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

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

Provider CCN: 315404 Period: From 07/01/2020 For 06/30/2021 Date/Time Prepared:

			10 00/ 30/ 2021	11/23/2021 9: 22 am
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost re	port	Date:	Ti me:
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report en	ter the number of times the provide	er resubmitted thi	s cost report
	3.01 [] No Medicare Utilization. Enter	"Y" for yes or leave blank for no.		
Contractor	4.[2]Cost Report Status	6. Contractor No. 12	<u>1001</u>	
use only	(1) As Submitted	7.[N] First Cost Report for this	s Provider CCN	
	(2) Settled without audit	8. [N] Last Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date: <u>01/04/2</u>	022	
	(4) Reopened (5) Amended	10.[0]If line 4, column 1 is "4"	: Enter number of	times reopened
	(3) Amerided	11.Contractor Vendor Code	4	
	5. Date Received: 11/17/2021	12.[F] Medicare Utilization. Ent	er "F" for full, '	'L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLLINGSWOOD MANOR (315404) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
1			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			2
3	Si gnatory Ti tle			3
4	Date			4

			Title	XVIII		
		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	5, 820	0	0	1. 00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3. 00
4.00	SNF - BASED HHA I	0	0	0		4. 00
5.00	SNF - BASED RHC I	0		0		5. 00
6.00	SNF - BASED FQHC I	0		0		6. 00
7.00	SNF - BASED CMHC I	0		0		7. 00
100.00	TOTAL	0	5, 820	0	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 COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315404 Peri od: Worksheet S-2 From 07/01/2020 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2021 11/23/2021 9:22 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 460 HADDON AVENUE PO Box: 1.00 2.00 Ci ty: COLLI NGSWOOD State: NJ Zi p Code: 08108 2.00 3.00 County: CAMDEN CBSA Code: 15804 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 1.00 2.00 3. 00 4.00 5.00 6.00 SNF and SNF-Based Component Identification: 4.00 SNF COLLINGSWOOD MANOR 315404 12/01/1997 N Р 0 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) 07/01/2020 06/30/2021 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR 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 1, 122, 729 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 1, 122, 729 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28.00 reports? (Y/N) Part A Part B Other 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility Ν 30.00 31.00 | ICF/IID 31.00 32.00 SNF-Based HHA Ν Ν 32.00 33.00 SNF-Based RHC 33 00 34.00 SNF-Based FQHC 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 69.383

Health Financial Systems	COLLI NGSWOOD	MANOR	In Lie	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315404 Period:					
COMPLEX INDENTIFICATION DATA			From 07/01/2020	Part I	
			To 06/30/2021	Date/Time Pre	
				11/23/2021 9:	22 am_
				Y/N	
				1. 00	
42.00 Are malpractice premiums and paid loss	ses reported in other tha	n the Administrative ar	nd General cost	N	42.00
center? Enter Y or N. If yes, check be	ox, and submit supporting	schedule listing cost	centers and		
amounts.		-			
43.00 Are there any home office costs as de-	fined in CMS Pub. 15-1, C	hapter 10?		Υ	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and ente	r the name and address	of the home	H53010	44. 00
office on lines 45, 46 and 47.					
1.00	2.00		3. 00		
If this facility is part of a chain o	rganization, enter the na	me and address of the I	nome office on the	lines	
bel ow.	_				
45. 00 Name: UNITED METHODIST HOMES OF NJ	Contractor's Name: UNITE	D METHODIST Contrac	tor's Number: 1200	1	45. 00
	HOMES	S OF NJ			
46.00 Street: 3311 HIGHWAY 33	PO Box:				46. 00
47.00 City: NEPTUNE	State: NJ	Zi p Coo	le: 0775	2	47. 00

	Financial Systems	COLLI NGSWOOD MA				eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	epared:
					Y/N	11/23/2021 9: Date	22 am
					1.00	2.00	
	General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	1, "Y" fo	r Yes or "N" 1	for No. For all	the date	
1. 00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1. 00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in			N N	2.00	3.00	2.00
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and i	in column				
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider o l, or members of the	es, drug r its e board	Y			3. 00
				Y/N	Type	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements preparcountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple	" for Audited, "C" [.] te copy or enter da [.]	for te	Υ	А	10/25/2021	4. 00
5.00	available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation.	revenues different	from	Υ			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6. 00	Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N)	ool? (Y/N) Column 2:	: Is the	provider the	N	N	6. 00
7. 00 8. 00	Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) so	ng the cost reporti		for Nursing	N N		7. 00 8. 00
	(7.1.) e	00 111011 4011 61101				Y/N 1.00	
	Bad Debts						
9. 00 10. 00	Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				t reporting	Y N	9.00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wai	ived? If "	Y", see instru	uctions.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	iod? If "Y			N	12. 00
		Descriptio	n	Pa_ Y/N	rt A Date	Part B Y/N	
		0		1. 00	2. 00	3. 00	
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and			Υ	10/13/2021	N	13. 00
14. 00	4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.			N		N	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",			N		N	15. 00
	see Instructions.				1		1
16. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report			N		N	16. 00
16. 00 17. 00	see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for			N N		N N	16. 00

Heal th	Financial Systems COLLINGS	/00D N	MANOR		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR	E	Provi der No.: 315404		eriod: com 07/01/2020	Worksheet S-2 Part II	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE			To		Date/Time Pre	pared:
		_		Ц,		11/23/2021 9:	22 am
			1. 00		2.	00	
	Cost Report Preparer Contact Information						
19.00	Enter the first name, last name and the title/position	DEAN	IDRA	F	FALLON		19. 00
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
20.00	Enter the employer/company name of the cost report	BAKE	ER TILLY US, LLP				20.00
	preparer.						
21.00	Enter the telephone number and email address of the cost	570-	-820-0301	[DEANDRA, FALLON	BAKERTI LLY. CO	21. 00
	report preparer in columns 1 and 2, respectively.			N	И		
	• • • • • •						

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

COLLINGSWOOD MANOR
In Lieu of Form CMS-2540-10
Period: Worksheet S-2
From 07/01/2020 Fart II

COMPLE	X REIMBURSEMENT QUESTIONNAIRE			From 07/01/2020 To 06/30/2021	Part II Date/Time Pre 11/23/2021 9::	
		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.					14. 00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15. 00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16. 00
17. 00	adjustments made to PS&R data for Other? Describe the other adjustments:					17. 00
18. 00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18. 00
			3. 00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		CPA, SENIOR MANAGER			19. 00
20. 00	Enter the employer/company name of the cost r preparer.	eport				20. 00
21. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					21. 00

Health Financial Systems	COLLI NGSWOOD MANOR	In Lieu of Form CMS-2540-10
VOLUNTARY CONTACT INFORMATION	Provi der No.: 315404	Peri od: Worksheet S-2
		From 07/01/2020 Part V

		To 06/30/2021 Date/Time Pre	pared:
		11/23/2021 9:	
		1. 00	
	Cost Report Preparer Contact Information		
1.00	First Name		1. 00
2.00	Last Name		2. 00
3.00	Ti tl e		3. 00
4.00	Empl oyer		4. 00
5.00	Phone Number		5. 00
6.00	E-mail Address		6. 00
7.00	Department		7. 00
8.00	Mailing Address 1		8. 00
9.00	Mailing Address 2		9. 00
10.00	Ci ty		10. 00
	State		11. 00
12.00	Zi p		12. 00
	Officer or Administrator of Provider Contact Information		
13. 00	First Name	DEANDRA	13. 00
14. 00	Last Name	FALLON	14. 00
	Ti tl e		15. 00
16. 00	Empl oyer		16. 00
	Phone Number	5708200100	17. 00
18. 00	E-mail Address	Deandra. Fallon@bakertilly.co	18. 00
40.00		m	40.00
	Department	4/ BUBLLO CO CTE 400	19. 00
	Mailing Address 1	46 PUBLIC SQ., STE 400	20.00
	Mailing Address 2	WILLIEC DADDE	21. 00
	City	WI LKES-BARRE	22. 00
23. 00		PA	
24. 00	∠ι p	18701	24. 00

In Lieu of Form CMS-2540-10 COLLI NGSWOOD MANOR Provi der No.: 315404

Health Financial Systems COLLINGSWOOD SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

						11/23/2021 9: 2	
				I npa	atient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	SKILLED NURSING FACILITY	60	21, 900		2, 359	5, 200	1.00
2. 00 3. 00	NURSING FACILITY	0	0	-		0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST			0	0	0	4. 00
5.00	Other Long Term Care	128	46, 720				5. 00
6. 00	SNF-Based CMHC		_		_	_	6. 00
7.00	HOSPICE	0	0	-	2 250	0	7. 00
8. 00	Total (Sum of lines 1-7)	188 Inpatient D	68, 620	U	2, 359 Di scharges	5, 200	8. 00
		Tripatrent	ay37 VI 31 C3		Di Schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1 00	CKLLLED NUDCLING FACILLETY	6.00	7.00	8. 00	9. 00	10.00	1 00
1. 00 2. 00	SKILLED NURSING FACILITY NURSING FACILITY	6, 656	14, 215 0		100	7 0	1. 00 2. 00
3. 00	ICF/IID	0	0			0	3. 00
4.00	HOME HEALTH AGENCY COST	0	0				4. 00
5.00	Other Long Term Care	29, 044	29, 044				5. 00
6.00	SNF-Based CMHC HOSPI CE		0	0	0	0	6. 00 7. 00
7. 00 8. 00	Total (Sum of lines 1-7)	35, 700	43, 259	_	0 100	7	8. 00
0.00	Trotal (our or trinos tr)	Di scha			age Length of		0.00
		2.1			TI 11 20011	TI II WIN	
	Component	0ther 11.00	Total 12. 00	Title V 13.00	Title XVIII 14.00	Title XIX 15.00	
1. 00	SKILLED NURSING FACILITY	57	164		23. 59	742. 86	1. 00
2.00	NURSING FACILITY	0	0			0.00	2. 00
3.00	ICF/IID	0	0			0. 00	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST	42	42				4. 00 5. 00
6. 00	Other Long Term Care SNF-Based CMHC	43	43				6. 00
7. 00	HOSPI CE	0	0	0.00	0. 00	0.00	7. 00
8. 00	Total (Sum of lines 1-7)	100	207			742. 86	8. 00
		Average Length of Stay		Admi s	si ons		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17. 00	18. 00	19. 00	20.00	
1.00	SKILLED NURSING FACILITY	86. 68	0		4	44	1. 00
2. 00 3. 00	NURSING FACILITY	0. 00 0. 00	0		0	0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST	0.00			U	U	4. 00
5. 00	Other Long Term Care	675. 44				40	5. 00
6.00	SNF-Based CMHC						6. 00
7.00	HOSPICE	0.00	0	-	0	0	7. 00
8. 00	Total (Sum of Lines 1-7)	208. 98 Admi ssi ons	Full Time	Equi val ent	4	84	8. 00
	Company	Total	Employees on	Nonnoi d			
	Component	Total	Employees on Payroll	Nonpai d Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	180	41. 45				1. 00
2.00	NURSING FACILITY	0	0.00				2.00
3. 00 4. 00	HOME HEALTH AGENCY COST	0	0. 00 0. 00			}	3. 00 4. 00
5. 00	Other Long Term Care	40	37. 13				5. 00
6.00	SNF-Based CMHC		0. 00	0. 00			6. 00
7.00	HOSPICE	0	0.00				7.00
8. 00	Total (Sum of lines 1-7)	220	78. 58	0.00			8. 00

SNF WAGE INDEX INFORMATION

Provider No.: 315404 F

Period: Worksheet S-3 From 07/01/2020 Part II

06/30/2021 Date/Time Prepared: 11/23/2021 9:22 am Amount Reclass. of Adj usted Pai d Hours Average Hourly Salaries from Salaries (col. Related to Reported Wage (col. 3 col . 4) Worksheet A-6 $1 \pm col. 2$ Salary in col 5. 00 2.00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 7, 612, 469 7, 612, 469 303, 207. 00 25. 11 1.00 Physician salaries-Part A 0.00 0.00 2.00 0 0 0 2.00 3.00 Physician salaries-Part B 0 0.00 0.00 3.00 Home office personnel 0 0.00 4.00 0 0.00 4.00 Sum of lines 2 through 4 0.00 5.00 0 0 0.00 5.00 0 303, 207. 00 6.00 Revised wages (line 1 minus line 5) 7, 612, 469 7, 612, 469 25.11 6.00 7.00 Other Long Term Care 1, 973, 216 1, 973, 216 77, 235. 00 25.55 7.00 HOME HEALTH AGENCY COST 8.00 0.00 0.00 8.00 0.00 9.00 CMHC 0 0 0.00 9.00 10.00 HOSPI CE 0 0 0.00 0.00 10.00 11.00 Other excluded areas 30, 714 30, 714 1, 719. 00 17.87 11.00 Subtotal Excluded salary (Sum of lines 7 2,003,930 2, 003, 930 78, 954. 00 25.38 12.00 12.00 through 11) Total Adjusted Salaries (line 6 minus line 13.00 5, 608, 539 C 5, 608, 539 224, 253. 00 25.01 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 220, 485 220, 485 6, 062. 00 36. 37 14.00 15.00 20,012 0 20.012 104.00 192.42 15.00 12, 370. 00 16.00 Home office salaries & wage related costs 718, 941 0 718, 941 58. 12 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1, 955, 977 1, 955, 977 17.00 18.00 Wage-related costs other (See Part IV) 0 3, 647 18.00 3,647 Wage related costs (excluded units) 515, 858 0 515, 858 19.00 20.00 Physician Part A - WRC 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1, 443, 766 0 1, 443, 766 22.00 instructions)

