This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315427 Worksheet S Parts I, II & III Peri od: From 07/01/2021 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 11/29/2022 11:18 am PART I - COST REPORT STATUS Provi der [ X ] Electronically prepared cost report Date: 11/29/2022 Time: 11:18 am use only ] Manually prepared cost report 2 [ 0 ] If this is an amended report enter the number of times the provider resubmitted this cost report 3 ] No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [ 1 ] Cost Report Status 6. Contractor No. (1) As Submitted use only 7.[ N ] First Cost Report for this Provider CCN (2) Settled without audit 8.[ N ] Last Cost Report for this Provider CCN (3) Settled with audit 9. NPR Date:

11. Contractor Vendor Code

for no utilization.

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

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

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

(4) Reopened

(5) Amended

5. Date Received:

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PITMAN MANOR (315427) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3. 00	4. 00	
	PART III - SETTLEMENT SUMMARY					
1.00	SKILLED NURSING FACILITY	0	4, 330	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	4, 330	0	0	100.00
Tho ob	pour amounts represent "due to" or "due from" the applicable	program for th	o alamant of t	ho obovo compl	ov i ndi oo+od	

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.

PI TMAN MANOR Health Financial Systems In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315427 Peri od: Worksheet S-2 From 07/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:18 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 535 NORTH OAK AVENUE PO Box: 1.00 2.00 City: PITMAN State: NJ Zi p Code: 08071 2.00 3.00 County: GLOUCESTER 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 XIX 4. 00 5. 00 6. 00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF PITMAN MANOR 315427 11/30/1993 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) 07/01/2021 06/30/2022 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 558, 672 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 00 558, 672 23 00 24.00 If depreciation is funded, enter the balance as of the end of the period. 24.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) 25.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? 26,00 N 26,00 (Y/N)27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report N 27 00 applies? (Y/N) Was there a substantial decrease in health insurance proportion of allowable cost from prior cost 28.00 N 28.00 reports? (Y/N) Part AlPart Blother 1.00 | 2.00 | 3.00 If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption. 29.00 Skilled Nursing Facility 29.00 Ν 30.00 Nursing Facility 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 SNF-Based FQHC 34.00 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 00 128 400

Health Financial Systems	PITMAN MAN	OR	In Lie	u of Form CMS-2	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315427	Peri od:	Worksheet S-2	
COMPLEX INDENTIFICATION DATA			From 07/01/2021	Part I	
			To 06/30/2022		
				11/29/2022 11	:18 am_
				Y/N	
				1. 00	
42.00 Are malpractice premiums and paid loss	ses reported in other than	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, Ch	napter 10?		Υ	43.00
44.00 If line 43 is yes, enter the home offi	ce chain number and enter	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	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	OF NJ			
46.00 Street: 3311 HIGHWAY 33	PO Box:				46. 00
47.00 City: NEPTUNE	State: NJ	Zi p Cod	le: 0775	2	47. 00

Heal th	Financial Systems PITMAN	MANOF	?	In Lie	eu of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			Provi der No.: 315427	Peri od: From 07/01/2021 To 06/30/2022		
				10 00/30/2022	11/29/2022 11	: 18 am
			1. 00	2.	00	
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position	DEAN	DRA	FALLON		19. 00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
20.00	Enter the employer/company name of the cost report	BAKE	R TILLY US, LLP			20. 00
	preparer.					
21.00	Enter the telephone number and email address of the cost	570-8	320-0301	DEANDRA. FALLON	@BAKERTI LLY. CO	21. 00
	report preparer in columns 1 and 2, respectively.			M		

Health Financial Systems PITMAN I SKILLED NURSING FACILITY HEALTH CARE PI TMAN MANOR

| Peri od: | Worksheet S-2 | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Provi der No.: 315427 COMPLEX REIMBURSEMENT QUESTIONNAIRE

				To 06/30/2022	Date/Time Prepared: 11/29/2022 11:18 am
		Part B			
		Date			
		4. 00			
	PS&R Data				
13. 00	Was the cost report prepared using the PS&R				13. 00
	only? If either col. 1 or 3 is "Y", enter				
	the paid through date of the PS&R used to				
	prepare this cost report in cols. 2 and 4. (see Instructions.)				
14. 00	Was the cost report prepared using the PS&R				14.00
14.00	for total and the provider's records for				14.00
	allocation? If either col. 1 or 3 is "Y"				
	enter the paid through date of the PS&R used				
	to prepare this cost report in columns 2 and				
	4.				
15. 00	If line 13 or 14 is "Y", were adjustments				15. 00
	made to PS&R data for additional claims that				
	have been billed but are not included on the PS&R used to file this cost report? If "Y",				
	see Instructions.				
16, 00	If line 13 or 14 is "Y", then were				16. 00
10.00	adjustments made to PS&R data for				10.00
	corrections of other PS&R Report				
	information? If yes, see instructions.				
17. 00	If line 13 or 14 is "Y", then were				17. 00
	adjustments made to PS&R data for Other?				
40.00	Describe the other adjustments:				10.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.				18. 00
	provider s records? IT if see mistractions.				
			3.00		
	Cost Report Preparer Contact Information				
19. 00	Enter the first name, last name and the title		CPA, SENIOR MANAGER		19. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
20.00	respectively.				20.00
20. 00	Enter the employer/company name of the cost r	eport			20. 00
21 00	preparer. Enter the telephone number and email address	of the cost			21. 00
21.00	report preparer in columns 1 and 2, respective				21.00
	1p-: - ppai o oo. ao . aa 2, 100pooti i	, ,		T .	ı

