	0	52.00
OUTPATIENT SERVICE COST CENTERS	'			·		
60. 00 06000 CLI NI C	0. 000000	0	(0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC						62.00
63.00 06300 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	o	(o o	0	63.00
71.00 07100 AMBULANCE (2)	0. 000000		(0	71.00
						1
100.00 Total (Sum of lines 40 - 71)		945, 414	(579, 275	0	100.00

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

Heal th	Financial Systems	CRANBURY	CENTER		In Lie	u of Form CMS-2	2540-10
APPORT	IONMENT OF ANCILLARY AND OUTPATIENT COSTS				Period: From 01/01/2022 To 12/31/2022	5/17/2023 2:3	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description						
	PART II - APPORTIONMENT OF VACCINE COST					1. 00	
1. 00	Drugs charged to patients - ratio of c	net to charges	(From Workshop	t C column 3	line 40)	0. 816672	1.00
2.00	Program vaccine charges (From your rec			t C, COLUMN 3	, 11116 47)	1, 031	2.00
3.00	Program costs (Line 1 x line 2) (Title			er this amoun	t to Worksheet	842	3.00
3.00	E, Part I, line 18)	χνιτι, τι 5 ρι ο	riders, transit	er till 3 alliouri	t to worksneet	042	3.00
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A	Part A Nursing	
		(From Wkst. B,			Cost (From	& Allied	
		Part I, Col.	(From Wkst. B,	Allied Healt	h Wkst. D Part	Health Costs	
		18		Costs to Tota		for Pass	
			14)	Costs - Part		Through (Col.	
				(Col. 2 / Col		3 x Col. 4)	
				1)			
	DART III OALOULATION OF DAGG TURQUOU OOCTO	1.00	2.00	3. 00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSTING &	ALLIED HEALIH				
	ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY	17, 060	0	0.00000	00 3, 705	0	40.00
	04100 LABORATORY	36, 367	0	0.00000		0	41.00
	04200 I NTRAVENOUS THERAPY	28, 734	0	0.00000		0	42.00
	04300 OXYGEN (INHALATION) THERAPY	19, 408	0	0.00000		0	43.00
	04400 PHYSI CAL THERAPY	517, 053	0	0.00000		0	44. 00
	04500 OCCUPATI ONAL THERAPY	511, 927	0	0. 00000		0	45. 00
	04600 SPEECH PATHOLOGY	179, 069	0	0. 00000		0	46. 00
	04700 ELECTROCARDI OLOGY	0	0	0.00000		0	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 103	0	0.00000		0	48. 00
	04900 DRUGS CHARGED TO PATIENTS	184, 158	0	0.00000		0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.00000	0 0	0	50.00
51.00	05100 SUPPORT SURFACES	23, 693	0	0.00000	0 6, 769	0	51.00
52.00	05200 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 00000	0 0	0	52. 00
100.00	Total (Sum of lines 40 - 52)	1, 525, 572	0	I	579, 275	0	100.00

	<i>y</i>	BURY CENTER		u of Form CMS-1	
OMPU I	ATION OF INPATIENT ROUTINE COSTS	Provi der No. : 315353	Peri od: From 01/01/2022 To 12/31/2022		pare
		Title XVIII	Skilled Nursing Facility		у р
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
00	Inpatient days including private room days			41, 286	
00	Private room days			265	1
00	Inpatient days including private room days applicable	3		4, 370	
00	Medically necessary private room days applicable to the	e Program		0	
0	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			12, 499, 750	5
0	General inpatient routine service charges			16, 418, 257	6
0	General inpatient routine service charges (I	line 5 divided by line 6)		0. 761332	
0	Enter private room charges from your records	Line 5 di vided by Tine 6)		122, 099	
0					
O	2)	rges fille o divided by private	2 Toom days, Time	460. 75	′
00	1 '				10
00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by			397. 26	11	
	semi-private room days)				
00	Average per diem private room charge differential (Line	•		63. 49	1
00	Average per diem private room cost differential (Line 7	•		48. 34	
00	Private room cost differential adjustment (Line 2 times			12, 810	
00	General inpatient routine service cost net of private in PROGRAM INPATIENT ROUTINE SERVICE COSTS	room cost differential (Line !	minus line 14)	12, 486, 940	15
00	Adjusted general inpatient service cost per diem (Line	15 divided by line 1)		302. 45	16
00	Program routine service cost (Line 3 times line 16)	- ·		1, 321, 707	17
00	Medically necessary private room cost applicable to pro	9 (0	1 .~
00	Total program general inpatient routine service cost			1, 321, 707	
00	Capital related cost allocated to inpatient routine ser line 30 for SNF; line 31 for NF, or line 32 for ICF/III		art II column 18,	1, 877, 851	20
00	Per diem capital related costs (Line 20 divided by lir	ne 1)		45. 48	21
00	Program capital related cost (Line 3 times line 21)			198, 748	
00	Inpatient routine service cost (Line 19 minus line 22)			1, 122, 959	
00	Aggregate charges to beneficiaries for excess costs (0	1
00	Total program routine service costs for comparison to	the cost limitation (Line 23 m	ninus line 24)	1, 122, 959	
00	Enter the per diem limitation (1)		2/) (1)		26
00	Inpatient routine service cost limitation (Line 3 times				27
00	Reimbursable inpatient routine service costs (Line 22 p (Transfer to Worksheet E, Part II, line 4) (See instruc		1111e 27)		28
	(Transfer to worksheet E, Part II, IIne 4) (see Instruc nes 26 and 27 are not applicable for title XVIII, but ma	•		l	I

