This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expires: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315353 Worksheet S Parts I, II & III Peri od: From 01/01/2023 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/13/2024 9: 24 am PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 5/13/2024 Time: 9:24 am use only | Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN

9. NPR Date:

11. Contractor Vendor Code

for no utilization.

8.[N] Last Cost Report for this Provider CCN

10.[0]If line 4, column 1 is "4": Enter number of times reopened

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

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

(2) Settled without audit

(3) Settled with audit

(4) Reopened

(5) Amended

5. Date Received:

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRANBURY CENTER (315353) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

| | | Title | XVIII | | |
|-------------------------------|---------|---------|--------|-----------|---------|
| Cost Center Description | Title V | Part A | Part B | Title XIX | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| PART III - SETTLEMENT SUMMARY | | | | | |
| 1.00 SKILLED NURSING FACILITY | 0 | 14, 355 | 886 | 0 | 1. 00 |
| 2.00 NURSING FACILITY | 0 | | | 0 | 2. 00 |
| 3. 00 I CF/I I D | | | | 0 | 3. 00 |
| 4. 00 SNF - BASED HHA I | 0 | 0 | 0 | | 4. 00 |
| 5. 00 SNF - BASED RHC I | 0 | | 0 | | 5. 00 |
| 6.00 SNF - BASED FQHC I | 0 | | 0 | | 6. 00 |
| 7.00 SNF - BASED CMHC I | 0 | | 0 | | 7. 00 |
| 7. 10 SNF - BASED CORF I | 0 | | 0 | | 7. 10 |
| 100. 00 TOTAL | 0 | 14, 355 | 886 | 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 01/01/2023 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 12/31/2023 5/13/2024 9: 24 am 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 CBSA Code: 3. 01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4.00 5.00 6.00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF CRANBURY CENTER 315353 09/07/1996 N Р 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) 12/31/2023 01/01/2023 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 85, 329 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 85 329 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) Ν 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 | D NURSING FACILITY AND SKILLED NURSING | FACILITY HEALTH CARE | Provi der No.: 315353 | Peri od: | Worksheet S-2 | |
| COMPLE | X INDENTIFICATION DATA | | | From 01/01/2023 | Part I | |
| | | | | To 12/31/2023 | | |
| | | | | | 5/13/2024 9: 2 | <u>4 am </u> |
| | | | | | Y/N | |
| | | | | | 1. 00 | |
| 42.00 | Are malpractice premiums and paid loss | es reported in other than | the Administrative ar | nd General cost | N | 42. 00 |
| | center? Enter Y or N. If yes, check box | x, and submit supporting | schedule listing cost | centers and | | |
| | amounts. | | G | | | |
| 43.00 | Are there any home office costs as def | ined in CMS Pub. 15-1, Ch | apter 10? | | Υ | 43. 00 |
| 44.00 | If line 43 is yes, enter the home office | ce chain number and enter | the name and address | of the home | HB0067 | 44. 00 |
| | office on lines 45, 46 and 47. | | | | | |
| | 1.00 | 2.00 | | 3. 00 | | |
| | If this facility is part of a chain or | ganization, enter the nam | e and address of the l | home office on the | lines | |
| | bel ow. | | | | | |
| 45.00 | Name: GENESIS HEALTHCARE | Contractor's Name: NOVITA | S Contrac | tor's Number: 1200 | 1 | 45. 00 |
| 46.00 | Street: 101 EAST STATE STREET | PO Box: | | | | 46. 00 |
| 47.00 | City: KENNETT SQUARE | State: PA | Zi p Cod | le: 1934 | 8 | 47. 00 |

| | Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI | CRANBURY CENT | | No.: 315353 | In Li∈ Period: | eu of Form CMS- Worksheet S-2 | |
|--------|--|--|----------------------------|----------------|----------------------------------|----------------------------------|---------|
| | X REI MBURSEMENT QUESTI ONNAI RE | TI HEALTH CARE | TTOVIGET | | From 01/01/2023 To 12/31/2023 | Part II Date/Time Pre | epared: |
| | | | | | Y/N | 5/13/2024 9: 2 Date | 24 am |
| | General Instruction: For all column 1 respons | and out on in column | 1 "V" fo | 5 Vac as "N" t | 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 | OF NO. FOR 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 |
| | column 1 is yes, enter in column 2 the date | | | | | | |
| 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 or I, or members of the | es, drug its e board | Y | | | 3. 00 |
| | rerationsings: (see Fisti detrois) | | | Y/N | Type | Date | |
| | Financial Data and Reports | | | 1.00 | 2. 00 | 3. 00 | |
| 4. 00 | Column 1: Were the financial statements prep Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple | " for Audited, "C" 1 te copy or enter dat | for te | Y | С | | 4.00 |
| 5. 00 | available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If | revenues different | from | N | | | 5. 00 |
| | reconciliation. | | | | Y/N | Legal Oper. | |
| | Approved Educational Activities | | | | 1. 00 | 2. 00 | |
| 6.00 | Column 1: Were costs claimed for Nursing Sch | ool? (Y/N) Column 2: | Is the | provider the | N | N | 6. 00 |
| 7. 00 | legal operator of the program? (Y/N) Were costs claimed for Allied Health Program | s? (Y/N) see instrud | ctions. | | N | | 7. 00 |
| 8. 00 | Were approvals and/or renewals obtained duri School and/or Allied Health Program? (Y/N) s | | ng period | for Nursing | N | | 8. 00 |
| | | | | | | Y/N 1.00 | |
| 9. 00 | Bad Debts Is the provider seeking reimbursement for ba | d dobte2 (V/N) soo i | netruetio | nc | | Υ | 9.00 |
| 10. 00 | If line 9 is "Y", did the provider's bad deb period? 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 | uctions. | N | 11. 00 |
| 12. 00 | Have total beds available changed from prior | cost reporting peri | od? If "Y | | | N | 12. 00 |
| | | Description | า | Y/N | rt A Date | Part B Y/N | |
| | I | 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 | 03/09/2024 | 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 |
| | provider's records? If "Y" see Instructions. | | | | | | |

| Heal th | Financial Systems CRANBU | RY CEN | TER | | | In Lie | u of Form CMS | -2540-1 | 0 |
|---|--|--------|------------|-------------|----|--------------------------------------|---------------|--------------|---|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | | RE | Provi der | No.: 315353 | | riod: om 01/01/2023 12/31/2023 | | - epared: | : |
| | | | 1. | 00 | | 2. (| 00 | - | |
| | Cost Report Preparer Contact Information | | | | | | | | _ |
| 19.00 | Enter the first name, last name and the title/position | JEAN | J | | PI | RICE | | 19.00 | 0 |
| | held by the cost report preparer in columns 1, 2, and 3, respectively. | | | | | | | | |
| 20.00 | Enter the employer/company name of the cost report | GENE | SIS HEALTH | CARE | | | | 20.0 | 0 |
| | preparer. | | | | | | | | |
| 21. 00 | Enter the telephone number and email address of the cost | 4108 | 3044481 | | JI | EAN. PRI CE@GENE | ESI SHCC. COM | 21.00 | 0 |
| | report preparer in columns 1 and 2, respectively. | - 1 | | | Į. | | | | |

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

In Lieu of Form CMS-2540-10
Worksheet S-2
From 01/21/2023 Part II

| COMPLE | X REIMBURSEMENT QUESTIONNAIRE | | | To 12/31/2023 | | |
|--------|--|------------------------|-----------------------|---------------|-----|------|
| | | Part B Date 4.00 | | | | |
| | PS&R Data | | | | | _ |
| 13. 00 | Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) | | | | 13. | . 00 |
| 14. 00 | Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. | 03/09/2024 | | | 14. | . 00 |
| 15. 00 | If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. | | | | 15. | . 00 |
| 16. 00 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. | | | | 16. | . 00 |
| | If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: | | | | | . 00 |
| 18. 00 | Was the cost report prepared only using the provider's records? If "Y" see Instructions. | | | | 18. | . 00 |
| | | | 3. 00 | | | |
| | Cost Report Preparer Contact Information | | | | | |
| 19. 00 | Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively. | | REIMBURSEMENT ANALYST | | 19. | . 00 |
| 20. 00 | Enter the employer/company name of the cost r preparer. | report | | | 20. | . 00 |
| 21. 00 | Enter the telephone number and email address report preparer in columns 1 and 2, respective | | | | 21. | . 00 |

Health Financial Systems CRANBURY CENTER In Lieu of Form CMS-2540-10

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

Provider No.: 315353 | Period: | Worksheet S-3 | From 01/01/2023 | Part I | Date/Time Prepared:

5/13/2024 9: 24 am Inpatient Days/Visits Title XVIII Component Number of Beds Bed Days Title V Title XIX Avai I abl e 4.00 5.00 1.00 2.00 3.00 1.00 SKILLED NURSING FACILITY 154 56, 210 3, 975 30, 751 1. 00 NURSING FACILITY 0 2.00 0 2.00 3.00 ICF/IID 0 3.00 0 HOME HEALTH AGENCY COST 4.00 0 Ω 4 00 5.00 Other Long Term Care 5.00 SNF-Based CMHC 6.00 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 7.00 Λ 7.00 8.00 Total (Sum of lines 1-7) 154 56, 210 3.975 30, 751 8.00 Inpatient Days/Visits Di scharges Component 0ther Total Title V Title XVIII Title XIX 6.00 8.00 9. 00 10.00 SKILLED NURSING FACILITY 1.00 6,095 40, 821 88 1.00 62 NURSING FACILITY 2.00 2 00 0 0 3.00 ICF/IID 0 3.00 4.00 HOME HEALTH AGENCY COST 0 4.00 Other Long Term Care SNF-Based CMHC 5.00 0 5.00 6.00 6 00 6.10 SNF-Based CORF 6.10 HOSPI CE 7.00 7.00 Total (Sum of lines 1-7) 6,095 88 8.00 40, 821 62 8.00 Di scharges Average Length of Stay 0ther Title V Title XVIII Title XIX Component Total 11. 00 13.00 14.00 15.00 12.00 1.00 SKILLED NURSING FACILITY 0. 00 495. 98 1.00 170 320 45.17 2.00 NURSING FACILITY 0 0.00 0.00 2.00 ICF/IID 0 3.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 4.00 Other Long Term Care 5.00 5.00 6.00 SNF-Based CMHC 6.00 SNF-Based CORF 6.10 6.10 HOSPI CE 0.00 7 00 0 00 0 00 7 00 Total (Sum of lines 1-7) 495. 98 8.00 170 320 0.00 45.17 8.00 Average Length Admi ssi ons of Stay Component Title V Title XVIII 0ther Title XIX Total 19.00 20.00 16.00 17.00 18.00 1.00 SKILLED NURSING FACILITY 127. 57 116 37 194 1.00 2.00 NURSING FACILITY 0.00 0 0 2.00 ICF/IID 3.00 0.00 3.00 0 0 HOME HEALTH AGENCY COST 4 00 4 00 5.00 Other Long Term Care 0.00 5.00 6.00 SNF-Based CMHC 6.00 6.10 SNF-Based CORF 6.10 7.00 HOSPI CE 0.00 Λ 7.00 Total (Sum of lines 1-7) 194 8.00 127.57 116 37 8.00 Admi ssi ons Full Time Equivalent Total Employees on Nonpai d Component Payrol I Workers 21.00 22.00 23.00 1.00 SKILLED NURSING FACILITY 347 81. 08 0.00 1. 00 NURSING FACILITY 0.00 2.00 2.00 0.00 3.00 LCF/LLD 0 0.00 0.00 3.00 4.00 HOME HEALTH AGENCY COST 0.00 0.00 4.00 5.00 Other Long Term Care 0.00 0.00 5.00 SNF-Based CMHC 0.00 0.00 6.00 6.00 6.10 SNF-Based CORF 0.00 0.00 6. 10 7.00 HOSPI CE 0.00 0.00 7.00 Total (Sum of lines 1-7) 347 81.08 0.00 8.00 8.00

| In Lieu of Form CMS-2540-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/T

| | | | | 1 | 0 12/31/2023 | 5/13/2024 9: 2 | |
|--------|--|-------------|---------------|----------------|----------------|----------------|--------|
| | · | Amount | Reclass. of | Adjusted | Paid Hours | Average Hourly | |
| | | Reported | Salaries from | Salaries (col. | Related to | Wage (col. 3 ÷ | |
| | | · | Worksheet A-6 | 1 ± col. 2) | Salary in col. | col . 4) | |
| | | | | | 3 | | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART II - DIRECT SALARIES | | | | | | |
| | SALARI ES | | | | | | |
| 1.00 | Total salaries (See Instructions) | 5, 456, 461 | 0 | 5, 456, 461 | · | | 1. 00 |
| 2.00 | Physician salaries-Part A | 0 | 0 | 0 | 0.00 | | 2. 00 |
| 3.00 | Physician salaries-Part B | 0 | 0 | 0 | 0.00 | | |
| 4.00 | Home office personnel | 0 | 0 | 0 | 0.00 | | |
| 5.00 | Sum of lines 2 through 4 | 0 | 0 | 0 | 0.00 | | |
| 6.00 | Revised wages (line 1 minus line 5) | 5, 456, 461 | 0 | 5, 456, 461 | · | | 6. 00 |
| 7.00 | Other Long Term Care | 0 | 0 | 0 | 0.00 | | |
| 8.00 | HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0.00 | | 8. 00 |
| 9.00 | CMHC | 0 | 0 | 0 | 0.00 | 0.00 | |
| 9. 10 | CORF | | | | | | 9. 10 |
| 10.00 | HOSPI CE | 0 | 0 | 0 | 0.00 | | 10. 00 |
| 11. 00 | Other excluded areas | 0 | 0 | 0 | 0.00 | | 11. 00 |
| 12.00 | Subtotal Excluded salary (Sum of lines 7 | 0 | 0 | 0 | 0.00 | 0.00 | 12.00 |
| | through 11) | | | | | | |
| 13.00 | Total Adjusted Salaries (line 6 minus line | 5, 456, 461 | 0 | 5, 456, 461 | 168, 639. 17 | 32. 36 | 13. 00 |
| | 12) | | | | | | |
| | OTHER WAGES & RELATED COSTS | | | | | | |
| 14. 00 | Contract Labor: Patient Related & Mgmt | 2, 800, 386 | | 2,000,000 | · | | |
| 15. 00 | Contract Labor: Physician services-Part A | 37, 211 | | 37, 211 | | | 15. 00 |
| 16. 00 | Home office salaries & wage related costs | 367, 158 | 0 | 367, 158 | 7, 450. 00 | 49. 28 | 16. 00 |
| | WAGE-RELATED COSTS | | | | | | |
| 17. 00 | Wage-related costs core (See Part IV) | 1, 075, 340 | 0 | 1, 075, 340 | | | 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, 075, 340 | 0 | 1, 075, 340 | | | 22. 00 |
| | instructions) | | | | | | |
| | | | | | | | |

Health Financial Systems
SNF WAGE INDEX INFORMATION CRANBURY CENTER

Provi der No.: 315353

| | | | | Ť | o 12/31/2023 | Date/Time Prep 5/13/2024 9: 24 | |
|--------|--|-------------|---------------|----------------|----------------|--------------------------------|--------|
| | | Amount | Reclass. of | Adj usted | Pai d Hours | Average Hourly | |
| | | Reported | Salaries from | Salaries (col. | Related to | Wage (col. 3 ÷ | |
| | | | Worksheet A-6 | 1 ± col. 2) | Salary in col. | col . 4) | |
| | | | | | 3 | | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - OVERHEAD COST - DIRECT SALARIES | | | | | | |
| 1.00 | Employee Benefits | 0 | 0 | 0 | 0.00 | 0.00 | 1. 00 |
| 2.00 | Administrative & General | 425, 761 | 0 | 425, 761 | 12, 850. 52 | 33. 13 | 2. 00 |
| 3.00 | Plant Operation, Maintenance & Repairs | 130, 086 | 0 | 130, 086 | 4, 246. 89 | 30. 63 | 3. 00 |
| 4.00 | Laundry & Li nen Servi ce | 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 | 401, 820 | -76, 755 | 325, 065 | 7, 064. 19 | 46. 02 | 7. 00 |
| 8.00 | Central Services and Supply | 0 | 25, 897 | 25, 897 | 1, 186. 74 | 21. 82 | 8. 00 |
| 9.00 | Pharmacy | 0 | 0 | 0 | 0.00 | 0.00 | 9. 00 |
| 10.00 | Medical Records & Medical Records Library | 0 | 50, 858 | 50, 858 | 2, 276. 94 | 22. 34 | 10.00 |
| 11. 00 | Soci al Servi ce | 192, 507 | 0 | 192, 507 | 4, 208. 84 | 45. 74 | 11.00 |
| 12.00 | Nursing and Allied Health Ed. Act. | | | | | | 12.00 |
| 13.00 | Other General Service | 128, 658 | 0 | 128, 658 | 5, 960. 48 | 21. 59 | 13.00 |
| 14.00 | Total (sum lines 1 thru 13) | 1, 278, 832 | 0 | 1, 278, 832 | 37, 794. 60 | 33. 84 | 14. 00 |

| Health Financial Systems | CRANBURY CENTER | In Lieu of For | rm CMS-2540-10 |
|--------------------------|-----------------------|---|----------------|
| SNF WAGE RELATED COSTS | Provi der No.: 315353 | From 01/01/2023 Part I' To 12/31/2023 Date/T | |

| | To 12/31/202 | 3 Date/Time Pre 5/13/2024 9:2 | |
|-------|--|----------------------------------|--------|
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | PART IV - WAGE RELATED COSTS | | |
| | Part A - Core List | | |
| | RETI REMENT COST | | |
| 1.00 | 401K Employer Contributions | 48, 160 | 1. 00 |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contribution | 0 | 2. 00 |
| 3.00 | Qualified and Non-Qualified Pension Plan Cost | 0 | 3. 00 |
| 4.00 | Prior Year Pension Service Cost | 0 | 4. 00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | |
| 5.00 | 401K/TSA Plan Administration fees | 0 | 5. 00 |
| 6.00 | Legal /Accounting/Management Fees-Pension Plan | 0 | 6. 00 |
| 7.00 | Employee Managed Care Program Administration Fees | 0 | 7. 00 |
| | HEALTH AND INSURANCE COST | | |
| 8.00 | Health Insurance (Purchased or Self Funded) | 394, 527 | 8. 00 |
| 9.00 | Prescription Drug Plan | 0 | 9. 00 |
| 10.00 | Dental, Hearing and Vision Plan | 0 | 10.00 |
| 11.00 | Life Insurance (If employee is owner or beneficiary) | 0 | 11. 00 |
| 12.00 | Accident Insurance (If employee is owner or beneficiary) | 0 | 12.00 |
| 13.00 | Disability Insurance (If employee is owner or beneficiary) | 0 | 13. 00 |
| 14.00 | Long-Term Care Insurance (If employee is owner or beneficiary) | 0 | 14. 00 |
| 15.00 | Workers' Compensation Insurance | 134, 742 | 15. 00 |
| 16.00 | | 0 | 16. 00 |
| | Non cumulative portion) | | |
| | TAXES | | |
| 17.00 | FICA-Employers Portion Only | 407, 132 | 17. 00 |
| 18.00 | Medicare Taxes - Employers Portion Only | 0 | 18. 00 |
| 19.00 | Unemployment Insurance | 0 | 19. 00 |
| 20.00 | State or Federal Unemployment Taxes | 62, 374 | 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 | 28, 405 | 23. 00 |
| 24.00 | Total Wage Related cost (Sum of lines 1 - 23) | 1, 075, 340 | 24. 00 |
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | Part B - Other than Core Related Cost | | |
| 25.00 | OTHER WAGE RELATED COSTS (SPECIFY) | 0 | 25. 00 |
| | | • | • |

| | | | | T | 12/31/2023 | Date/Time Prep 5/13/2024 9: 24 | oared: |
|--------|--|-------------|----------|----------------|----------------|-----------------------------------|--------|
| | Occupational Category | Amount | Fri nge | Adj usted | Pai d Hours | Average Hourly | T GIII |
| | occupational category | Reported | | Salaries (col. | | Wage (col. 3 ÷ | |
| | | ., | | | Salary in col. | col . 4) | |
| | | | | ĺ | 3 | ĺ | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | Di rect Sal ari es | | | | | | |
| | Nursing Occupations | | | | | | |
| 1.00 | Registered Nurses (RNs) | 1, 274, 833 | 183, 785 | 1, 458, 618 | 24, 575. 44 | 59. 35 | 1.00 |
| 2.00 | Licensed Practical Nurses (LPNs) | 1, 079, 916 | 240, 504 | | | 44. 40 | 2.00 |
| 3.00 | Certified Nursing Assistant/Nursing | 1, 822, 880 | 470, 664 | 2, 293, 544 | 76, 532. 52 | 29. 97 | 3.00 |
| | Assi stants/Ai des | | | | | | |
| 4.00 | Total Nursing (sum of lines 1 through 3) | 4, 177, 629 | 894, 953 | 5, 072, 582 | · | 38. 77 | 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 | | |
| 11. 00 | Speech Therapists | 0 | 0 | 0 | 0.00 | | 11. 00 |
| 12. 00 | Respiratory Therapists | 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 | | | | | | |
| 14. 00 | Registered Nurses (RNs) | 0 | | 0 | 0. 00 | | 14.00 |
| 15. 00 | Licensed Practical Nurses (LPNs) | 104, 799 | | 104, 799 | · | 55. 39 | 15. 00 |
| 16. 00 | Certified Nursing Assistant/Nursing | 56, 043 | | 56, 043 | 1, 649. 39 | 33. 98 | 16. 00 |
| 47.00 | Assi stants/Ai des | 4.0.040 | | 4/0.040 | 0 = 11 11 | | 47.00 |
| 17. 00 | Total Nursing (sum of lines 14 through 16) | 160, 842 | | 160, 842 | · | | 17. 00 |
| 18. 00 | Physical Therapists | 258, 449 | | 258, 449 | · | | |
| 19. 00 | Physical Therapy Assistants | 119, 538 | | 119, 538 | | | |
| 20. 00 | Physical Therapy Aides | 105 050 | | 0 | 0.00 | | 20.00 |
| 21. 00 | Occupational Therapists | 185, 852 | | 185, 852 | | | 21.00 |
| 22. 00 | Occupational Therapy Assistants | 116, 574 | | 116, 574 | · | | 22. 00 |
| 23. 00 | Occupational Therapy Aides | 120 150 | | 120 150 | 0.00 | | 23.00 |
| 24. 00 | Speech Therapists | 139, 158 | | 139, 158 | · | | |
| 25. 00 | Respiratory Therapists | 11, 449 | | 11, 449 | | | 25. 00 |
| 26. 00 | Other Medical Staff | 37, 211 | | 37, 211 | 438. 00 | 84. 96 | 26. 00 |