In Lieu of Form CMS-2540-10 PITMAN MANOR

 
 Heal th Financial
 Systems
 PITMAN N

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

Provi der No.: 315427 

				10		11/29/2022 11:	
				Inpa	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	72	26, 280	0	2, 016	8, 409	1. 00
2. 00 3. 00	NURSING FACILITY	0	0	0		0	2. 00 3. 00
4. 00	HOME HEALTH AGENCY COST		J	0	0	0	4. 00
5.00	Other Long Term Care	178	64, 970				5. 00
6.00	SNF-Based CMHC			0	0		6. 00
7. 00 8. 00	HOSPICE Total (Sum of lines 1-7)	250	0 91, 250	0	2, 016	0 8, 409	7. 00 8. 00
0.00	Tretar (cam or rrince : 7)	Inpatient D		9	Di scharges	67 167	0.00
	Component	O+box	Total	T: +1 o 1/	T: +1 o V/////	Ti +Lo VIV	
	Component	0ther 6.00	<u>Total</u> 7. 00	Title V 8.00	Title XVIII 9.00	Title XIX 10.00	
1. 00	SKILLED NURSING FACILITY	10, 189	20, 614	0	51	21	1. 00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	I CF/II D	0	0			0	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	43, 959	43, 959				4. 00 5. 00
6. 00	SNF-Based CMHC	10, 707	10, 707				6. 00
7. 00	HOSPI CE	0	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	54, 148 Di scha	64, 573	0 Aver	age Length of	21 Stay	8. 00
			<u> </u>				
	Component	Other	Total	Title V 13.00	Title XVIII	Title XIX	
1. 00	SKILLED NURSING FACILITY	11.00	12. 00 120		14. 00 39. 53	15. 00 400. 43	1. 00
2.00	NURSING FACILITY	0	0		07.00	0.00	2. 00
3.00	ICF/IID	0	0			0. 00	3. 00
4. 00 5. 00	HOME HEALTH AGENCY COST Other Long Term Care	55	55				4. 00 5. 00
6.00	SNF-Based CMHC	33	33				6. 00
7.00	HOSPI CE	0	0				7. 00
8. 00	Total (Sum of lines 1-7)	103 Average Length	175	0.00 Admis		400. 43	8. 00
		of Stay		Adiii S	21 0112		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1.00	CVILLED NUDCING FACILLEY	16. 00	17. 00	18. 00 98	19. 00	20.00	1. 00
2.00	SKILLED NURSING FACILITY NURSING FACILITY	171. 78 0. 00	0	98	6	23	2. 00
3.00	ICF/IID	0. 00	J		0	0	3. 00
4.00	HOME HEALTH AGENCY COST						4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	799. 25				49	5. 00 6. 00
7. 00	HOSPI CE	0.00	0	0	0	0	7. 00
8.00	Total (Sum of lines 1-7)	368. 99	0	98	6	72	8. 00
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d			
		24.00	Payrol I	Workers			
1.00	SKILLED NURSING FACILITY	21.00	22. 00 37. 84	23. 00			1. 00
2.00	NURSING FACILITY	0	0.00				2. 00
3.00	ICF/IID	0	0. 00	0. 00			3.00
4. 00 E. 00	HOME HEALTH AGENCY COST	40	0.00				4.00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	49	36. 62 0. 00				5. 00 6. 00
7. 00	HOSPI CE	0	0. 00				7. 00
8. 00	Total (Sum of lines 1-7)	176	74. 46	0.00			8.00

SNF WAGE INDEX INFORMATION

22.00

instructions)