Health Financial Systems
SNF WAGE INDEX INFORMATION COLLI NGSWOOD MANOR

Provi der No.: 315404

				Ť	o 06/30/2021	Date/Time Prep 11/23/2021 9:	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.		Wage (col. 3 ÷	
		·	Worksheet A-6	1 ± col . 2)	Salary in col.	col . 4)	
					3		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	C	0.00	0.00	1.00
2.00	Administrative & General	1, 175, 200	0	1, 175, 200	31, 109. 00	37. 78	2. 00
3.00	Plant Operation, Maintenance & Repairs	353, 051	0	353, 051	17, 794. 00	19. 84	3. 00
4.00	Laundry & Linen Service	28, 512	0	28, 512	4, 058. 00	7. 03	4. 00
5.00	Housekeepi ng	329, 325	0	329, 325	16, 244. 00	20. 27	5. 00
6.00	Di etary	602, 375	0	602, 375	41, 038. 00	14. 68	6. 00
7.00	Nursing Administration	0	0	C	0.00	0.00	7. 00
8.00	Central Services and Supply	0	0	O.	0.00	0.00	8. 00
9.00	Pharmacy	0	0	C	0.00	0.00	9. 00
10.00	Medical Records & Medical Records Library	0	0	C	0.00	0.00	10.00
11. 00	Social Service	54, 773	0	54, 773	2, 120. 00	25. 84	11. 00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	194, 607	0	194, 607	10, 125. 00	19. 22	13.00
14.00	Total (sum lines 1 thru 13)	2, 737, 843	0	2, 737, 843	122, 488. 00	22. 35	14.00

Heal th Financial	- 9	COLLI NGSWOOD MANOR		u of Form CMS-2	2540-10
SNF WAGE RELATED) COSTS	Provi der No.: 315404	Peri od:	Worksheet S-3	
			From 07/01/2020		
			To 06/30/2021	Date/Time Prep 11/23/2021 9:3	pared:
					22 am
				Amount	
				Reported	
				1. 00	
PART IV -	WAGE RELATED COSTS				
Part A -	Core List				
RETI REMEN	T COST				
1.00 401K Empl	oyer Contributions			0	1. 00
2.00 Tax Shellt	ered Annuity (TSA) Employer Contribution			0	2. 00
3.00 Qualified	and Non-Qualified Pension Plan Cost			118, 400	3.00
4.00 Prior Yea	r Pension Service Cost			0	4.00
PLAN ADMI	NISTRATIVE COSTS (Paid to External Organi	zation)			

		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Qualified and Non-Qualified Pension Plan Cost	118, 400	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)	920, 830	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	12, 382	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)	4, 208	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	Workers' Compensation Insurance	261, 080	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	547, 546	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	85, 631	19. 00
20.00	State or Federal Unemployment Taxes	0	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	5, 900	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 955, 977	24. 00
		Amount	
		Reported	
		1. 00	
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COST	3, 647	25. 00

					rom 07/01/2020		
				T	06/30/2021	Date/Time Pre	
				A 11 1 1	D : 1 !!	11/23/2021 9:	
	Occupational Category	Amount	Fringe	Adjusted		Average Hourly	
		Reported	Benefits	Salaries (col.		Wage (col. 3 ÷	
				1 + col . 2)	Salary in col.	col . 4)	
		1.00	2. 00	3.00	3 4. 00	5. 00	
	Di rect Sal ari es	1.00	2.00	3.00	4. 00	5.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	965, 443	248, 505	1, 213, 948	21, 890. 00	55. 46	1. 00
2.00	Licensed Practical Nurses (LPNs)	142, 882	36, 778				2.00
3.00	Certified Nursing Assistant/Nursing	848, 565	218, 421		·		3. 00
3.00	Assistants/Aides	040, 303	210, 421	1, 000, 900	47, 670. 00	22. 30	3.00
4.00	Total Nursing (sum of lines 1 through 3)	1, 956, 890	503, 704	2, 460, 594	74, 135. 00	33. 19	4. 00
5. 00	Physical Therapists	248, 862	64, 057		·		5. 00
6. 00	Physical Therapy Assistants	72, 854	18, 753				6. 00
7. 00	Physical Therapy Aides	72,034	10, 733		0.00		7. 00
8.00	Occupational Therapists	73, 605	18, 946	~			
9. 00	Occupational Therapy Assistants	45, 945	11, 826		1, 485. 00		
10.00	Occupational Therapy Assistants	43, 743	11, 020		0.00		
11. 00	Speech Therapists	102, 691	26, 433				
12. 00	Respiratory Therapists	58, 054	14, 943				
13. 00	Other Medical Staff	311, 796	80, 256				13. 00
13.00	Contract Labor	311,770	00, 230	372,032	12,004.00	32. 44	13.00
	Nursing Occupations						
14. 00	Registered Nurses (RNs)	27, 816		27, 816	480. 00	57. 95	14. 00
	Licensed Practical Nurses (LPNs)	146, 701		146, 701			
	Certified Nursing Assistant/Nursing	45, 968		45, 968	·		
. 0. 00	Assi stants/Ai des	107 700		10,700	1,710.00	21.00	
17. 00	Total Nursing (sum of lines 14 through 16)	220, 485		220, 485	6, 062. 00	36. 37	17. 00
18. 00	Physical Therapists	0		0	0.00		18. 00
19. 00	Physical Therapy Assistants	O		0	0.00		
20. 00	Physical Therapy Aides	o		l o	0.00		
21. 00	Occupational Therapists			l o	0.00		
22. 00	Occupational Therapy Assistants			l o	0.00		
23. 00		O		0	0.00		
	Speech Therapists			Ö	0.00		
25. 00	Respiratory Therapists	O		0	0.00		
26. 00		0		0			26. 00

From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 9:22 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB₂ 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75. 00 PA₂

Health Financial Systems	COLLI NGSWOOD MANOR		In Lie	In Lieu of Form CMS-2540-	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi	ler No.: 315404	Peri od:	Worksheet S-	7
			From 07/01/2020 To 06/30/2021	Date/Time Pro	epared:
				11/23/2021 9	
			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 Vipayments beginning 10/01/2003. Congress experexpenses. For lines 101 through 106: Enter incolumn 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" with direct patient care and related expenses (See instructions)	cted this increase to be un nocolumn 1 the amount of t reach category to total S or yes or "N" for no if th	sed for direct he expense for NF revenue from e spending refl	patient care and each category. Er Worksheet G-2, F ects increases as	related nter in Part I, ssociated	
101.00 Staffing 102.00 Recruitment					101. 00 102. 00
103.00 Retention of employees					103. 00
104.00 Training					103.00
105. 00 OTHER (SPECIFY)					105.00
106.00 Total SNF revenue (Worksheet G-2, Part I, Ii	ne 1, column 3)				106. 00

	Financial Systems	COLLI NGSWOOD				u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		eriod: rom 07/01/2020	Worksheet A	
					0 06/30/2021	Date/Time Pre 11/23/2021 9:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	22 4111
				+ col. 2)	ons	Tri al Bal ance	
					Increase/Decre ase (Fr Wkst	(col. 3 +- col. 4)	
					A-6)	,	
	ASSUSPENDENCE AND ASSUSPENDENC	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		1, 343, 168	1, 343, 168	0	1, 343, 168	1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT		1, 343, 100	1, 343, 100		1, 343, 100	2. 00
3.00	00300 EMPLOYEE BENEFITS	O	1, 959, 624			1, 959, 624	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	1, 175, 200	2, 296, 416			3, 471, 616	4. 00
5. 00 6. 00	00600 LAUNDRY & LINEN SERVICE	353, 051 28, 512	753, 138 18, 153			1, 106, 189 46, 665	5. 00 6. 00
7. 00	00700 HOUSEKEEPI NG	329, 325	321, 098			650, 423	7. 00
8. 00	00800 DI ETARY	602, 375	1, 012, 897	1, 615, 272	0	1, 615, 272	8. 00
9. 00 10. 00	00900 NURSI NG ADMINI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	9. 00 10. 00
11. 00	01100 PHARMACY		0		0	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	o	0	0	0	0	12. 00
13.00	01300 SOCIAL SERVICE	54, 773	0	54, 773	0	54, 773	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	180, 277	0 28, 778	209, 055	0	0 209, 055	14. 00 15. 00
15. 00	01501 CHAPLAI N	14, 330	28, 778	14, 330	0	14, 330	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	2, 268, 685	601, 526	2, 870, 211	0	2, 870, 211	30.00
31. 00 32. 00	03200 CF/IID	0	0	0	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	1, 973, 216	109, 310	2, 082, 526	_	2, 082, 526	33. 00
40.00	ANCILLARY SERVICE COST CENTERS		= 4.0			- 1/0	
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	0	5, 162 13, 722			5, 162 13, 722	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY		13, 722	13, 722	0	13, 722	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	58, 054	925	58, 979		58, 979	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	321, 716 119, 550	124, 345			330, 402	44. 00 45. 00
46. 00	04500 SPEECH PATHOLOGY	102, 691	0	119, 550 102, 691	80, 561 35, 098	200, 111 137, 789	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21, 508			21, 508	48. 00
49. 00 50. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	89, 750	89, 750 0	0	89, 750 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		0		0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS						
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 FQHC		O	0	J	O	62. 00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	0	0	_	70.00
	07100 AMBULANCE 07300 CMHC	0	0	0	0	0	71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>				0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF		0	0	0	0	81.00
83. 00	08300 HOSPI CE	0	0		0	0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	7, 581, 755	8, 699, 520	16, 281, 275	0	16, 281, 275	89. 00
	NONREI MBURSABLE COST CENTERS						
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	30, 714	12, 448 0	43, 162	0	43, 162 0	90. 00 91. 00
92. 00	09200 PHYSI CLANS PRI VATE OFFI CES		0		0	0	92.00
93. 00	09300 NONPALD WORKERS	O	0	0	0	0	93. 00
94. 00 100. 00	09400 PATIENTS LAUNDRY TOTAL	0 7, 612, 469	0 8, 711, 968	0 16, 324, 437	0	0 16, 324, 437	94.00
100.00	A LIGITAL	1,012,409	0, / 11, 700	10, 324, 437	ı O	10, 324, 437	100.00

COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10

Health Financial Systems COLLII
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provi der No.: 315404 | Peri od: | From 07/01/2020 | To 06/30/2021 | Date/Ti me Prepared:

				То	06/30/2021	Date/Time Prepared: 11/23/2021 9: 22 am
	Cost Center Description	Adjustments to	Net Expenses			11/23/2021 7. 22 dill
	·		For Allocation	n		
		Wkst A-8)	(col. 5 +-			
		/ 00	col . 6)	-		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00			
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES	-107	1, 343, 061			1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUI PMENT	0	0	1		2.00
3.00	00300 EMPLOYEE BENEFITS	-57, 475	1, 902, 149			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-825, 768	2, 645, 848	3		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-11, 139	1, 095, 050)		5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	0	46, 665	1		6. 00
7. 00	00700 HOUSEKEEPI NG	0	650, 423	1		7. 00
8.00	00800 DI ETARY	-11, 586	_	.1		8.00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	0	0			9.00
11. 00	01100 PHARMACY	0	0			11.00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0			12. 00
13. 00	01300 SOCIAL SERVICE	0	54, 773	8		13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1		14. 00
15.00	01500 ACTI VI TI ES	0	209, 055	5		15. 00
15. 01	01501 CHAPLAI N	0	14, 330			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 SKILLED NURSING FACILITY	0	_, -, -, -,	1		30.00
31.00	03100 NURSING FACILITY	0	0	1		31.00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	1			32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	0	2,002,320)		33.00
40. 00	04000 RADI OLOGY	0	5, 162			40. 00
41. 00	04100 LABORATORY	0	13, 722	1		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0)		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	58, 979	1		43. 00
44. 00	04400 PHYSI CAL THERAPY	0	330, 402	1		44. 00
45. 00	04500 OCCUPATIONAL THERAPY	0	200, 111	1		45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	137, 789 0	1		46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21, 508	1		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	89, 750	1		49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	1		50.00
51. 00	05100 SUPPORT SURFACES	0	0			51.00
	OUTPATIENT SERVICE COST CENTERS					
60.00	06000 CLI NI C	0		•		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0)		61. 00
62. 00	O6200 FOHC OTHER REIMBURSABLE COST CENTERS					62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0			70. 00
71. 00	07100 AMBULANCE		•	•		71.00
73. 00	07300 CMHC	0	•	•		73. 00
	SPECIAL PURPOSE COST CENTERS					
	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	_			80. 00
	08100 NTEREST EXPENSE	0	0	1		81. 00
82.00	08200 UTI LI ZATI ON REVI EW - SNF	0	0			82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	-906, 075	15, 375, 200			83. 00 89. 00
69.00	NONREI MBURSABLE COST CENTERS	-900,073	15, 375, 200	/		87.00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	43, 162	2		90. 00
	09100 BARBER AND BEAUTY SHOP	0	0	1		91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0)		92. 00
	09300 NONPALD WORKERS	0	0			93. 00
	09400 PATIENTS LAUNDRY	0	0			94. 00
100.00	TOTAL	-906, 075	15, 418, 362	<u>'</u>		100.00

Health Financial Systems COLLINGSWOOD MANOR			In Lie	u of Form CMS-2	2540-10	
RECLASSI FI CATI ONS			Period: From 07/01/2020	Worksheet A-6		
				To 06/30/2021	Date/Time Pre 11/23/2021 9:	pared:
			Increases		1172372021 7.	22 (111)
	Cost Cente	Cost Center Line #		Sal ary	Non Salary	
	2.00 3.0		3. 00	4. 00	5. 00	
(1) A - TO RECLASS OT AND ST						
1. 00	OCCUPATIONAL THERAP	Υ	45. 0	0 38, 035	42, 526	1. 00
2. 00	SPEECH PATHOLOGY		46. 0	0 16, 571	18, 527	2. 00
TOTALS						
100.00	Total Reclassificat	,		54, 606	61, 053	100. 00
	of columns 4 and 5					
	equal sum of column	s 8 and				
	9)					