| | To 12/31/2023 | Date/lime Prepared: 5/13/2024 9:24 am |
|------------------|---------------|---------------------------------------|
| | Group | Days |
| 1.00 | 1. 00 RUX | 2.00 |
| 2.00 | RUL | 2.00 |
| 3.00 | RVX | 3.00 |
| 4. 00 | RVL | 4.00 |
| 5. 00 | RHX | 5. 00 |
| 6.00 | RHL | 6. 00 |
| 7. 00 8. 00 | RMX RML | 8.00 |
| 9.00 | RLX | 9. 00 |
| 10. 00 | RUC | 10.00 |
| 11. 00 | RUB | 11. 00 |
| 12.00 | RUA | 12.00 |
| 13. 00 14. 00 | RVC RVB | 13. 00 14. 00 |
| 15. 00 | RVA | 15. 00 |
| 16. 00 | RHC | 16.00 |
| 17. 00 | RHB | 17. 00 |
| 18.00 | RHA | 18.00 |
| 19. 00 20. 00 | RMC RMB | 19. 00 20. 00 |
| 21. 00 | RMA | 21. 00 |
| 22. 00 | RLB | 22. 00 |
| 23. 00 | RLA | 23. 00 |
| 24. 00 | ES3 | 24. 00 |
| 25. 00 26. 00 | ES2 ES1 | 25. 00 26. 00 |
| 27. 00 | HE2 | 27. 00 |
| 28. 00 | HE1 | 28. 00 |
| 29. 00 | HD2 | 29. 00 |
| 30. 00 31. 00 | HD1 HC2 | 30. 00 31. 00 |
| 32.00 | HC1 | 32.00 |
| 33. 00 | HB2 | 33.00 |
| 34. 00 | HB1 | 34.00 |
| 35. 00 | LE2 | 35. 00 |
| 36. 00 37. 00 | LE1 LD2 | 36. 00 37. 00 |
| 38.00 | LD2 LD1 | 38.00 |
| 39. 00 | LC2 | 39.00 |
| 40. 00 | LC1 | 40.00 |
| 41.00 | LB2 | 41.00 |
| 42. 00 43. 00 | LB1 CE2 | 42. 00 43. 00 |
| 44. 00 | CE1 | 44. 00 |
| 45. 00 | CD2 | 45. 00 |
| 46. 00 | CD1 | 46. 00 |
| 47. 00 | CC2 | 47. 00 |
| 48. 00 49. 00 | CC1 CB2 | 48. 00 49. 00 |
| 50.00 | CB2 CB1 | 50.00 |
| 51. 00 | CA2 | 51.00 |
| 52. 00 | CA1 | 52.00 |
| 53.00 | SE3 | 53.00 |
| 54. 00 55. 00 | SE2 SE1 | 54. 00 55. 00 |
| 56. 00 | SSC | 56.00 |
| 57. 00 | SSB | 57.00 |
| 58.00 | SSA | 58. 00 |
| 59. 00 60. 00 | I B2 I B1 | 59. 00 60. 00 |
| 61. 00 | I A2 | 61.00 |
| 62. 00 | I A1 | 62.00 |
| 63. 00 | BB2 | 63.00 |
| 64.00 | BB1 | 64. 00 |
| 65. 00 66. 00 | BA2 BA1 | 65. 00 66. 00 |
| 67. 00 | PE2 | 67.00 |
| 68. 00 | PE1 | 68. 00 |
| 69. 00 | PD2 | 69.00 |
| 70.00 | PD1 | 70.00 |
| 71.00 | PC2 | 71.00 |
| 72. 00 73. 00 | PC1 PB2 | 72. 00 73. 00 |
| 74. 00 | PB1 | 74.00 |
| 75. 00 | PA2 | 75. 00 |
| | | |

| Health Financial Systems | CRANBURY CENTE | R | | In Lie | u of Form CMS- | 2540-10 |
|---|--|---|---|--|--|---------|
| PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | | Provi der | No.: 315353 | Peri od: | Worksheet S-7 | 7 |
| | | | | From 01/01/2023 To 12/31/2023 | Date/Time Pre 5/13/2024 9:2 | |
| | | | | Group | Days | |
| | | | | 1. 00 | 2. 00 | |
| 76. 00 | | | | PA1 | | 76. 00 |
| 99. 00 | | | | AAA | | 99. 00 |
| 100. 00 TOTAL | - | | | | | 100. 00 |
| | | | Expenses | Percentage | Y/N | |
| | | | 1. 00 | 2. 00 | 3. 00 | |
| A notice published in the Federal Register Vo payments beginning 10/01/2003. Congress exper expenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" for with direct patient care and related expenses (See instructions) | cted this increase to n column 1 the amoun r each category to to or yes or "N" for no | o be used t of the o otal SNF if the specification | for direct pexpense for erevenue from pending refle | oatient care and each category. Er Worksheet G-2, F ects increases as | related hter in Part I, ssociated | |
| 101. 00 Staffing | | | | | | 101. 00 |
| 102.00 Recrui tment | | | | | | 102. 00 |
| 103.00 Retention of employees | | | | | | 103. 00 |
| 104. 00 Trai ni ng | | | | | | 104. 00 |
| 105.00 OTHER (SPECIFY) | no 1 - oolumn 2) | | | | | 105. 00 |
| 106.00 Total SNF revenue (Worksheet G-2, Part I, Ii | ne i, corumn 3) | | | | | 106. 00 |

| Heal th I | Financial Systems | CRANBURY CE | NTER | | In Lie | u of Form CMS-2 | 2540-10 |
|-----------|---|-----------------|-------------|--------------------------|----------------------------------|-----------------|------------------|
| RECLASS | IFICATION AND ADJUSTMENT OF TRIAL BALANCE OF | EXPENSES | Provi der | | Peri od: | Worksheet A | |
| | | | | | From 01/01/2023 To 12/31/2023 | Date/Time Pre | narod: |
| | | | | | 10 12/31/2023 | 5/13/2024 9: 2 | |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 | Recl assi fi cati | Reclassi fied | |
| | · | | | + col . 2) | ons | Trial Balance | |
| | | | | | Increase/Decre | (col. 3 +- | |
| | | | | | ase (Fr Wkst | col . 4) | |
| | | | | | A-6) | | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| | 00100 CAP REL COSTS - BLDGS & FLXTURES | | 2, 087, 513 | | | 2, 087, 513 | 1. 00 |
| 1 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | 22, 699 | | | 22, 699 | 2. 00 |
| | 00300 EMPLOYEE BENEFITS | 0 | 1, 047, 695 | | | 1, 047, 695 | 3. 00 |
| | DO400 ADMINISTRATIVE & GENERAL | 425, 761 | 2, 124, 439 | | | 2, 550, 200 | 4.00 |
| | DOSOO PLANT OPERATION, MAINT. & REPAIRS | 130, 086 | 442, 824 | | | 572, 910 | 5.00 |
| | 00600 LAUNDRY & LINEN SERVICE | 0 | 224, 210 | | | 224, 210 | 6. 00 |
| | 00700 HOUSEKEEPI NG | 0 | 467, 359 | | | 467, 359 | 7. 00 |
| | 00800 DI ETARY | 401 020 | 1, 242, 813 | | | 1, 242, 813 | 8.00 |
| | DO900 NURSING ADMINISTRATION D1000 CENTRAL SERVICES & SUPPLY | 401, 820 | 111, 395 | | | | 9.00 |
| | 01100 PHARMACY | | 86, 338 | 86, 33 | 8 25, 897 | 112, 235 0 | 10. 00 11. 00 |
| | 01200 MEDICAL RECORDS & LIBRARY | | 0 | | 50, 858 | _ | 12.00 |
| | 01300 SOCIAL SERVICE | 192, 507 | 24, 214 | 216, 72 | | 216, 721 | 13. 00 |
| | 01400 NURSING AND ALLIED HEALTH EDUCATION | 192, 507 | 24, 214 | 210,72 | | 210, 721 | 14. 00 |
| | 01500 ACTIVITIES | 128, 658 | 36, 301 | 164, 95 | | 164, 959 | 15. 00 |
| | NPATIENT ROUTINE SERVICE COST CENTERS | 120,030 | 30, 301 | 104, 73 | 7] 0] | 104, 737 | 13.00 |
| | 03000 SKILLED NURSING FACILITY | 4, 177, 629 | 354, 699 | 4, 532, 32 | 8 0 | 4, 532, 328 | 30. 00 |
| | 03100 NURSING FACILITY | 1, 1, 1, 1, 02, | 001,077 | 1, 002, 02 | | 0 | 31. 00 |
| | 03200 CF/IID | | 0 | | | Ö | 32. 00 |
| | 03300 OTHER LONG TERM CARE | | 0 | | 0 | 0 | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | -1 | | |
| | 04000 RADI OLOGY | 0 | 10, 200 | 10, 200 | 0 0 | 10, 200 | 40.00 |
| | 04100 LABORATORY | o | 26, 703 | | | 26, 703 | 41. 00 |
| 42.00 | 04200 INTRAVENOUS THERAPY | o | 11, 403 | | | 11, 403 | 42. 00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | | o | 0 | 43. 00 |
| 44.00 | 04400 PHYSI CAL THERAPY | 0 | 299, 479 | 299, 47 | 9 0 | 299, 479 | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 316, 494 | 316, 49 | 4 0 | 316, 494 | 45. 00 |
| 46.00 | 04600 SPEECH PATHOLOGY | 0 | 153, 249 | 153, 24 | 9 0 | 153, 249 | 46. 00 |
| | 04700 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 47. 00 |
| | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 48. 00 |
| | 04900 DRUGS CHARGED TO PATIENTS | 0 | 176, 578 | 176, 57 | 8 0 | 176, 578 | 49. 00 |
| | D5000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | | 0 | 0 | 50. 00 |
| | D5100 SUPPORT SURFACES | 0 | 7, 098 | | | 7, 098 | 51. 00 |
| | 05200 OTHER ANCILLARY SERVICE COST CENTERS | 0 | 0 | | 0 | 0 | 52. 00 |
| _ | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 06000 CLINIC | 0 | 0 | | 0 | _ | 60.00 |
| | 06100 RURAL HEALTH CLINIC | 0 | U | (| 9 | 0 | 61.00 |
| | 06200 FQHC 06300 OTHER OUTPATIENT SERVICE COST CENTER | o | 0 | | | 0 | 62. 00 63. 00 |
| | OTHER REIMBURSABLE COST CENTERS | U | | ' | J | U | 03.00 |
| | 07000 HOME HEALTH AGENCY COST | | 0 | | | 0 | 70. 00 |
| | 07100 AMBULANCE | | 0 | | | 0 | 71.00 |
| | 07200 CORF | | 0 | | | 0 | 72.00 |
| | 07300 CMHC | 0 | 0 | | | Ö | 73. 00 |
| | 07400 OTHER REIMBURSABLE COST | 0 | 0 | | | Ö | 74. 00 |
| | SPECIAL PURPOSE COST CENTERS | <u> </u> | | | <u> </u> | | 71.00 |
| | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | 0 | | 0 | 0 | 80. 00 |
| | 08100 INTEREST EXPENSE | | 0 | | ol ol | 0 | 81. 00 |
| | 08200 UTILIZATION REVIEW | o | 0 | | o o | 0 | 82. 00 |
| | 08300 HOSPI CE | 0 | 0 | | o | 0 | 83. 00 |
| | 08400 OTHER SPECIAL PURPOSE COST CENTERS | o | 0 | | o | 0 | 84. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 5, 456, 461 | 9, 273, 703 | 14, 730, 16 ₉ | 4 0 | 14, 730, 164 | 89. 00 |
| N | NONREI MBURSABLE COST CENTERS | | | | | | |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | (| 0 0 | 0 | 90. 00 |
| | 09100 BARBER AND BEAUTY SHOP | 0 | 5, 490 | 5, 490 | o c | 5, 490 | |
| | 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | | 0 | 0 | 92. 00 |
| | 09300 NONPALD WORKERS | 0 | 0 | | 0 | 0 | 93. 00 |
| | 09400 PATIENTS LAUNDRY | 0 | 0 | | 0 | 0 | 94. 00 |
| | 09500 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| 0 | 0 | 95. 00 |
| 100.00 | TOTAL | 5, 456, 461 | 9, 279, 193 | 14, 735, 65 | 4 0 | 14, 735, 654 | 100. 00 |
| | | | | | | | |

 Heal th Financial
 Systems
 CRAN

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A Provi der No.: 315353

| | | | | | To 12/31/2023 | Date/Time Prepared: 5/13/2024 9:24 am |
|------------------|---|----------------|-------------------------|---|---------------|---------------------------------------|
| | Cost Center Description | Adjustments to | Net Expenses | | | 57 137 2024 9. 24 dill |
| | | , | For Allocation | | | |
| | | Wkst A-8) | (col. 5 +- col. 6) | | | |
| | | 6.00 | 7.00 | | | |
| | GENERAL SERVICE COST CENTERS | | | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | 0 | _, , | 1 | | 1.00 |
| 2. 00 3. 00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS | -8, 648 | 22, 699 1, 039, 047 | 1 | | 2.00 |
| 4. 00 | 00400 ADMI NI STRATI VE & GENERAL | -500, 425 | | | | 4.00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 0 | | | | 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | 0 | 224, 210 | • | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | 0 | 467, 359 | • | | 7. 00 |
| 8. 00 9. 00 | 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON | 0 | 1, 242, 813 436, 460 | | | 8. 00 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 112, 235 | • | | 10. 00 |
| 11. 00 | 01100 PHARMACY | 0 | 0 | | | 11. 00 |
| 12.00 | 01200 MEDI CAL RECORDS & LI BRARY | 0 | 50, 858 | | | 12. 00 |
| 13. 00 14. 00 | 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 216, 721 0 | | | 13. 00 14. 00 |
| 15. 00 | 01500 ACTIVITIES | -32,779 | | | | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | | | | |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 537 | 4, 532, 865 | 1 | | 30. 00 |
| 31.00 | 03100 NURSING FACILITY | 0 | 0 | | | 31.00 |
| 32. 00 33. 00 | 03200 CF/IID 03300 OTHER LONG TERM CARE | 0 | 0 | | | 32. 00 33. 00 |
| 00.00 | ANCI LLARY SERVI CE COST CENTERS | | | | | 35. 55 |
| 40.00 | 04000 RADI OLOGY | 0 | 10, 200 | | | 40. 00 |
| 41.00 | 04100 LABORATORY | 0 | 26, 703 | 1 | | 41. 00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | 0 | 11, 403 | 1 | | 42.00 |
| 43. 00 44. 00 | 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY | 0 | 299, 479 | | | 43. 00 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 316, 494 | 1 | | 45. 00 |
| 46.00 | 04600 SPEECH PATHOLOGY | 0 | 153, 249 | | | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | | | 47.00 |
| 48. 00 49. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS | 0 | 0 176, 578 | | | 48. 00 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | I | | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | 0 | 7, 098 | | | 51.00 |
| 52.00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | 0 | 0 | | | 52. 00 |
| 60. 00 | OUTPATIENT SERVICE COST CENTERS 06000 CLINIC | 1 0 | 0 | | | 60.00 |
| 61.00 | 06100 RURAL HEALTH CLINIC | 0 | | | | 61. 00 |
| 62. 00 | 06200 FQHC | | | | | 62. 00 |
| 63.00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | | | 63. 00 |
| 70.00 | OTHER REIMBURSABLE COST CENTERS | | | | | 70.00 |
| 70.00 | 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE | 0 | 0 | | | 70. 00 71. 00 |
| | 07200 CORF | 0 | 0 | | | 71.00 |
| 73.00 | 07300 CMHC | 0 | 0 | | | 73. 00 |
| 74.00 | 07400 OTHER REI MBURSABLE COST | 0 | 0 | | | 74. 00 |
| 00.00 | SPECIAL PURPOSE COST CENTERS | | | | | 20, 00 |
| 80. 00 81. 00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE | 0 | 0 | | | 80. 00 81. 00 |
| 82. 00 | 08200 UTI LI ZATI ON REVI EW | 0 | Ö | | | 82. 00 |
| 83. 00 | 08300 H0SPI CE | 0 | 0 | | | 83. 00 |
| 84.00 | 08400 OTHER SPECIAL PURPOSE COST CENTERS | 0 | 0 | | | 84. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS | -541, 315 | 14, 188, 849 | | | 89. 00 |
| 90. 00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | | | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 0 | 5, 490 | | | 91. 00 |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | | | 92. 00 |
| | 09300 NONPALD WORKERS | 0 | 0 | | | 93.00 |
| 94. 00 95. 00 | 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | | 94. 00 95. 00 |
| 100.00 | | -541, 315 | 14, 194, 339 | | | 100.00 |
| | 1 | | | ' | | 1 |

| Health Financial Systems | CRANBURY CENT | ER | | In Lie | u of Form CMS- | 2540-10 |
|--------------------------|---------------------|----------|-----------------------------|---------------|-----------------------------|----------------|
| RECLASSI FI CATI ONS | | | Peri od: From 01/01/2023 | Worksheet A-6 | | |
| | | | | To 12/31/2023 | Date/Time Pre 5/13/2024 9:2 | pared: 4 am |
| | | | Increases | | | |
| | Cost Cente | r | Li ne # | Sal ary | Non Salary | |
| | 2.00 | | 3.00 | 4. 00 | 5.00 | |
| (1) A - DEFAULT | | | | | | |
| 1. 00 | CENTRAL SERVICES & | SUPPLY | 10.0 | 0 25, 897 | 0 | 1.00 |
| 2. 00 | MEDICAL RECORDS & L | J BRARY | 12. 0 | 0 50, 858 | 0 | 2. 00 |
| TOTALS | | | | | | |
| 100. 00 | Total Reclassificat | ` | | 76, 755 | 0 | 100. 00 |
| | of columns 4 and 5 | | | | | |
| | equal sum of column | is 8 and | | | | |
| I | 9) | | | | | 1 |

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

| Health Financial Systems | CRANBURY CENTE | ER | | In Lie | u of Form CMS-2 | 2540-10 |
|--------------------------|---------------------|-----------|-----------|-----------------------------|--------------------------------|----------------|
| RECLASSI FI CATI ONS | | Provi der | | Peri od: From 01/01/2023 | Worksheet A-6 | |
| | | | | To 12/31/2023 | Date/Time Pre 5/13/2024 9:2 | pared: 4 am |
| | | | Decreases | | | |
| | Cost Center | - | Li ne # | Sal ary | Non Salary | |
| | 6. 00 | | 7. 00 | 8. 00 | 9. 00 | |
| (1) A - DEFAULT | | | | | | |
| 1.00 | NURSING ADMINISTRAT | I ON | 9. C | 0 25, 897 | 0 | 1. 00 |
| 2.00 | NURSING ADMINISTRAT | I ON | 9. C | 0 50, 858 | 0 | 2. 00 |
| TOTALS | | | | | | |
| 100. 00 | | | | 76, 755 | 0 | 100. 00 |

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

Health Financial Systems CRANBURY CENTER In Lieu of Form CMS-2540-10
RECONCILIATION OF CAPITAL COSTS CENTERS Provider No.: 315353 Period: Worksheet A-7