Total Adjusted Wage Related cost (see

Provider No.: 315427 Peri od: Worksheet S-3 From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 11/29/2022 11:18 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 2.00 5. 00 1.00 3.00 4.00 PART II - DIRECT SALARIES SALARI ES 1.00 Total salaries (See Instructions) 7, 975, 507 7, 975, 507 264, 012. 00 30, 21 1.00 Physician salaries-Part A 0.00 2.00 0 0 0 0.00 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 0.00 5.00 0 0 7, 975, 507 7, 975, 507 264, 012. 00 6.00 Revised wages (line 1 minus line 5) 30.21 6.00 7.00 Other Long Term Care 1, 931, 004 1, 931, 004 76, 163. 00 25.35 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 20, 149 20, 149 1, 426. 00 14.13 11.00 Subtotal Excluded salary (Sum of lines 7 1, 951, 153 77, 589. 00 25. 15 12.00 12.00 1, 951, 153 through 11) Total Adjusted Salaries (line 6 minus line 13.00 6,024,354 C 6, 024, 354 186, 423. 00 32.32 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 481, 691 481, 691 14, 812. 00 32. 52 14.00 15.00 21,006 0 21, 006 104.00 201.98 15.00 16.00 Home office salaries & wage related costs 732, 232 0 732, 232 12, 693. 00 57.69 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1, 931, 004 1, 931, 004 17.00 Wage-related costs other (See Part IV) 20, 149 0 20, 149 18.00 18.00 Wage related costs (excluded units) 444, 204 0 444, 204 19.00 Physician Part A - WRC 0 20.00 20.00 21.00 Physician Part B - WRC 0 21.00 0

1,506,949

0

1, 506, 949

22.00

In Lieu of Form CMS-2540-10 Health Financial Systems PITMAN MANOR Provi der No.: 315427 Peri od:

SNF WAGE INDEX INFORMATION

Worksheet S-3 Part III Date/Time Prepared: From 07/01/2021 06/30/2022 11/29/2022 11:18 am Average Hourly Amount Reclass. of Adj usted Paid Hours Salaries from Salaries (col. Related to Wage (col. 3 ÷ Reported col . 4) Worksheet A-6  $1 \pm col. 2$ Salary in col 5.00 1.00 2.00 3.00 4.00 PART III - OVERHEAD COST - DIRECT SALARIES 1.00 Employee Benefits 0.00 0.00 1.00 1, 149, 676 413, 325 2.00 Administrative & General 1, 149, 676 0 29, 372. 00 39. 14 2.00 3.00 Plant Operation, Maintenance & Repairs 413, 325 0 22, 233. 00 18.59 3.00 4.00 Laundry & Linen Service 96, 316 96, 316 5, 629. 00 17.11 4.00 5.00 Housekeepi ng 519, 639 0 519, 639 25, 065. 00 20.73 5.00 0 50, 892. 00 Di etary 825, 518 825, 518 16.22 6.00 6.00 Nursing Administration 0.00 0.00 7.00 0 0 7.00 8.00 Central Services and Supply 0 0 0 0.00 0.00 8.00 9.00 0 0 0 0.00 0.00 9. 00 Pharmacy Medical Records & Medical Records Library 0 0.00 10.00 0 n 0.00 10.00 Social Service 11.00 63,055 0 63, 055 2,050.00 30.76 11.00 12.00 Nursing and Allied Health Ed. Act. 12.00 16. 79 13.00 13.00 Other General Service 239, 227 0 239, 227 14, 252. 00 14.00 Total (sum lines 1 thru 13) 3, 306, 756 0 3, 306, 756 149, 493. 00 22. 12 14. 00

Health Financial Systems	PI TMAN MANOR	In Lie	u of Form CMS-	2540-10
SNF WAGE RELATED COSTS	Provi der No.: 315427	From 07/01/2021	Worksheet S-3 Part IV Date/Time Pre 11/29/2022 11	pared:
			Amount Reported 1.00	To um

	10 00/30/2022	11/29/2022 11	
		Amount	
		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	138, 501	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)	727, 028	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	10, 667	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, 205	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	Workers' Compensation Insurance	232, 440	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	598, 020	
18. 00		0	18. 00
19. 00	Unemployment Insurance	101, 081	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
	Executive Deferred Compensation	0	21. 00
	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	1, 811, 942	24. 00
		Amount	
		Reported	
		1.00	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	3, 780	25. 00

				T	o 06/30/2022	Date/Time Prep 11/29/2022 11:	
	Occupational Category	Amount	Fri nge	Adj usted	Pai d Hours	Average Hourly	
	occupational satisfies	Reported		Salaries (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				ĺ	3	ĺ	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Di rect Sal ari es						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	1, 203, 936	274, 136				1. 00
2.00	Licensed Practical Nurses (LPNs)	132, 355	30, 137		i i		2. 00
3.00	Certified Nursing Assistant/Nursing	825, 032	187, 860	1, 012, 892	38, 385. 00	26. 39	3. 00
	Assistants/Aides	0.444.000	400 400	0 /50 /5/	74 /45 00	07.05	
4.00	Total Nursing (sum of lines 1 through 3)	2, 161, 323	492, 133		i i		4. 00
5.00	Physical Therapists	190, 271	43, 325	233, 596			5. 00
6.00	Physical Therapy Assistants	0	0	0	0.00		
7.00	Physical Therapy Aides	0	0	0	0.00		7. 00
8.00	Occupational Therapists	20, 114	4, 580				
9.00	Occupational Therapy Assistants	55, 886	12, 725		i i		
10.00	Occupational Therapy Aides	0 175	0	· · · · · ·	0.00		
11.00	Speech Therapists	30, 175	6, 871				
12.00	Respiratory Therapists	50, 532	11, 506		i i		12.00
13. 00	Other Medical Staff	209, 299	47, 657	256, 956	7, 091. 00	36. 24	13. 00
	Contract Labor						
14. 00	Nursing Occupations Registered Nurses (RNs)	5, 808		5, 808	97.00	59. 88	14. 00
15. 00	Licensed Practical Nurses (LPNs)	111, 076		111, 076			
16. 00	Certified Nursing Assistant/Nursing	364, 807		364, 807			
10.00	Assistants/Aides	304, 607		304, 607	12, 379.00	29.00	10.00
17. 00	Total Nursing (sum of lines 14 through 16)	481, 691		481, 691	14, 812. 00	32. 52	17. 00
18. 00	Physical Therapists	101,071		0	0.00		
19. 00	Physical Therapy Assistants			0	0.00		
20. 00	Physical Therapy Aides			0	0.00		
21. 00	Occupational Therapists			0	0.00		
22. 00	Occupational Therapy Assistants			0	0.00		
23. 00	Occupational Therapy Aides			0	0.00		
24. 00				1 0	0.00		
25. 00	Respiratory Therapists	o		0			
26. 00		O					