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

Health Financial Systems	COLLINGSWOOD MANOR In Lieu of Form CMS-25					2540-10
RECLASSI FI CATI ONS				Peri od:	Worksheet A-6	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	narod:
					11/23/2021 9:	
	Decreases					
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6. 00		7. 00	8. 00	9. 00	
(1) A - TO RECLASS OT AND ST						
1.00	PHYSI CAL THERAPY		44.0	0 54, 606	61, 053	1.00
2. 00			0.0	0 0	0	2.00
TOTALS						
100. 00				54, 606	61, 053	100. 00

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10

Provider No.: 315404 | Period: | Worksheet A-7 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared:

				To	06/30/2021	Date/Time Prep 11/23/2021 9:	pared: 22 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						
1.00	Land	257, 870	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	25, 339, 756	194, 313	0	194, 313	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	1, 906, 692	330, 628	0	330, 628	0	5. 00
6.00	Movable Equipment	218, 670	0	0	0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	27, 722, 988	524, 941	0	524, 941	0	7. 00
8.00	Reconciling Items	0	0	0	0	0	8. 00
9. 00	Total (line 7 minus line 8)	27, 722, 988	524, 941	0	524, 941	0	9. 00
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1. 00	Land	257, 870	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	25, 534, 069	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	2, 237, 320	0				5. 00
6. 00	Movable Equipment	218, 670	0				6. 00
7. 00	Subtotal (sum of lines 1-6)	28, 247, 929	0				7. 00
8.00	Reconciling Items	0	0				8. 00
9. 00	Total (line 7 minus line 8)	28, 247, 929	0				9. 00

Provi der No.: 315404

Peri od: Worksheet A-8

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

				To 06/30/2021	Date/Time Prep 11/23/2021 9:	
				Expense Classification on		ZZ dili
				To/From Which the Amount is		
					,,	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
		1. 00	2. 00	3. 00	4. 00	
1. 00	Investment income on restricted funds	В	-107	CAP REL COSTS - BLDGS &	1.00	1. 00
	(chapter 2)			FI XTURES		
2.00	Trade, quantity, and time discounts (chapter		0)	0.00	2. 00
0.00	8)				0.00	0.00
3.00	Refunds and rebates of expenses (chapter 8)		Ü		0.00	3.00
4. 00	Rental of provider space by suppliers		Ü)	0.00	4. 00
5. 00	(chapter 8)		0		0.00	5. 00
5.00	Tel ephone services (pay stations excluded) (chapter 21)		U		0.00	3.00
6. 00	Television and radio service (chapter 21)	В	0 260	PLANT OPERATION, MAINT. &	5. 00	6. 00
0.00	l lerevision and radio service (chapter 21)	В	-0, 307	REPAIRS	3.00	0.00
7. 00	Parking Lot (chapter 21)		0		0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	0		0.00	8.00
0.00	physician adjustment	A-0-2	0		ļ	0.00
9. 00	Home office cost (chapter 21)	1	Ō		0.00	9. 00
10. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0		0.00	
	Capi tal expendi tures (chapter 24)		· ·		0.00	00
12. 00	Adjustment resulting from transactions with	A-8-1	-187, 431	ı		12. 00
	related organizations (chapter 10)					
13.00	Laundry and Linen service		0		0.00	13. 00
14.00	Revenue - Employee meals	В	-11, 368	BDI ETARY	8.00	14. 00
15.00	Cost of meals - Guests		0		0.00	15. 00
16.00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					ĺ
17.00	Sale of drugs to other than patients		0		0.00	17. 00
18.00	Sale of medical records and abstracts		0		0.00	18. 00
19.00	Vending machines		0		0.00	19. 00
20.00	Income from imposition of interest, finance		0		0.00	20. 00
	or penalty charges (chapter 21)					
21. 00	Interest expense on Medicare overpayments		0	O TOTAL CONTRACTOR OF THE PROPERTY OF THE PROP	0.00	21. 00
	and borrowings to repay Medicare					
	overpayments		_	l	'	
22. 00	Utilization reviewphysicians' compensation		0	OUTILIZATION REVIEW - SNF	82. 00	22. 00
00.00	(chapter 21)			DAR DEL COCTO DI DOC O	4 00	00.00
23. 00	Depreciationbuildings and fixtures		Ü	CAP REL COSTS - BLDGS &	1.00	23. 00
24.00	Depreciationmovable equipment		0	FIXTURES	2 00	24.00
24. 00	Depreciationmovabre equipment		U	CAP REL COSTS - MOVABLE	2. 00	24.00
25. 00	MISCELLANEOUS INCOME	В	107	EQUIPMENT ADMINISTRATIVE & GENERAL	4.00	25. 00
	MARKETI NG SAL/BEN/OTHER	A		BADMINISTRATIVE & GENERAL	•	25. 00
25. 01	NON-ALLOWABLE EXPENSE	A		BADMINISTRATIVE & GENERAL	4.00	1
25. 02		A		ADMINISTRATIVE & GENERAL		25. 02
	MARKETING BENEFITS	A		EMPLOYEE BENEFITS		25. 03
25. 04	ELECTRIC REVENUE	B		PLANT OPERATION, MAINT. &	5.00	
20.00	LEESTIN O NEVENOE		- 1, 090	REPAIRS	3.00	23.03
25. 06	MAINTENANCE SERVICES	В	_880	PLANT OPERATION, MAINT. &	5.00	25. 06
20.00			300	REPAIRS	3.00	20.00
25. 07	FOOD	A	-218	BDI ETARY	8. 00	25. 07
	Total (sum of lines 1 through 99) (Transfer		-906, 075			100.00
	to Worksheet A, col. 6, line 100)		, 0 , 0			
(1) Do	scription all chapter references in this co	Lump portain to	CMS Dub 15 1	· 1		•

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

Heal th Financial Systems COLLINGSWOOD MANOR
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS ANOR In Lieu of Form CMS-2540-10
Provider No.: 315404 Period: Worksheet A-8-1
From 07/01/2020 Parts I-II

OFFICE COSTS				From 07/01/2020 To 06/30/2021		
	Li ne No.	Cost (Center	Expense		9. 22 aiii
	1.00	2.		3. (
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:				D ORGANIZATIONS	OR	
1. 00 2. 00 3. 00 4. 00 5. 00	4. 00 0. 00 0. 00 0. 00 0. 00	ADMI NI STRATI VE	& GENERAL	HOME OFFICE COS	51	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00	0. 00 0. 00 0. 00					6. 00 7. 00 8. 00
9.00 10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	0.00					9.00
	Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	_		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANIZATIONS	OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 TOTALS (sum of lines 1-9). Transfer column	953, 387 0 0 0 0 0 0 0 0 0 953, 387	1, 140, 818 0 0 0 0 0 0 0 0 0 0 1, 140, 818				1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
6, line 100 to Worksheet A-8, column 3, line 12.						

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315404 Peri od: From 07/01/2020 | Parts I-II OFFICE COSTS 06/30/2021 Date/Time Prepared:

 			11/23/2021 9:	22 am
Symbol (1)	Name	Percentage of		
		Ownershi p		
1.00	2. 00	3. 00		

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

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

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

1.00	G	UNITED METHODIST HOMES OF NJ	100.00	1.00
2. 00			0.00	2. 00
3. 00			0.00	3.00
4. 00			0.00	4. 00
5. 00			0.00	5. 00
6. 00			0.00	6.00
7. 00			0.00	7. 00
8. 00			0.00	8. 00
9. 00			0.00	9. 00
10. 00			0.00	10.00
100.00 G. Other (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	

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		UNITED METHODIST HOMES OF NJ	100.00 SI	UPPORT SERVICES	1.00
2.00			0.00		2.00
3.00			0.00		3.00
4.00			0.00		4. 00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (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.

COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315404 Peri od: Worksheet B From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 9:22 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 ЗА GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1 00 1 00 1, 343, 061 1, 343, 061 2.00 0 2 00 3.00 00300 EMPLOYEE BENEFITS 1, 902, 149 0 1, 902, 149 3.00 00400 ADMINISTRATIVE & GENERAL 0 2, 949, 173 4 00 2 645 848 58, 280 245 045 4 00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 1,095,050 17, 784 0 90,884 1, 203, 718 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 46,665 21, 727 7, 340 75, 732 6.00 7.00 00700 HOUSEKEEPI NG 650, 423 9, 878 0 84, 776 745,077 7.00 00800 DI ETARY 1,603,686 155,066 1,800,235 8 00 8 00 41, 483 9.00 00900 NURSING ADMINISTRATION Ω 9.00 01000 CENTRAL SERVICES & SUPPLY 10.00 10.00 0 0 0 01100 PHARMACY 11.00 0 0 11.00 0 0 01200 MEDICAL RECORDS & LIBRARY 0 12.00 0 0 0 12.00 13.00 01300 SOCIAL SERVICE 54,773 4, 939 0 14, 100 73, 812 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 14.00 01500 ACTI VI TI ES 0 46, 408 279, 171 15.00 209.055 15.00 23, 708 15.01 01501 CHAPLAI N 14, 330 0 3,689 18, 019 15.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 2, 870, 211 249, 974 0 584, 010 3, 704, 195 30.00 03100 NURSING FACILITY 31.00 0 31.00 0 0 32.00 03200 | CF/IID Λ 32.00 899, 622 3, 490, <u>101</u> 03300 OTHER LONG TERM CARE 0 33.00 2,082,526 507, 953 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40.00 5.162 0 0 5, 162 0 41.00 04100 LABORATORY 13, 722 C 0 13, 722 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 58, 979 0 14, 944 73, 923 43.00 04400 PHYSI CAL THERAPY 0 44.00 330, 402 15, 666 82, 817 428, 885 44.00 230, 886 04500 OCCUPATIONAL THERAPY 200, 111 30, 775 45.00 45.00 46.00 04600 SPEECH PATHOLOGY 137, 789 0 0 26, 435 164, 224 46.00 04700 ELECTROCARDI OLOGY 0 47 00 47 00 C Ω 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 21,508 C 0 21, 508 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 49.00 89, 750 89, 750 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 0 05100 SUPPORT SURFACES O 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 60.00 61 00 06100 RURAL HEALTH CLINIC 0 0 0 ol 0 61 00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 07100 AMBULANCE 0 0 71 00 Ω 71 00 0 73.00 07300 CMHC 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 83.00 SUBTOTALS (sum of lines 1-84)
NONREIMBURSABLE COST CENTERS 15, 375, 200 0 1, 894, 242 15, 367, 293 89.00 89.00 1.343.061 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 43, 162 0 7, 907 51, 069 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 Ω 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92 00 0 0 0 92 00 Ω 0 0 93.00 09300 NONPALD WORKERS 0 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 94.00 Cross Foot Adjustments 0 98.00 98.00 0 0 0 0 0 99 00 99.00 Negative Cost Centers 0

15, 418, 362

1, 343, 061

0

1, 902, 149

15, 418, 362 100. 00

TOTAL

100.00

NNOR In Lieu of Form CMS-2540-10
Provider No.: 315404 Period: Worksheet B
From 07/01/2020 Part I
To 04/20/2021 Part (Time Propagate) Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				T	o 06/30/2021	Date/Time Pre 11/23/2021 9:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	ZZ dili
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00 5. 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	2, 949, 173 284, 700	1, 488, 418				1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	17, 912 176, 223	25, 524 11, 604	119, 168 0	932, 904		6. 00 7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	425, 786 0	48, 732 0	0	31, 326	2, 306, 079 0	8. 00 9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
11. 00 12. 00	O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	11. 00 12. 00
13.00	01300 SOCIAL SERVICE	17, 458	5, 802	ō	3, 730	0	13. 00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 66, 029	0 27, 852	0	0 17, 903	0	14. 00 15. 00
15. 01	01501 CHAPLAI N	4, 262	27,032	ő	0	0	15. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	876, 103	293, 660	95, 334	188, 768	853, 262	30. 00
31. 00 32. 00	03100 NURSING FACILITY	0	243,000	95, 334	0	0	31. 00 32. 00
33. 00	03300 OTHER LONG TERM CARE	825, 468	1, 056, 841	23, 834	679, 347	1, 452, 817	33. 00
	ANCILLARY SERVICE COST CENTERS	1 004					
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY	1, 221 3, 245	0	0	0	0	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	Ō	ō	0	42. 00
43. 00 44. 00	04300 0XYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	17, 484 101, 439	0 18, 403	0	0 11, 830	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	54, 608	16, 403	0	0	0	45. 00
46.00	04600 SPEECH PATHOLOGY	38, 842	0	0	O	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	5, 087 21, 227	0	0	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	Ö	o	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	0	o	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	l ol	0	0	ol	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	Ö		· ·	0	61. 00
62. 00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00 73. 00	07100 AMBULANCE	0	0	_	· ·	0	71.00
73.00	O7300 CMHC SPECIAL PURPOSE COST CENTERS	j U	0	<u> </u>	l O	0	73. 00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	0	0	О	О	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2, 937, 094	1, 488, 418	119, 168	932, 904	2, 306, 079	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	12, 079	0	0	-	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0		-	0	91.00
92. 00 93. 00	09200 NONPAID WORKERS	0	0	0	-	0	92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY	Ö	0	ő	-	0	94. 00
98.00	, ,	0	0	0	o	0	98. 00
99. 00 100. 00	Negative Cost Centers TOTAL	2, 949, 173	0 1, 488, 418	0 119, 168	932, 904	0 2, 306, 079	99. 00 100. 00
		. '		•	. '		-

| Peri od: | Worksheet B | From 07/01/2020 | Part | | To 06/30/2021 | Date/Time Prepared: Provi der No.: 315404