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	41, 286	1.00
2.00	Program inpatient days (see instructions)	4, 370	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. 105847	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00
5.00	priogram harsing & arried hearth costs for pass-through. (Trie 3 times fine 4)	0] 5.00

Health Financial Systems	CRANBURY CENT	ER	In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	TITLE XVIII	Provi der No.: 315353		Worksheet E Part I Date/Time Prepared: 5/17/2023 2:33 pm
		Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS	<u>5 piii </u>
			-	1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSE	MENT		1.00	
1.00	Inpatient PPS amount (See Instructions)			2, 918, 848	1. 00
2.00	Nursing and Allied Health Education Activities (pass through par	vments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	,,		2, 918, 848	3. 00
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			412, 729	
6.00	Allowable bad debts (From your records)			81, 600	
7.00	Allowable Bad debts for dual eligible beneficiaries (See instruc	ctions)		75, 488	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			53, 040	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, 559, 159	11.00
12.00	Interim payments (See instructions)			2, 499, 010	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			541	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			669	
14. 99	Sequestration amount (see instructions)			34, 226	
15. 00	Balance due provider/program (see Instructions)			24, 713	
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER (OF COST OR CHARGES -	TITLE XVIII ONLY		47.00
17. 00	Ancillary services Part B			0	
18.00	Vaccine cost (From Wkst D, Part II, line 3)			842 842	
19.00	Total reasonable costs (Sum of lines 17 and 18)			1, 031	
20. 00 21. 00	Medicare Part B ancillary charges (See instructions) Cost of covered services (Lesser of line 19 or line 20)			842	
21.00	Primary payor amounts			042	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instruc	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)	31. 31.3)		0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			842	
26. 00	Interim payments (See instructions)			719	
27.00	Tentati ve adjustment			0	27. 00
28.00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			11	
29. 00	Balance due provider/program (see instructions)			112	
30. 00	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub.15-2,	section 115.2	0	30. 00

Health Financial Systems	CRANBURY CENT	CRANBURY CENTER			
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provi der No.: 315353	From 01/01/2022	Worksheet E Part II Date/Time Prepared: 5/17/2023 2:33 pm	
		Title XIX	Skilled Nursing	PPS	