Health Financial Systems
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA In Lieu of Form CMS-2540-10
Worksheet S-7 PITMAN MANOR Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11:18 am Provi der No.: 315427

		11/29/2022 11:18 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 6. 00	RHX RHL	5. 00
7.00	RMX	7.00
8.00	RML	8.00
9. 00 10. 00	RLX RUC	9.00
11. 00	RUB	11. 00
12. 00	RUA	12.00
13. 00	RVC	13. 00
14. 00	RVB	14. 00
15. 00	RVA	15. 00
16. 00	RHC	16. 00
17.00	RHB	17. 00
18.00	RHA	18. 00
19.00	RMC	19.00
20. 00	RMB	20.00
21.00	RMA	21.00
22.00	RLB	22.00
23.00	RLA	23. 00
24. 00	ES3	24. 00
25. 00	ES2	25. 00
26. 00	ES1	26.00
27. 00	HE2	27.00
28. 00	HE1	28. 00
29. 00	HD2	29.00
30.00	HD1	30.00
31.00	HC2	31.00
32.00	HC1	32.00
33. 00	HB2	33.00
34.00	HB1	34.00
35. 00	LE2	35.00
36.00	LE1	36.00
37.00	LD2	37.00
38.00	LD1	38.00
39. 00	LC2	39.00
40. 00	LC1	40.00
41.00	LB2	41.00
42.00	LB1	42.00
43.00	CE2	43.00
44.00	CE1	44.00
45. 00	CD2	45.00
46. 00	CD1	46.00
47. 00	CC2	47.00
48. 00	CC1	48.00
49. 00	CB2	49.00
50. 00	CB1	50.00
51. 00	CA2	51.00
52. 00	CA1	52.00
53. 00	SE3	53.00
54. 00	SE2	54.00
55. 00	SE1	55. 00
56. 00	SSC	56. 00
57. 00	SSB	57.00
58. 00	SSA	58.00
59. 00	I B2	59.00
60.00	I B1	60.00
61. 00	I A2	61.00
62. 00	I A1	62.00
63.00	BB2	63.00
64. 00	BB1	64.00
65.00	BA2	65.00
66. 00	BA1 PE2	66.00
67. 00		67.00
68.00	PE1	68.00
69. 00 70. 00	PD2 PD1	69.00
71. 00	PC2	71.00
72. 00 73. 00	PC1 PB2	72.00
73. 00	PB1	74. 00
74. UU		
75. 00	PA2	75. 00

!	Peri od: From 07/01/2021 To 06/30/2022 Group 1.00 PA1 AAA	Worksheet S-7 Date/Time Pre 11/29/2022 11 Days 2.00	pared:					
	Group 1.00 PA1	11/29/2022 11 Days	:18 am					
Funancea	1. 00 PA1		76. 00					
Evnances	PA1	2. 00	76. 00					
Evmanaga			76. 00					
Evnance	AAA							
Evnances			99. 00					
Evenence			100. 00					
Expenses	Percentage	Y/N						
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)								
			101. 00 102. 00 103. 00 104. 00 105. 00 106. 00					
f ex e	for direct p expense for e evenue from ending refle	33 provided for an increase for direct patient care and spense for each category. En evenue from Worksheet G-2, P ending reflects increases as	O3 provided for an increase in the RUG for direct patient care and related spense for each category. Enter in evenue from Worksheet G-2, Part I, ending reflects increases associated					