			То	06/30/2021	Date/Time Prep 11/23/2021 9:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	22 (1111
,	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 O0100 CAP REL COSTS - BLDGS & FIXTU					 -	1. 00
2. 00 00200 CAP REL COSTS - MOVABLE EQUIF	PMEN I				 -	2. 00
3.00 00300 EMPLOYEE BENEFITS					 -	3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL					 -	4.00
5.00 00500 PLANT OPERATION, MAINT. & REF	PALRS				 -	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE					 -	6. 00
7. 00 00700 HOUSEKEEPI NG					 -	7. 00
8. 00 00800 DI ETARY 9. 00 00900 NURSI NG ADMI NI STRATI ON					 -	8.00
9. 00 00900 NURSI NG ADMINI STRATI ON 10. 00 01000 CENTRAL SERVI CES & SUPPLY	0				 -	9. 00 10. 00
11. 00 011000 CENTRAL SERVICES & SUPPLY		0	0		 -	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0	0	0	<u> </u>	12.00
13. 00 01200 MEDICAL RECORDS & ELBRART		0	0	0	100, 802	13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDU	ICATION O	0	0	0	0	14. 00
15. 00 01500 ACTIVITIES	0	0	0	0	0	15. 00
15. 01 01501 CHAPLAI N	l ŏ	0	0	0	Ö	15. 00
INPATIENT ROUTINE SERVICE COST CEN		<u> </u>	<u> </u>	<u> </u>	0	13.01
30. 00 03000 SKILLED NURSING FACILITY	O	0	0	ol	100, 802	30. 00
31.00 03100 NURSING FACILITY		o	Ö	o	0	31. 00
32. 00 03200 CF/IID	o	o	Ö	o	0	32. 00
33.00 03300 OTHER LONG TERM CARE		o	0	o	0	33. 00
ANCILLARY SERVICE COST CENTERS		-1	-1	-1	-	
40. 00 04000 RADI OLOGY	0	0	0	0	0	40. 00
41. 00 04100 LABORATORY	0	O	O	O	0	41. 00
42. 00 04200 I NTRAVENOUS THERAPY	o	o	0	o	0	42. 00
43.00 04300 OXYGEN (INHALATION) THERAPY	o	О	0	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	О	0	0	0	44. 00
45. 00 04500 OCCUPATIONAL THERAPY	o	О	0	0	0	45. 00
46.00 04600 SPEECH PATHOLOGY	o	О	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48.00 04800 MEDICAL SUPPLIES CHARGED TO F	PATI ENTS 0	0	0	0	0	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51. 00 05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLI NI C	0	0	0	0	0	60. 00
61.00 06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS		ما				70.00
70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71. 00 07100 AMBULANCE	0	0	0	0	0	71.00
73. 00 07300 CMHC	0	U _I	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTICE PREMIUMS & PAID L	OSSES					80. 00
81. 00 08100 INTEREST EXPENSE	1033E3				 -	81. 00
82.00 08200 UTILIZATION REVIEW - SNF					ļ	82. 00
83. 00 08300 HOSPI CE	o	0	0	o	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)		ő	ő	Ö		89. 00
NONREI MBURSABLE COST CENTERS		o _l	<u> </u>	<u> </u>	100, 002	07.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS &	CANTEEN O	O	0	O	0	90. 00
91. 00 09100 BARBER AND BEAUTY SHOP	0	ol	Ö	n	0	91. 00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	ام	ol	0	o o	0	92. 00
93. 00 09300 NONPALD WORKERS	l ol	ol	O	ol	0	93. 00
94. 00 09400 PATIENTS LAUNDRY	l ol	ol	O	o	0	94. 00
98.00 Cross Foot Adjustments	l ol	o			- 1	98. 00
99.00 Negative Cost Centers	o	o	0	О	0	99. 00
100. 00 TOTAL	0	О	0	О	100, 802	100. 00
	·	•	·	•		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						To 06/30/2021		
				OTHER GENER	RAL SERVICE		11/23/2021 9:	ZZ alli
				1071147150				
		Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Stepdown Adjustments	
			EDUCATI ON				Adj d3tilicitts	
			14. 00	15. 00	15. 01	16.00	17. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS - BLDGS & FIXTURES	1		I	1	I	1.00
2.00		CAP REL COSTS - BEDGS & TIXTURES CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3. 00		EMPLOYEE BENEFITS						3. 00
4.00		ADMINISTRATIVE & GENERAL						4. 00
5.00	1	PLANT OPERATION, MAINT. & REPAIRS						5. 00
6. 00 7. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						6. 00 7. 00
8. 00		DI ETARY						8.00
9.00	1	NURSING ADMINISTRATION						9. 00
10.00		CENTRAL SERVICES & SUPPLY						10. 00
11. 00		PHARMACY MEDICAL RECORDS & LIBRARY						11.00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE						12. 00 13. 00
14. 00		NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15.00	1	ACTI VI TI ES	0	390, 955				15. 00
15. 01		CHAPLAI N	0	0	22, 28	31		15. 01
20.00		ENT ROUTINE SERVICE COST CENTERS		200 055	7 20	7 510 401		20.00
30. 00 31. 00	1	SKILLED NURSING FACILITY NURSING FACILITY	0	390, 955 0		6, 510, 401 0 0	0	
32. 00		ICF/IID		0	l .	0 0	0	
33.00	03300	OTHER LONG TERM CARE	0	0	14, 95	7, 543, 367	0	33. 00
		LARY SERVICE COST CENTERS		_	ı			
40. 00 41. 00		RADI OLOGY LABORATORY	0	0		0 6, 383	0	40. 00 41. 00
41.00		INTRAVENOUS THERAPY	0	0		0 16, 967	0	
43. 00	1	OXYGEN (INHALATION) THERAPY	i o	Ö		0 91, 407	-	
44. 00		PHYSI CAL THERAPY	0	0		0 560, 557		
45. 00		OCCUPATIONAL THERAPY	0	0		0 285, 494		
46. 00 47. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0		0 203, 066	0	
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 26, 595		48. 00
49. 00		DRUGS CHARGED TO PATIENTS	0	0		0 110, 977		49. 00
50.00	1	DENTAL CARE - TITLE XIX ONLY	0	0	•	0 0	0	50. 00
51. 00		SUPPORT SURFACES	0	0		0 0	0	51.00
60. 00		TIENT SERVICE COST CENTERS CLINIC	0	0		0 0	0	60.00
61. 00		RURAL HEALTH CLINIC	0	Ö		0 0		
62. 00	06200							62. 00
70.00		REI MBURSABLE COST CENTERS		0				70.00
70. 00 71. 00	1	HOME HEALTH AGENCY COST AMBULANCE	0	0		0 0		1
73.00	07300		0	0		0 0	0	1
		AL PURPOSE COST CENTERS						
80.00		MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00		INTEREST EXPENSE UTILIZATION REVIEW - SNF						81. 00 82. 00
83. 00	1	HOSPICE	0	0		0 0	0	
89. 00		SUBTOTALS (sum of lines 1-84)	0	390, 955	22, 28	15, 355, 214		
00 -		MBURSABLE COST CENTERS						
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0	i	0 63, 148	0	
91. 00 92. 00		PHYSICIANS PRIVATE OFFICES		0		0 0	0	
93. 00	1	NONPALD WORKERS	l ő	0		0 0	ő	
94. 00	09400	PATIENTS LAUNDRY	0	0		0	0	
98. 00		Cross Foot Adjustments	0	0	1	0	0	
99. 00 100. 00		Negative Cost Centers TOTAL		0 390, 955	1	0 31 15, 418, 362	0	99. 00 100. 00
100.00	1	1.0	١	370, 733	1 22,20	, 10, 410, 302	1	1.00.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2540-10 COLLI NGSWOOD MANOR

| Peri od: | Worksheet B | From 07/01/2020 | Part I | Date/Time Prepared: | Provi der No.: 315404

			10 06/30/2021 Date/Trille Pr	
	Cost Center Description	Total		
		18. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6. 00
7.00	00700 HOUSEKEEPI NG			7. 00
8.00	00800 DI ETARY			8. 00
9.00	00900 NURSING ADMINISTRATION			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY			10. 00
11. 00	01100 PHARMACY			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY			12.00
13.00	01300 SOCI AL SERVI CE			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION			14.00
15. 00	01500 ACTI VI TI ES			15. 00
15. 01	01501 CHAPLAI N			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 SKILLED NURSING FACILITY	6, 510, 401		30. 00
31.00	03100 NURSING FACILITY	0		31. 00
32.00	03200 CF/IID	0		32. 00
33.00	03300 OTHER LONG TERM CARE	7, 543, 367		33. 00
	ANCILLARY SERVICE COST CENTERS			
40.00	04000 RADI OLOGY	6, 383		40. 00
41.00	04100 LABORATORY	16, 967		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0		42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	91, 407		43.00
44.00	04400 PHYSI CAL THERAPY	560, 557		44.00
45.00	04500 OCCUPATI ONAL THERAPY	285, 494		45. 00
46.00	04600 SPEECH PATHOLOGY	203, 066		46. 00
47.00	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 595		48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	110, 977		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50. 00
51. 00	05100 SUPPORT SURFACES	0		51. 00
	OUTPATIENT SERVICE COST CENTERS			
60. 00	06000 CLI NI C	0		60. 00
61. 00	06100 RURAL HEALTH CLINIC	0		61. 00
62. 00	06200 FQHC			62. 00
	OTHER REIMBURSABLE COST CENTERS			
70.00	07000 HOME HEALTH AGENCY COST	0		70.00
71. 00	07100 AMBULANCE	0		71.00
73. 00	07300 CMHC	0		73. 00
00.00	SPECIAL PURPOSE COST CENTERS			
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			80.00
81.00	08100 I NTEREST EXPENSE			81.00
82. 00	08200 UTILIZATION REVIEW - SNF			82. 00
83. 00		15 255 244		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	15, 355, 214		89. 00
00.00	NONREI MBURSABLE COST CENTERS	(0.4:0		- 00 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	63, 148		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0		91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0		92. 00
93.00	09300 NONPALD WORKERS	0		93. 00
94.00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00	Cross Foot Adjustments	0		98. 00
99.00	Negative Cost Centers	15 410 0/0		99. 00
100.00	D TOTAL	15, 418, 362		100. 00

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315404

				-	То	06/30/2021	Date/Time Pre 11/23/2021 9:	pared:
			CAPI TAL REI	LATED COSTS			11/23/2021 9	zz alli
	Cook Cooks Decoriation	D:+1	DI DCC 0	MOVADLE	٫ ا	C	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FIXTURES	MOVABLE EQUI PMENT	;	Subtotal	EMPLOYEE BENEFITS	
		Capi tal		243111112141			BENET 1 10	
		Related Costs		0.00				
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00		2A	3. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES							1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT							2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0		0	0	0	3. 00
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	58, 280 17, 784		0	58, 280 17, 784	0	4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE		21, 727		o	21, 727	0	6. 00
7.00	00700 HOUSEKEEPI NG	0	9, 878		0	9, 878	0	7. 00
8.00	00800 DI ETARY	0	41, 483	1	0	41, 483	0	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0	0	0	9. 00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY		0		0	0	0	10. 00 11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	o	0		o	Ö	0	12. 00
13.00	01300 SOCIAL SERVICE	0	4, 939		0	4, 939	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	1	0	0	0	14.00
15. 00 15. 01	01500 ACTI VI TI ES 01501 CHAPLAI N	0	23, 708 0		0	23, 708 0	0	15. 00 15. 01
13.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l of	0		U <u> </u>		0	13.01
30.00	03000 SKILLED NURSING FACILITY	0	249, 974		0	249, 974	0	30. 00
31. 00	03100 NURSING FACILITY	0	0	•	0	0	0	31. 00
32.00	03200 1 CF/I I D	0	000 (33	•	0	000 (22	0	32. 00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	899, 622		0	899, 622	0	33. 00
40. 00	04000 RADI OLOGY	0	0		0	0	0	40. 00
41.00	04100 LABORATORY	0	0		0	0	0	41. 00
42.00	04200 NTRAVENOUS THERAPY	0	0		0	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0 15, 666		0	0 15, 666	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0		o	13, 000	0	45. 00
46.00	04600 SPEECH PATHOLOGY	0	0		0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	(0	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51. 00	05100 SUPPORT SURFACES	O	0		0	Ö	0	51. 00
	OUTPATIENT SERVICE COST CENTERS							
60.00	06000 CLINIC	0	0		0	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC		0	1	0	0	0	61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS							02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	•	0	0	0	70. 00
71.00	07100 AMBULANCE	0	0		0	0	0	71.00
73. 00	O7300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0	0	0	73. 00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80. 00
81.00	08100 INTEREST EXPENSE							81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	_	_			_	_	82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	1 242 041	•	0	1 242 041	0	83. 00 89. 00
69.00	NONREI MBURSABLE COST CENTERS	l O	1, 343, 061		U _I	1, 343, 061	0	69.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		0	(0	0	0	91. 00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	0	92.00
93. 00 94. 00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY		0		0	0	0	93. 00 94. 00
98. 00	Cross Foot Adjustments		O		-	ő		98. 00
99. 00	Negative Cost Centers		0		0	o	0	99. 00
100.00	TOTAL	0	1, 343, 061		0	1, 343, 061	0	100. 00

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315404

				To	06/30/2021	Date/Time Pre 11/23/2021 9:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	22 4111
		& GENERAL	OPERATION, MAINT. &	LINEN SERVICE			
			REPAI RS				
	OFNEDAL CEDIMOR COCT OFNEDO	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	58, 280					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	5, 626	23, 410	1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	354	401		12 542		6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	3, 482 8, 414	183 766	1	13, 543 455	51, 118	7. 00 8. 00
9. 00	00900 NURSI NG ADMINI STRATI ON	0,414	700	i I	433	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	o	0	Ö	o	0	10. 00
11. 00	01100 PHARMACY	0	0	0	o	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	345	91	0	54	0	13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	1, 305	438	0	260	0	14. 00 15. 00
15. 00	01501 CHAPLAI N	84	430	1	260	0	15. 00
10.01	INPATIENT ROUTINE SERVICE COST CENTERS	3 1		,	<u> </u>		10.01
30.00	03000 SKILLED NURSING FACILITY	17, 312	4, 619	17, 986	2, 740	18, 914	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200 CF/IID	0	0	0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	16, 313	16, 623	4, 496	9, 862	32, 204	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	24	0	O	O	0	40. 00
41. 00	04100 LABORATORY	64	0		0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	Ö	o	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	346	0	0	О	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	2, 005	289	0	172	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	1, 079	0	0	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	768	0	0	0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	101	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	419	0	Ö	o	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	o	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS	1 0		ı	ما		
60. 00 61. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	60. 00 61. 00
62. 00	06200 FOHC	١	U		U U	U	62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0	- I	0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00							81.00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 H0SPI CE	0	0	О	О	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	58, 041	23, 410	22, 482	13, 543	51, 118	89. 00
	NONREI MBURSABLE COST CENTERS	000		1 al	ام		
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	239	0	0	0	0	90. 00 91. 00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0	0	0	0	91.00
93. 00	09300 NONPALD WORKERS		0		0	0	93.00
94. 00	09400 PATIENTS LAUNDRY	O	0	o	o	0	94. 00
98. 00	Cross Foot Adjustments			0	o	0	98. 00
99. 00		0	0	0	0	0	99. 00
100.00	D TOTAL	58, 280	23, 410	22, 482	13, 543	51, 118	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