			Facility		
				4.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			1. 00	
1.00	Inpatient ancillary services (see Instructions)			0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2.00
3.00	Outpatient services	3)		0	3.00
4. 00	Inpatient routine services (see instructions)			0	4.00
5.00	Utilization reviewphysicians' compensation (from provider reco	rde)		0	5.00
6.00	Cost of covered services (Sum of Lines 1 - 5)	1 43)		0	6.00
7. 00	Differential in charges between semiprivate accommodations and I	ass than saminrivate a	commodations	0	7.00
8.00	SUBTOTAL (Line 6 minus line 7)	ess than semi pri vate a	Commoda ti oris	0	8.00
9. 00	Primary payor amounts			0	9. 00
10.00	Total Reasonable Cost (Line 8 minus line 9)			0	10.00
10.00	REASONABLE CHARGES			U	10.00
11. 00	Inpatient ancillary service charges			0	11. 00
	Outpatient service charges			0	12.00
	Inpatient routine service charges			0	13. 00
	Differential in charges between semiprivate accommodations and I	occ than comingivate a	acommodati onc	0	14.00
	Total reasonable charges	ess than semipit vate a	COMMODALIONS	0	15.00
13.00	CUSTOMARY CHARGES			U	15.00
14 00	Aggregate amount actually collected from patients liable for pay	mont for sorvices on a	charge basis	0	16. 00
17. 00	Amounts that would have been realized from patients liable for p			0	17. 00
17.00	had such payment been made in accordance with 42 CFR 413.13(e)	ayment for services on	a charge basis	U	17.00
18 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.000000	18. 00
	Total customary charges (see instructions)			0.000000	
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00
20. 00	Cost of covered services (see Instructions)			0	20.00
21. 00	Deductibles			0	21.00
22. 00	Subtotal (Line 20 minus line 21)			0	22. 00
23. 00	Coi nsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	24. 00
	Allowable bad debts (from your records)			0	25. 00
26. 00	Subtotal (sum of lines 24 and 25)			0	26.00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneously	collected based on co	rrection of	0	27. 00
27.00	cost limit	corrected based on co	Trection of	O	27.00
28. 00	Recovery of excess depreciation resulting from provider terminat	ion or a decrease in p	rogram	0	28. 00
20.00	utilization		og. a	J	20.00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fro	m disposition of depre	ciable assets (0	30.00
	if minus, enter amount in parentheses)				
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 2	7 and 28)		0	31.00
32. 00	Interim payments	- /		0	•
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate o	verpayments in parenth	eses) (see	0	33. 00
	Instructions)	, , , ,		-	

WOLKSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315353 Period:
From 01/01/2022
To 12/31/2022 Date/Time Prepared:
5/17/2023 2:33 pm

Title XVIII Skilled Nursing PPS

		11 11	e XVIII S	Killed Nursing	PPS	
		Innation	t Part A	Facility	t B	
		<u>'</u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 513, 290		719	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	enter zero					0.00
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 05			0		0	3. 05
3.03	Provider to Program				U U	3. 03
3.50	ADJUSTMENTS TO PROGRAM	07/13/2022	14, 280		0	3. 50
3. 51			0		o	3. 51
3.52			0		o	3. 52
3.53			0		o	3. 53
3.54			0		o	3. 54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		-14, 280		0	3. 99
	- 3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 499, 010		719	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
F 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5. 00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			o o		ol	5. 02
5.03			0		o	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	5. 99
	- 5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
<i>(</i> 01	the cost report. (1)		24 712		110	/ O1
6. 01	PROGRAM TO PROVIDER		24, 713 0		112 0	6. 01
6. 02 7. 00	PROVIDER TO PROGRAM Total Medicare program liability (see instructions)		2, 523, 723		831	6. 02 7. 00
7.00	Total medicale program frability (see Histructions)		2, 523, 723 Contract		Contractor	7.00
			COILLIACI	tor maine	Number	
			1.	00	2. 00	
8. 00	Name of Contractor				2.00	8. 00
	1: 0 5 1/ 1				' '	2. 20