Health Financial Systems		PITMAN MA	NOR		In Lie	u of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT	OF TRIAL BALANCE OF	EXPENSES	Provi der		eri od:	Worksheet A	
					rom 07/01/2021 o 06/30/2022	Date/Time Pre 11/29/2022 11	
Cost Center Descrip	oti on	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	. TO alli
3001 3011101 B030111	,	00.0.100	0 21.101	+ col . 2)	ons	Trial Balance	
				Í	Increase/Decre	(col. 3 +-	
					ase (Fr Wkst	col . 4)	
					A-6)		
OFFICE OFFICE OFFI		1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENT 1.00 00100 CAP REL COSTS - BLD			400.044	422.044		(22.044	1 00
1.00   00100   CAP REL COSTS - BLD 2.00   00200   CAP REL COSTS - MOV			623, 844	623, 844 0		623, 844 0	1. 00 2. 00
3.00 00300 EMPLOYEE BENEFITS	ABLE EQUIPMENT	0	1, 815, 722	·	_	1, 815, 722	3. 00
4. 00   00400   ADMI NI STRATI VE & GE	NERΔI	1, 149, 676	2, 594, 487	3, 744, 163		3, 744, 163	4. 00
5. 00 00500 PLANT OPERATION, MA		413, 325	883, 860			1, 297, 185	5. 00
6. 00   00600 LAUNDRY & LINEN SER		96, 316	23, 079			119, 395	6. 00
7. 00 00700 HOUSEKEEPI NG		519, 639	96, 758			616, 397	7. 00
8. 00   00800 DI ETARY		825, 518	1, 184, 003	2, 009, 521	0	2, 009, 521	8. 00
9.00 00900 NURSING ADMINISTRAT	ION	0	0	0	0	0	9. 00
10.00 01000 CENTRAL SERVICES &	SUPPLY	0	0	0	0	0	10.00
11.00  01100   PHARMACY		0	0	0	0	0	11. 00
12.00 01200 MEDICAL RECORDS & L	I BRARY	0	0	0	0	0	12. 00
13. 00   01300   SOCIAL SERVICE		63, 055	0	63, 055	0	63, 055	13.00
14. 00 01400 NURSING AND ALLIED	HEALIH EDUCATION	0	0	000 505	0	0	14. 00
15. 00   01500   ACTI VI TI ES		169, 044	51, 461	220, 505		220, 505	15. 00
15. 01 01501 CHAPLAIN	COST CENTERS	70, 183	330	70, 513	0	70, 513	15. 01
30.00 O3000 SKI LLED NURSING FAC		2, 370, 621	803. 982	3, 174, 603	0	3, 174, 603	30. 00
31. 00   03100   NURSI NG FACILITY	,1 L1 11	2, 370, 021	003, <del>1</del> 02	3, 174, 003	0	3, 174, 003	31. 00
32. 00   03200   CF/IID		0	0		0	0	32. 00
33. 00 03300 OTHER LONG TERM CAR	RE	1, 931, 004	137, 521	2, 068, 525	0	2, 068, 525	33. 00
ANCILLARY SERVICE COST CE			,	, , , , , , , , ,			
40. 00 04000 RADI OLOGY		0	5, 788	5, 788	0	5, 788	40.00
41. 00   04100   LABORATORY		0	15, 030	15, 030	0	15, 030	41. 00
42.00 04200 I NTRAVENOUS THERAPY		0	0	0	0	0	42.00
43.00   04300   0XYGEN (I NHALATI ON)	THERAPY	50, 532	5, 040			55, 572	43. 00
44. 00   04400   PHYSI CAL THERAPY		190, 270	90, 868			187, 224	44.00
45. 00 04500 OCCUPATI ONAL THERAP	γY	76, 000	0	76, 000			45. 00
46. 00   04600   SPEECH PATHOLOGY 47. 00   04700   ELECTROCARDI OLOGY		30, 175	0	30, 175	19, 424	49, 599 0	46. 00 47. 00
47. 00   04700   ELECTROCARDI OLOGY 48. 00   04800   MEDI CAL SUPPLI ES CH	INDOED TO DATIENTS	0	6, 213	6, 213	0	6, 213	47.00
49. 00 04900 DRUGS CHARGED TO PA		0	83, 770			83, 770	49. 00
50. 00   05000 DENTAL CARE - TITLE		0	03, 770	03,770	0	03,770	50.00
51. 00 05100 SUPPORT SURFACES	, , , , , , , , , , , , , , , , , , , ,	ol	0	Ö	0	0	51. 00
OUTPATIENT SERVICE COST (	CENTERS	<u> </u>					
60. 00 06000 CLINIC		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 (							
70.00 07000 HOME HEALTH AGENCY	COST	0	0	0	-	0	70. 00
71. 00 07100 AMBULANCE		0	0	0	0	0	
73.00 07300 CMHC SPECIAL PURPOSE COST CENT	rene	U	0		0	0	73. 00
80. 00 08000 MALPRACTI CE PREMI UN			0	0	0	0	80. 00
81. 00 08100 I NTEREST EXPENSE	IS & FAID LUSSES		0		0	0	81. 00
82. 00 08200 UTI LI ZATI ON REVI EW	- SNF	0	0		0	Ö	82. 00
83. 00   08300   HOSPI CE		ol	0	Ö	0	0	83. 00
89.00   SUBTOTALS (sum of I	ines 1-84)	7, 955, 358	8, 421, 756	16, 377, 114	0	16, 377, 114	89. 00
NONREI MBURSABLE COST CENT	,						
90. 00 09000 GIFT, FLOWER, COFFE		20, 149	5, 085	25, 234	0	25, 234	
91.00 09100 BARBER AND BEAUTY S		0	0	0	0	0	91. 00
92. 00   09200   PHYSI CI ANS   PRI VATE	OFFI CES	0	0	0	0	0	92. 00
93. 00   09300   NONPALD WORKERS		0	0	0	0	0	93.00
94. 00 09400 PATIENTS LAUNDRY		7 075 507	0 404 044	14 400 040	0	16 402 249	94.00
100. 00   TOTAL		7, 975, 507	8, 426, 841	16, 402, 348	l O	16, 402, 348	100.00