From 01/01/20

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/13/2024 9: 24 am

| | | | | | | 5/13/2024 9: 2 | 4 am |
|------|---|------------------|--------------|-----------------|--------|-----------------|-------|
| | | | | Acqui si ti ons | | | |
| | 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 | 3 | | | | | |
| 1.00 | Land | 0 | 0 | 0 | 0 | 0 | 1. 00 |
| 2.00 | Land Improvements | 105, 797 | 0 | 0 | 0 | 0 | 2. 00 |
| 3.00 | Buildings and Fixtures | 0 | 0 | 0 | 0 | 0 | 3. 00 |
| 4.00 | Building Improvements | 276, 284 | 3, 822 | 0 | 3, 822 | 0 | 4. 00 |
| 5.00 | Fixed Equipment | 34, 569 | 2, 054 | 0 | 2, 054 | 0 | 5. 00 |
| 6.00 | Movable Equipment | 151, 347 | 0 | 0 | 0 | 0 | 6. 00 |
| 7.00 | Subtotal (sum of lines 1-6) | 567, 997 | 5, 876 | 0 | 5, 876 | 0 | 7. 00 |
| 8.00 | Reconciling Items | 0 | 0 | 0 | 0 | 0 | 8. 00 |
| 9.00 | Total (line 7 minus line 8) | 567, 997 | 5, 876 | 0 | 5, 876 | 0 | 9. 00 |
| | Description | Endi ng Bal ance | Ful I y | | | | |
| | | | Depreci ated | | | | |
| | | | Assets | | | | |
| | | 6. 00 | 7. 00 | | | | |
| | ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES | 5 | | | | | |
| 1.00 | Land | 0 | 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 | 280, 106 | 0 | | | | 4. 00 |
| 5.00 | Fixed Equipment | 36, 623 | 0 | | | | 5. 00 |
| 6.00 | Movable Equipment | 151, 347 | 0 | | | | 6. 00 |
| 7.00 | Subtotal (sum of lines 1-6) | 573, 873 | 0 | | | | 7. 00 |
| 8.00 | Reconciling Items | 0 | 0 | | | | 8. 00 |
| 9.00 | Total (line 7 minus line 8) | 573, 873 | 0 | | | | 9. 00 |

Peri od: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

| | | | | 10 12/31/2023 | 5/13/2024 9: 2 | |
|------------------|--|-----------------|----------------|--|-----------------|------------------|
| | | | , | Expense Classification on | | |
| | | | | To/From Which the Amount is | to be Adjusted | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | 5 (4) | (0) 5 1 5 | | | | |
| | Description (1) | (2) Basis For | Amount | Cost Center | Li ne No. | |
| | | Adjustment | 2.00 | 2.00 | 4.00 | |
| 1 00 | Investment income on restricted funds | 1.00 | 2.00 | 3. 00 | 4. 00 | 1. 00 |
| 1. 00 | Investment income on restricted funds (chapter 2) | | U | 1 | 0.00 | 1.00 |
| 2.00 | Trade, quantity, and time discounts (chapter | | 0 | | 0.00 | 2. 00 |
| 2.00 | 8) | | | | 0.00 | 2.00 |
| 3. 00 | Refunds and rebates of expenses (chapter 8) | | 0 | | 0.00 | 3. 00 |
| 4. 00 | Rental of provider space by suppliers | | Ö | | 0.00 | 4. 00 |
| | (chapter 8) | | | | | |
| 5.00 | Telephone services (pay stations excluded) | | Ö | | 0.00 | 5. 00 |
| | (chapter 21) | | | | | |
| 6.00 | Television and radio service (chapter 21) | A | -32, 779 | 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 | D | 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 | O TOTAL CONTRACTOR OF THE PROPERTY OF THE PROP | 0.00 | 11. 00 |
| 40.00 | Capital expenditures (chapter 24) | | 440.000 | | | 40.00 |
| 12. 00 | Adjustment resulting from transactions with | A-8-1 | 148, 289 | ' | | 12. 00 |
| 12.00 | related organizations (chapter 10) | | | | 0.00 | 12 00 |
| 13. 00 14. 00 | Laundry and linen service | | 0 | 1 | 0.00 | |
| 15. 00 | Revenue - Employee meals Cost of meals - Guests | | 0 | | 1 | |
| 16. 00 | Sale of medical supplies to other than | | 0 | | 0.00 | 16. 00 |
| 10.00 | patients | | | | 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 | | Ö | | 0.00 | |
| 19. 00 | Vending machines | | Ö | | 0.00 | 19. 00 |
| 20.00 | Income from imposition of interest, finance | | Ö | | 0.00 | 20. 00 |
| | or penalty charges (chapter 21) | | | | | |
| 21.00 | Interest expense on Medicare overpayments | | 0 | | 0.00 | 21. 00 |
| | and borrowings to repay Medicare | | | | | |
| | overpayments | | | | | |
| 22. 00 | Utilization reviewphysicians' compensation | | 0 | UTILIZATION REVIEW | 82.00 | 22. 00 |
| | (chapter 21) | | | | | |
| 23. 00 | Depreciationbuildings and fixtures | | 0 | CAP REL COSTS - BLDGS & | 1.00 | 23. 00 |
| | | - | | FI XTURES | | |
| 24. 00 | Depreciationmovable equipment | | 0 | CAP REL COSTS - MOVABLE | 2.00 | 24. 00 |
| 25 00 | MLCC INCOME | P | F F00 | EQUI PMENT | 4 00 | 25 00 |
| 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 | | BEMPLOYEE BENEFITS | 3. 00 30. 00 | 25. 02 25. 03 |
| | HEP/SALINE Total (sum of lines 1 through 99) (Transfer | A | -541, 315 | SKILLED NURSING FACILITY | 30.00 | 100.00 |
| 100.00 | to Worksheet A, col. 6, line 100) | | -041, 310 | , | | 100.00 |
| (1) Do | • | lump portois to | CMC Dub 15 1 | | 1 | ı |
| (i) be | scription - all chapter references in this co | rumi pertari to | UNIS PUD. 15-1 | I. | | |

 ⁽¹⁾ Description - an Chapter Ferences in this column pertain to cms
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

Provi der No.: 315353 OFFICE COSTS

| OFFICE COSTS | | | | To 12/31/2023 Date/Time Pre 5/13/2024 9:2 | |
|---|-----------------|-------------------|----------------|---|--------|
| | Li ne No. | Cost | Center | Expense Items | |
| | 1.00 | 2. | 00 | 3. 00 | |
| PART I. COSTS INCURRED AND ADJUSTMENTS REQUICLAIMED 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 | 4. 00 | ADMI NI STRATI VE | & GENERAL | HOME OFFICE CAPITAL | 2.00 |
| 3.00 | | PHYSI CAL THERA | | PT | 3.00 |
| 4.00 | | OCCUPATI ONAL T | | ОТ | 4.00 |
| 5. 00 | 46. 00 | SPEECH PATHOLO | GY | ST | 5.00 |
| 6.00 | 30.00 | SKILLED NURSIN | G FACILITY | NURSING PURCHASED SERVICES | 6. 00 |
| 7. 00 | 30.00 | SKILLED NURSIN | G FACILITY | RT | 7.00 |
| 8. 00 | 4. 00 | ADMI NI STRATI VE | & GENERAL | MEDICAL DIRECTOR | 8. 00 |
| 9. 00 | 1. 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 |
| | Amount | Amount | Adjustments | | |
| | Allowable In | Included in | (col. 4 minus | | |
| | Cost | Wkst. A, col. | col . 5) | | |
| | | 5 | | | |
| DART I COOTO INCUERSE AND AD MOTHER DECIMA | 4.00 | 5.00 | 6.00 | | |
| PART I. COSTS INCURRED AND ADJUSTMENTS REQUICLAIMED HOME OFFICE COSTS: | | | | | |
| 1.00 | 665, 089 | 551, 373 | 113, 716 | b | 1. 00 |
| 2.00 | 34, 573 | 0 | 34, 573 | 3 | 2. 00 |
| 3. 00 | 297, 929 | 297, 929 | (| | 3. 00 |
| 4. 00 | 316, 339 | 316, 339 | (| | 4. 00 |
| 5. 00 | 153, 249 | | | | 5. 00 |
| 6.00 | 160, 842 | 160, 842 | | | 6. 00 |
| 7. 00 | 11, 449 | 11, 449 | (| | 7. 00 |
| 8. 00 | 37, 211 | 37, 211 | C | | 8. 00 |
| 9. 00 | 1, 710, 262 | 1, 710, 262 | (| | 9. 00 |
| 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line | 3, 386, 943 | 3, 238, 654 | 148, 289 | | 10. 00 |
| 12. | | | | | |
| ·-· | 1 | 1 | I | | 1 |

| | | | | 3/13/2024 9.2 | 4 alli |
|---|-----------------|-----------------|---------------|---------------|--------|
| | Symbol (1) | Name | Percentage of | | |
| | | | Ownershi p | | |
| | 1.00 | 2. 00 | 3. 00 | | |
| PART II. INTERRELATIONSHIP TO RELATED ORGANIZ | ZATION(S) AND/C | 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.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in rel ated organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Rel ated Organi | zation(s) and/ | or Home Office | |
|-----------------|-------------------------|------------------|---|
| Name | Percentage of Ownership | Type of Business | |
| 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 | GRS | 100.00 PT 0T ST | 2.00 |
| 3. 00 | CSU | 100.00 NURSING PURCHASED SERVICES | 3.00 |
| 4. 00 | RHS | 100.00 RT | 4.00 |
| 5. 00 | GPS | 100.00 MEDICAL DIRECTOR | 5.00 |
| 6. 00 | NEXT HC | 46. 40 | 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 | 12/31/2023 | Date/Time Pre | |
|------------------|----------------|--|-------------------------|---------------------|---------------|--------------------|-------------------------|------------------|
| | | | | CAPI TAL REL | ATED COSTS | | 5/13/2024 9: 2 | 4 alli |
| | | Cost Center Description | Net Expenses | BLDGS & | MOVABLE | EMPLOYEE | Subtotal | |
| | | | for Cost Allocation | FIXTURES | EQUI PMENT | BENEFI TS | | |
| | | | (from Wkst A col. 7) | | | | | |
| | | | 0 | 1.00 | 2. 00 | 3. 00 | 3A | |
| 1. 00 | | AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES | 2, 087, 513 | 2, 087, 513 | | | | 1. 00 |
| 2.00 | 1 | CAP REL COSTS - BEDGS & FIXTURES CAP REL COSTS - MOVABLE EQUI PMENT | 22, 699 | 2,067,513 | 22, 699 | | | 2. 00 |
| 3.00 | | EMPLOYEE BENEFITS | 1, 039, 047 | 29, 019 | 316 | 1, 068, 382 | 0 (40 075 | 3. 00 |
| 4. 00 5. 00 | 1 | ADMINISTRATIVE & GENERAL PLANT OPERATION, MAINT. & REPAIRS | 2, 049, 775 572, 910 | 480, 610 62, 461 | 5, 226 679 | 83, 364 25, 471 | 2, 618, 975 661, 521 | 4. 00 5. 00 |
| 6.00 | 00600 | LAUNDRY & LINEN SERVICE | 224, 210 | 73, 741 | 802 | 0 | 298, 753 | 6. 00 |
| 7. 00 8. 00 | 1 | HOUSEKEEPI NG DI ETARY | 467, 359 1, 242, 813 | 7, 155 100, 077 | 78 1, 088 | 0 | 474, 592 1, 343, 978 | 7. 00 8. 00 |
| 9. 00 | | NURSING ADMINISTRATION | 436, 460 | 39, 206 | 426 | 63, 648 | 539, 740 | |
| 10.00 | 1 | CENTRAL SERVICES & SUPPLY | 112, 235 | 29, 169 | 317 | 5, 071 | 146, 792 | 10.00 |
| 11. 00 12. 00 | 1 | PHARMACY MEDICAL RECORDS & LIBRARY | 50, 858 | 0 8, 895 | 0 97 | 9, 958 | 69, 808 | 11. 00 12. 00 |
| 13.00 | | SOCIAL SERVICE | 216, 721 | 5, 963 | 65 | 37, 693 | 260, 442 | 13.00 |
| 14. 00 15. 00 | | NURSING AND ALLIED HEALTH EDUCATION ACTIVITIES | 0 132, 180 | 0 0 | 0 | 25, 191 | 0 157, 371 | 14. 00 15. 00 |
| | I NPAT | ENT ROUTINE SERVICE COST CENTERS | | - | | | | |
| 30. 00 31. 00 | | SKILLED NURSING FACILITY NURSING FACILITY | 4, 532, 865 | 1, 100, 802 | 11, 969 | 817, 986 | 6, 463, 622 0 | 30. 00 31. 00 |
| 32. 00 | | ICF/IID | 0 | 0 | O | Ö | 0 | 32. 00 |
| 33. 00 | | OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| 40. 00 | | LARY SERVICE COST CENTERS RADIOLOGY | 10, 200 | 0 | 0 | ol | 10, 200 | 40. 00 |
| 41.00 | | LABORATORY | 26, 703 | 0 | 0 | O | 26, 703 | 41. 00 |
| 42. 00 43. 00 | | INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY | 11, 403 | 0 | 0 | 0 | 11, 403 0 | 42. 00 43. 00 |
| 44.00 | 04400 | PHYSI CAL THERAPY | 299, 479 | 82, 686 | 899 | ō | 383, 064 | 44. 00 |
| 45. 00 46. 00 | 1 | OCCUPATIONAL THERAPY SPEECH PATHOLOGY | 316, 494 153, 249 | 57, 741 5, 267 | 628 57 | 0 | 374, 863 158, 573 | 45. 00 46. 00 |
| 47. 00 | | ELECTROCARDI OLOGY | 155, 247 | 0 | 0 | o | 130, 373 | 47. 00 |
| 48. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS | 174 570 | 3, 926 795 | 43 | 0 | 3, 969 | |
| 49. 00 50. 00 | 1 | DENTAL CARE - TITLE XIX ONLY | 176, 578 | 795 | 0 | 0 | 177, 382 0 | 49. 00 50. 00 |
| 51.00 | | SUPPORT SURFACES | 7, 098 | 0 | 0 | 0 | 7, 098 | 51.00 |
| 52. 00 | | OTHER ANCILLARY SERVICE COST CENTERS TIENT SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 52. 00 |
| 60.00 | 06000 | CLINIC | 0 | 0 | 0 | 0 | 0 | 60.00 |
| 61. 00 62. 00 | 06100 | RURAL HEALTH CLINIC | O | 0 | 0 | 0 | 0 | 61. 00 62. 00 |
| 63. 00 | 06300 | OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | 0 | 0 | 0 | |
| 70. 00 | | REIMBURSABLE COST CENTERS HOME HEALTH AGENCY COST | O | ol | 0 | ol | 0 | 70. 00 |
| 71. 00 | 07100 | AMBULANCE | Ö | Ö | Ö | Ö | Ö | 71. 00 |
| 72. 00 73. 00 | 07200 07300 | | 0 | 0 | 0 | 0 | 0 | 72. 00 73. 00 |
| 74. 00 | 1 | OTHER REIMBURSABLE COST | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| 00.00 | | AL PURPOSE COST CENTERS | | | | | | 00.00 |
| 80. 00 81. 00 | | MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE | | | | | | 80. 00 81. 00 |
| 82. 00 | | UTILIZATION REVIEW | | | | | | 82. 00 |
| 83. 00 84. 00 | | HOSPICE OTHER SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 83. 00 84. 00 |
| 89. 00 | | SUBTOTALS (sum of lines 1-84) | 14, 188, 849 | 2, 087, 513 | 22, 699 | 1, 068, 382 | 14, 188, 849 | 89. 00 |
| 90. 00 | | IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOPS & CANTEEN | | 0 | O | ام | 0 | 90. 00 |
| 91. 00 | | BARBER AND BEAUTY SHOP | 5, 490 | Ö | Ö | o | 5, 490 | |
| 92.00 | | PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | 0 | 0 | 92. 00 93. 00 |
| 93. 00 94. 00 | | NONPALD WORKERS PATIENTS LAUNDRY | | 0 | 0 | 0 | 0 | 93. 00 94. 00 |
| 95.00 | | OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 0 | o | 0 | 95.00 |
| 98. 00 99. 00 | | Cross Foot Adjustments Negative Cost Centers | 0 | 0) 0 | 0 | 0 0 | 0 | 98. 00 99. 00 |
| 100.00 | | TOTAL | 14, 194, 339 | 2, 087, 513 | 22, 699 | 1, 068, 382 | 14, 194, 339 | |
| | | | | | | | | |

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared:

| | | | T | o 12/31/2023 | Date/Time Pre 5/13/2024 9:2 | |
|--|---------------------|-------------------|---------------|---------------|-----------------------------|------------------|
| Cost Center Description | ADMI NI STRATI VE | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | 4 (111 |
| | & 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 O0100 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 OO400 ADMINISTRATIVE & GENERAL | 2, 618, 975 | | | | | 4. 00 |
| 5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS | 149, 672 | 811, 193 | 1 | | | 5. 00 |
| 6.00 00600 LAUNDRY & LI NEN SERVI CE 7.00 00700 HOUSEKEEPI NG | 67, 594 107, 378 | 39, 473 3, 830 | | 585, 800 | | 6. 00 7. 00 |
| 8. 00 00800 DI ETARY | 304, 080 | 53, 571 | 0 | 40, 867 | 1, 742, 496 | 8. 00 |
| 9. 00 00900 NURSI NG ADMINI STRATI ON | 122, 118 | 20, 987 | Ö | 16, 010 | 1, 7 12, 170 | 9. 00 |
| 10. 00 01000 CENTRAL SERVICES & SUPPLY | 33, 212 | 15, 614 | 1 | 11, 911 | 0 | 10.00 |
| 11. 00 01100 PHARMACY | 0 | 0 | 0 | 0 | 0 | 11. 00 |
| 12.00 01200 MEDICAL RECORDS & LIBRARY | 15, 794 | 4, 761 | 0 | 3, 632 | 0 | 12.00 |
| 13. 00 01300 SOCI AL SERVI CE | 58, 926 | 3, 192 | | 2, 435 | 0 | 13.00 |
| 14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | | 0 | 0 | 14.00 |
| 15.00 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS | 35, 606 | 0 | <u> </u> | U | 0 | 15. 00 |
| 30. 00 03000 SKI LLED NURSING FACILITY | 1, 462, 424 | 589, 249 | 405, 820 | 449, 522 | 1, 742, 496 | 30. 00 |
| 31. 00 03100 NURSI NG FACILITY | 0 | 0 | 0 | 0 | 0 | 31. 00 |
| 32. 00 03200 I CF/I I D | 0 | 0 | 0 | 0 | 0 | 32. 00 |
| 33.00 03300 OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40. 00 04000 RADI OLOGY | 2, 308 | 0 | 0 | 0 | 0 | 40.00 |
| 41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY | 6, 042 | 0 | 0 | 0 | 0 | 41.00 |
| 42.00 04200 INTRAVENOUS THERAPY 43.00 04300 0XYGEN (INHALATION) THERAPY | 2, 580 | 0 | | 0 | 0 | 42. 00 43. 00 |
| 44. 00 04400 PHYSI CAL THERAPY | 86, 670 | 44, 261 | | 33, 765 | 0 | 44. 00 |
| 45. 00 04500 OCCUPATI ONAL THERAPY | 84, 814 | 30, 908 | ő | 23, 579 | 0 | 45. 00 |
| 46. 00 04600 SPEECH PATHOLOGY | 35, 878 | 2, 820 | 0 | 2, 151 | 0 | 46. 00 |
| 47. 00 04700 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 47. 00 |
| 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 898 | 2, 101 | 1 | 1, 603 | 0 | 48. 00 |
| 49. 00 04900 DRUGS CHARGED TO PATIENTS | 40, 133 | 426 | | 325 | 0 | 49.00 |
| 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 51. 00 05100 SUPPORT SURFACES | 0 1, 606 | 0 | | 0 | 0 | 50. 00 51. 00 |
| 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS | 1,000 | 0 | | 0 | 0 | 52. 00 |
| OUTPATIENT SERVICE COST CENTERS | <u> </u> | | | <u> </u> | | 02.00 |
| 60. 00 06000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 60. 00 |
| 61.00 06100 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61. 00 |
| 62. 00 06200 FQHC | | | | | | 62. 00 |
| 63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | 0 | 0 | 0 | 63. 00 |
| OTHER REIMBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST | l ol | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 07100 AMBULANCE | 0 | 0 | | 0 | 0 | 70.00 |
| 72. 00 07200 CORF | 0 | 0 | ő | Ö | 0 | 72.00 |
| 73. 00 07300 CMHC | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| 74.00 07400 OTHER REIMBURSABLE COST | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | | | | 80.00 |
| 81.00 08100 INTEREST EXPENSE 82.00 08200 UTI LI ZATI ON REVI EW | | | | | | 81.00 |
| 82.00 08200 UTI LI ZATI ON REVI EW 83.00 08300 HOSPI CE | | 0 | | 0 | 0 | 82. 00 83. 00 |
| 84. 00 08400 OTHER SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 84. 00 |
| 89.00 SUBTOTALS (sum of lines 1-84) | 2, 617, 733 | 811, 193 | 405, 820 | 585, 800 | 1, 742, 496 | 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 | 1, 242 | 0 | 0 | 0 | 0 | 91.00 |
| 92.00 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | 0 | 0 | 92.00 |
| 93. 00 09300 NONPAI D WORKERS 94. 00 09400 PATI ENTS LAUNDRY | | 0 | | 0 | 0 | 93. 00 94. 00 |
| 95. 00 09500 OTHER NONREIMBURSABLE COST CENTERS | | 0 | 0 | 0 | 0 | 95. 00 |
| 98.00 Cross Foot Adjustments | | 0 | Ō | o | 0 | 98. 00 |
| 99.00 Negative Cost Centers | 0 | 0 | 0 | О | 0 | 99. 00 |
| 100. 00 TOTAL | 2, 618, 975 | 811, 193 | 405, 820 | 585, 800 | 1, 742, 496 | 100. 00 |
| | | | | | | |