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

					To 06/30/202		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	11/23/2021 9: SOCI AL SERVI CE	
	Sect Control Boson Per on	ADMI NI STRATI ON	SERVICES &		RECORDS &	0001712 021111 02	
			SUPPLY		LI BRARY		
	OSUSPAN OSPANOS OSOS OSPASSOS	9. 00	10. 00	11. 00	12. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1 00
1. 00 2. 00	00200 CAP REL COSTS - BLDGS & FIXTURES						1. 00 2. 00
3. 00	00300 EMPLOYEE BENEFITS						3.00
4. 00	00400 ADMI NI STRATI VE & 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	0					9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0				10.00
11. 00	01100 PHARMACY	0	0		0		11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	0	12. 00
13.00	01300 SOCIAL SERVICE	0	0		0	0 5, 429	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	
15. 00	01500 ACTIVITIES	0	0		-	0	
15. 01	O1501 CHAPLAIN I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l 0	0		0	0 0	15. 01
30. 00	03000 SKILLED NURSING FACILITY		0		0	0 5, 429	30.00
31. 00	03100 NURSING FACILITY		0		-	0 0,427	1
32. 00	03200 CF/11D		0	•		o o	
33. 00	03300 OTHER LONG TERM CARE	o	0			0 0	1
	ANCILLARY SERVICE COST CENTERS	-1	-			-1	1
40.00	04000 RADI OLOGY	0	0		0	0 0	40. 00
41.00	04100 LABORATORY	0	0		0	0 0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0 0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	0	0		0	0	
45. 00	04500 OCCUPATI ONAL THERAPY	0	0		0	0	
46. 00	04600 SPEECH PATHOLOGY	0	0		0	0	
47. 00	04700 ELECTROCARDI OLOGY	0	0		0	0	
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
49. 00 50. 00	O4900 DRUGS CHARGED TO PATIENTS O5000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0 0	49. 00 50. 00
51. 00	05100 SUPPORT SURFACES		0				1
31.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		U	0 0	31.00
60. 00	06000 CLINIC	0	0		0	0 0	60.00
61. 00	06100 RURAL HEALTH CLINIC	o	0			0 0	1
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS					•	1
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0 0	70. 00
71. 00	07100 AMBULANCE	0	0			0	
73. 00	07300 CMHC	0	0		0	0 0	73. 00
	SPECIAL PURPOSE COST CENTERS			Г		<u> </u>	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82. 00 83. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	o	0		0	0 0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)		0			0 5, 429	
07.00	NONREI MBURSABLE COST CENTERS	<u> </u>	0		Ο _Ι	O ₁ 5, 429	07.00
90. 00		0	0		0	0 0	90.00
91. 00	09100 BARBER AND BEAUTY SHOP		0			0 0	1
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		0		0	0 0	1
93. 00	09300 NONPALD WORKERS	0	0		0	0 0	1
94.00	09400 PATIENTS LAUNDRY	0	0		0	0 0	1
98. 00	Cross Foot Adjustments	0	0		0		98. 00
99. 00	Negative Cost Centers	0	0		-	0 0	
100.00	TOTAL	0	0		0	0 5, 429	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Cost Center Description							То	06/30/2021	Date/Time Pre	
COSH CENTRAL SERVICE COST CENTERS					OTHER GENER	RAL SERVICE			11/23/2021 9:.	22 am
ALLIED HEALTH FINAL SERVICE COST CEVERES 1.00 CORREAL SERVICE COST CEVERES 1.00										
EQUEATION 15.00 15.01 16.00 17.00			Cost Center Description		ACTI VI TI ES	CHAPLAI N		Subtotal		
SENERAL SERVICE COSTS - BLOGS & FIXTURES									Auj us tillerits	
1.00					15. 00	15. 01		16. 00	17. 00	
2.00 0.0020 CAP REL COSTS - MOVABLE FOULPMENT	1 00									1 00
3.00		1								
0.000 0.000 DLANT DEFRATION, MAINT. & REPAIRS										
0.000 0.0000 LAUNDRY & LINEN SERVICE	4.00	00400	ADMINISTRATIVE & GENERAL							4. 00
7.00 00700 HOUSEKEEPING		1								
B.00 00800 DIETARY										
9.00 0.0000 NURSING ADMINISTRATION 9.000 10.00 11.00 11.000		1								
10. 00 10000 CENTRAL SERVICES & SUPPLY		1								
12 00 10200 MEDICAL RECORDS & LIBRARY		1								
13. 00 01300 SOCIAL SERVICE 14. 00 01500 NURSIN KA DALLIED HEALTH EDUCATION 0 25, 711 1 10 10 10 10 10 10										
14. 00 01-400 NURSI NG AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 0 15. 01 15.00 01-500										
15. 00 01500 ACTIVITIES				0						
15. 01		1		0	25 711					
INPATE ENT ROUTINE SERVICE COST CENTERS 30, 00 30, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 31, 00 32, 00 33, 00 33, 00 32, 00 32, 00 32, 00 32, 00 33, 00 33, 00 32, 00 32, 00 32, 00 32, 00 32, 00 33, 00 32, 00 32, 00 32, 00 32, 00 32, 00 32, 00 33, 00 32, 00 32, 00 32, 00 32, 00 33, 00 32, 00 32, 00 32, 00 32, 00 32, 00 33, 00 32,				0		1	84			
31 00 03100 NURSI NG FACILITY										
32.00 03200 1CF/I I D				0	25, 711		28	342, 713		
33.00 03300 OTHER LONG TERN CARE 0 0 56 979, 176 0 33.00				0				-		
ANCILLARY SERVICE COST CENTERS		1		0			-	- 1		
40.00 04000 RADI OLOGY	33.00			l ol	U		30	979, 170	U	33.00
A2. 00 04200 NTRAVERIOUS THERAPY 0 0 0 0 0 42. 00	40. 00			0	0		0	24	0	40. 00
43.00 04300 04300 04300 04300 0440	41.00	04100	LABORATORY	0	0		0	64	0	41.00
44. 00 04400 PHYSICAL THERAPY		1		0	0		0	-	_	
45.00 04500 OCCUPATIONAL THERAPY 0 0 0 1,079 0 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 0 768 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 101 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 101 0 48.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 62.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 61.00 06100 RURAL HEALTH AGENCY COST 0 0 0 0 0 0 71.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71.00 07100 AMBULANCE 0 0 0 0 0 0 71.00 07300 CMHC SON ONLOWING SPECIAL PURPOSE COST CENTERS 80.00 80.00 08200 WILL LIZATION REVIEW - SNF 81.00 81.00 83.00 08300 WILL LIZATION REVIEW - SNF 82.00 83.00 08300 UTIL LIZATION REVIEW - SNF 0 0 0 0 0 80.00 O9000 GIFF, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.00 09000 GIFF, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 90.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 90.00 09100 DARBER AND BEAUTY SHOP 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES 0 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES 0 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES 0 0 0 0 0 90.00 09400 PURSI CLANS PRIVATE OFFICES				0	0		0	1		
46.00 04600 SPEECH PATHOLOGY 0 0 0 0 768 0 46.00 47.00 04700 LECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 101 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 419 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 50.00 51.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0		0			
47. 00 04700 04700 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 1011 0 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 4199 0 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50. 00 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 51. 00 OSTORO STREAKES 0 0 0 0 0 0 52. 00 OSTORO STREAKES 0 0 0 0 0 0 53. 00 OSTORO STREAKES 0 0 0 0 0 0 54. 00 OSTORO STREAKES 0 0 0 0 0 55. 00 OSTORO STREAKES 0 0 0 0 0 56. 00 OSTORO STREAKES 0 0 0 0 57. 00 OSTORO STREAKES 0 0 0 0 58. 00 OSTORO STREAKES 0 0 0 0 59. 00				o	0		0			
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 419 0 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 60. 00 06000 CLI NI C 0 0 0 0 0 0 61. 00 06100 RURAL HEALTH CLINI C 0 0 0 0 0 62. 00 06200 FOHC 0 0 0 0 0 0 70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 71. 00 07100 AMBULANCE 0 0 0 0 0 0 0 71. 00 07300 CMHC SEPECIAL PURPOSE COST CENTERS 80. 00 08000 MALPRACTI CENTERS 80. 00 81. 00 81. 00 81. 00 08100 INTEREST EXPENSE 81. 00 82. 00 08300 HOSPI CE SUBTOTALS Sum of Lines 1-84) 0 25,711 84 1,342,822 0 89. 00 83. 00 SUBTOTALS (Sum of Lines 1-84) 0 25,711 84 1,342,822 0 89. 00 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 92. 00 09300 NONPAID WORKERS 0 0 0 0 0 93. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 Negative Cost Centers 0 0 0 0 99. 00 09400 PATIENTS LAUNDRY 0 0 0 0 99. 00 09400 PATIENTS LAUNDRY 0 0 0 0 99. 00 09400 PATIENTS LAUNDRY 0 0 0 0 99. 00 09400 PATIENTS LAUNDRY 0 0 0 0 99. 00 09400 PATIENTS LAUNDRY 0 0 0 0 99. 00 09400 PATIENTS LAUNDRY	47.00			0	0		0		0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 51.00				0	0		0			
51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0				0	0		0		-	
OUTPATIENT SERVICE COST CENTERS O		1		0	-		-	-		
60. 00	31.00			<u> </u>	0	l .		<u> </u>	0	31.00
62. 00 O6200 FOHC OTHER REI MBURSABLE COST CENTERS	60.00			0	0		0	0	0	60.00
OTHER REIMBURSABLE COST CENTERS O				0	0		0	0	0	
70.00	62. 00						\perp			62. 00
71. 00	70.00				0	I	0	ما	0	70.00
73. 00				0						
80. 00		1		Ö				-		
81. 00		SPECIA	AL PURPOSE COST CENTERS							
82. 00										
83. 00										
89. 00 SUBTOTALS (sum of lines 1-84) 0 25,711 84 1,342,822 0 89. 00				0	0		0	0	0	
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 239 0 90.00		00300						1, 342, 822		
91. 00		NONRE		-1				, , , , ,		
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 93. 00 94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94. 00 98. 00 Cross Foot Adjustments 0 0 0 0 98. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00				0	0		0	239		
93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 93. 00 94. 00 94. 00 95. 00				0	-	•	0	0		
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 98.00 Cross Foot Adjustments 0 0 0 0 0 98.00 99.00 Negative Cost Centers 0 0 0 0 0 99.00				0	-		U	0		
98.00 Cross Foot Adjustments		1			-		0	0		
99.00 Negative Cost Centers 0 0 0 99.00				l ol	-		0	ő		
100. 00 TOTAL 0 25, 711 84 1, 343, 061 0 100. 00	99. 00		Negative Cost Centers	o			-	О		99.00
	100.00)	TOTAL	0	25, 711	l	84	1, 343, 061	0	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLLI NGSWOOD MANOR

| Peri od: | Worksheet B | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Provi der No.: 315404

			To 06/30/2021 Date/Time Pre	
	Cost Center Description	Total	11/23/2021 7.	22 (1111
		18. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES			1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT			2. 00
3.00	00300 EMPLOYEE BENEFITS			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE			6. 00
7. 00	00700 HOUSEKEEPI NG			7. 00
8. 00	00800 DI ETARY			8. 00
9. 00	00900 NURSING ADMINISTRATION			9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY			1
	01100 PHARMACY			10.00
11.00				11.00
	01200 MEDI CAL RECORDS & LI BRARY			12.00
	01300 SOCIAL SERVICE			13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION			14. 00
15. 00	01500 ACTI VI TI ES			15. 00
15. 01	01501 CHAPLAI N			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			1
	03000 SKILLED NURSING FACILITY	342, 713		30. 00
31. 00	03100 NURSING FACILITY	0		31. 00
32.00	03200 CF/IID	0		32. 00
33.00	03300 OTHER LONG TERM CARE	979, 176		33. 00
	ANCILLARY SERVICE COST CENTERS			
40.00	04000 RADI OLOGY	24		40. 00
41.00	04100 LABORATORY	64		41.00
42.00	04200 I NTRAVENOUS THERAPY	ol		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	346		43.00
	04400 PHYSI CAL THERAPY	18, 132		44. 00
	04500 OCCUPATI ONAL THERAPY	1, 079		45. 00
46. 00	04600 SPEECH PATHOLOGY	768		46. 00
	04700 ELECTROCARDI OLOGY	0		47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	101		48. 00
	04900 DRUGS CHARGED TO PATIENTS	419		49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00	1 1	0		51.00
31.00	O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	l ol		31.00
40.00	06000 CLINIC	0		60.00
60.00	1 1	0		1
61.00	06100 RURAL HEALTH CLINIC	U		61.00
62. 00	06200 FOHC			62. 00
70.00	OTHER REIMBURSABLE COST CENTERS			70.00
70.00	07000 HOME HEALTH AGENCY COST	0		70.00
71. 00	07100 AMBULANCE	0		71. 00
73. 00	07300 CMHC	0		73. 00
	SPECIAL PURPOSE COST CENTERS	1		
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
	08100 I NTEREST EXPENSE			81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF			82. 00
83. 00	08300 H0SPI CE	0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	1, 342, 822		89. 00
	NONREI MBURSABLE COST CENTERS			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	239		90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0		91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	o		92. 00
93.00	09300 NONPALD WORKERS	l ol		93. 00
94.00	09400 PATIENTS LAUNDRY	ol		94.00
98.00	Cross Foot Adjustments	o		98. 00
99. 00	Negative Cost Centers	o		99. 00
100.00		1, 343, 061		100.00
32.30	i i i			