 
 Heal th Financial
 Systems
 PI

 RECLASSIFICATION
 AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
 Provider No.: 315427 | Period: | Worksheet A | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

					To 06/30/2022	Date/Time Pre	
	Cost Center Description	Adjustments to	Net	Evnenses		11/29/2022 11	: 18 am
	cost center bescriptron	Expenses (Fr					
		Wkst A-8)		I . 5 +-			
		<u> </u>	1 7	ol. 6)			
		6.00		7. 00			
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES	0		623, 844			1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	1	0			2. 00
3.00	00300 EMPLOYEE BENEFITS	-43, 417		1, 772, 305			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-787, 491		2, 956, 672			4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	-20, 840	1	1, 276, 345			5. 00
6. 00 7. 00	O0600   LAUNDRY & LI NEN SERVI CE   O0700   HOUSEKEEPI NG	0	1	119, 395			6. 00 7. 00
8. 00	00800 DI ETARY	-432 0	1	615, 965 2, 009, 521			8.00
9. 00	00900 NURSING ADMINISTRATION		1 .	2,007,321			9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0		0			10.00
11. 00	01100 PHARMACY	0		Ö			11. 00
	01200 MEDICAL RECORDS & LIBRARY	0		o			12.00
	01300 SOCIAL SERVICE	0		63, 055			13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0		o			14. 00
15. 00	01500 ACTI VI TI ES	0		220, 505			15. 00
15. 01	01501 CHAPLAI N	0		70, 513			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 SKILLED NURSING FACILITY	0	1	3, 174, 603			30. 00
	03100 NURSING FACILITY	0	1	0			31. 00
	03200   CF/IID	0	1	0 0.0 505			32.00
33.00	03300 OTHER LONG TERM CARE	0	)	2, 068, 525			33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0		E 700			40.00
40. 00 41. 00	04000 RADI OLOGY 04100 LABORATORY			5, 788 15, 030			40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY		()	15, 030			42.00
	04300 OXYGEN (INHALATION) THERAPY	0		55, 572			43. 00
44. 00	04400 PHYSI CAL THERAPY	0		187, 224			44. 00
	04500 OCCUPATI ONAL THERAPY	0		150, 490			45. 00
46.00	04600 SPEECH PATHOLOGY	0	ol .	49, 599			46. 00
47.00	04700 ELECTROCARDI OLOGY	0	ol .	o			47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		6, 213			48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0		83, 770			49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	1	0			50. 00
51. 00	05100 SUPPORT SURFACES	0		0			51. 00
(0.00	OUTPATIENT SERVICE COST CENTERS		J	٥			(0.00
60. 00 61. 00	06000   CLI NI C   06100   RURAL HEALTH CLI NI C	0		0			60. 00 61. 00
	06200 FQHC	0	1	۷			62.00
02.00	OTHER REIMBURSABLE COST CENTERS	1					02.00
70. 00	07000 HOME HEALTH AGENCY COST	0	ı	0			70.00
71. 00	07100 AMBULANCE	0	1	o			71.00
73. 00	07300 CMHC	0	1	o			73. 00
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES	0		0			80. 00
81. 00	08100 I NTEREST EXPENSE	0		0			81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF	0	1	0			82. 00
83. 00	08300 H0SPI CE	0		0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-852, 180	) 1!	5, 524, 934			89. 00
00.00	NONREI MBURSABLE COST CENTERS	_		25 22 1			00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	()	25, 234 0			90. 00 91. 00
91. 00 92. 00	09200 PHYSICIANS PRIVATE OFFICES		()	0			91.00
	09300 NONPALD WORKERS	0	3	0			93.00
	09400 PATIENTS LAUNDRY	0		0			94. 00
100.00		-852, 180		5, 550, 168			100.00
	· · · · · ·						