| | | | | | 12/31/2023 | 5/13/2024 9: 2 | |
|------------------|--|-------------------|------------|----------|------------|----------------|------------------|
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | SOCIAL SERVICE | |
| | | ADMI NI STRATI ON | SERVICES & | | RECORDS & | | |
| | | | SUPPLY | | LI BRARY | | |
| | | 9. 00 | 10. 00 | 11. 00 | 12. 00 | 13. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | | | | | 2.00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | | | | 3. 00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | | | | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | | | | 5. 00 |
| 6. 00 | 00600 LAUNDRY & LINEN SERVICE | | | | | | 6. 00 |
| 7. 00 | 00700 HOUSEKEEPI NG | | | | | | 7. 00 |
| 8. 00 | 00800 DI ETARY | | | | | | 8. 00 |
| 9. 00 | 00900 NURSI NG ADMI NI STRATI ON | 698, 855 | | | | | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 207, 529 | | | | 10.00 |
| 11.00 | 01100 PHARMACY | 0 | 0 | 0 | 00.005 | | 11.00 |
| 12.00 | 01200 MEDI CAL RECORDS & LI BRARY | 0 | 0 | 0 | 93, 995 | | 12.00 |
| 13.00 | 01300 SOCI AL SERVI CE | 0 | 0 | 0 | 0 | 324, 995 | 13.00 |
| 14.00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | 0 | 0 | 0 | 14.00 |
| 15. 00 | 01500 ACTIVITIES | 0 | O | O | 0 | 0 | 15. 00 |
| 20.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | (00.055 | 207 520 | | 00.051 | 224 005 | 20.00 |
| 30.00 | 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY | 698, 855 | 207, 529 | 0 | 82, 051 | 324, 995 | 30. 00 31. 00 |
| 31. 00 32. 00 | 03200 CF/IID | 0 | 0 | 0 | 0 | 0 | 31.00 |
| 33. 00 | 1 | 0 | 0 | 0 | 0 | | 33. 00 |
| 33.00 | ANCI LLARY SERVI CE COST CENTERS | l U | υ | U | 0 | U | 33.00 |
| 40. 00 | 04000 RADI OLOGY | 0 | O | 0 | 115 | 0 | 40. 00 |
| 41. 00 | 04100 LABORATORY | 0 | 0 | 0 | 229 | 0 | 41. 00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | | 0 | 0 | 58 | Ö | 42. 00 |
| 43. 00 | 04300 OXYGEN (INHALATION) THERAPY | | 0 | 0 | 0 | Ö | 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | | 0 | 0 | 4, 326 | Ö | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 4, 147 | Ö | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | 0 | 0 | 2, 119 | Ö | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | 0 | 2,, | Ö | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | Ö | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 950 | Ö | 49. 00 |
| 50. 00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | o | 0 | 0 | 0 | 50.00 |
| 51. 00 | 05100 SUPPORT SURFACES | 0 | o | 0 | 0 | 0 | 51.00 |
| 52.00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | o | 0 | 0 | 0 | 0 | 52. 00 |
| | OUTPATIENT SERVICE COST CENTERS | <u>'</u> | ' | <u>'</u> | | <u> </u> | |
| 60.00 | 06000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 60.00 |
| 61.00 | 06100 RURAL HEALTH CLINIC | o | o | 0 | 0 | 0 | 61. 00 |
| 62.00 | 06200 FQHC | | | | | | 62. 00 |
| 63.00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | 0 | 0 | 0 | 63. 00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 | 07100 AMBULANCE | 0 | 0 | 0 | 0 | 0 | 71. 00 |
| 72. 00 | 07200 CORF | 0 | 0 | 0 | 0 | 0 | 72. 00 |
| 73. 00 | 07300 CMHC | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| 74. 00 | 07400 OTHER REIMBURSABLE COST | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | ı | |
| 80.00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80.00 |
| 81. 00 | 08100 I NTEREST EXPENSE | | | | | | 81.00 |
| 82.00 | 08200 UTI LI ZATI ON REVI EW | | | | | | 82. 00 |
| 83. 00 | 08300 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 83. 00 |
| 84. 00 | 08400 OTHER SPECIAL PURPOSE COST CENTERS | (00.055 | 0 | 0 | 0 | 0 | 84.00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 698, 855 | 207, 529 | 0 | 93, 995 | 324, 995 | 89. 00 |
| 00.00 | NONREI MBURSABLE COST CENTERS | | ما | | 0 | 0 | 00 00 |
| 90. 00 91. 00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP | 0 | 0 | 0 | 0 | | 90.00 |
| | 1 | 0 | 0 | 0 | 0 | 0 | 91.00 |
| 92.00 | 09200 PHYSI CLANS PRI VATE OFFI CES | 0 | 0 | ŭ | 0 | 0 | 92.00 |
| 93. 00 94. 00 | 09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY | | O O | 0 | 0 | 0 | 93. 00 94. 00 |
| 94. 00 95. 00 | 09500 OTHER NONREIMBURSABLE COST CENTERS | | 0 | 0 | 0 | 0 | 95.00 |
| 98. 00 | Cross Foot Adjustments | | 0 | U | 0 | | 98.00 |
| 99. 00 | | | 0 | Λ | Λ | 0 | 99. 00 |
| 100.00 | | 698, 855 | 207, 529 | o | 93, 995 | | |
| | The state of the s | | , -2-, | ٥١ | , . , 0 | ,.,0 | |
| | | | | | | | |

| | | | | | To 12/31/2023 | | |
|------------------|---|----------------------------|---------------|------------------|---------------|--------------------|------------------|
| | | | OTHER GENERAL | | | 5/13/2024 9: 2 | 4 am |
| | | | SERVI CE | | | | |
| | Cost Center Description | NURSI NG AND | ACTI VI TI ES | Subtotal | Post Stepdown | Total | |
| | | ALLIED HEALTH EDUCATION | | | Adjustments | | |
| | | 14. 00 | 15. 00 | 16.00 | 17. 00 | 18. 00 | |
| | GENERAL SERVICE COST CENTERS | T | T | T | <u> </u> | | |
| 1. 00 2. 00 | 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | | | | | 1.00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | | | | 3. 00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | | | | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | | | | 5. 00 |
| 6. 00 7. 00 | 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING | | | | | | 6.00 |
| 8.00 | 00800 DI ETARY | | | | | | 7. 00 8. 00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | | | | | | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | | | | | | 10.00 |
| 11.00 | 01100 PHARMACY | | | | | | 11.00 |
| 12. 00 13. 00 | 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE | | | | | | 12. 00 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | | | | | 14.00 |
| 15. 00 | 01500 ACTI VI TI ES | 0 | | 7 | | | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 SKILLED NURSING FACILITY | 0 | | | | | |
| 31. 00 32. 00 | 03100 NURSING FACILITY 03200 CF/IID | 0 | | 1 | 0 0 | | 1 |
| 33. 00 | 03300 OTHER LONG TERM CARE | | l . | 1 | 0 0 | 0 | |
| 00.00 | ANCI LLARY SERVI CE COST CENTERS | | | 1 | <u> </u> | | 00.00 |
| 40. 00 | 04000 RADI OLOGY | 0 | (| | | | |
| 41.00 | 04100 LABORATORY | 0 | (| - | | , | |
| 42. 00 43. 00 | 04200 NTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY | 0 | | 14, 04 | 0 0 | 14, 041 0 | 1 |
| 44. 00 | 04400 PHYSI CAL THERAPY | | | 552, 08 | - | 552, 086 | 1 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | d | 518, 31 | | 518, 311 | |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | (| 201, 54 | | 201, 541 | |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | | | 0 | 0 571 | |
| 48. 00 49. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS | 0 | | 8, 57 219, 21 | | 8, 571 219, 216 | |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | Ö | | | 0 0 | 0 | 1 |
| 51. 00 | 05100 SUPPORT SURFACES | 0 | (| 8, 70 | 4 0 | 8, 704 | 51.00 |
| 52.00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | 0 | (| | 0 0 | 0 | 52. 00 |
| 60. 00 | OUTPATIENT SERVICE COST CENTERS 06000 CLINIC | 0 | | J | ol o | 0 | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | | | 1 | 0 0 | 0 | |
| 62. 00 | 06200 FQHC | | | | | | 62.00 |
| 63.00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER | 0 | (| | 0 0 | 0 | 63. 00 |
| 70.00 | OTHER REIMBURSABLE COST CENTERS | | 1 | | | | |
| 70. 00 71. 00 | 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE | 0 | | 1 | 0 0 | 0 | |
| 71.00 | 07200 CORF | | | 1 | 0 0 | 0 | |
| | 07300 CMHC | 0 | d | | 0 0 | 0 | 1 |
| 74. 00 | 07400 OTHER REIMBURSABLE COST | 0 | (| ol | 0 0 | 0 | 74. 00 |
| 00.00 | SPECIAL PURPOSE COST CENTERS | | | 1 | | | 00.00 |
| 80. 00 81. 00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE | | | | | | 80. 00 81. 00 |
| 82. 00 | 08200 UTILIZATION REVIEW | | | | | | 82.00 |
| 83.00 | 08300 H0SPI CE | 0 | | | 0 0 | 0 | |
| 84. 00 | 08400 OTHER SPECIAL PURPOSE COST CENTERS | 0 | | | 0 0 | 0 | |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 0 | 192, 977 | 7 14, 187, 60 | 7 0 | 14, 187, 607 | 89. 00 |
| 90. 00 | NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | | ٦ | 0 0 | 0 | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | | _ | 6, 73 | - | | |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | 0 | | | 0 0 | 0 | |
| 93. 00 | 09300 NONPALD WORKERS | 0 | (| | 0 0 | 0 | |
| 94. 00 | 09400 PATIENTS LAUNDRY | 0 | (| | 0 | 0 | |
| 95. 00 98. 00 | 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments | 0 | | 3 | | 0 | |
| 99. 00 | Negative Cost Centers | | | ól – | o o | 0 | |
| 100.00 | | 0 | | 14, 194, 33 | 9 0 | - | |
| | | | | | | | |

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315353

| | | | | | То | 12/31/2023 | Date/Time Prep 5/13/2024 9: 2 | oared: |
|------------------|-------|--|---------------------------|--------------------|------------|--------------------|-------------------------------|------------------|
| | | | | CAPI TAL REL | ATED COSTS | | 37 137 2024 7. 2 | 4 (111) |
| | | Cost Center Description | Directly | BLDGS & | MOVABLE | Subtotal | EMPLOYEE | |
| | | obst conto. Dosd. pt. c | Assigned New | FIXTURES | EQUI PMENT | oub to tu. | 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 | 29, 019 | 316 | 29, 335 | 29, 335 | 3. 00 |
| 4.00 | | ADMINISTRATIVE & GENERAL | 0 | 480, 610 | | 485, 836 | 2, 289 | 4. 00 |
| 5. 00 6. 00 | | PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE | 0 | 62, 461 73, 741 | 679 802 | 63, 140 74, 543 | 699 0 | 5. 00 6. 00 |
| 7. 00 | | HOUSEKEEPI NG | o o | 7, 155 | | 7, 233 | 0 | 7. 00 |
| 8.00 | | DIETARY | 0 | 100, 077 | 1, 088 | 101, 165 | 0 | 8. 00 |
| 9. 00 10. 00 | | NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY | 0 | 39, 206 29, 169 | 426 317 | 39, 632 29, 486 | 1, 748 139 | 9. 00 10. 00 |
| 11. 00 | | PHARMACY | 0 | 27, 107 | 0 | 27, 400 | 0 | 11. 00 |
| 12. 00 | | MEDICAL RECORDS & LIBRARY | O | 8, 895 | | 8, 992 | 273 | 12. 00 |
| 13. 00 14. 00 | | SOCIAL SERVICE NURSING AND ALLIED HEALTH EDUCATION | 0 | 5, 963 0 | 65 | 6, 028 0 | 1, 035 0 | 13. 00 14. 00 |
| 15. 00 | | ACTIVITIES | | 0 | | 0 | 692 | 15. 00 |
| | | IENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 31. 00 | | SKILLED NURSING FACILITY NURSING FACILITY | 0 | 1, 100, 802 0 | 11, 969 | 1, 112, 771 0 | 22, 460 0 | 30. 00 31. 00 |
| 32.00 | | ICF/IID | | 0 | | o | 0 | 32.00 |
| 33.00 | | OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| 40.00 | | LARY SERVICE COST CENTERS RADIOLOGY | l ol | 0 | | ol | 0 | 40.00 |
| 40. 00 41. 00 | | LABORATORY | | 0 | | ol | 0 | 40. 00 41. 00 |
| 42. 00 | 04200 | I NTRAVENOUS THERAPY | Ö | 0 | o | Ō | 0 | 42.00 |
| 43.00 | | OXYGEN (INHALATION) THERAPY | 0 | 0 | 0 | 0 | 0 | 43.00 |
| 44. 00 45. 00 | | PHYSI CAL THERAPY OCCUPATI ONAL THERAPY | | 82, 686 57, 741 | 899 628 | 83, 585 58, 369 | 0 | 44. 00 45. 00 |
| 46. 00 | | SPEECH PATHOLOGY | o o | 5, 267 | 57 | 5, 324 | 0 | 46. 00 |
| 47. 00 | | ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 47. 00 |
| 48. 00 49. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS | | 3, 926 795 | 43 | 3, 969 804 | 0 | 48. 00 49. 00 |
| 50.00 | | DENTAL CARE - TITLE XIX ONLY | o o | 0 | ó | 0 | 0 | 50. 00 |
| 51.00 | 1 | SUPPORT SURFACES | 0 | 0 | | 0 | 0 | 51.00 |
| 52. 00 | | OTHER ANCILLARY SERVICE COST CENTERS TIENT SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 52. 00 |
| 60.00 | | CLI NI C | 0 | 0 | 0 | 0 | 0 | 60. 00 |
| 61.00 | 1 | RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61.00 |
| 62. 00 63. 00 | 06200 | FQHC OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | 0 | 0 | 0 | 62. 00 63. 00 |
| 00.00 | | REIMBURSABLE COST CENTERS | <u> </u> | | <u> </u> | <u> </u> | | 00.00 |
| 70.00 | | HOME HEALTH AGENCY COST | 0 | 0 | | 0 | 0 | 70.00 |
| 71. 00 72. 00 | 07100 | AMBULANCE CORE | | 0 | 0 | 0 | 0 | 71. 00 72. 00 |
| 73. 00 | 07300 | | 0 | 0 | Ö | Ö | 0 | 73. 00 |
| 74. 00 | | OTHER REIMBURSABLE COST | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| 80. 00 | | AL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81. 00 | | INTEREST EXPENSE | | | | | | 81. 00 |
| 82. 00 | | UTILIZATION REVIEW | | | | | | 82. 00 |
| 83. 00 84. 00 | | HOSPICE OTHER SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 83. 00 84. 00 |
| 89. 00 | 00400 | SUBTOTALS (sum of lines 1-84) | 0 | 2, 087, 513 | 22, 699 | 2, 110, 212 | 29, 335 | |
| 00.05 | | IMBURSABLE COST CENTERS | | | | | | |
| 90. 00 91. 00 | | GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP | 0 | 0 | 0 | 0 | 0 | 90. 00 91. 00 |
| 92. 00 | | PHYSICIANS PRIVATE OFFICES | | 0 | o | o | 0 | 92. 00 |
| 93.00 | | NONPAI D WORKERS | 0 | 0 | 0 | О | 0 | 93. 00 |
| 94. 00 95. 00 | | PATIENTS LAUNDRY OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 94. 00 95. 00 |
| 98. 00 | 0,300 | Cross Foot Adjustments | | J | | o | O | 98. 00 |
| 99. 00 | | Negative Cost Centers | | 0 | 0 | 0 | 0 | |
| 100.00 |) | TOTAL | 0 | 2, 087, 513 | 22, 699 | 2, 110, 212 | 29, 335 | 100. 00 |

| | | | | 11 | 0 12/31/2023 | 5/13/2024 9:2 | pared: 4 am |
|------------------|--|-------------------|-------------|---|---------------|---------------|------------------|
| | Cost Center Description | ADMI NI STRATI VE | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | · | & GENERAL | OPERATI ON, | LINEN SERVICE | | | |
| | | | MAINT. & | | | | |
| | | 4.00 | REPAI RS | / 00 | 7.00 | 0.00 | |
| | GENERAL SERVICE COST CENTERS | 4.00 | 5. 00 | 6.00 | 7. 00 | 8. 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 | 488, 125 | | | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 27, 896 | 91, 735 | 5 | | | 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | 12, 598 | 4, 464 | 91, 605 | | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | 20, 013 | 433 | 0 | 27, 679 | | 7. 00 |
| 8.00 | 00800 DI ETARY | 56, 674 | 6, 058 | | 1, 931 | 165, 828 | 8. 00 |
| 9.00 | 00900 NURSI NG ADMI NI STRATI ON | 22, 760 | 2, 373 | | 756 | 0 | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 6, 190 | 1, 766 | 1 | 563 | 0 | 10.00 |
| 11. 00 | 01100 PHARMACY | 0 044 | 0 | _ | 0 | 0 | 11.00 |
| 12. 00 13. 00 | 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE | 2, 944 10, 983 | 538 361 | | 172 115 | 0 | 12. 00 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 10, 963 | 301 | | 0 | 0 | 14.00 |
| 15. 00 | | 6, 636 | 0 | | 0 | 0 | 15.00 |
| 10.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 0,000 | | <u>, </u> | ٥ | | 10.00 |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 272, 568 | 66, 637 | 91, 605 | 21, 240 | 165, 828 | 30.00 |
| 31.00 | 03100 NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 31.00 |
| 32.00 | 03200 CF/IID | 0 | 0 | 0 | O | 0 | 32. 00 |
| 33.00 | 03300 OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40. 00 | 04000 RADI OLOGY | 430 | 0 | 1 | 0 | 0 | 40. 00 |
| 41.00 | | 1, 126 | 0 | 0 | 0 | 0 | 41.00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | 481 | 0 | 0 | 0 | 0 | 42.00 |
| 43. 00 44. 00 | 04300 0XYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY | 0 16, 153 | 5, 005 | | 1, 595 | 0 | 43. 00 44. 00 |
| 45. 00 | 04500 OCCUPATIONAL THERAPY | 15, 808 | 3, 495 | | 1, 114 | 0 | 45.00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 6, 687 | 319 | 1 | 102 | 0 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | 1 | 0 | 0 | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 167 | 238 | 0 | 76 | 0 | 48. 00 |
| 49.00 | 04900 DRUGS CHARGED TO PATIENTS | 7, 480 | 48 | 0 | 15 | 0 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0 | 0 | 0 | 50.00 |
| 51. 00 | 05100 SUPPORT SURFACES | 299 | 0 | 0 | 0 | 0 | 51.00 |
| 52. 00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 52. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | ما | | |
| 60. 00 61. 00 | 06000 CLI NI C 06100 RURAL HEALTH CLI NI C | 0 | 0 | 0 | 0 | 0 | 60. 00 61. 00 |
| 62. 00 | 06200 FOHC | 0 | U | 0 | U | U | 62.00 |
| 63. 00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | 0 | 0 | 0 | 63.00 |
| 00.00 | OTHER REIMBURSABLE COST CENTERS | <u> </u> | | , | ٥ | | 00.00 |
| 70.00 | | 0 | 0 | 0 | 0 | 0 | 70.00 |
| 71.00 | 07100 AMBULANCE | 0 | 0 | 0 | o | 0 | 71. 00 |
| 72. 00 | 07200 CORF | 0 | 0 | 0 | 0 | 0 | 72. 00 |
| 73. 00 | | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| 74. 00 | 07400 OTHER REIMBURSABLE COST | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| 00.00 | SPECIAL PURPOSE COST CENTERS | | | | | | 00.00 |
| 80. 00 81. 00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE | | | | | | 80. 00 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 | 0 | o o | Ö | 0 | 84. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 487, 893 | 91, 735 | 91, 605 | 27, 679 | 165, 828 | 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 | 232 | 0 | 0 | 0 | 0 | 91.00 |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | 0 | 0 | 92.00 |
| 93. 00 | 09300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 93. 00 |
| 94.00 | 09400 PATIENTS LAUNDRY | 0 | 0 | 0 | 0 | 0 | 94.00 |
| 95. 00 98. 00 | 09500 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments | ١ | 0 | , 0 | 0 | 0 | 95. 00 98. 00 |
| 98.00 | Negative Cost Centers | | 0 | | 0 | 0 | 98.00 |
| 100.00 | 1 1 0 | 488, 125 | 91, 735 | 91, 605 | 27, 679 | | |
| . 55. 50 | · 1 · - · · · - | .50, 120 | , 1, 755 | , ,,,,,,,,, | 27,077 | .50, 520 | , |