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					Γο 06/30/2021	Date/Time Pre 11/23/2021 9:	
		CAPI TAL REI	LATED COSTS			1172372021 7.	22 4111
	Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FIXTURES (SOLIARE EEET)	(SQUARE FEET)	BENEFITS (GROSS		& GENERAL (ACCUM COST)	
		,	,	SALARI ES)		, ,	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	147, 118					1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT		(1			2.00
3. 00 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	6, 384	1	7, 389, 18 951, 91		12, 469, 189	3. 00 4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 948	c	353, 05	1 0	1, 203, 718	5. 00
6. 00 7. 00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	2, 380 1, 082		28, 51 329, 32		75, 732 745, 077	6. 00 7. 00
8. 00	00800 DI ETARY	4, 544		602, 37		1, 800, 235	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	C		0	0	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0				0	10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	C		0	0	12. 00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	541		54, 77	0 0	73, 812 0	13. 00 14. 00
15. 00	01500 ACTIVITIES	2, 597		180, 27	-	•	15. 00
15. 01	01501 CHAPLAIN	0	C	14, 33	0	18, 019	15. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	27, 382		2, 268, 68	5 0	3, 704, 195	30. 00
31. 00	03100 NURSING FACILITY	0	C		0	0	31. 00
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	98, 544		1	0 5 0		32. 00 33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	70, 344		7, 773, 21	5 0	3, 470, 101	33.00
40.00	04000 RADI OLOGY	0	C	1	0	-,	40.00
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0		1		13, 722 0	41. 00 42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	d	58, 05	4 O	73, 923	43. 00
44. 00 45. 00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	1, 716	C	321, 71 119, 55		428, 885 230, 886	
46. 00	04600 SPEECH PATHOLOGY	0		102, 69		164, 224	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	C		0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0				21, 508 89, 750	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0	0	50. 00
51. 00	O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	C		0	0	51. 00
60. 00	06000 CLINIC	0	C		0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	C		0	0	61.00
62. 00	06200 FOHC OTHER REIMBURSABLE COST CENTERS						62. 00
	07000 HOME HEALTH AGENCY COST	0	C	•	0		70. 00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0		1		-	71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	0		7	<u> </u>		73.00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83.00	08300 H0SPI CE	0	C	1	0	_	83. 00
89. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	147, 118	C	7, 358, 46	-2, 949, 173	12, 418, 120	89. 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	С	30, 71	4 O	51, 069	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	C	1	0	-	91.00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0		1	0 0	0	92. 00 93. 00
94.00	09400 PATIENTS LAUNDRY	0	C		0	0	94. 00
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00		1, 343, 061	C	1, 902, 14	9	2, 949, 173	
102.00	Part I)	0 120141	0.00000	0.25742	4	0 224517	102 00
103. 00 104. 00		9. 129141	0. 000000	0. 25742	o d	0. 236517 58, 280	
	Part II)						
105.00	Unit cost multiplier (Wkst. B, Part			0.00000	ין	0. 004674	105. 00
		•	•	•	•		•

Provi der No.: 315404

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

PLANT CONTROL CONTRO					Т	o 06/30/2021	Date/Time Pre 11/23/2021 9:	
REPAIR SERVICE COST CENTERS SQUARE FEET A. 00		Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		22 (111)
REPAIR SAMPHER COST CENTERS SCRIMERY		·	·		(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
SUMPRIES				,			(DI RECT NUR	
ENERAL SERVICE COST CENTERS 5.00 6.00 7.00 8.00 9.00				LAUNDIN'I)			•	
1.00 100				6. 00	7.00	8. 00		
2.00	1 00		I	I	ı			1 00
3.00 0.0000 DATE OF BENEFITS 3.00 3.00 0.0000 DATE OF CREATION, MAINT & REPAIRS 1.88 786 5.00 0.0000 DATE OF CREATION, MAINT & REPAIRS 1.88 786 5.00 0.0000 DATE OF CREATION, MAINT & REPAIRS 1.88 786 5.00 0.0000 DATE OF CREATION, MAINT & REPAIRS 1.86 0 1.35, 324 1.15, 255 8.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000		· ·						1
5.00								1
0.000 0.0000 LANDRY & LINEN SERVICE 2,380 243,568 1,062	4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
0.00 00700				•				1
8. 00 0 08000 UNESN KA AVAINI STRATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					l .			1
9.00 09000 NURSING ADMINISTRATION 0 0 0 0 0 0 0 0 0 10.00 11.00 110.00 110.00 ENTRAL SERVICE & SUPPLY 0 0 0 0 0 0 0 10.00 11.00 110.00 110.00 MIDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 11.00 11.00 12.00 110.00 MIDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 11.00				0	1			1
10. 00 01000 CENTRAL SERVICE'S & SUPPLY 0 0 0 0 0 0 0 11.00 11					4, 344	115, 255	0	1
11.00 01100 PHARMACY 0 0 0 0 0 0 11.00 12.00 12.00 12.00 01200 08DICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 12.00 13.00 14.00				٥	Ö	o		1
13.0 0 13500 SOCIAL SERVICE 541 0 541 0 0 0 0 0 0 14.00			0	0	0	0		1
14 00 01-400 NRSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 0 15.00			0	0	0	0	0	1
15.00 01500 ACTIVITIES 2.597			541	0	541	0	_	1
15. 01			0	0	2 507	0	_	1
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 31.				0	1	0		1
30.00 03000 SKILLED NURSING FACILITY	13.01				1 0	<u> </u>	0	15.01
32.00 03200 CIFF LONG TERM CARE	30.00		27, 382	194, 854	27, 382	42, 645	0	30. 00
33.00 03300 OTHER LONG TENI CARE 98,544 48,714 98,544 72,610 0 33.00	31.00	03100 NURSING FACILITY	1		. 0	0	0	31. 00
ANCILLARY SERVICE COST CENTERS			0	0	0	0	_	
40.00 04000 RADI OLOCY	33. 00		98, 544	48, 714	98, 544	72, 610	0	33. 00
41.00	40.00			1 0			0	40.00
42.00 04200 INTRAVENOUS THERAPY 0 0 0 0 0 0 43.00 43.00 04300 0XYOEN (INHALATION) THERAPY 1,716 0 1,716 0 0 0 0 44.00 04400 PHYSICAL THERAPY 1,716 0 1,716 0 0 0 0 45.00 04500 0CCUPATIONAL THERAPY 0 0 0 0 0 0 0 46.00 04600 04600 04600 0 0 0 0 0 0 0 47.00 04700 04000 04000 0 0 0 0 0		1	_	0		0		
43. 00 04300 DAYSEN (INHALATION) THERAPY		· ·		ĺ	Ö	o		1
45.00 04500 0CCUPATIONAL THERAPY 0 0 0 0 0 0 56.00 47.00 04700 048.00 050.0		· ·	0	0	0	0	0	1
44.00 04600 SPEECH PATHOLOGY 0 0 0 0 0 46.00 47.00 04700 ELCTROCARDIOLOGY 0 0 0 0 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 60.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 61.00 06100 OTHER TERMINATION 0 0 0 0 0 62.00 06200 FOHC 0 0 0 0 0 0 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 62.00 06200 FOHC 0 0 0 0 0 0 0 62.00 07100 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 61.00 07100 MBULANCE 0 0 0 0 0 0 0 61.00 07100 MBULANCE 0 0 0 0 0 0 0 0 61.00 07100 MBULANCE 0 0 0 0 0 0 0 0 61.00 08100 INTEREST EXPENSE 82.00 83.00 61.00 08100 INTEREST EXPENSE 82.00 83.00 61.00 08000 MALPRACTICE PREMILIMS & PAID LOSSES 81.00 61.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 61.00 09000 09000 0900 09000 09000 09000 09000 61.00 090000 090000 090000 09000 09000 09000 090000 090000 090000 090000 0900	44.00		1, 716	0	1, 716	0		44. 00
47.00 04700 CATOOL CLECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0			0	0	0	0		1
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0	0	0	0		1
49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 50.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 50.00 DUTPATIENT SERVICE COST CENTERS		1	0	0		0	_	1
50. 00				0		0		
51.00			0	0	Ö	o		1
60. 00	51.00		0	0	0	0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 61.00 62.00 07000 FOHC 07100 07000 More HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0				,				
62. 00 O6200 FOHC OTHER REI MBURSABLE COST CENTERS								
OTHER REIMBURSABLE COST CENTERS O			0	0	0	0	0	
70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 77. 00 071.00 07100 MMBULANCE 0 0 0 0 0 0 0 0 0	02.00							02.00
73.00	70. 00		0	0	0	0	0	70. 00
SPECIAL PURPOSE COST CENTERS 80.00 80.00 MALPRACTICE PREMIUMS & PAID LOSSES 81.00		07100 AMBULANCE	0	0	0	0	0	71. 00
80. 00	73. 00		0	0	0	0	0	73. 00
81.00 08100 INTEREST EXPENSE 82.00 82.00 UTILIZATION REVIEW - SNF 82.00 83.00 08300 HOSPICE 0 0 0 0 0 0 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 138,786 243,568 135,324 115,255 0 89.00	00.00			ı	1			00.00
82. 00								
83. 00					•			
SUBTOTALS (sum of lines 1-84) 138,786 243,568 135,324 115,255 0 89.00			0	0	o	0	0	
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 90. 00 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 0 92. 00 93. 00 93. 00 93. 00 90. 00 0 0 0 0 0 0 0 0			138, 786	243, 568	135, 324	115, 255	0	
91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 91.00 92.00 93.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 92.00 93.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 0 0 0 0 0 0 0 0 0								
92. 00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92. 00 93. 00 93. 00 94. 00 94. 00 94. 00 98. 00 99. 00 0 0 0 0 0 94. 00 99. 00 0 0 0 0 0 0 0 0 0					_	-		
93. 00 09300 NONPAID WORKERS 0 0 0 0 0 93. 00 94. 00 98. 00 99. 00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 10. 724554 0. 489260 Cost to be allocated (per Wkst. B, Part II) 105. 00 Unit cost multiplier (Wkst. B, Part I 0. 168677 0. 092303 0. 100078 0. 443521 0. 000000 105. 00 0 93. 00 0 93. 00 0 94. 00 0 94. 00 98. 00 99. 00 0 0 0 0 0 94. 00 98. 00 99. 00 0 0 0 0 0 0 0 0 0		· ·	-	1	•			
94. 00 94. 00 98. 00 98. 00 Cross Foot Adjustments 99. 00 Negative Cost Centers 102. 00 Cost to be allocated (per Wkst. B, Part I) 10. 724554 0. 489260 Cost to be allocated (per Wkst. B, Part II) 105. 00 Unit cost multiplier (Wkst. B, Part I 0. 168677 0. 092303 0. 100078 0. 443521 0. 000000 105. 00 0. 94. 00 98. 00 99			-	1		0		
98.00 99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 0.168677 0.092303 0.100078 0.443521 0.000000 105.00			0	0	Ö	o		
102.00 Cost to be allocated (per Wkst. B, Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 10.724554 Cost to be allocated (per Wkst. B, Part II) 105.00 Unit cost multiplier (Wkst. B, Part II) 10.724554 22,482 13,543 51,118 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII								
Part I) Unit cost multiplier (Wkst. B, Part I) 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 105.00 Unit cost multiplier (Wkst. B, Part I) 0. 489260 22, 482 13, 543 51, 118 0 104.00 105.00 0. 000000 105.00								1
103.00 Unit cost multiplier (Wkst. B, Part I) 10.724554 0.489260 6.893855 20.008494 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 23,410 22,482 13,543 51,118 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part II) 0.168677 0.092303 0.100078 0.443521 0.000000 105.00	102.00		1, 488, 418	119, 168	932, 904	2, 306, 079	0	102. 00
104.00 Cost to be allocated (per Wkst. B, Part 23,410 22,482 13,543 51,118 0 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.168677 0.092303 0.100078 0.443521 0.000000 105.00	102.00		10 724554	0 400240	4 0030EE	20 000404	0 000000	103 00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part 0.168677 0.092303 0.100078 0.443521 0.000000 105.00			1		1			
105.00 Unit cost multiplier (Wkst. B, Part 0.168677 0.092303 0.100078 0.443521 0.000000 105.00	154.00		25, 410	22, 402	15, 545	31, 110		
	105.00	Unit cost multiplier (Wkst. B, Part	0. 168677	0. 092303	0. 100078	0. 443521	0. 000000	105. 00
		11)	l	l	l			l