Health Financial Systems	PITMAN MANOR		In Lie	u of Form CMS-2	2540-10
RECLASSIFI CATIONS	Provi der	F	eriod: rom 07/01/2021	Worksheet A-6	
	To 06/30/2022 Date 11/2			11/29/2022 11	pared: <u>: 18_am</u> _
		Increases			
	Cost Center	Li ne #	Sal ary	Non Salary	
	2. 00	3. 00	4. 00	5. 00	
(1) A - TO RECLASS OT AND ST					
1. 00	OCCUPATI ONAL THERAPY	45.00	35, 635	38, 855	1.00
2. 00	SPEECH PATHOLOGY	46.00	9, 292	10, 132	2.00
TOTALS					1
100.00	Total Reclassifications (Sum		44, 927	48, 987	100.00
	of columns 4 and 5 must				
	equal sum of columns 8 and				
	9)				

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

Health Financial Systems	PITMAN MANOR	2		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315427	Period: From 07/01/2021	Worksheet A-6	
				To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :18 am
		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	PHYSICAL THERAPY		44. (	00 44, 927	48, 987	1.00
2. 00			0. (	00	0	2.00
TOTALS						
100. 00				44, 927	48, 987	100. 00

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

In Lieu of Form CMS-2540-10 Health Financial Systems PITMAN MANOR Provi der No.: 315427 Peri od: Worksheet A-7

RECONCILIATION OF CAPITAL COSTS CENTERS

Subtotal (sum of lines 1-6)

Total (line 7 minus line 8)

Reconciling Items

7.00

8.00

9.00

From 07/01/2021

7.00

8. 00

9.00

Date/Time Prepared: 11/29/2022 11:18 am 06/30/2022 Acqui si ti ons Description Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1.00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 39, 437 0 0 1.00 Land Improvements 0 2.00 0 2.00 3.00 Buildings and Fixtures 14, 281, 189 3.00 231, 674 231, 674 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 1, 969, 628 203, 443 0 203, 443 0 5.00 0 6.00 Movable Equipment 171, 892 0 6.00 Subtotal (sum of lines 1-6) 0 7.00 16, 462, 146 435, 117 0 7.00 435, 117 0 8.00 Reconciling Items 0 8.00 9.00 Total (line 7 minus line 8) 16, 462, 146 435, 117 0 435, 117 9.00 Fully Endi ng Bal ance Description Depreci ated Assets 6.00 7. 00 ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1.00 39, 437 Land 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 0 3.00 14, 512, 863 Building Improvements 0 4.00 4.00 Fixed Equipment 5.00 2, 173, 071 5.00 6.00 Movable Equipment 171, 892 0 6.00

16, 897, 263

16, 897, 263

0

0

0

Provi der No.: 315427

Peri od: From 07/01/2021 | Worksheet A-8 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

				10 06/30/2022	2   Date/lime Prep   11/29/2022 11:	
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cost Center	Li ne No.	
		Adjustment				
	I	1. 00	2. 00	3. 00	4. 00	
1. 00	Investment income on restricted funds		0	)	0.00	1. 00
2. 00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		0		0.00	2. 00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3. 00
4. 00	Rental of provider space by suppliers		0		0.00	4. 00
	(chapter 8)					
5.00	Tel ephone services (pay stations excluded)		0		0.00	5. 00
4 00	(chapter 21)	В	20, 000	DIANT ODERATION MAINT 0	F 00	/ 00
6. 00	Television and radio service (chapter 21)	В	-20, 000	PLANT OPERATION, MAINT. & REPAIRS	5. 00	6. 00
7. 00	Parking Lot (chapter 21)		0		0.00	7. 00
8.00	Remuneration applicable to provider-based	A-8-2	0		!	8. 00
	physici an adjustment				ļ	
9.00	Home office cost (chapter 21)		0		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain Capital expenditures (chapter 24)		U	,	0.00	11. 00
12. 00	Adjustment resulting from transactions with	A-8-1	-92, 307	7		12. 00
	related organizations (chapter 10)					
13. 00	Laundry and linen service		0		0.00	
14.00	Revenue - Employee meals		0			14.00
15. 00 16. 00	Cost of meals - Guests		0		0.00	•
10.00	Sale of medical supplies to other than patients		U		0.00	10.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vending machines		0		0.00	
20. 00	Income from imposition of interest, finance		0	P	0.00	20. 00
21 00	or penalty charges (chapter 21)		0		0.00	21 00
21. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		U	,	0.00	21. 00
	overpayments				ļ	
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82. 00	22. 00
	(chapter 21)					
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
24. 00	Depreciationmovable equipment		0	FIXTURES  CAP REL COSTS - MOVABLE	2.00	24. 00
24.00	Bepreer at ron movabre equipment		O	EQUI PMENT	2.00	24.00
25.00	MARKETI NG SAL/OTHER	A	-400, 350	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETING BENEFITS	A	-43, 417	EMPLOYEE BENEFITS	3.00	
25. 02	NON-ALLOWABLE EXPENSES	A		ADMINISTRATIVE & GENERAL		25. 02
25. 03		A		ADMINISTRATIVE & GENERAL		25. 03
25. 04	ELECTRI C REVENUE	В	-540	PLANT OPERATION, MAINT. &	5. 00	25. 04
25. 05	HOUSEKEEPING SERVICES	В	_ // 2.2	REPAIRS HOUSEKEEPING	7.00	25. 05
25. 06	MAINTENANCE SERVICES	В		PLANT OPERATION, MAINT. &	5.00	1
20.00			300	REPAIRS		
25. 07	OTHER INCOME	В	-6, 097	ADMINISTRATIVE & GENERAL	4.00	25. 07
100.00	Total (sum of lines 1 through 99) (Transfer		-852, 180			100. 00
	to Worksheet A, col. 6, line 100)	1		1	1	
(1) De	scription - all chapter references in this co	lumn pertain to	CMS Pub 15-1	1		