| | | | | ' | 0 12/31/2023 | 5/13/2024 9: 2 | |
|------------------|---|-------------------------------|-----------------------|----------|-----------------------|----------------|------------------|
| | Cost Center Description | NURSI NG ADMI NI STRATI ON | CENTRAL SERVICES & | PHARMACY | MEDI CAL RECORDS & | SOCIAL SERVICE | |
| | | 9.00 | SUPPLY 10. 00 | 11 00 | LI BRARY | 13. 00 | |
| | GENERAL SERVICE COST CENTERS | 9.00 | 10.00 | 11. 00 | 12.00 | 13.00 | |
| 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 | 00700 HOUSEKEEPI NG | | | | | | 7. 00 |
| 8.00 | 00800 DI ETARY | | | | | | 8. 00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | 67, 269 | | | | | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 38, 144 | _ | | | 10.00 |
| 11.00 | 01100 PHARMACY | 0 | 0 | (| 10.010 | | 11.00 |
| 12.00 | 01200 MEDICAL RECORDS & LIBRARY | 0 | 0 | | 12, 919 | 10 500 | 12.00 |
| 13.00 | 01300 SOCIAL SERVICE | 0 | 0 | | 0 | 18, 522 | 13.00 |
| 14. 00 15. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES | | 0 | | | 0 1 0 | 14. 00 15. 00 |
| 15.00 | INPATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | U | |) | 0 | 15.00 |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 67, 269 | 38, 144 | | 11, 278 | 18, 522 | 30. 00 |
| 31. 00 | 03100 NURSING FACILITY | 07,207 | 0. 144 | | , | 0 | 31. 00 |
| 32. 00 | 03200 CF/11D | o | 0 | | - | Ö | 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | o | 0 | d | - | Ō | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | , , | - | | | | |
| 40.00 | 04000 RADI OLOGY | 0 | 0 | C | 16 | 0 | 40.00 |
| 41.00 | 04100 LABORATORY | 0 | 0 | C | 31 | 0 | 41. 00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | (| 8 | 0 | 42.00 |
| 43. 00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | C | 0 | 0 | 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 0 | 0 | (| 594 | 0 | 44.00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 0 | | 570 | 0 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | 0 | | 291 | 0 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 47. 00 |
| 48. 00 49. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS | | 0 | | 131 | 0 0 | 48. 00 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | | 0 | | 0 | | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | o o | 0 | | 0 | ĺ | 51. 00 |
| 52. 00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | o | 0 | | o o | Ö | 52. 00 |
| | OUTPATIENT SERVICE COST CENTERS | , -, | | | | | |
| 60.00 | 06000 CLI NI C | 0 | 0 | C | 0 | 0 | 60. 00 |
| 61.00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | C | 0 | 0 | 61. 00 |
| 62.00 | 06200 FQHC | | | | | | 62. 00 |
| 63. 00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | (| 0 | 0 | 63. 00 |
| 70.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 70.00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | | | | 70.00 |
| 71. 00 72. 00 | 07100 AMBULANCE 07200 CORF | 0 | 0 | | 0 | 0 | 71. 00 72. 00 |
| 73. 00 | 07300 CMHC | | 0 | | | | 73. 00 |
| 74.00 | 07400 OTHER REIMBURSABLE COST | | 0 | | | | 74.00 |
| 74.00 | SPECIAL PURPOSE COST CENTERS | ١ | J | | , | | 74.00 |
| 80. 00 | 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | | | | 80. 00 |
| 81. 00 | 08100 NTEREST EXPENSE | | | | | | 81. 00 |
| 82.00 | 08200 UTI LI ZATI ON REVI EW | | | | | | 82. 00 |
| 83.00 | 08300 HOSPI CE | 0 | 0 | C | 0 | 0 | 83. 00 |
| 84.00 | 08400 OTHER SPECIAL PURPOSE COST CENTERS | 0 | 0 | C | | 0 | 84. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 67, 269 | 38, 144 | (| 12, 919 | 18, 522 | 89. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | | - | | 90.00 |
| 91.00 | 09100 BARBER AND BEAUTY SHOP | 0 | 0 | | 0 | " | 91.00 |
| 92.00 | 09200 PHYSI CLANS PRI VATE OFFI CES | 0 | 0 | (| 0 | 0 | 92.00 |
| 93. 00 94. 00 | 09300 NONPAI D WORKERS 09400 PATIENTS LAUNDRY | | 0 | | _ | 0 | 93. 00 94. 00 |
| 94. 00 95. 00 | 09500 OTHER NONREIMBURSABLE COST CENTERS | | 0 | | _ | 0 | 95.00 |
| 98. 00 | Cross Foot Adjustments | | 0 | | | | 98. 00 |
| 99. 00 | Negative Cost Centers | | 0 | | 0 | 0 | 99. 00 |
| 100.00 | | 67, 269 | 38, 144 | ď | 12, 919 | | |
| | • | | * 11 | | | • | • |

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315353

| | | | | | | To 12/31/2023 | Date/Time Pre 5/13/2024 9: 2 | |
|------------------|----------------|---|------------------------------|---------------|------------|-------------------------------|------------------------------|------------------|
| | | | | OTHER GENERAL | | | 37 137 2024 9. 2 | 4 alli |
| | | | | SERVI CE | | | | |
| | | Cost Center Description | NURSING AND ALLIED HEALTH | ACTI VI TI ES | Subtotal | Post Step-Down Adjustments | Total | |
| | | | EDUCATI ON | | | Auj us tillerits | | |
| | | | 14.00 | 15. 00 | 16. 00 | 17. 00 | 18. 00 | |
| 1. 00 | | AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES | 1 | I | I | | I | 1.00 |
| 2.00 | 1 | CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT | | | • | | | 2. 00 |
| 3. 00 | | EMPLOYEE BENEFITS | | | | | | 3. 00 |
| 4.00 | | ADMINISTRATIVE & GENERAL | | | | | | 4. 00 |
| 5. 00 6. 00 | 1 | PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE | | | | | | 5. 00 6. 00 |
| 7. 00 | 1 | HOUSEKEEPI NG | | | | | | 7. 00 |
| 8.00 | | DI ETARY | | | | | | 8. 00 |
| 9.00 | | NURSI NG ADMINI STRATI ON | | | | | | 9.00 |
| 10. 00 11. 00 | | CENTRAL SERVICES & SUPPLY PHARMACY | | | | | | 10. 00 11. 00 |
| 12. 00 | 1 | MEDICAL RECORDS & LIBRARY | | | | | | 12. 00 |
| 13.00 | 1 | SOCIAL SERVICE | | | | | | 13. 00 |
| 14. 00 15. 00 | 1 | NURSING AND ALLIED HEALTH EDUCATION ACTIVITIES | 0 | 7, 328 | | | | 14. 00 15. 00 |
| 15.00 | | IENT ROUTINE SERVICE COST CENTERS | | 1, 320 | 1 | | | 13.00 |
| 30.00 | | SKILLED NURSING FACILITY | 0 | 7, 328 | 1, 895, 65 | 0 0 | 1, 895, 650 | 30. 00 |
| 31.00 | | NURSING FACILITY | 0 | 0 | 1 | 0 0 | | |
| 32. 00 33. 00 | | ICF/IID OTHER LONG TERM CARE | 0 | 0 | 1 | 0 0 | 0 | 1 |
| 33.00 | | LARY SERVICE COST CENTERS | | | 1 | 0 0 | | 33.00 |
| 40.00 | | RADI OLOGY | 0 | 0 | | | | 1 |
| 41. 00 | 1 | LABORATORY | 0 | 0 | | | 1, 157 | 1 |
| 42. 00 43. 00 | | INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY | 0 | 0 | 48 | 0 0 | 489 0 | 1 |
| 44. 00 | | PHYSI CAL THERAPY | 0 | Ö | 106, 93 | - | 106, 932 | |
| 45. 00 | | OCCUPATIONAL THERAPY | 0 | 0 | , | | 79, 356 | 1 |
| 46. 00 47. 00 | | SPEECH PATHOLOGY ELECTROCARDI OLOGY | 0 | 0 | | 0 0 0 | 12, 723 0 | 1 |
| 48. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 4, 45 | | 4, 450 | 1 |
| 49. 00 | | DRUGS CHARGED TO PATIENTS | 0 | 0 | 8, 47 | | 8, 478 | 1 |
| 50.00 | | DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 1 | 0 0 | 0 | |
| 51. 00 52. 00 | | SUPPORT SURFACES OTHER ANCILLARY SERVICE COST CENTERS | 0 | 0 | 1 | 0 0 | 299 0 | 1 |
| 32.00 | | TIENT SERVICE COST CENTERS | | | | 0 | | 32.00 |
| 60.00 | 1 | CLINIC | 0 | 1 | 1 | 0 0 | 0 | |
| 61. 00 62. 00 | 06100 06200 | RURAL HEALTH CLINIC | 0 | 0 | | 0 | 0 | 61. 00 62. 00 |
| 63.00 | 1 | OTHER OUTPATIENT SERVICE COST CENTER | 0 | 0 | | 0 0 | 0 | 1 |
| | | REIMBURSABLE COST CENTERS | | | | | | |
| 70.00 | | HOME HEALTH AGENCY COST | 0 | 0 | | 0 0 | | |
| 71. 00 72. 00 | 07100 | AMBULANCE CORE | 0 | 0 | 1 | 0 0 | 0 | |
| | 07300 | | | | | 0 0 | Ö | |
| 74.00 | 07400 | OTHER REIMBURSABLE COST | 0 | 0 | | 0 0 | 0 | |
| 90 00 | | AL PURPOSE COST CENTERS | | I | 1 | | | 90.00 |
| 80. 00 81. 00 | | MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE | | | | | | 80. 00 81. 00 |
| 82. 00 | | UTILIZATION REVIEW | | | | | | 82. 00 |
| 83. 00 | | HOSPI CE | 0 | 0 | | 0 0 | 0 | |
| 84. 00 89. 00 | 08400 | OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-84) | 0 | 0 7, 328 | 2, 109, 98 | 0 0 | 0 2, 109, 980 | |
| 09.00 | NONRE | IMBURSABLE COST CENTERS | 0 | 7, 320 | 2, 109, 90 | 0 | 2, 109, 980 | 39.00 |
| 90. 00 | 09000 | GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | l . | 0 0 | 0 | |
| 91.00 | | BARBER AND BEAUTY SHOP | 0 | 0 | 23 | 0 | 232 | 1 |
| 92. 00 93. 00 | | PHYSICIANS PRIVATE OFFICES NONPAID WORKERS | 0 | | | | 0 | 1 |
| 94. 00 | | PATIENTS LAUNDRY | 0 | 0 | | o o | ő | 1 |
| 95. 00 | 09500 | OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 | 0 | |
| 98. 00 99. 00 | | Cross Foot Adjustments Negative Cost Centers | 0 | 0 | | 0 | 0 | 1 |
| 100.00 |) | TOTAL | | 7, 328 | 2, 110, 21 | 2 0 | | |
| | 1 | ı | ' | , , , , , , | | | | |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

| | | | | | o 12/31/2023 | Date/Time Pre 5/13/2024 9: 2 | |
|--------------------|---|---------------|-----------------------------|----------------------|----------------|------------------------------|-------------------|
| | | CAPITAL REI | ATED COSTS | | | 37 137 2024 7. 2 | 4 alli |
| | Cost Center Description | BLDGS & | MOVABLE | EMPLOYEE | Reconciliation | ADMI NI STRATI VE | |
| | | FIXTURES | EQUI PMENT (SQUARE FEET) | BENEFITS (GROSS | | & GENERAL | |
| | | (SQUARE FEET) | (SQUARE FEET) | SALARI ES) | | (ACCUM. COST) | |
| | GENERAL SERVICE COST CENTERS | 1.00 | 2. 00 | 3. 00 | 4A | 4. 00 | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | 42, 010 | | | | | 1. 00 |
| 2. 00 3. 00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS | 584 | 42, 010 584 | | | | 2. 00 3. 00 |
| 4. 00 | 00400 ADMINISTRATIVE & GENERAL | 9, 672 | | | | 11, 575, 364 | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 1, 257 | 1, 257 | | | 661, 521 | 5. 00 |
| 6. 00 7. 00 | 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING | 1, 484 144 | 1, 484 144 | | | 298, 753 474, 592 | 6. 00 7. 00 |
| 8.00 | 00800 DI ETARY | 2, 014 | 2, 014 | | _ | 1, 343, 978 | 1 |
| 9. 00 10. 00 | 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY | 789 587 | 789 587 | | | 539, 740 146, 792 | 9. 00 10. 00 |
| 11.00 | 01100 PHARMACY | 0 | 0 | _ | | 0 | 11.00 |
| 12. 00 13. 00 | 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE | 179 120 | 179 120 | | | 69, 808 260, 442 | 12. 00 13. 00 |
| 14.00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | 0 | 0 | 0 | 14. 00 |
| 15. 00 | 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS | 0 | 0 | 128, 658 | 0 | 157, 371 | 15. 00 |
| 30.00 | 03000 SKILLED NURSING FACILITY | 22, 153 | · | | | | 30. 00 |
| 31. 00 32. 00 | 03100 NURSING FACILITY 03200 CF/IID | 0 | 0 0 | | | | 31. 00 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 0 | Ō | | | l e | 33. 00 |
| 40. 00 | ANCILLARY SERVICE COST CENTERS 04000 RADIOLOGY | 0 | 0 | 0 | 0 | 10, 200 | 40. 00 |
| 41.00 | 04100 LABORATORY | Ö | Ō | 0 | 0 | 26, 703 | 41. 00 |
| 42. 00 43. 00 | 04200 NTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | 0 | | 11, 403 | 42. 00 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 1, 664 | 1, 664 | · · | _ | 383, 064 | 44. 00 |
| 45. 00 46. 00 | 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY | 1, 162 106 | | | | 374, 863 158, 573 | 1 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | | _ | 0 | 47. 00 |
| 48. 00 49. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS | 79 16 | 79 16 | | _ | 3, 969 177, 382 | 48. 00 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | | | 0 | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | 0 | 0 | | | | 51. 00 52. 00 |
| 52. 00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS | | U | | 0 | | 52.00 |
| 60. 00 61. 00 | 06000 CLINIC 06100 RURAL HEALTH CLINIC | 0 | 0 0 | | | l e | 60. 00 61. 00 |
| 62. 00 | 06200 FQHC | | U | | 0 | | 62.00 |
| 63. 00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 63. 00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 72. 00 | 07100 AMBULANCE | 0 | 0 | | | 1 | |
| 73.00 | 07200 CORF 07300 CMHC | 0 | 0 | 0 | | l | 1 |
| 74. 00 | 07400 OTHER REIMBURSABLE COST SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 74. 00 |
| 80. 00 | | | | | | | 80. 00 |
| 81. 00 82. 00 | 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW | | | | | | 81. 00 82. 00 |
| 83. 00 | 08300 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 83. 00 |
| 84. 00 | 08400 OTHER SPECIAL PURPOSE COST CENTERS | 12.010 | 0 | O F 454 441 | _ | 1 | 84. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS | 42, 010 | 42, 010 | 5, 456, 461 | -2, 618, 975 | 11, 569, 874 | 89. 00 |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | | | | 90.00 |
| 91. 00 92. 00 | 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | | 5, 490 0 | 91. 00 92. 00 |
| 93. 00 | 09300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 93. 00 |
| 94. 00 95. 00 | 09400 PATIENTS LAUNDRY 09500 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 | 0 | 94. 00 95. 00 |
| 98. 00 | Cross Foot Adjustments | | | | | | 98. 00 |
| 99. 00 102. 00 | Negative Cost Centers Cost to be allocated (per Wkst. B, | 2, 087, 513 | 22, 699 | 1, 068, 382 | | 2, 618, 975 | 99. 00 102. 00 |
| | Part I) | | | | | | |
| 103. 00 104. 00 | | 49. 690859 | 0. 540324 | 0. 195801 29, 335 | | 0. 226254 488, 125 | |
| | Part II) | | | | | | |
| 105.00 | Unit cost multiplier (Wkst. B, Part | | | 0. 005376 | | 0. 042169 | 105.00 |
| | | | | | | | |

COST ALLOCATION - STATISTICAL BASIS

Provi der No.: 315353 Peri od:

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/13/2024 9: 24 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, MAINT. & (TOTAL PATIENT REPAI RS (TOTAL PATIENT DAYS) (SQUARE FEET) DAYS) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 30, 497 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 1, 484 6.00 40, 821 6.00 7.00 00700 HOUSEKEEPI NG 144 28,869 7.00 8.00 00800 DI ETARY 2,014 2,014 122, 463 8.00 00900 NURSING ADMINISTRATION 40, 821 9 00 789 C 789 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 587 587 0 0 10.00 11.00 01100 PHARMACY 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 179 179 0 12.00 0 01300 SOCIAL SERVICE 0 13 00 120 Ω 120 13 00 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C C 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 22, 153 40,821 22, 153 122, 463 40, 821 30.00 03100 NURSING FACILITY 31.00 31.00 0 32.00 03200 | CF/IID 0 32.00 0 0 0 0 03300 OTHER LONG TERM CARE 0 0 33 00 33.00 Ω 0 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 40.00 C 0 0 41.00 04100 LABORATORY 0 0 0 0 0 41.00 04200 I NTRAVENOUS THERAPY 0 0 42 00 42 00 0 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 43.00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 44.00 1,664 1,664 44.00 04500 OCCUPATIONAL THERAPY 45.00 1.162 1.162 0 45.00 04600 SPEECH PATHOLOGY 46.00 106 106 0 46.00 04700 ELECTROCARDI OLOGY 47.00 47.00 0 C 0 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 79 48 00 79 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 49.00 16 16 0 05000 DENTAL CARE - TITLE XIX ONLY 50.00 0 C 0 Λ 50.00 05100 SUPPORT SURFACES 0 0 0 51.00 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 n O Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 0 63.00 0 0 Λ 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST C 70.00 07100 AMBULANCE 71.00 71.00 0 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 72.00 73.00 07300 CMHC 0 0 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 83.00 08300 H0SPLCE Λ 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 30, 497 40, 821 28, 869 122, 463 40, 821 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 09100 BARBER AND BEAUTY SHOP 0 0 0 91.00 91.00 0 0 09200 PHYSICIANS PRIVATE OFFICES 92.00 0 0 0 92.00 0 0 93 00 09300 NONPALD WORKERS 0 93 00 Ω 0 09400 PATIENTS LAUNDRY 94.00 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 95.00 95.00 C 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99 00 102.00 Cost to be allocated (per Wkst. B, 811, 193 405, 820 585, 800 1, 742, 496 698, 855 102. 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 26. 599108 9. 941452 20. 291662 14. 228755 17. 119987 103. 00 67, 269 104. 00 104.00 Cost to be allocated (per Wkst. B, 91, 735 91, 605 27, 679 165, 828 Part II) 105.00 Unit cost multiplier (Wkst. B, Part 3.008001 2. 244066 0.958779 1.354107 1. 647902 105. 00

In Lieu of Form CMS-2540-10 Health Financial Systems CRANBURY CENTER COST ALLOCATION - STATISTICAL BASIS Provider No.: 315353 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/13/2024 9:24 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NURSI NG AND RECORDS & SERVICES & (COSTED ALLI ED HEALTH SUPPLY REQUIS.) LI BRARY (TOTAL PATIENT **EDUCATION** (COSTED (GROSS DAYS) (ASSI GNED REQUIS.) CHARGES) TIME) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 00700 HOUSEKEEPI NG 7.00 8.00 00800 DI ETARY 8.00 00900 NURSING ADMINISTRATION 9 00 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 48,805 10.00 11.00 01100 PHARMACY 11.00 01200 MEDICAL RECORDS & LIBRARY 12.00 0 18, 738, 056 12.00 01300 SOCIAL SERVICE 40 821 13 00 0 Ω 13 00 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION 0 C 0 0 14.00 01500 ACTI VI TI ES 15.00 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 48,805 0 16, 357, 022 40,821 0 30.00 03100 NURSING FACILITY 0 0 31.00 31.00 32.00 03200 | CF/IID 0 0 0 32.00 0 0 03300 OTHER LONG TERM CARE 0 Ω O 0 33 00 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 0 22, 869 0 40.00 0 41.00 04100 LABORATORY 0 45, 609 0 0 41.00 0000000000 04200 INTRAVENOUS THERAPY 42 00 42 00 Ω 11, 484 0 43.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 862, 414 04400 PHYSI CAL THERAPY 44.00 0 0 0 0 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 826, 795 0 45.00 04600 SPEECH PATHOLOGY 46.00 Ω 422, 382 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 47.00 C 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 48 00 48.00 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 49.00 0 189, 441 49.00 0 50.00 C C Λ 50.00 05100 SUPPORT SURFACES 0 40 0 0 51.00 51.00 05200 OTHER ANCILLARY SERVICE COST CENTERS 52.00 0 0 0 0 0 52.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 O 0 Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 61.00 06200 FQHC 62.00 62.00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0 63.00 0 C 0 Λ 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST C 70.00 07100 AMBULANCE 71.00 71.00 0 0 0 0 0 0 72.00 07200 CORF 0 0 0 0 72.00 73.00 07300 CMHC 0 0 0 0 73.00 07400 OTHER REIMBURSABLE COST 0 74.00 74.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 08200 UTILIZATION REVIEW 82.00 82.00 83.00 08300 H0SPLCE 0 83.00 84.00 08400 OTHER SPECIAL PURPOSE COST CENTERS 0 84.00 89.00 SUBTOTALS (sum of lines 1-84) 48, 805 18, 738, 056 40, 821 0 89.00 0 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 0 09100 BARBER AND BEAUTY SHOP 0 0 0 0 91.00 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 92.00 0 0 0 93 00 09300 NONPALD WORKERS 0 93 00 Ω 0 09400 PATIENTS LAUNDRY 94.00 0 0 0 0 94.00 09500 OTHER NONREIMBURSABLE COST CENTERS 0 0 95.00 95.00 C 98.00 98.00 Cross Foot Adjustments 99 00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, 207, 529 93, 995 324, 995 0 102.00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 4. 252208 0.000000 0.005016 7. 961466 0.000000 103.00