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

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

Provi der No.: 315353 | Peri od: From 01/01/202 To 12/31/202

1 y)					5/17/2023 2: 3	33 pm
		General Fund	Specific En Purpose Fund	dowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4.00	
	SSETS					
	JRRENT ASSETS ash on hand and in banks	1, 422	O	0	0	1.
	emporary investments	1, 422	0	0		
	otes receivable	Ö	o	0	Ō	
00 Ac	ccounts receivable	2, 272, 840	0	0	0	4.
4	ther recei vabl es	20, 894		0	0	1
	ess: allowances for uncollectible notes and accounts	-428, 893	0	0	0	6
- 1	ecei vabl e nventory	89, 619	0	0	0	7
	repaid expenses	403, 969	1	0		
	ther current assets	0	Ö	0	Ö	
	ue from other funds	0	0	0	0	
	OTAL CURRENT ASSETS (Sum of lines 1 - 10)	2, 359, 851	0	0	0	11
_	XED ASSETS					
4	and	0	0	0	-	
1	and improvements	105, 797		0	0	
1	ess: Accumulated depreciation uildings	-21, 164		0		
	ess Accumulated depreciation		0	0		
	easehold improvements	276, 284	_	0	l o	
	ess: Accumulated Amortization	-25, 859		0	0	18
00 Fi	ixed equipment	34, 569	0	0	0	19
4	ess: Accumulated depreciation	-4, 738	0	0	0	
1	utomobiles and trucks	0	0	0	0	
- 1	ess: Accumul ated depreciation	0	0	0	0	
- 1	ajor movable equipment	151, 347		0	0	
	ess: Accumulated depreciation inor equipment - Depreciable	-54, 730		0		
	inor equipment nondepreciable	0	o o	0	٥	
	ther fixed assets	o o	o	0	Ö	1 -
	OTAL FIXED ASSETS (Sum of lines 12 - 27)	461, 506	0	0	0	28
ОТ	THER ASSETS					
	nvestments	0	0	0	-	
- 1	eposits on leases	1 200 221	0	0	-	
	ue from owners/officers	1, 280, 231		0	0	
	ther assets OTAL OTHER ASSETS (Sum of lines 29 - 32)	1, 280, 231	0	0		
	OTAL ASSETS (Sum of Lines 11, 28, and 33)	4, 101, 588	1	0	•	
	abilities and Fund Balances					
	JRRENT LI ABI LI TI ES	075 040			1 ^	١.,
	ccounts payable	875, 940	1	0		
	alaries, wages, and fees payable ayroll taxes payable	0	0	0	0	
	otes & Loans payable (Short term)			0		
	eferred income	0	o o	0	٥	1 .
	ccel erated payments	0				40
00 Du	ue to other funds	264	0	0	0	4
	ther current liabilities	3, 335, 119		0		
	OTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4, 211, 323	0	0	0	43
	DNG TERM LIABILITIES ortgage payable	1 0	o	0	0	1
4	ortgage payable otes payable			0		
	nsecured Loans		0	0		
1	oans from owners:	0	Ö	0	0	
4	ther long term liabilities	0	O	0	0	
00 AF	PIC DISTRIBUTIONS; R/E EARNINGS	599, 701	0	0	0	4
	OTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	599, 701	1	0	0	
	OTAL LIABILITIES (Sum of lines 43 and 50)	4, 811, 024	0	0	0	5
	APITAL ACCOUNTS eneral fund balance	-709, 436				5:
- 1	pecific purpose fund	-707, 430	0			5
	onor created - endowment fund balance - restricted			0		5
	onor created - endowment fund balance - unrestricted			0		5
	overning body created - endowment fund balance			0		5
- 1	lant fund balance – invested in plant				0	
	lant fund balance - reserve for plant improvement,				0	5
	eplacement, and expansion	700 434		2		
	OTAL FUND BALANCES (Sum of lines 52 thru 58) OTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-709, 436 4, 101, 588	1	0	0	
	9)	4, 101, 300	1 4	U	I	1 00

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

Provi der No.: 315353

						5/17/2023 2: 33	3 pm
		General	Fund	Special Pu	irpose Fund	Endowment Fund	
				·			
		1. 00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-709, 436				2.00
3.00	Total (sum of line 1 and line 2)		-709, 436		0		3.00
4.00	Additions (credit adjustments)						4.00
5.00		0		C		0	5.00
6.00		0		C		0	6.00
7.00		0		C		0	7.00
8.00		0		C)	0	8.00
9.00		0		C)	0	9.00
10.00	Total additions (sum of line 5 - 9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-709, 436		0		11.00
12.00	Deductions (debit adjustments)						12.00
13.00		o		l c)	ol	13.00
14.00		o		l c)	ol	14.00
15.00		o		l c)	ol	15.00
16.00		o		l c)	ol	16.00
17.00		o		l c)	ol	17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0		18.00
19.00	Fund balance at end of period per balance		-709, 436		0		19.00
	sheet (Line 11 - line 18)						
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0		C)		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 31)						2. 00
3.00	Total (sum of line 1 and line 2)	0		C)		3. 00
4.00	Additions (credit adjustments)						4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00							
	Total additions (sum of line 5 - 9)	0		C			10.00
11. 00	Subtotal (line 3 plus line 10)	0		0			11.00
12. 00		0		0			11. 00 12. 00
	Subtotal (line 3 plus line 10)	0 0	0	C			11.00
12. 00	Subtotal (line 3 plus line 10)	0	0	C			11. 00 12. 00 13. 00 14. 00
12. 00 13. 00 14. 00 15. 00	Subtotal (line 3 plus line 10)	0	0 0 0	C			11. 00 12. 00 13. 00 14. 00 15. 00
12. 00 13. 00 14. 00	Subtotal (line 3 plus line 10)	0 0	0 0 0 0	C			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
12. 00 13. 00 14. 00 15. 00	Subtotal (line 3 plus line 10)	0 0	0 0 0 0	C			11. 00 12. 00 13. 00 14. 00 15. 00
12. 00 13. 00 14. 00 15. 00 16. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)	0 0	0 0 0 0	C			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance	0 0	0 0 0 0	С			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17)	0 0	0 0 0 0	c			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