Heal th	Financial Systems	COLLI NGSWO	OD MANOR		In Lie	u of Form CMS-	2540-10
COST ALLOCATION - STATISTICAL BASIS			Provi der No.: 315404		Period: Worksheet B-1 From 07/01/2020		
					To 06/30/2021		pared:
	Cost Contor Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11/23/2021 9: NURSI NG AND	22 am
	Cost Center Description	SERVICES &	(COSTED REQ	RECORDS &	SOCIAL SERVICE	ALLI ED HEALTH	
		SUPPLY	UIS)	LI BRARY	(PATIENT DA	EDUCATI ON	
		(COSTED REQ		(TIME SPENT)	YS)	(ASSI GNED	
		UI S) 10. 00	11. 00	12.00	13. 00	TI ME) 14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS			•			2. 00 3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7.00	00700 HOUSEKEEPI NG 00800 DI ETARY						7.00
8. 00 9. 00	00900 NURSING ADMINISTRATION						8. 00 9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	o					10.00
11. 00	01100 PHARMACY	0	0				11. 00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0		14 215		12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 14, 215 0 0	0	13.00
15. 00	01500 ACTIVITIES		0			0	1
15. 01	01501 CHAPLAI N	0	0		0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	0	0	1	0 14, 215 0 0	0	
31.00	03200 I CF/IID	0	0	l .		0	1
33. 00	03300 OTHER LONG TERM CARE	o	0	1	0	Ö	1
	ANCILLARY SERVICE COST CENTERS			1	1		
40.00	04000 RADI OLOGY	0	0	1	0	0	
41. 00 42. 00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0	1	0 0	0	
	04300 OXYGEN (INHALATION) THERAPY	0	0	1		0	1
44.00	04400 PHYSI CAL THERAPY	0	0		0	0	1
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	1	0	0	45. 00
46. 00 47. 00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0		0 0	0 1	46. 00 47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	O	0		0	0	1
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	
51. 00	05100 SUPPORT SURFACES	0	0) (0	0	51.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0		1 (0 0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	O	0		0	Ō	
62. 00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0		J		0	70.00
	07100 AMBULANCE	0	0	1	0 0	0	1 _ 1 11
	07300 CMHC	0	0	1	0		
	SPECIAL PURPOSE COST CENTERS						
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF			•			81. 00 82. 00
83. 00	08300 HOSPI CE	o	0		0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	0		14, 215	0	89. 00
00.00	NONREI MBURSABLE COST CENTERS			ı			00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0	1	0 0	0	
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	Ö	0	1		0	1
93. 00	09300 NONPALD WORKERS	0	0		0	0	
94.00	09400 PATIENTS LAUNDRY	0	0	1	0	0	
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers						98. 00 99. 00
102.00	1 1 0	0	O		100, 802	О	102. 00
	Part I)						
103.00		0. 000000	0. 000000	0.00000		0.000000	
104.00	Cost to be allocated (per Wkst. B, Part II)		C	'	5, 429	0	104. 00
105.00		0. 000000	0. 000000	0. 000000	0. 381921	0. 000000	105. 00
				l			I

COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Provi der No.: 315404

				10 06/30/2021 Date/lime Pr 11/23/2021 9	
		OTHER GENER	RAL SERVICE	1.7237202.	
	Cost Contan Decemintion	ACTIVITIES	CHADLALN		
	Cost Center Description	ACTIVITIES (PATIENT DA	CHAPLAIN (PATIENT DA		
		YS)	YS)		
	T	15. 00	15. 01		
1 00	GENERAL SERVICE COST CENTERS				1 00
1. 00 2. 00	OO100 CAP REL COSTS - BLDGS & FIXTURES OO200 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	O0600 LAUNDRY & LINEN SERVICE O0700 HOUSEKEEPING				6. 00 7. 00
8. 00	00800 DI ETARY				8. 00
9.00	00900 NURSING ADMINISTRATION				9. 00
10.00	01000 CENTRAL SERVI CES & SUPPLY				10.00
11. 00 12. 00	O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY				11. 00 12. 00
	01300 SOCIAL SERVICE				13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION				14. 00
	01500 ACTI VI TI ES	14, 215	40.050		15. 00
15. 01	O1501 CHAPLAI N I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	43, 259		15. 01
30. 00	03000 SKILLED NURSING FACILITY	14, 215	14, 215		30.00
	03100 NURSING FACILITY	0	0		31. 00
32.00	03200 CF/ D	0	0		32. 00
33. 00	O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	29, 044		33. 00
40. 00	04000 RADI OLOGY	0	0		40. 00
	04100 LABORATORY	0	0		41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0		42. 00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0		43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	O		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0		47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		48. 00 49. 00
	O4900 DRUGS CHARGED TO PATIENTS O5000 DENTAL CARE - TITLE XIX ONLY	0	0		50.00
51. 00	05100 SUPPORT SURFACES	0	0		51. 00
	OUTPATIENT SERVICE COST CENTERS				
60.00	06000 CLINIC	0	0		60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	U		61. 00 62. 00
02.00	OTHER REIMBURSABLE COST CENTERS				- 02.00
	07000 HOME HEALTH AGENCY COST	0	0		70. 00
	07100 AMBULANCE	0	0		71. 00
73. 00	O7300 CMHC SPECI AL PURPOSE COST CENTERS	0	0		73. 00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES				80.00
	08100 I NTEREST EXPENSE				81. 00
82.00	08200 UTILIZATION REVIEW - SNF				82. 00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	14, 215	0 43, 259		83. 00 89. 00
07.00	NONREI MBURSABLE COST CENTERS	14, 213	45, 257		09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		91. 00
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		92. 00 93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0		94. 00
98. 00	Cross Foot Adjustments				98. 00
99. 00	Negative Cost Centers				99. 00
102.00	Cost to be allocated (per Wkst. B, Part I)	390, 955	22, 281		102. 00
103.00	1 1	27. 502990	0. 515060		103. 00
104.00		25, 711	84		104. 00
405.55	Part II)	4 0007	0.0040:-		405.00
105.00	Unit cost multiplier (Wkst. B, Part	1. 808723	0. 001942		105. 00
	1 1117	1	ı	I	1

Health Financial Systems	COLLI NGSWOOD MA	ANOR		In Lie	eu of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY A	AND OUTPATIENT COST CENTERS	Provi der	No.: 315404	From 07/01/2020		aarad.
				To 06/30/2021	Date/Time Pre 11/23/2021 9:	
Cost Center Description			Total (from	Total Charges	Ratio (col. 1	
			Wkst. B, Pt I	,	di vi ded by	
			COL 10)		601 2	

	T	06/30/2021	Date/Time Prep 11/23/2021 9:2	
Cost Center Description	Total (from	Total Charges		22 4111
	Wkst. B, Pt I,		di vi ded by	
	col . 18)		col. 2	
	1. 00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS				
40. 00 04000 RADI OLOGY	6, 383	5, 162	1. 236536	40.00
41. 00 04100 LABORATORY	16, 967	14, 108	1. 202651	41.00
42.00 04200 I NTRAVENOUS THERAPY	0	0	0. 000000	42.00
43.00 04300 0XYGEN (INHALATION) THERAPY	91, 407	58, 979	1. 549823	43.00
44. 00 O4400 PHYSI CAL THERAPY	560, 557	439, 758	1. 274694	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	285, 494	295, 431	0. 966364	45.00
46. 00 04600 SPEECH PATHOLOGY	203, 066	128, 766	1. 577016	46.00
47. 00 04700 ELECTROCARDI OLOGY	0	0	0.000000	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 595	21, 508	1. 236517	48.00
49.00 O4900 DRUGS CHARGED TO PATIENTS	110, 977	88, 872	1. 248729	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0. 000000	50.00
51. 00 05100 SUPPORT SURFACES	0	0	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS				
60. 00 06000 CLI NI C	0	0	0. 000000	60.00
61.00 06100 RURAL HEALTH CLINIC				61.00
62. 00 06200 FQHC				62.00
71. 00 07100 AMBULANCE	0	0	0. 000000	
100. 00 Total	1, 301, 446	1, 052, 584	l	100. 00

Health Financial Systems	COLLI NGSWO	OD MANOR		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315404	Peri od: From 07/01/2020 To 06/30/2021		epared: 22 am
		Title	XVIII (1)	Skilled Nursing Facility		
		Heal th Care Pr			Program Cost	
Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	I ENT COST					1
ANCILLARY SERVICE COST CENTERS	1 00/50/		T.	0 0.44	1	
40. 00 04000 RADI OLOGY	1. 236536			0 3, 044		
41. 00 04100 LABORATORY	1. 202651	12, 926		0 15, 545	l .	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 549823			0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 274694			0 256, 730		
45. 00 04500 OCCUPATI ONAL THERAPY	0. 966364			0 179, 203	l .	
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	1. 577016			0 133, 516		1
	0.000000	0		0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49.00 04900 DRUGS CHARGED TO PATIENTS	1. 236517 1. 248729	80, 352		0 100, 338	_	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			100, 336		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	1			0	
OUTPATIENT SERVICE COST CENTERS	0.00000	U U		0 0	0	31.00
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0.00000					61.00
62. 00 06200 FQHC						62.00
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)	2. 223000	567, 249		0 688, 376		100.00
(1) For title V and XIX use columns 1, 2, and 4 onl	y.	,,,	ı	.,	-	1

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

Health Financial Systems COLLINGSWOOD MANOR In Lieu of Form CMS-254						2540-10	
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315404	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 9:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of cos	st to charges	(From Workshee	t C, column 3	line 49)	1. 248729	1.00
2.00	Program vaccine charges (From your recor	ds, or the PS	&R)		·	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title)	KVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)		1				
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health		Cost (From	& Allied	
		Part I, Col. 18	(From Wkst. B, Part I, Col.	Costs to Tota		Health Costs for Pass	
		18		Costs - Part		Through (Col.	
			14)	(Col. 2 / Col		3 x Col . 4)	
				1)		0 x 30.1 1,	
		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	6, 383		1 0.00000			
41. 00	04100 LABORATORY	16, 967	0	0.00000			41. 00
42.00	04200 NTRAVENOUS THERAPY	0	0	0.00000		0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	91, 407	l e	0.00000		0	43.00
44. 00 45. 00	04400 PHYSI CAL THERAPY	560, 557	l e	0.00000		l e	44. 00 45. 00
46. 00	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY	285, 494 203, 066	ł	0. 00000 0. 00000		l	46.00
47. 00	04700 ELECTROCARDI OLOGY	203,000		0.00000		0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 595		0.00000		0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	110, 977		0.00000			49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0		0. 00000		Ö	50.00
51.00	05100 SUPPORT SURFACES	0	0	0.00000	0	0	51.00
100.00	Total (Sum of lines 40 - 52)	1, 301, 446	0		688, 376	0	100. 00

Private room days Inpatient days including private room days applicable to the Program Inpatient days including private room days applicable to the Program Inpatient days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program Interest days including private room days applicable to the Program interest days including applicable to the Program interest days including applicable to the Program interest days included by Interest days included by Interest days including applicable to program (line 4 times line 13) Interest days including applicable to program (line 4 times line 13) Interest days including applicable to program (line 4 times line 13) Interest days including applicable to program (line 4 times line 13) Interest days including applicable to program (line 4 times line 18) Interest days including applicable to program (line 4 times line 18) Interest days including applicable to program (line 4 times line 18) Interest days including applicable to program (line 4 times line 18) Interest days including applicable to program (line 4 times line 18) Interest days including applicable to program (line 4 times line 18) Interest days including app	leal th	Financial Systems COLLINGSWOOD N	MANOR	In Lie	u of Form CMS-2	2540-1
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Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	15. 00	General inpatient routine service cost net of private room cos	t differential (Line 5	minus line 14)	6, 510, 401	15.00
Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX						
Medically necessary private room cost applicable to program (line 4 times line 13) Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	16. 00		ided by line 1)			
Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	17.00					
Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	18. 00 19. 00				_	
line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	20.00			rt II column 18		
Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	.0. 00		313 (ITOIII WKST. D, Tai	t ii corumii io,	342,713	20.00
Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	21. 00				24. 11	21.00
Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	2. 00					
Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	3. 00	Inpatient routine service cost (Line 19 minus line 22)			1, 023, 547	23. 0
Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	24. 00				Ĭ	24. 0
On Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1) Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX	5. 00	00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24) 1,023,547				
Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX 1.00	6. 00					
(Transfer to Worksheet E, Part II, line 4) (See instructions) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX 1.00	7.00					
Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX 1.00	28. 00		e resser of line 25 or	line 2/)		28. 00
1.00	′1) Li		ed for title V and or t	itle XIX	I	I
	1) [1103 20 and 27 are not appricable for title Aviii, but may be us		THE MIN		
					1 00	
PART IT CALCIDATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		DART III ON OU ATLON OF INDATLENT NUROLNO A ALLER USALTU COOTO	FOR DRO BAGO TUROUGU		1.00	

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	14, 215	1.00
2.00	Program inpatient days (see instructions)	2, 359	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. 165951	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems COLLINGSWOOD M			u of Form CMS-2	
)MPU I	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315404	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D-1 Parts I-II Date/Time Pre 11/23/2021 9:3	pare
		Title XIX	Skilled Nursing Facility	Cost	
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days including private room days			14, 215	
00	Private room days			0	2.
00	Inpatient days including private room days applicable to the Pr			5, 200	
00 00	Medically necessary private room days applicable to the Program			0	4. 5.
JU	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			6, 510, 401) 3
0	General inpatient routine service charges			7, 511, 844	6
0	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 866685	
0	Enter private room charges from your records			0	8
00	Average private room per diem charge (Private room charges line	8 divided by private	room days, line	0.00	9
	2)				
00	Enter semi-private room charges from your records			7, 511, 844	
00	Average semi-private room per diem charge (Semi-private room c semi-private room days)	narges line 10, divide	a by	528. 44	11
00	Average per diem private room charge differential (Line 9 minus	line 11)		0. 00	1 12
00	Average per diem private room cost differential (Line 7 times I			0.00	
00	Private room cost differential adjustment (Line 2 times line 13			0	1
00	General inpatient routine service cost net of private room cost PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus line 14)	6, 510, 401	15
00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		458. 00	16
00	Program routine service cost (Line 3 times line 16)	,		2, 381, 600	
00	Medically necessary private room cost applicable to program (I			0	18
00	Total program general inpatient routine service cost (Line 17			2, 381, 600	
00	Capital related cost allocated to inpatient routine service cos line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	ts (From Wkst. B, Par	t II column 18,	342, 713	20
00	Per diem capital related costs (Line 20 divided by line 1)			24. 11	
00	Program capital related cost (Line 3 times line 21)			125, 372	
00	Inpatient routine service cost (Line 19 minus line 22)			2, 256, 228	
00	Aggregate charges to beneficiaries for excess costs (From prov		nuo lino 24)	0	
00	Total program routine service costs for comparison to the cost Enter the per diem limitation (1)	limitation (Line 23 mi	nus iine 24)	2, 256, 228 0. 00	
00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)	0.00	27
	Reimbursable inpatient routine service costs (Line 22 plus the		, , ,	2, 381, 600	
	(Transfer to Worksheet E, Part II, line 4) (See instructions)			_,,,	
Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH			
00	Total SNF inpatient days			14, 215	1
00	Program inpatient days (see instructions)		VI V	5, 200	
00	Total nursing & allied health costs. (see instructions) (Do not	complete for titles V	or XIX)	0 3/5011	-
00	Nursing & allied health ratio. (line 2 divided by line 1)			0. 365811	4