38, 144

0.000000

0. 781559

12, 919

0.000689

18, 522

0.453737

0 104.00

0.000000 105.00

Part II)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

104.00

105.00

CRANBURY CENTER In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:24 am Provi der No.: 315353

| | | | 5/13/2024 9: | 24 am |
|--------|---|----------------|--------------|---------|
| | | OTHER GENERAL | | |
| | | SERVI CE | | |
| | Cost Center Description | ACTI VI TI ES | | |
| | | (TOTAL PATIENT | | |
| | | DAYS) | | |
| | | 15. 00 | | |
| | GENERAL SERVICE COST CENTERS | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | | | 1. 00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | | 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | 3.00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | | | 4. 00 |
| 5. 00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | 5. 00 |
| 6. 00 | 00600 LAUNDRY & LINEN SERVICE | | | 6. 00 |
| 7. 00 | 00700 HOUSEKEEPING | | | 7. 00 |
| 8. 00 | 00800 DI ETARY | | | 8. 00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | | | 9. 00 |
| 10. 00 | 01000 CENTRAL SERVICES & SUPPLY | | | 10.00 |
| | | | | |
| 11. 00 | 01100 PHARMACY | | | 11.00 |
| 12.00 | 01200 MEDI CAL RECORDS & LI BRARY | | | 12.00 |
| 13.00 | 01300 SOCIAL SERVICE | | | 13.00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | | | 14. 00 |
| 15. 00 | 01500 ACTI VI TI ES | 40, 821 | | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 40, 821 | | 30. 00 |
| 31. 00 | 03100 NURSING FACILITY | 0 | | 31. 00 |
| | 03200 I CF/I I D | 0 | | 32. 00 |
| 33.00 | 03300 OTHER LONG TERM CARE | 0 | | 33.00 |
| | ANCILLARY SERVICE COST CENTERS | | | |
| 40.00 | 04000 RADI OLOGY | 0 | | 40. 00 |
| 41.00 | 04100 LABORATORY | 0 | | 41. 00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | O | | 42.00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | O | | 43.00 |
| 44.00 | 04400 PHYSI CAL THERAPY | o | | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | | 45. 00 |
| | 04600 SPEECH PATHOLOGY | 0 | | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | | | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | | | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | | | 50.00 |
| 51. 00 | 05100 SUPPORT SURFACES | | | 51.00 |
| 52. 00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | 0 | | 52.00 |
| 02.00 | OUTPATIENT SERVICE COST CENTERS | 9 | | 32.00 |
| 60.00 | 06000 CLI NI C | 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 |
| | OTHER REIMBURSABLE COST CENTERS | ' | | |
| 70.00 | 07000 HOME HEALTH AGENCY COST | 0 | | 70.00 |
| 71.00 | 07100 AMBULANCE | O | | 71. 00 |
| 72. 00 | 07200 CORF | O | | 72. 00 |
| | 07300 CMHC | 0 | | 73. 00 |
| | 07400 OTHER REIMBURSABLE COST | 0 | | 74. 00 |
| | SPECIAL PURPOSE COST CENTERS | - | | |
| 80. 00 | 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | 80.00 |
| 81. 00 | 08100 I NTEREST EXPENSE | | | 81.00 |
| 82. 00 | 08200 UTI LI ZATI ON REVI EW | | | 82.00 |
| 83. 00 | 08300 H0SPI CE | 0 | | 83.00 |
| 84. 00 | 08400 OTHER SPECIAL PURPOSE COST CENTERS | | | 84. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 40, 821 | | 89. 00 |
| 07.00 | NONREI MBURSABLE COST CENTERS | 10, 02 1 | | - 07.00 |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | | | 91.00 |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | 0 | | 92.00 |
| 93. 00 | 09300 NONPAI D WORKERS | | | 93.00 |
| 94. 00 | 09400 PATIENTS LAUNDRY | | | 94. 00 |
| 95. 00 | 09500 OTHER NONREIMBURSABLE COST CENTERS | | | 95. 00 |
| 98. 00 | Cross Foot Adjustments | | | 98.00 |
| 99. 00 | Negative Cost Centers | | | 99. 00 |
| 102.00 | | 192, 977 | | 102.00 |
| 102.00 | Part I) | 174,711 | | 102.00 |
| 103.00 | 1 1 7 | 4. 727395 | | 103. 00 |
| 103.00 | 1 | 1 | | 103.00 |
| 104.00 | Cost to be allocated (per Wkst. B, Part II) | 7, 328 | | 104.00 |
| 105.00 | | 0. 179515 | | 105. 00 |
| 100.00 | | 0. 179313 | | 100.00 |
| | 1 1117 | 1 | | 1 |
| | | | | |

| Health Financial Systems | CRANBURY CENTER | In Lieu of Form CMS-2540-10 |
|---------------------------------|--|-----------------------------|
| RATIO OF COST TO CHARGES FOR AN | CILLARY AND OUTPATIENT COST CENTERS Provider No.: 315353 | Peri od: Worksheet C |

| RATI 0 | OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | Provi der | No.: 315353 | Peri od: | Worksheet C | |
|--------|--|-----------|---------------|----------------------------------|-----------------------------------|--------|
| | | | | From 01/01/2023 To 12/31/2023 | Doto/Time Dros | aanad. |
| | | | | 10 12/31/2023 | Date/Time Prep 5/13/2024 9: 24 | |
| | Cost Center Description | | Total (from | Total Charges | | T GIII |
| | | | Wkst. B, Pt I | | di vi ded by | |
| | | | col . 18) | | col. 2 | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 40.00 | 04000 RADI OLOGY | | 12, 62 | 22, 869 | 0. 551970 | 40.00 |
| 41.00 | 04100 LABORATORY | | 32, 97 | 45, 609 | 0. 722971 | 41.00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | | 14, 04 | 11, 484 | 1. 222658 | 42.00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | | | 0 0 | 0. 000000 | 43.00 |
| 44.00 | 04400 PHYSI CAL THERAPY | | 552, 08 | 862, 414 | 0. 640164 | 44.00 |
| 45.00 | 04500 OCCUPATI ONAL THERAPY | | 518, 3 | 1 826, 795 | 0. 626892 | 45.00 |
| 46.00 | 04600 SPEECH PATHOLOGY | | 201, 54 | 422, 382 | 0. 477153 | 46.00 |
| 47.00 | 04700 ELECTROCARDI OLOGY | | | 0 | 0.000000 | 47.00 |
| 48.00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 8, 5 | 71 0 | 0.000000 | 48.00 |
| 49.00 | 04900 DRUGS CHARGED TO PATIENTS | | 219, 2 | 189, 441 | 1. 157173 | 49.00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | | | 0 | 0.000000 | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | | 8, 70 | 04 40 | 217. 600000 | 51.00 |
| 52.00 | 05200 OTHER ANCILLARY SERVICE COST CENTERS | | | 0 | 0.000000 | 52.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 60.00 | 06000 CLI NI C | | | 0 | 0.000000 | 60.00 |
| 61.00 | 06100 RURAL HEALTH CLINIC | | | | | 61.00 |
| 62.00 | 06200 FQHC | | | | | 62.00 |
| 63.00 | 06300 OTHER OUTPATIENT SERVICE COST CENTER | | | 0 | 0.000000 | 63.00 |
| 71. 00 | 07100 AMBULANCE | | | 0 | 0.000000 | 71.00 |
| 100.00 | Total | | 1, 568, 0 | 2, 381, 034 | | 100.00 |
| | | | | | | |

| Provider No.: 315353 Period: From 01/01/2023 To 12/31/2024 9: 24 am |
|---|
| Ratio of Cost |
| Ratio of Cost to Charges (Fr. Wkst. C Column 3) 1.00 2.00 3.00 4.00 5.00 |
| Ratio of Cost to Charges (Fr. Wkst. C Column 3) |
| Ratio of Cost to Charges (Fr. Wkst. C Column 3) |
| Ratio of Cost to Charges (Fr. Wkst. C Col umn 3) 1.00 2.00 3.00 4.00 5.00 PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS |
| to Charges (Fr. Wkst. C Col umn 3) No |
| to Charges (Fr. Wkst. C Col umn 3) No |
| to Charges (Fr. Wkst. C Col umn 3) No |
| CFr. Wkst. C Col umn 3 1.00 2.00 3.00 4.00 5.00 |
| Col umn 3) 1.00 2.00 3.00 4.00 5.00 |
| 1.00 2.00 3.00 4.00 5.00 |
| PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST |
| ANCI LLARY SERVI CE COST CENTERS 40. 00 |
| 40. 00 04000 RADI OLOGY 0. 551970 7, 259 0 4, 007 0 40. 41. 00 04100 LABORATORY 0. 722971 4, 207 0 3, 042 0 41. 42. 00 04200 I NTRAVENOUS THERAPY 1. 222658 5, 381 0 6, 579 0 42. 43. 00 04300 OXYGEN (I NHALATI ON) THERAPY 0. 000000 0 0 0 0 0 43. 44. 00 04400 PHYSI CAL THERAPY 0. 640164 290, 740 0 186, 121 0 44. 45. 00 04500 OCCUPATI ONAL THERAPY 0. 626892 340, 300 0 213, 331 0 45. 46. 00 04600 SPEECH PATHOLOGY 0. 477153 144, 275 0 68, 841 0 46. 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 0 0 |
| 41. 00 04100 LABORATORY 0. 722971 4, 207 0 3, 042 0 41. 42. 00 04200 I NTRAVENOUS THERAPY 1. 222658 5, 381 0 6, 579 0 42. 43. 00 04300 OXYGEN (I NHALATION) THERAPY 0. 000000 0 0 0 0 0 0 0 43. 44. 00 04400 PHYSI CAL THERAPY 0. 640164 290, 740 0 186, 121 0 44. 45. 00 04500 OCCUPATI ONAL THERAPY 0. 626892 340, 300 0 213, 331 0 45. 46. 00 04600 SPEECH PATHOLOGY 0. 477153 144, 275 0 68, 841 0 46. 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 0 0 0 0 |
| 42. 00 04200 INTRAVENOUS THERAPY 1. 222658 5, 381 0 6, 579 0 42. 43. 00 04300 OXYGEN (INHALATION) THERAPY 0. 000000 0 0 0 0 0 0 43. 44. 00 04400 PHYSI CAL THERAPY 0. 640164 290, 740 0 186, 121 0 44. 45. 00 04500 OCCUPATI ONAL THERAPY 0. 626892 340, 300 0 213, 331 0 45. 46. 00 04600 SPEECH PATHOLOGY 0. 477153 144, 275 0 68, 841 0 46. 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 0 0 47. |
| 44. 00 04400 PHYSI CAL THERAPY 0. 640164 290, 740 0 186, 121 0 44. 45. 00 04500 OCCUPATI ONAL THERAPY 0. 626892 340, 300 0 213, 331 0 45. 46. 00 04600 SPEECH PATHOLOGY 0. 477153 144, 275 0 68, 841 0 46. 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 0 47. |
| 45. 00 04500 OCCUPATI ONAL THERAPY 0. 626892 340, 300 0 213, 331 0 45. 46. 00 04600 SPEECH PATHOLOGY 0. 477153 144, 275 0 68, 841 0 46. 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 0 47. |
| 46. 00 04600 SPEECH PATHOLOGY 0. 477153 144, 275 0 68, 841 0 46. 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 47. |
| 47. 00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 47. |
| |
| 40 OO OAGOO MEDICAL SUDDILES CHARCED TO DATIENTS O OOOOOO O O O |
| 46. 00 04600 MEDITCAL SUPPLIES CHARGED TO PATTENTS 0. 000000 0 0 0 0 0 46. |
| 49. 00 04900 DRUGS CHARGED TO PATIENTS 1.157173 76,462 0 88,480 0 49. |
| 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 50. |
| 51. 00 05100 SUPPORT SURFACES 217. 600000 0 0 0 51. |
| 52. 00 05200 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 52. |
| OUTPATIENT SERVICE COST CENTERS |
| 60. 00 06000 CLINIC 0. 000000 0 0 0 60. |
| 61. 00 06100 RURAL HEALTH CLINIC 61. |
| 62. 00 06200 FQHC |
| 63. 00 06300 OTHER OUTPATIENT SERVICE COST CENTER 0. 000000 0 0 0 63. |
| 71. 00 07100 AMBULANCE (2) 0. 000000 0 71. |
| 100.00 Total (Sum of lines 40 - 71) 868,624 0 570,401 0 100. |
| (1) For title V and XIX use columns 1, 2, and 4 only. |

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

| | Financial Systems | CRANBURY | CENTER | | In Lie | u of Form CMS-2 | 2540-10 |
|--------|--|-----------------|----------------|-------------------------------|--|-----------------------------|----------------|
| APPORT | IONMENT OF ANCILLARY AND OUTPATIENT COSTS | | | No.: 315353 | Peri od: From 01/01/2023 To 12/31/2023 | Date/Time Pre 5/13/2024 9:2 | pared: 4 am |
| | | | Ti tl | e XVIII | Skilled Nursing Facility | PPS | |
| | Cost Center Description | | | | , | 1. 00 | |
| | PART II - APPORTIONMENT OF VACCINE COST | | | | | 1.00 | |
| 1.00 | Drugs charged to patients - ratio of co | ost to charges | (From Workshee | t C, column 3 | , line 49) | 1. 157173 | 1.00 |
| 2.00 | Program vaccine charges (From your rec | ords, or the PS | &R) | | | 3, 005 | 2.00 |
| 3.00 | Program costs (Line 1 x line 2) (Title | XVIII, PPS pro | viders, transf | er this amoun | t to Worksheet | 3, 477 | 3.00 |
| | E, Part I, line 18) | | | | | | |
| | Cost Center Description | Total Cost | Nursing & | Ratio of | Program Part A | | |
| | | (From Wkst. B, | | | Cost (From | & Allied | |
| | | · · | (From Wkst. B, | | | Heal th Costs | |
| | | 18 | | Costs to Tota | | for Pass | |
| | | | 14) | Costs - Part (Col. 2 / Col | | Through (Col. 3 x Col. 4) | |
| | | | | 1) | | 3 X COI. 4) | |
| | | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - CALCULATION OF PASS THROUGH COSTS | FOR NURSING & | ALLIED HEALTH | • | | | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40.00 | 04000 RADI OLOGY | 12, 623 | C | 0.0000 | | 0 | 40.00 |
| | 04100 LABORATORY | 32, 974 | C | 0.0000 | | | 41.00 |
| | 04200 I NTRAVENOUS THERAPY | 14, 041 | C | 0.0000 | | 0 | 42.00 |
| | 04300 OXYGEN (INHALATION) THERAPY | 0 | C | 0.0000 | | 0 | 43.00 |
| | 04400 PHYSI CAL THERAPY | 552, 086 | C | 0. 00000 | | 0 | 44. 00 |
| | 04500 OCCUPATI ONAL THERAPY | 518, 311 | C | 0. 00000 | | 0 | 45. 00 |
| | 04600 SPEECH PATHOLOGY | 201, 541 | C | 0. 00000 | | 0 | 46. 00 |
| | 04700 ELECTROCARDI OLOGY | 0 | C | 0.0000 | | 0 | 47. 00 |
| | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 8, 571 | C | 0.0000 | | 0 | 48. 00 |
| | 04900 DRUGS CHARGED TO PATIENTS | 219, 216 | C | 0.0000 | | 0 | 49. 00 |
| | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0.0000 | | 0 | 50.00 |
| | 05100 SUPPORT SURFACES | 8, 704 | (| 0.0000 | | 0 | 51.00 |
| | 05200 OTHER ANCILLARY SERVICE COST CENTERS | 1.5(0.0) | | 0.0000 | | 0 | 52.00 |
| 100.00 | Total (Sum of lines 40 - 52) | 1, 568, 067 | C | ין | 570, 401 | 0 | 100. 00 |

| Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 8.00 Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | PPS | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 | | | | |
|--|---|---|--|--|--|--|
| PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS Inpatient days including private room days 2.00 Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program Medically necessary private room days applicable to the Program PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential djustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost (Line 3 times line 16) 1 | 0, 821 131 3, 975 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS 1.00 Inpatient days including private room days 2.00 Private room days 3.00 Inpatient days including private room days applicable to the Program 4.00 Medically necessary private room days applicable to the Program 5.00 Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service charges 7.00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 8.00 Enter private room charges from your records 9.00 Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records 11.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room cost differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 17.00 Program routine service cost (Line 3 times line 16) 17.00 Program routine service cost (Line 3 times line 16) | 0, 821 131 3, 975 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS 1.00 Inpatient days including private room days 2.00 Private room days 3.00 Inpatient days including private room days applicable to the Program 4.00 Medically necessary private room days applicable to the Program 5.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records 9.00 Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 11.00 Average semi-private room cost differential (Line 9 minus line 11) 12.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) 1, 1, 2 | 0, 821 131 3, 975 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| Inpatient days including private room days Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records Average semi-private room charges (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 2 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | 131 3, 975 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Program routine service cost (Line 3 times line 16) | 131 3, 975 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 8.00 Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost (Line 3 times line 15) Program routine service cost (Line 3 times line 16) | 3, 975 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges Comeral inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | 0 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | 9, 540 1, 247 74621 5, 937 27. 00 5, 310 | 5. 00 6. 00 7. 00 8. 00 9. 00 | | | | |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 6.00 General inpatient routine service charges 7.00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6) 8.00 Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records 11.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room cost differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 17.00 PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) | 1, 247 74621 5, 937 27. 00 5, 310 | 6. 00 7. 00 8. 00 9. 00 | | | | |
| General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | 74621 5, 937 27. 00 5, 310 | 7. 00 8. 00 9. 00 | | | | |
| General inpatient routine service cost/charge ratio (Line 5 divided by line 6) Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Provate room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | 74621 5, 937 27. 00 5, 310 | 7. 00 8. 00 9. 00 | | | | |
| Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) | 5, 937 27. 00 5, 310 | 8. 00 9. 00 10. 00 | | | | |
| Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) 10.00 Enter semi-private room charges from your records 11.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12.00 PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) | 27. 00 5, 310 | 9. 00 | | | | |
| 2) 10.00 Enter semi-private room charges from your records 11.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 17.00 Program routine service cost (Line 3 times line 16) 17.10 Program routine service cost (Line 3 times line 16) | 5, 310 | 10. 00 | | | | |
| Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12.00 PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) | | | | | | |
| semi-private room days) 12.00 Average per diem private room charge differential (Line 9 minus line 11) 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12.00 PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) | 99. 00 | 11. 00 | | | | |
| 13.00 Average per diem private room cost differential (Line 7 times line 12) 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12.0 PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) | | | | | | |
| 14.00 Private room cost differential adjustment (Line 2 times line 13) 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) 12.0 PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) 1.1 | 28. 00 | | | | | |
| 15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14) PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) 1.1 | 21. 69 | 13.00 | | | | |
| PROGRAM INPATIENT ROUTINE SERVICE COSTS 16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.00 Program routine service cost (Line 3 times line 16) 17.10 Adjusted general inpatient service cost per diem (Line 15 divided by line 1) 17.10 Program routine service cost (Line 3 times line 16) | 2, 841 | 14.00 | | | | |
| 17.00 Program routine service cost (Line 3 times line 16) | 6, 699 | 15. 00 | | | | |
| | 09. 07 | | | | | |
| | 8, 553 | 17. 00 18. 00 | | | | |
| | | | | | | |
| 2.00 Total program general inpatient routine service cost (Line 17 plus line 18) 1,228,553 1,200 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, 1,895,650 | | | | | | |
| line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) | 5, 650 | | | | | |
| 21.00 Per diem capital related costs (Line 20 divided by line 1) | | | | | | |
| Program capital related cost (Line 3 times line 21) | | | | | | |
| 100 Inpatient routine service cost (Line 19 minus line 22) 100 Aggregate charges to beneficiaries for excess costs (From provider records) | | | | | | |
| 00 Aggregate charges to beneficiaries for excess costs (From provider records) | | | | | | |
| OD Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) 1,043,954 | | | | | | |
| 26.00 Enter the per diem limitation (1) 27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) | - | 26. 00 27. 00 | | | | |
| 28.00 Reimbursable inpatient routine service costs frimitation (Line 3 times the per dreim frimitation frime 26) (1) (Transfer to Worksheet E, Part II, line 4) (See instructions) | | 28. 00 | | | | |
| (1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX | - 1 | | | | | |

| | | 1.00 | |
|----|---|-----------|-------|
| | PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH | | |
| 1. | 00 Total SNF inpatient days | 40, 821 | 1. 00 |
| 2. | 00 Program inpatient days (see instructions) | 3, 975 | 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. 097376 | 4.00 |
| 5. | 00 Program nursing & allied health costs for pass-through. (line 3 times line 4) | 0 | 5. 00 |
| | | | |
| | | | |

| Health Financial Systems | CRANBURY CENT | ER | In Lieu | u of Form CMS-2540-10 |
|---|---------------|-----------------------|---------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII | | Provi der No.: 315353 | | Worksheet E Part I Date/Time Prepared: 5/13/2024 9:24 am |
| | | | | |