Heal th	Financial Systems CRANBURY CEN	ITER		In Li€	eu of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Period: From 01/01/2022 To 12/31/2022		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services		1		1	
1. 00	SKILLED NURSING FACILITY		16, 460, 76	5	16, 460, 765	1. 00
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE			0	0	4. 00
5. 00	Total general inpatient care services (Sum of lines 1 - 4)		16, 460, 76	5	16, 460, 765	5. 00
	All Other Care Services				T	
6.00	ANCI LLARY SERVI CES		2, 478, 89		2, 478, 891	6. 00
7.00	CLI NI C			0	1	7. 00
8.00	HOME HEALTH AGENCY COST			0	0	
9.00	AMBULANCE			0	0	9. 00
10. 00	RURAL HEALTH CLINIC			0	0	
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
11. 10	CORF			0	0	11. 10
12.00	HOSPI CE			0	0	12. 00
13. 00	OTHER (SPECIFY)			0	0	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column	3 to	18, 939, 65	6 0	18, 939, 656	14. 00
	Worksheet G-3, Line 1)					
	Cost Center Description			1.00		
	DART AL ARERATING EVERYORS			1. 00	2. 00	
4 00	PART II - OPERATING EXPENSES				44 040 400	1 00
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)				14, 843, 132	
2.00	Add (Specify)			0		2.00
3.00				0		3.00
4.00				0		4.00
5.00				0		5. 00
6.00				0		6. 00
7.00	T + 1 A (C			0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)				0	
9.00	Deduct (Specify)			0		9. 00
10.00				0		10.00
11. 00				0		11.00
12.00				0		12.00
13.00	T			0		13.00
	Total Deductions (Sum of lines 9 - 13)				0	
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)				14, 843, 132	15.00

Health Financial Systems	CRANBURY CENTER	In Lieu of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING	EXPENSES Provi der No.: 315353	Period: Worksheet G-3 From 01/01/2022
		To 12/31/2022 Date/Time Prepared: 5/17/2023 2:33 pm

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der No.: 315353	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			12,01,2022	5/17/2023 2: 3	
				1. 00	
	1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			18, 939, 656	1. 00
2.00				4, 800, 246	2. 00
3.00				14, 139, 410	3. 00
4.00				14, 843, 132	4. 00
5.00					5. 00
	Other income:				
6.00					
7.00				0	7. 00
	8.00 Revenues from communications (Telephone and Internet service)				8. 00
9.00	.00 Revenue from television and radio service			0	9. 00
10.00	10.00 Purchase discounts			0	10.00
11. 00	11.00 Rebates and refunds of expenses			0	11. 00
12.00	12.00 Parking Lot receipts			0	12.00
13.00	13.00 Revenue from Laundry and Linen service			0	13.00
14.00	14.00 Revenue from meals sold to employees and guests			0	14.00
15.00	15.00 Revenue from rental of living quarters			0	15.00
16.00	16.00 Revenue from sale of medical and surgical supplies to other than patients			0	16. 00
17.00 Revenue from sale of drugs to other than patients			0	17. 00	
18.00	18.00 Revenue from sale of medical records and abstracts			0	18. 00
19.00	19.00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	20.00 Revenue from gifts, flower, coffee shops, canteen			0	20. 00
21.00				0	21. 00
22.00	22.00 Rental of skilled nursing space			0	22. 00
23.00	3.00 Governmental appropriations			0	23. 00
24.00				-5, 714	24. 00
24. 50				0	24. 50
25. 00	5.00 Total other income (Sum of lines 6 - 24)			-5, 714	25. 00
26. 00	6.00 Total (Line 5 plus line 25)			-709, 436	26. 00
27. 00				0	27. 00
28. 00				0	28. 00
29. 00				0	29. 00
	.00 Total other expenses (Sum of Lines 27 - 29)			0	30.00
	31.00 Net income (or loss) for the period (Line 26 minus line 30)			-709, 436	