Health Financial Systems	COLLI NGSWOOD MA	In Lieu of Form CMS-2540-1		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	TITLE XVIII	Provi der No.: 315404	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part I Date/Time Prepared: 11/23/2021 9:22 am

				11/23/2021 9.	ZZ dIII
		Title XVIII	Skilled Nursing Facility	PPS	
			Taciffty		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT	Į.		
1.00	Inpatient PPS amount (See Instructions)			1, 441, 369	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)	3		1, 441, 369	
4.00	Primary payor amounts			0	4. 00
5.00	Coinsurance			107, 132	5. 00
6.00	Allowable bad debts (From your records)			8, 954	6. 00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		1, 936	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			5, 820	8. 00
9.00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			1, 340, 057	11. 00
12.00	Interim payments (See instructions)			1, 334, 237	12. 00
13.00	Tentati ve adjustment			0	13. 00
14.00	OTHER adjustment (See instructions)			0	14. 00
14.50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			0	14. 75
14. 99	Sequestration amount (see instructions)			0	14. 99
15.00	Balance due provider/program (see Instructions)			5, 820	15. 00
16.00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	TITLE XVIII ONLY		
	Ancillary services Part B			0	
	Vaccine cost (From Wkst D, Part II, line 3)			0	1
	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
	Medicare Part B ancillary charges (See instructions)			0	
	Cost of covered services (Lesser of line 19 or line 20)			0	
22. 00	Primary payor amounts			0	22. 00
	Coi nsurance and deducti bl es			0	
	Allowable bad debts (From your records)			0	
	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
	Adjusted reimbursable bad debts (see instructions)			0	
	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
	Interim payments (See instructions)				
	Tentative adjustment				27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	
28. 55					
	Sequestration amount (see instructions)		0	28. 99	
	Balance due provider/program (see instructions)	a with CMC Dub 15 2	000+i on 11F 0	0	
30.00	Protested amounts (Nonallowable cost report items) in accordance	0	30.00		

Health Financial Systems	COLLI NGSWOOD M	ANOR	In Lie	u of Form CMS-2	2540-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	T TITLE V and TITLE XIX ONLY	Provi der No.: 315404	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part II Date/Time Pre 11/23/2021 9:2	
		Title XIX	Skilled Nursing Facility	Cost	

		II tie xix	Facility	COST	
				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 services			0	3. 00
4.00	Inpatient routine services (see instructions)			2, 381, 600	
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			2, 381, 600	
7. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			2, 381, 600	
9.00	Primary payor amounts			0	
10.00	Total Reasonable Cost (Line 8 minus line 9)			2, 381, 600	10. 00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges			-	11. 00
12.00	Outpatient service charges			0	
13. 00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	17. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	
19. 00	Total customary charges (see instructions)			0	19. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
20. 00	Cost of covered services (see Instructions)			0	
21. 00	Deducti bl es			0	
22. 00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl cost limit	y collected based on c	orrection of	0	27. 00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28. 00
	uti l i zati on				
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30. 00	Amounts applicable to prior cost reporting periods resulting fr if minus, enter amount in parentheses)	om disposition of depr	eciable assets (0	30. 00
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	1	,		0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpavments in parent	heses) (see	0	33. 00
	Instructions)	1	, (
			•		

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: From 07/01/2020 To 06/30/2021 Provi der No.: 315404 Worksheet E-1 Date/Time Prepared: 11/23/2021 9:22 am Title XVIII Skilled Nursing PPS

		11 (1	e Aviii	Facility	FF3	
		Inpatien	t Part A		rt B	
		·				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 334, 237		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	lenter zero					
3.00	List separately each retroactive lump sum adjustment				•	3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	
3. 03			0		0	
3. 04			0		0	
3. 05	Dravi dan ta Dragnam		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTIVIENTS TO FROGRAM		0		0	
3. 52			Ö		0	
3. 53			Ö		Ö	
3. 54			o		0	1
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50		0		0	3. 99
	- 3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 334, 237		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after				I	5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	
5. 52			0		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	PROGRAM TO PROVIDER		5, 820		0	6. 01
6. 02	PROVI DER TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 340, 057		0	7. 00
			Contract	or Name	Contractor	
					Number	
0.00	lu		1. 1		2.00	0.05
8.00	Name of Contractor		Novitas Solutio	ons	12001	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 COLLINGSW
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column onl y)

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

1. 00 2. 00 3. 00 4. 00 5. 00	Assets CURRENT ASSETS Cash on hand and in banks	General Fund	Specific Endowment Purpose Fund 2.00 3.00		Plant Fund 4.00	
1. 00 2. 00 3. 00 4. 00 5. 00	CURRENT ASSETS	1.00			4. 00	
1. 00 2. 00 3. 00 4. 00 5. 00	CURRENT ASSETS					
1.00 2.00 3.00 4.00 5.00						
2.00 3.00 4.00 5.00				ما		
3. 00 4. 00 5. 00		61, 490		0	0	
4. 00 5. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
5.00	Accounts recei vable	2, 887, 971		0	0	
	Other recei vabl es	0	l ö	Ö	0	5. 00
6.00	Less: allowances for uncollectible notes and accounts	-495, 400	o	0	0	6.00
	recei vabl e					
	Inventory	204, 922		0	0	7. 00
	Prepaid expenses	163, 367	0	0	0	
	Other current assets Due from other funds	33, 054, 642		0	0	
	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	35, 876, 992		0	0	11.00
	FIXED ASSETS	00,010,772		<u> </u>	Ü	11.00
	Land	257, 870	0	0	0	12.00
13. 00	Land improvements	0	0	0	0	13. 00
	Less: Accumulated depreciation	0	0	0	0	14. 00
	Buildings	25, 534, 069		0	0	15.00
	Less Accumulated depreciation	-14, 473, 661	0	0	0	16.00
	Leasehold improvements Less: Accumulated Amortization	0	0	0	0	17. 00 18. 00
	Fi xed equipment	2, 237, 320		0	0	19.00
	Less: Accumulated depreciation	-1, 355, 182		0	0	20.00
1	Automobiles and trucks	218, 670		o	0	21. 00
	Less: Accumulated depreciation	-180, 487	o	O	0	22. 00
23. 00	Major movable equipment	0	0	0	0	23. 00
1	Less: Accumulated depreciation	0	0	0	0	24. 00
1	Mi nor equipment - Depreciable	0	0	0	0	25. 00
	Mi nor equi pment nondepreci abl e	0	0	0	0	26.00
4	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	12, 238, 599	0	0	0	27. 00 28. 00
- H	OTHER ASSETS	12, 230, 377	<u> </u>	<u> </u>	0	26.00
	Investments	0	0	ol	0	29. 00
1	Deposits on Leases	0	o	0	0	
31. 00	Due from owners/officers	0	o	0	0	31.00
1	Other assets	207, 609		0	0	32. 00
	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	207, 609		0	0	33.00
	TOTAL ASSETS (Sum of lines 11, 28, and 33) Liabilities and Fund Balances	48, 323, 200	0	0	0	34. 00
	CURRENT LIABILITIES					
	Accounts payable	648, 136	O	0	0	35. 00
	Sal ari es, wages, and fees payable	958, 387	o	0	0	36.00
	Payroll taxes payable	0	0	0	0	37. 00
	Notes & Loans payable (Short term)	0	0	0	0	38. 00
	Deferred income	0	0	0	0	39. 00
	Accel erated payments	0				40.00
	Due to other funds Other current liabilities	1, 000	0	0	0	
1	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 607, 523		0	0	
- t	LONG TERM LIABILITIES	1,007,323	<u> </u>	<u> </u>		45.00
	Mortgage payable	1, 096, 153	O	0	0	44. 00
1	Notes payable	3, 859, 159		O	0	
46. 00	Unsecured Loans	0	0	0	0	46. 00
	Loans from owners:	0	0	0	0	47. 00
	Other long term liabilities	4, 272, 147		0	0	
4	OTHER (SPECIFY)	0 007 450	0	0	0	
	TOTAL LIABILITIES (Sum of Lines 44 - 49	9, 227, 459		0	0	50. 00 51. 00
	TOTAL LIABILITIES (Sum of lines 43 and 50) CAPITAL ACCOUNTS	10, 834, 982	<u> </u>	U]	U	31.00
	General fund balance	37, 488, 218				52.00
	Specific purpose fund	,,	o			53.00
54.00	Donor created - endowment fund balance - restricted			О		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
	Governing body created - endowment fund balance			0	ŀ	56. 00
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58)	37, 488, 218	o		0	59. 00
57.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	48, 323, 200		ŏ	0	
60.00	59)	1	I - 1	-1	O,	1

| Peri od: | Worksheet G-1 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES COLLI NGSWOOD MANOR

Provi der No.: 315404

					To 06/30/2021	Date/Time Prep 11/23/2021 9:	pared: 22 am
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY RECONCILIATION ROUNDING	0 1 0 0	40, 098, 902 -2, 610, 685 37, 488, 217		0 0 0	0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING	0 0	1 37, 488, 218		0	0 0	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17. 00 18. 00 19. 00	Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	Endowment Fund	0 37, 488, 218 Pl ant		0 0	0	17. 00 18. 00 19. 00
		6.00	7.00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY RECONCILIATION ROUNDING	0.00	0 0	8.00	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0	0 0 0		0 0 0		9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems COLLINGSWOOD MANOR					u of Form CMS-2	
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	No.: 315404	Peri od: From 07/01/2020 To 06/30/2021	Worksheet G-2 Parts I-II Date/Time Pre 11/23/2021 9:3	pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1. 00	SKILLED NURSING FACILITY		7, 511, 8	44	7, 511, 844	1.00
2. 00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3.00
4.00	OTHER LONG TERM CARE		7, 082, 7	51	7, 082, 751	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		14, 594, 5	95	14, 594, 595	5.00
	All Other Care Services					
6. 00	ANCI LLARY SERVI CES		981, 4	60 0	981, 460	6. 00
7. 00	CLI NI C			0	0	7. 00
8. 00	HOME HEALTH AGENCY COST			0	0	8. 00
9. 00	AMBULANCE			0	0	9. 00
10. 00	RURAL HEALTH CLINIC			0	0	10.00
10. 10	FQHC			0	0	10. 10
11. 00	CMHC			0	0	11. 00
12. 00	HOSPI CE			0 0	0	12.00
13. 00	OTHER (SPECIFY)			0 0	0	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column	3 to	15, 576, 0	55 0	15, 576, 055	14. 00
	Worksheet G-3, Line 1)					

		1. 00	2. 00	
	PART II - OPERATING EXPENSES			
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)		16, 324, 437	1.00
2.00	Add (Specify)	0		2.00
3.00		0		3. 00
4.00		0		4. 00
5.00		0		5. 00
6.00		0		6. 00
7.00		0		7. 00
8.00	Total Additions (Sum of lines 2 - 7)		0	8. 00
9.00	Deduct (Specify)	0		9. 00
10.00		0		10.00
11. 00		0		11.00
12.00		0		12.00
13.00		0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)		0	14.00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)		16, 324, 437	15. 00

Health Financial Systems	COLLI NGSWOOD MANOR	In Lie	u of Form CMS-2	2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315404	From 07/01/2020	Worksheet G-3 Date/Time Pre 11/23/2021 9:	pared:

STATE	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider No.: 315404	Peri od:	Worksheet G-3		
			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 9:		
				1. 00		
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1			15, 576, 055	1. 00	
2.00	Less: contractual allowances and discounts on patients accounts	i		2, 320, 011	2. 00	
3. 00	Net patient revenues (Line 1 minus line 2)	. = 3		13, 256, 044 16, 324, 437	3. 00 4. 00	
	4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)					
5.00	Net income from service to patients (Line 3 minus 4)			-3, 068, 393	5. 00	
,	Other income:		1	0.4 000	,	
6.00	Contributions, donations, bequests, etc			96, 093	6. 00	
7. 00	Income from investments			107	7. 00	
8. 00	Revenues from communications (Telephone and Internet service)			0	8. 00	
9.00	Revenue from television and radio service			8, 369		
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			11, 368		
15. 00	Revenue from rental of living quarters			0	15. 00	
16. 00	Revenue from sale of medical and surgical supplies to other that	n patients		0	16. 00	
17. 00	Revenue from sale of drugs to other than patients			0		
18. 00	Revenue from sale of medical records and abstracts			0	18. 00	
19. 00					19. 00	
	20.00 Revenue from gifts, flower, coffee shops, canteen				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	I NSURANCE REVENUE			3, 847		
24. 01	CATERING / COUNTRY STORE			21, 541		
24. 02	TRANS - RESIDENTIAL			5, 118		
24. 03	MI SCELLANEOUS I NCOME			187	24. 03	
24. 05	GRANT REVENUE			246, 530		
24. 06	MAINTENANCE SERVICES			880		
24. 07	ELECTRI C I NCOME			1, 890		
24. 50	COVI D-19 PHE Fundi ng			61, 778		
25. 00	Total other income (Sum of lines 6 - 24)			457, 708		
26. 00	Total (Line 5 plus line 25)			-2, 610, 685		
27. 00	LOSS ON SALE OF ASSETS			0	27. 00	
27. 01	BARBER AND BEAUTY			0	27. 01	
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)			-2, 610, 685	31. 00	