| Title XVIII | | | | | 5/13/2024 9: 24 | 4 am | |
|--|--------|--|------------------------|-----------------|-----------------|--------|--|
| PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT | | | Title XVIII | | PPS | | |
| PART A - I IMPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT Inpatient PPS amount (See Instructions) 2,895,288 1.00 2.00 3.00 | | | | | | | |
| PART A - I IMPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT Inpatient PPS amount (See Instructions) 2,895,288 1.00 2.00 Nursing and Allied Health Education Activities (pass through payments) 2,895,288 3.00 2.00 3.00 Subtotal (Sum of lines 1 and 2) 2,895,288 3.00 0.00 0.00 Coinsurance 577,000 5.00 | | | | | 1.00 | | |
| 1.00 | | PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS | EMENT | | | | |
| 2. 00 Nursing and Allied Health Education Activities (pass through payments) 2, 09, 2895, 288 3, 00 4. 00 Primary payor amounts 0 4, 00 5. 00 Coin nsurance 527, 000 5, 00 6. 00 All owable Bad debts (From your records) 104, 135 6, 00 7. 00 All owable Bad debts for dual eligible beneficiaries (See instructions) 88, 434 7, 00 9. 00 Recovery of bad debts - for statistical records only 0 9, 00 11. 00 Subtotal (See instructions) 0 | 1.00 | | | | 2, 895, 288 | 1.00 | |
| 4. 00 Coinsurance Coinsu | 2.00 | Nursing and Allied Health Education Activities (pass through pa | yments) | | 0 | 2. 00 | |
| 5. 00 Coinsurance 5.77,000 5. 00 6.00 All owable bad debts (From your records) 104,135 6. 00 8. 00 Adj usted reimbursable bad debts. (See instructions) 88,434 7. 00 8. 00 Adj usted reimbursable bad debts. (See instructions) 67,688 8. 00 9. 00 Recovery of bad debts - for statistical records only 0 9. 00 11. 00 Subtotal (See instructions) 2,435,976 11. 00 12. 01 Interim payments (See instructions) 2,371,536 12. 00 13. 00 Tentative adj ustment 0 14. 00 14. 00 Demonstration payment adj ustment amount before sequestration 0 14. 50 14. 55 Sequestration payment adj ustment amount after sequestration 0 14. 55 14. 95 Sequestration of monoclaims based amounts (see instructions) 48, 731 14. 75 15. 00 Palance due provider/program (see Instructions) 48, 731 14. 75 16. 00 Protested amounts (Nonal lowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16. 00 17. 00 | 3.00 | Subtotal (Sum of lines 1 and 2) | | | 2, 895, 288 | 3. 00 | |
| 6.00 | 4.00 | Primary payor amounts | | | ol | 4.00 | |
| 7. 00 All lowable Bad debts for dual eligible beneficiaries (See instructions) 88, 434 7. 00 8. 00 Adjusted reimbursable bad debts. (See instructions) 67,688 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, 435, 976 11. 00 13. 00 Interim payments (See instructions) 2, 371, 536 12. 00 13. 00 Tentative adjustment 0 14. 00 14. 00 OTHER adjustment (See instructions) 0 14. 50 14. 55 Demonstration payment adjustment amount before sequestration 0 14. 50 14. 55 Demonstration payment adjustment amount sequestration 0 14. 50 14. 55 Deguestration amount (see instructions) 48. 731 14. 99 15. 00 Balance due provider/program (see Instructions) 48. 731 14. 99 15. 00 Balance due provider/program (see Instructions) 14. 355 15. 00 16. 00 Protested amounts (Nonal lowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16. 00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 3, 477 19. 00 19. | 5.00 | Coinsurance | | | 527, 000 | 5. 00 | |
| 8. 00 | 6.00 | Allowable bad debts (From your records) | | | 104, 135 | 6.00 | |
| 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, 435, 976 11.00 12.00 Interim payments (See instructions) 2, 371, 536 12.00 13.00 Tentative adjustment (See instructions) 0 14.00 14.00 OTHER adjustment (See instructions) 0 14.00 14.55 Demonstration payment adjustment amount before sequestration 0 14.50 14.55 Demonstration payment adjustment amount after sequestration 0 14.55 14.55 Sequestration for non-claims based amounts (see instructions) 14.55 14.75 Sequestration amount (see instructions) 14.55 15.00 Bal ance due provider/program (see Instructions) 14.35 16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 15.00 18.00 Vaccine cost (From Wkst D, Part II, line 3) 3,477 18.00 19.00 Total reasonable costs (Sum of lines 17 and 18) | 7.00 | Allowable Bad debts for dual eligible beneficiaries (See instru | ctions) | | 88, 434 | 7. 00 | |
| 10.00 Utilization review 0 10.00 11. | | Adjusted reimbursable bad debts. (See instructions) | | | 67, 688 | | |
| 11. 00 | 9.00 | Recovery of bad debts - for statistical records only | | | 0 | 9. 00 | |
| 12.00 Interim payments (See instructions) 2,371,536 12.00 13.00 Tentative adjustment (See instructions) 0 13.00 14.00 0 14.50 0 0 0 14.50 0 0 0 14.50 0 0 14.55 0 0 0 0 0 0 0 0 14.55 0 0 0 0 0 0 0 0 0 | 10.00 | Utilization review | | | ol | 10.00 | |
| 13.00 Tentative adjustment 0 13.00 14.00 14.00 0 0 0 0 0 0 0 0 0 | 11. 00 | Subtotal (See instructions) | | | 2, 435, 976 | 11. 00 | |
| 14. 00 OTHER adj ustment (See instructions) 0 14. 00 14. 50 Demonstration payment adjustment amount after sequestration 0 14. 55 Demonstration payment adjustment amount after sequestration 0 14. 55 14. 75 Sequestration for non-claims based amounts (see instructions) 1, 354 14. 75 14. 99 Sequestration amount (see instructions) 48, 731 14. 95 15. 00 Bal ance due provider/program (see Instructions) 14, 355 15. 00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115. 2) 0 14. 00 17. 00 Ancillary services Part B 0 17. 00 18. 00 Vaccine cost (From Wkst D, Part II, line 3) 3, 477 18. 00 19. 00 Total reasonable costs (Sum of lines 17 and 18) 3, 477 18. 00 20. 00 Medicare Part B ancillary charges (See instructions) 3, 005 20. 00 21. 00 Primary payor amounts 0 22. 00 22. 00 Primary payor amounts 0 23. 00 24. 01 Allowable Bad debts (From your records) 0 24. 01 24. 02 Adjusted rei | 12.00 | | | | 2, 371, 536 | 12.00 | |
| 14.50 Demonstration payment adjustment amount before sequestration 0 14.50 | | | | | | | |
| 14.55 Demonstration payment adjustment amount after sequestration 0 14.55 14.75 Sequestration for non-claims based amounts (see instructions) 1,354 14.75 14.99 Sequestration amount (see instructions) 48,731 14.99 15.00 Bal ance due provider/program (see Instructions) 14,355 15.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16.00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 17.00 18.00 Vaccine cost (From Wkst D, Part II, line 3) 3,477 18.00 19.00 Total reasonable costs (Sum of lines 17 and 18) 3,477 18.00 20.00 Medicare Part B ancillary charges (See instructions) 3,005 20.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 3,005 21.00 22.00 Primary payor amounts 0 22.00 23.00 Coi insurance and deductibles 0 23.00 24.01 Allowable bad debts (From your records) 0 24.00 24.02 Adjusted reimbursable bad debts (see instructions) 0 24.02 <t< td=""><td></td><td colspan="6"></td></t<> | | | | | | | |
| 14. 75 Sequestration for non-claims based amounts (see instructions) 1, 354 14. 75 14. 99 Sequestration amount (see instructions) 48, 731 14. 99 15. 00 Bal ance due provider/program (see Instructions) 14, 355 15. 00 16. 00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16. 00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 0 17. 00 18. 00 Vaccine cost (From Wkst D, Part II, line 3) 3, 477 18. 00 19. 00 Total reasonable costs (Sum of lines 17 and 18) 3, 477 18. 00 20. 00 Medicare Part B ancillary charges (See instructions) 3, 005 20. 00 21. 00 Cost of covered services (Lesser of line 19 or line 20) 3, 005 21. 00 22. 00 Primary payor amounts 0 22. 00 23. 00 Coinsurance and deductibles 0 23. 00 24. 01 Allowable bad debts (From your records) 0 24. 01 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 02 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 a | | | | | | | |
| 14. 99 Sequestration amount (see instructions) 14. 99 15. 00 Bal ance due provider/program (see Instructions) 14. 355 15. 00 16. 00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115. 2) 0 16. 00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY | | | | | | | |
| Balance due provider/program (see Instructions) 14, 355 15.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 17.00 Ancillary services Part B 0 17.00 18.00 Vaccine cost (From Wkst D, Part II, line 3) 3,477 18.00 19.00 Total reasonable costs (Sum of lines 17 and 18) 3,477 19.00 20.00 Medicare Part B ancillary charges (See instructions) 3,005 20.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 3,005 21.00 22.00 Primary payor amounts 0 22.00 23.00 Coinsurance and deductibles 0 23.00 24.01 Allowable bad debts (From your records) 0 24.00 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 0 24.01 24.02 Adjusted reimbursable bad debts (see instructions) 0 24.02 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 10 27.00 Tentative adjustment 0 27.00 | | | | | | | |
| 16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16.00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 17.00 Ancillary services Part B 0 17.00 18.00 Vaccine cost (From Wkst D, Part II, line 3) 3, 477 18.00 19.00 Total reasonable costs (Sum of lines 17 and 18) 3, 477 19.00 Medicare Part B ancillary charges (See instructions) 3, 477 19.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 3, 005 20.00 Primary payor amounts 0 22.00 Primary payor amounts 0 22.00 Coinsurance and deductibles 0 24.00 Allowable bad debts (From your records) 0 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 0 24.01 Adjusted reimbursable bad debts (see instructions) 0 24.01 Adjusted reimbursable bad debts (see instructions) 0 24.02 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 1 Tentative adjustment 0 27.00 Tentative adjustment | | | | | | | |
| PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY | | | | | | | |
| 17. 00 Ancillary services Part B 0 17. 00 18. 00 Vaccine cost (From Wkst D, Part II, line 3) 3, 477 18. 00 19. 00 Total reasonable costs (Sum of lines 17 and 18) 3, 477 19. 00 20. 00 Medicare Part B ancillary charges (See instructions) 3, 005 20. 00 21. 00 Cost of covered services (Lesser of line 19 or line 20) 3, 005 21. 00 22. 00 Primary payor amounts 0 22. 00 23. 00 Coinsurance and deductibles 0 23. 00 24. 01 Allowable bad debts (From your records) 0 24. 00 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 01 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3, 005 25. 00 26. 00 Interim payments (See instructions) 2, 059 26. 00 27. 00 Tentative adjustment 0 27. 00 | 16. 00 | | | | 0 | 16. 00 | |
| 18.00 Vaccine cost (From Wkst D, Part II, line 3) 3, 477 18.00 19.00 Total reasonable costs (Sum of lines 17 and 18) 3, 477 19.00 20.00 Medicare Part B ancillary charges (See instructions) 3,005 20.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 3,005 21.00 22.00 Primary payor amounts 0 22.00 23.00 Coi nsurance 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 instructions) 0 24.01 24.02 Adjusted reimbursable bad debts (see instructions) 0 24.02 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3,005 25.00 26.00 Interim payments (See instructions) 2,059 26.00 27.00 Tentative adjustment 0 27.00 | 47.00 | | OF COST OR CHARGES - I | TILE XVIII ONLY | | 47.00 | |
| 19. 00 Total reasonable costs (Sum of lines 17 and 18) 3, 477 19. 00 20. 00 Medicare Part B ancillary charges (See instructions) 3, 005 20. 00 21. 00 Cost of covered services (Lesser of line 19 or line 20) 3, 005 21. 00 22. 00 Primary payor amounts 0 22. 00 23. 00 Coi nsurance 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 instructions) 0 24. 00 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 02 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3, 005 25. 00 26. 00 Interim payments (See instructions) 2, 059 26. 00 27. 00 Tentative adjustment 0 27. 00 | | | | | | | |
| 20.00 Medicare Part B ancillary charges (See instructions) 3,005 20.00 21.00 Cost of covered services (Lesser of line 19 or line 20) 3,005 21.00 22.00 Primary payor amounts 0 22.00 23.00 Coi nsurance 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 instructions) 0 24.01 24.02 Adjusted reimbursable bad debts (see instructions) 0 24.02 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3,005 25.00 26.00 Interim payments (See instructions) 2,059 26.00 27.00 Tentative adjustment 0 27.00 | | | | | | | |
| 21. 00 Cost of covered services (Lesser of line 19 or line 20) 3,005 21. 00 22. 00 Primary payor amounts 0 22. 00 23. 00 Coinsurance and deductibles 0 23. 00 24. 00 Allowable bad debts (From your records) 0 24. 00 24. 01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 0 24. 01 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 02 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3,005 25. 00 26. 00 Interim payments (See instructions) 2,059 26. 00 27. 00 Tentative adjustment 0 27. 00 | | | | | | | |
| 22. 00 Pri mary payor amounts 0 22. 00 23. 00 Coi nsurance and deducti blies 0 23. 00 24. 00 Al I owable bad debts (From your records) 0 24. 00 24. 01 All lowable Bad debts for dual eligible beneficiaries (see instructions) 0 24. 01 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 02 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3, 005 25. 00 26. 00 Interim payments (See instructions) 2, 059 26. 00 27. 00 Tentative adjustment 0 27. 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 instructions) 0 24. 01 24. 02 Adjusted reimbursable bad debts (see instructions) 0 24. 02 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3, 005 25. 00 26. 00 Interim payments (See instructions) 2, 059 26. 00 27. 00 Tentative adjustment 0 27. 00 | | , | | | | | |
| 24.00 Allowable bad debts (From your records) 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 0 24.00 24.01 25.00 27.00 | | 1 3.3 | | | | | |
| 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.02 Adjusted reimbursable bad debts (see instructions) 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 26.00 Interim payments (See instructions) 27.00 Tentative adjustment 0 24.01 3,005 25.00 2,059 26.00 27.00 | | | | | | | |
| 24. 02 Adj usted reimbursable bad debts (see instructions) 0 24. 02 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3, 005 25. 00 26. 00 Interim payments (See instructions) 2, 059 26. 00 27. 00 Tentative adj ustment 0 27. 00 | | , , | - 1 | | | | |
| 25. 00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 3,005 25. 00 26. 00 Interim payments (See instructions) 2,059 26. 00 27. 00 Tentative adjustment 0 27. 00 | | | | | | | |
| 26.00 Interim payments (See instructions) 2,059 26.00 27.00 Tentative adjustment 0 27.00 | | , , | | | | | |
| 27. 00 Tentati ve adjustment 0 27. 00 | | | | | | | |
| | | | | | | | |
| ==: -= | | 1 | | | | | |
| 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) 60 28.99 | | | | | | | |
| 29.00 Balance due provider/program (see instructions) 886 29.00 | 29. 00 | | | | 886 | 29. 00 | |
| 30.00 Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2 | 30. 00 | Protested amounts (Nonallowable cost report items) in accordance | e with CMS Pub.15-2, s | ection 115.2 | o l | 30. 00 | |

| Health Financial Systems | | | | | CRAN | BURY CENT | ER | | | In Lie | u of Form C | MS-2540-10 |
|------------------------------|------------|-------|-------|-------|------|-----------|-----------|---------------|---------|---------------------------------|-------------|------------|
| CALCULATION OF REIMBURSEMENT | SETTLEMENT | TITLE | V and | TITLE | XIX | ONLY | Provi der | r No.: 315353 | | od: 01/01/2023 12/31/2023 | | Prepared: |
| | | | | | | | Ti | tle XIX | Ski I I | ed Nursina | PF | PS |

| | | | Facility | | |
|--------|---|--------------------------|-----------------|-----------|--------|
| | | | | | |
| | PONUMENTAL ON OF MET COOT OF COMPTED OFFICE OF | | | 1. 00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | |
| 1.00 | Inpatient ancillary services (see Instructions) | -> | | 0 | |
| 2.00 | Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line | 5) | | 0 | 2.00 |
| 3.00 | Outpati ent servi ces | | | 0 | 3. 00 |
| 4.00 | Inpatient routine services (see instructions) | | | 0 | 4. 00 |
| 5. 00 | Utilization reviewphysicians' compensation (from provider reco | rds) | | 0 | 5. 00 |
| 6.00 | Cost of covered services (Sum of lines 1 - 5) | | | 0 | 6. 00 |
| 7. 00 | Differential in charges between semiprivate accommodations and I | ess than semiprivate a | ccommodati ons | 0 | 7. 00 |
| 8.00 | SUBTOTAL (Line 6 minus line 7) | | | 0 | 8. 00 |
| 9.00 | Pri mary payor amounts | | | 0 | |
| 10.00 | Total Reasonable Cost (Line 8 minus line 9) | | | 0 | 10.00 |
| | REASONABLE CHARGES | | | | |
| 11. 00 | Inpatient ancillary service charges | | | - | 11. 00 |
| 12. 00 | Outpatient service charges | | | 0 | 12.00 |
| 13. 00 | , , | | | 0 | |
| 14. 00 | Differential in charges between semiprivate accommodations and I | ess than semiprivate a | ccommodations | 0 | |
| 15. 00 | Total reasonable charges | | | 0 | 15. 00 |
| | CUSTOMARY CHARGES | | | | |
| 16. 00 | Aggregate amount actually collected from patients liable for pay | | | 0 | 16.00 |
| 17. 00 | Amounts that would have been realized from patients liable for p | ayment for services on | a charge basis | 0 | 17.00 |
| | had such payment been made in accordance with 42 CFR 413.13(e) | | | | |
| 18. 00 | Ratio of line 16 to line 17 (not to exceed 1.000000) | | | 0. 000000 | |
| 19. 00 | Total customary charges (see instructions) | | | 0 | 19. 00 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 20.00 | Cost of covered services (see Instructions) | | | 0 | 20.00 |
| 21. 00 | Deducti bl es | | | 0 | 21.00 |
| 22. 00 | Subtotal (Line 20 minus line 21) | | | 0 | 22. 00 |
| 23. 00 | Coinsurance | | | 0 | 23. 00 |
| 24.00 | Subtotal (Line 22 minus line 23) | | | 0 | 24.00 |
| 25. 00 | Allowable bad debts (from your records) | | | 0 | 25. 00 |
| 26. 00 | Subtotal (sum of lines 24 and 25) | | | 0 | 26. 00 |
| 27. 00 | Unrefunded charges to beneficiaries for excess costs erroneously | collected based on con | rection of | 0 | 27. 00 |
| 28. 00 | cost limit Recovery of excess depreciation resulting from provider terminat | ion or a decrease in p | rogram | 0 | 28. 00 |
| | utilization | | -9 | | |
| 29. 00 | Other Adjustments (see instructions) Specify | | | 0 | 29. 00 |
| 30. 00 | Amounts applicable to prior cost reporting periods resulting fro if minus, enter amount in parentheses) | m disposition of depre | ciable assets (| 0 | 30. 00 |
| 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 | , and 20) | | 0 | |
| 33. 00 | Balance due provider/program (Line 31 minus line 32) (indicate o | vernavments in narenth | 292) (292 | 0 | 33. 00 |
| 33.00 | Instructions) | voi payments in parentin | 303/ (366 | U | 33.00 |
| | 111311 4011 5113) | | ı | | 1 |

Provi der No.: 315353 Peri od: Worksheet E-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/13/2024 9:24 am Title XVIII Skilled Nursing PPS

| Inpatient Part A | | | | | Facility | | |
|--|-------|--|--------------|---|------------|--------|-------|
| 1.00 Total Interim payments paid to provider 2.00 3.00 4.00 | | | I npati en | t Part A | | t B | |
| Total interim payments paid to provider 2, 319, 557 2, 059 1.00 2.00 | | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| InterIm payments payable on Individual bills, either submitted or to be submitted for the cost reporting period. If none, enter zero | | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, enter zero | 1.00 | Total interim payments paid to provider | | 2, 319, 557 | | 2, 059 | 1.00 |
| Services rendered in the cost reporting period. If none, enter zero 1.5 to separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NDNE" or enter a zero. (1) | 2.00 | Interim payments payable on individual bills, either | | 0 | | 0 | 2.00 |
| Online Contractor Online | | | | | | | |
| List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | services rendered in the cost reporting period. If none, | | | | | |
| amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | | | |
| For the cost reporting period. Also show date of each | 3.00 | | | | | | 3. 00 |
| payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | | | |
| Program to Provider | | | | | | | |
| ADJUSTMENTS TO PROVIDER | | | | | | | |
| 3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.04 3.05 | 0.04 | | 05 (07 (0000 | F4 070 | | | 0.01 |
| 3.04 3.04 3.05 3.04 3.06 3.04 3.06 3.04 3.05 3.50 3.50 3.51 3.51 3.52 3.53 3.54 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wiskt. E. Part I line 12 for Part A. and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROGRAM 5.02 5.03 Provider to Program 5.00 Determined net settlement amount (balance due) based on the cost report. (1) PROGRAM TO PROVIDER 14.355 8.66 6.00 Determined net settlement amount (balance due) based on the cost report. (1) PROGRAM TO PROVIDER 1.00 Contractor Name Number 1.00 2.00 Rame of Contractor Review. Also on Contractor Name R | | ADJUSTMENTS TO PROVIDER | 05/26/2023 | 51, 9/9 | | | |
| 3. 04 0 0 0 3. 04 3. 05 | | | | 0 | | | |
| 3.05 Provider to Program 0 | | | | - | | | |
| Provider to Program ADJUSTMENTS TO PROGRAM 0 | | | | | | | |
| 3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 551 3. 51 3. 52 0 0 0 0 3. 551 3. 52 3. 53 0 0 0 0 3. 552 3. 53 3. 54 0 0 0 0 3. 533 3. 54 3. 99 -3. 98) | 3.05 | Dravi dan ta Dragnam | | U | | U | 3. 05 |
| 3.51 3.52 3.53 3.54 0 0 0 3.552 3.53 3.54 0 0 0 3.553 3.54 3.59 3. | 2 50 | | | | | | 2 50 |
| 3.52 3.53 3.54 3.59 3.53 3.54 3.99 3.53 3.54 3.99 3.59 | | ADJUSTIVIENTS TO FROGRAW | | · · | | | |
| 3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.59 | | | | - 1 | | | |
| 3.54 3.99 Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 51,979 0 3.54 3.99 -3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,371.536 2,059 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,371.536 2,059 4.00 Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR | | | | 0 | | | |
| Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 51,979 0 3.99 -3.98 | | | | 0 | | | |
| - 3.98) Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 Provider to Program 5.50 TENTATIVE TO PROGRAM 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 FORGRAM TO PROVIDER 7.00 Total Medicare program liability (see instructions) 8.00 Name of Contractor 8.00 Name of Contractor 8.00 Name of Contractor 8.00 Name of Contractor 8.00 Total Medicare program liability (see instructions) 8.00 Name of Contractor Number 1.00 2.00 8.00 8.00 8.00 8.00 | | Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 | | 51 979 | | | |
| A.00 | 0. 77 | | | 01, 777 | | Ĭ | 0. 77 |
| Ciransfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B) TO BE COMPLETED BY CONTRACTOR | 4.00 | | | 2, 371, 536 | | 2.059 | 4.00 |
| TO BE COMPLETED BY CONTRACTOR | | | | _, _, , , , , , , , , , , , , , , , , , | | _, | |
| 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | 26 for Part B) | | | | | |
| desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | TO BE COMPLETED BY CONTRACTOR | | | | | |
| Write "NONE" or enter a zero. (1) Program to Provider | 5.00 | | | | | | 5.00 |
| Program to Provider | | | | | | | |
| TENTATIVE TO PROVIDER | | | | | | | |
| Description | | | | | | | |
| Description | | TENTATI VE TO PROVI DER | | | | l . | |
| Provider to Program | | | | | | | |
| TENTATI VE TO PROGRAM | 5.03 | Durani dan ta Durangan | | 0 | | 0 | 5. 03 |
| 5.51 0 0 5.51 | F F0 | | | | | | F F0 |
| Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 | | TENTATIVE TO PROGRAM | | · · | | | |
| Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 0 5.99 - 5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 14,355 886 6.01 6.02 PROVIDER TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 2,385,891 2,945 7.00 7.00 2.00 8.00 Name of Contractor 8.00 Name of Contractor 8.00 | | | | - | | | |
| - 5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) - 5.98) - 6.00 - 6.00 - 7.00 Total Medicare program liability (see instructions) - 6.01 - 7.00 Total Medicare program liability (see instructions) - 7.00 Total Medicare program liability (see instructions) - 8.00 Name of Contractor - 7.00 Name of Contractor - 8.00 | | Subtatal (Sum of Lines E O1 | | 0 | | | |
| 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 Name of Contractor | 5. 99 | | | U | | ا | 5. 99 |
| the cost report. (1) PROGRAM TO PROVIDER 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor Name Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 | 6 00 | | | | | | 6.00 |
| 6.01 PROGRAM TO PROVIDER (6.02 PROVIDER TO PROGRAM (7.00 PROGRAM (7.00 PROVIDER TO PROGRAM (7.00 PROGRAM (7.00 PROGRAM (7.00 PROVIDER TO PROGRAM (7.00 PROGRAM | 0.00 | ` ' | | | | | 0.00 |
| 6.02 PROVIDER TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 Name of Contractor | 6, 01 | | | 14, 355 | | 886 | 6, 01 |
| 7.00 Total Medicare program liability (see instructions) 2,385,891 2,945 7.00 Contractor Name Contractor Number Number 1.00 2.00 8.00 Name of Contractor 8.00 | | | | | | | |
| Contractor Name Contractor Number 1.00 2.00 8.00 Name of Contractor 8.00 | | 1 | | 2, 385, 891 | | | |
| 1.00 2.00 8.00 Name of Contractor 8.00 | | | | | or Name | | |
| 8.00 Name of Contractor 8.00 | | | | | | | |
| ļ ļ | | | | 1. | 00 | 2. 00 | |
| | | ! | | | | | 8. 00 |

⁽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)

Provider No.: 315353 Period: From 01/01/20

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/13/2024 9:24 am |

| oni y) | | Cararal Fund | C | | 5/13/2024 9: 2 | 4 am |
|--------------------------------------|---|--------------------------|---------------------------------------|----------------|----------------|----------|
| | | General Fund | Specific E Purpose Fund | Endowment Fund | Plant Fund | |
| | Accets | 1. 00 | 2. 00 | 3. 00 | 4. 00 | |
| | Assets CURRENT ASSETS | | | | | 1 |
| 1. 00 | Cash on hand and in banks | 6, 315 | 0 | 0 | 0 | 1.0 |
| 2. 00 | Temporary investments | 0 | 0 | 0 | 0 | |
| 3. 00 | Notes recei vable | 0 | 0 | 0 | 0 | 1 |
| 4.00 | Accounts receivable | 2, 747, 488 | 0 | 0 | 0 | |
| 5. 00 6. 00 | Other receivables Less: allowances for uncollectible notes and accounts | 12, 782 -508, 835 | 0 | 0 | 0 | |
| 3. 00 | recei vabl e | -300, 633 | U | ٥ | U | 0.0 |
| 7. 00 | Inventory | 89, 619 | 0 | o | 0 | 7.0 |
| 3. 00 | Prepai d expenses | 251, 932 | 0 | 0 | 0 | 8.0 |
| 9. 00 | Other current assets | 1, 017 | 0 | o | 0 | 9.0 |
| 10. 00 | Due from other funds | 0 | 0 | 0 | 0 | |
| 11. 00 | TOTAL CURRENT ASSETS (Sum of lines 1 - 10) | 2, 600, 318 | 0 | 0 | 0 | 11.0 |
| 10.00 | FI XED ASSETS | | | ما | | 112.0 |
| 12. 00 13. 00 | Land improvements | 105, 797 | 0 | 0 | 0 | |
| 14. 00 | Less: Accumulated depreciation | -32, 077 | 0 | 0 | 0 | |
| 15. 00 | Buildings | -32,077 | 0 | 0 | 0 | 1 |
| 16. 00 | Less Accumulated depreciation | 0 | 0 | 0 | 0 | |
| 17. 00 | Leasehold improvements | 280, 106 | 0 | o | 0 | |
| 18. 00 | Less: Accumulated Amortization | -42, 596 | 0 | o | 0 | |
| 19. 00 | Fi xed equipment | 36, 623 | 0 | O | 0 | |
| 20. 00 | Less: Accumulated depreciation | -9, 704 | 0 | 0 | 0 | 20.0 |
| 21. 00 | Automobiles and trucks | 0 | 0 | 0 | 0 | 21.0 |
| 22. 00 | Less: Accumulated depreciation | 0 | 0 | 0 | 0 | 22.0 |
| 23. 00 | Maj or movable equipment | 151, 347 | 0 | 0 | 0 | 23.0 |
| 24. 00 | Less: Accumulated depreciation | -73, 183 | 0 | 0 | 0 | 24.0 |
| 25. 00 | Mi nor equi pment - Depreci abl e | 0 | 0 | 0 | 0 | |
| 26. 00 | Mi nor equipment nondepreciable | 0 | 0 | 0 | 0 | 1 |
| 27. 00 | Other fixed assets | 0 | 0 | 0 | 0 | |
| 28. 00 | TOTAL FIXED ASSETS (Sum of lines 12 - 27) | 416, 313 | 0 | 0 | 0 | 28.0 |
| | OTHER ASSETS | 1 | | | | |
| 29. 00 | Investments | 0 | 0 | 0 | 0 | • |
| 30.00 | Deposits on Leases | 1 2/7 //4 | 0 | 0 | 0 | |
| 31.00 | Due from owners/officers | 1, 267, 664 | 0 | U O | 0 | |
| 32. 00 33. 00 | Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32) | 1, 267, 664 | 0 | 0 | 0 | |
| 34. 00 | TOTAL ASSETS (Sum of Lines 11, 28, and 33) | 4, 284, 295 | 0 | 0 | 0 | |
| 71.00 | Liabilities and Fund Balances | 1, 201, 270 | <u> </u> | ٥ | 0 | 1 0 1. 0 |
| | CURRENT LI ABI LI TI ES | | | | | 1 |
| 35. 00 | Accounts payable | 1, 101, 686 | 0 | 0 | 0 | 35. C |
| 36. 00 | Salaries, wages, and fees payable | 0 | 0 | 0 | 0 | 36.0 |
| 37. 00 | Payroll taxes payable | 0 | 0 | 0 | 0 | 37. C |
| 38. 00 | Notes & Loans payable (Short term) | 0 | 0 | 0 | 0 | |
| 39. 00 | Deferred income | 0 | 0 | 0 | 0 | |
| 40. 00 | Accel erated payments | 0 | | | | 40. C |
| 41. 00 | Due to other funds | 269 | l | 0 | 0 | |
| 42. 00 | Other current liabilities | 3, 690, 532 | | 0 | 0 | |
| 43. 00 | TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) | 4, 792, 487 | 0 | 0 | 0 | 43.0 |
| 44.00 | LONG TERM LIABILITIES | | | ام | | 144.6 |
| 44.00 | Mortgage payable | 0 | 0 | 0 | 0 | 1 |
| 45. 00 | Notes payable | 0 | 0 | 0 | 0 | 1 |
| 46. 00 47. 00 | Unsecured Loans Loans from owners: | 0 | 0 | 0 | 0 | |
| 48. 00 | Other long term liabilities | 0 | 0 | 0 | 0 | |
| 49. 00 | API C DI STRI BUTI ONS; R/E EARNI NGS | -86, 044 | 0 | 0 | 0 | |
| 50.00 | TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 | -86, 044 | | 0 | 0 | |
| 51. 00 | TOTAL LIABILITIES (Sum of lines 43 and 50) | 4, 706, 443 | | o | 0 | |
| | CAPITAL ACCOUNTS | | · · · · · · · · · · · · · · · · · · · | - 1 | | |
| 52. 00 | General fund balance | -422, 148 | | | | 52. (|
| 3. 00 | Specific purpose fund | | 0 | | | 53.0 |
| 4.00 | Donor created - endowment fund balance - restricted | | | 0 | | 54.0 |
| | Donor created - endowment fund balance - unrestricted | | | 0 | | 55. 0 |
| 55. 00 | | | | 0 | | 56.0 |
| 6. 00 | Governing body created - endowment fund balance | | | | 0 | 57. (|
| 56. 00 57. 00 | Plant fund balance - invested in plant | | | I | | |
| 56. 00 57. 00 | Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, | | | | 0 | 58.0 |
| 55. 00 56. 00 57. 00 58. 00 | Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion | 400 4 1- | _ | _ | | |
| 56. 00 57. 00 | Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, | -422, 148 4, 284, 295 | 1 | 0 | 0 | 59. (|

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES CRANBURY CENTER

Provi der No.: 315353

| | | | | | То | 12/31/2023 | Date/Time Prep 5/13/2024 9:24 | |
|----------------------------|---|----------------|----------------|----------|------|------------|----------------------------------|----------------------------|
| | | General | Fund | Speci al | Purp | ose Fund | Endowment Fund | ı cılıı |
| | | | | · | | | | |
| | | 1.00 | 2.00 | 2.00 | | 4.00 | F 00 | |
| 1. 00 | Fund balances at beginning of period | 1.00 | 2.00 | 3. 00 | | 4. 00 | 5. 00 | 1. 00 |
| 2. 00 | Net income (loss) (from Wkst. G-3, line 31) | | -422, 148 | | | C | | 2. 00 |
| 3.00 | Total (sum of line 1 and line 2) | | -422, 148 | | | (| , | 3. 00 |
| 4.00 | Additions (credit adjustments) | | 122, 110 | | | | | 4. 00 |
| 5. 00 | | o | | | 0 | | 0 | 5. 00 |
| 6.00 | | 0 | | | 0 | | 0 | 6. 00 |
| 7.00 | | 0 | | | 0 | | 0 | 7.00 |
| 8.00 | | 0 | | | 0 | | 0 | 8.00 |
| 9.00 | | 0 | | | 0 | | 0 | 9. 00 |
| 10.00 | Total additions (sum of line 5 - 9) | | 0 | | | C |) | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | | -422, 148 | | | C |) | 11. 00 |
| 12. 00 | Deductions (debit adjustments) | | | | | | | 12.00 |
| 13. 00 | | 0 | | | 0 | | 0 | 13. 00 |
| 14. 00 | | 0 | | | 0 | | 0 | 14. 00 |
| 15.00 | | 0 | | | 0 | | 0 | 15. 00 |
| 16.00 | | 0 | | | 0 | | 0 | 16.00 |
| 17. 00 | Total deductions (sum of lines 12 17) | 0 | 0 | | U | | 0 | 17. 00 |
| 18. 00 19. 00 | Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance | | -422, 148 | | | C | 1 | 18. 00 19. 00 |
| 19.00 | sheet (Line 11 - line 18) | | -422, 140 | | | C | 1 | 19.00 |
| | Tender (Erne 11 11110 10) | Endowment Fund | PI ant | Fund | | | | |
| | | | | | | | | |
| | | 6.00 | 7. 00 | 8. 00 | | | | |
| 1.00 | Fund balances at beginning of period | 0 | | | 0 | | | 1. 00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 31) | | | | | | | 2. 00 |
| 3.00 | Total (sum of line 1 and line 2) | 0 | | | 0 | | | 3. 00 |
| 4.00 | Additions (credit adjustments) | | 0 | | | | | 4. 00 |
| 5. 00 6. 00 | | | 0 | | | | | 5. 00 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 | J | | 0 | | | 10. 00 |
| 11. 00 | Subtotal (line 3 plus line 10) | l ol | | | 0 | | | 11. 00 |
| 12.00 | Deductions (debit adjustments) | | | | | | | 12.00 |
| 13.00 | | | 0 | | | | | 13.00 |
| 14.00 | | | 0 | | | | | 14.00 |
| | | 1 | 0 | | | | | 15.00 |
| 15. 00 | | 1 | O ₁ | l | | | | |
| 16. 00 | | | 0 | | | | | 16. 00 |
| 16. 00 17. 00 | | | 0 | | | | | 16. 00 17. 00 |
| 16. 00 17. 00 18. 00 | Total deductions (sum of lines 13 - 17) | 0 | 0 | | 0 | | | 16. 00 17. 00 18. 00 |
| 16. 00 17. 00 | Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18) | 0 | 0 | | 0 | | | 16. 00 17. 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-2 From 01/01/2023 Parts I-II |

| | JENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provi der | No.: 315353 | Period: From 01/01/2023 To 12/31/2023 | | pared: |
|--------|---|-----------|-------------|---|--------------|--------|
| | Cost Center Description | | Inpatient | Outpati ent | Total | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | | | |
| | General Inpatient Routine Care Services | | | | | |
| 1.00 | SKILLED NURSING FACILITY | | 16, 357, 02 | 2 | 16, 357, 022 | 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, 357, 02 | 2 | 16, 357, 022 | 5. 00 |
| | All Other Care Services | | | | | 1 |
| 6.00 | ANCI LLARY SERVI CES | | 2, 489, 30 | 0 | 2, 489, 307 | 6. 00 |
| 7.00 | CLINIC | | | 0 | | 7. 00 |
| 8.00 | HOME HEALTH AGENCY COST | | | 0 | 0 | 8. 00 |
| 9.00 | AMBULANCE | | | 0 | 0 | 9. 00 |
| 10.00 | RURAL HEALTH CLINIC | | | 0 | 0 | 10.00 |
| 10. 10 | FQHC | | | 0 | 0 | 10. 10 |
| 11. 00 | CMHC | | | 0 | 0 | 11. 00 |
| | CORF | | | 0 | 0 | 11. 10 |
| 12.00 | HOSPI CE | | | 0 0 | 0 | 12.00 |
| | OTHER (SPECIFY) | | | 0 0 | o o | 13. 00 |
| 14. 00 | Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 | to | 18, 846, 32 | 9 0 | 18, 846, 329 | 1 |
| | Worksheet G-3, Line 1) Cost Center Description | | | | | |
| | Cost Center Description | | | 1. 00 | 2. 00 | |
| | PART II - OPERATING EXPENSES | | | 1.00 | 2.00 | |
| 1.00 | Operating Expenses (Per Worksheet A, Col. 3, Line 100) | | | | 14, 735, 654 | 1.00 |
| 2. 00 | Add (Specify) | | | 0 | | 2. 00 |
| 3. 00 | Add (Specify) | | | 0 | | 3. 00 |
| 4. 00 | | | | | | 4.00 |
| 5. 00 | | | | 0 | | 5. 00 |
| 6. 00 | | | | 0 | | 6. 00 |
| 7. 00 | | | | 0 | | 7. 00 |
| 8. 00 | Total Additions (Sum of Lines 2 7) | | | 0 | 0 | 1 |
| 9. 00 | Total Additions (Sum of lines 2 - 7) | | | 0 | | 9.00 |
| 10.00 | Deduct (Specify) | | | 0 | | 10.00 |
| | | | | 0 | | 11. 00 |
| 11. 00 | | | | 0 | | 12.00 |
| 12.00 | | | | | | 13.00 |
| 13.00 | Total Dadustians (Cum of Lines 0 12) | | | 0 | 1 | |
| 14. 00 | Total Deductions (Sum of lines 9 - 13) | | | | 0 | |
| 15.00 | Total Operating Expenses (Sum of lines 1 and 8, minus line 14) | | | | 14, 735, 654 | 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 | Peri od: From 01/01/2023 | Worksheet G-3 | |
| | | | Date/Time Prepared: | |

| | | From 01/01/2023 | Worksheet G-3 Date/Time Prepared: 5/13/2024 9:24 am | | |
|--------|---|-----------------|---|-----------------------------|--------|
| | | | | 1 00 | |
| 1. 00 | Total nations revenues (From What C.2. Part I col. 2 line 1 | 4) | | 1. 00 18, 846, 329 | 1. 00 |
| 2. 00 | Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14) | | | | 2. 00 |
| 3. 00 | Less: contractual allowances and discounts on patients accounts | | | 4, 571, 621 14, 274, 708 | 3. 00 |
| 4. 00 | Net patient revenues (Line 1 minus line 2) | | | 14, 735, 654 | |
| 5.00 | Less: total operating expenses (From Worksheet G-2, Part II, line 15) | | | -460, 946 | |
| 5.00 | Net income from service to patients (Line 3 minus 4) Other income: | | | | 5.00 |
| 6. 00 | Contributions, donations, bequests, etc | | | 0 | 6. 00 |
| 7. 00 | Income from investments | | | 0 | 7. 00 |
| 8. 00 | Revenues from communications (Telephone and Internet service) | | | 0 | |
| 9. 00 | Revenue from television and radio service | | | 0 | |
| 10.00 | Purchase di scounts | | | 0 | 10. 00 |
| 11. 00 | Rebates and refunds of expenses | | | 0 | 11. 00 |
| 12. 00 | Parking Lot receipts | | | 0 | 12. 00 |
| 13. 00 | Revenue from Laundry and Linen service | | | 0 | 13. 00 |
| 14.00 | Revenue from meals sold to employees and guests | | | 0 | 14. 00 |
| 15.00 | Revenue from rental of living quarters | | | 0 | 15. 00 |
| 16.00 | Revenue from sale of medical and surgical supplies to other than | n patients | | 0 | 16. 00 |
| 17.00 | Revenue from sale of drugs to other than patients | • | | 0 | 17. 00 |
| 18.00 | Revenue from sale of medical records and abstracts | | | 0 | 18. 00 |
| 19.00 | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | 19. 00 |
| 20.00 | Revenue from gifts, flower, coffee shops, canteen | | | 0 | 20.00 |
| 21. 00 | Rental of vending machines | | | 0 | 21.00 |
| 22. 00 | Rental of skilled nursing space | | | 0 | 22. 00 |
| 23. 00 | Governmental appropriations | | | 0 | 23. 00 |
| 24. 00 | MI SC I NCOME | | | 38, 798 | 24.00 |
| 24. 50 | COVI D-19 PHE Funding | | | 0 | 24. 50 |
| 25.00 | Total other income (Sum of lines 6 - 24) | | | 38, 798 | |
| 26. 00 | Total (Line 5 plus line 25) | | | -422, 148 | |
| 27. 00 | Other expenses (specify) | | | 0 | 27. 00 |
| 28. 00 | | | | 0 | 28. 00 |
| 29. 00 | | | | 0 | 29. 00 |
| 30.00 | Total other expenses (Sum of lines 27 - 29) | | | 0 | 30.00 |
| 31. 00 | Net income (or loss) for the period (Line 26 minus line 30) | | | -422, 148 | 31. 00 |