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

PITMAN MANOR

Health Financial Systems PITMAN M
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315427 OFFICE COSTS

011102 00313			Т	o 06/30/2022	Date/Time Pro	
	Li ne No.	Cost	Center	Expense		
	1.00		00	3. (		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUICLAIMED HOME OFFICE COSTS:						
1.00		ADMI NI STRATI VE	& GENERAL	HOME OFFICE ALL	_OCATI ON	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 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line 12.						
12.	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minus			
	Cost	Wkst. A, col.	col. 5)			
	0031	5	(01. 3)			
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI				D ORGANI ZATI ONS	OR	
CLAIMED HOME OFFICE COSTS:						
1.00	962, 062	1, 054, 369	-92, 307			1.00
2. 00	0	0	0			2. 00
3. 00	0	0	0			3. 00
4. 00	0	0	0			4. 00
5. 00	0	0	0			5. 00
6. 00	0	0	0			6. 00
7. 00	0	0	0			7. 00
8. 00	0	0	0			8. 00
9. 00	0	0	0			9. 00
10.00 TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	962, 062	1, 054, 369	-92, 307			10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider No.: 315427 Peri od: Worksheet A-8-1 From 07/01/2021 OFFICE COSTS Parts I-II 06/30/2022 Date/Time Prepared:

			_	11/29/2022 11	18 am
	Symbol (1)	Name	Percentage of		
			Ownershi p		
	1.00	2. 00	3. 00		
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ATION(S) AND/O	R HOME OFFICE:			

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

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

1.00	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	1

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

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

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

1.00	UNITED METHODIST HOMES OF NJ	100.00 SUPPORT 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.

Health Financial Systems PITMAN MANOR In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315427 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:18 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS All ocation (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 00 623.844 623 844 1 00 2.00 0 2.00 3.00 00300 EMPLOYEE BENEFITS 1, 772, 305 0 1, 772, 305 3.00 00400 ADMINISTRATIVE & GENERAL 0 3, 201, 647 4 00 2, 956, 672 218 327 4 00 26, 648 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 1, 276, 345 6, 951 0 94,098 1, 377, 394 5.00 8, 496 6.00 00600 LAUNDRY & LINEN SERVICE 119, 395 21, 927 149, 818 6.00 7.00 00700 HOUSEKEEPI NG 615, 965 3, 862 0 118, 302 738, 129 7.00 00800 DI FTARY 2,009,521 187. 938 8 00 8 00 16, 219 2, 213, 678 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 12.00 13.00 01300 SOCIAL SERVICE 63,055 1, 933 0 14, 355 79, 343 13.00 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 14.00 01500 ACTI VI TI ES 0 268, 258 15.00 220, 505 9, 268 38, 485 15.00 15.01 01501 CHAPLAI N 70, 513 0 15, 978 86, 491 15.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 3, 174, 603 99, 929 0 539, 701 3, 814, 233 30.00 31.00 03100 NURSING FACILITY 0 31.00 0 0 32.00 03200 | CF/IID Λ 32.00 447, 940 03300 OTHER LONG TERM CARE 0 33.00 2,068,525 439, 614 2, 956, 079 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40.00 5.788 0 0 5, 788 0 41.00 04100 LABORATORY 15,030 C 0 15,030 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 55, 572 0 11, 504 67,076 43.00 0 44.00 04400 PHYSI CAL THERAPY 187, 224 1,826 33, 089 222, 139 44.00 04500 OCCUPATIONAL THERAPY 25, 415 175, 905 150, 490 45.00 45.00 8, 985 46.00 04600 SPEECH PATHOLOGY 49, 599 0 0 58, 584 46.00 04700 ELECTROCARDI OLOGY 0 47 00 C 0 Ω 47 00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 213 C 0 6, 213 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 49.00 83,770 83, 770 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 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 623, 072 0 15, 519, 575 89.00 89.00 15.524.934 1. 767. 718

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94.00

98.00

99.00

100.00

09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN

09100 BARBER AND BEAUTY SHOP

09300 NONPALD WORKERS

TOTAL

09400 PATIENTS LAUNDRY

09200 PHYSICIANS PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

Peri od: Worksheet B
From 07/01/2021 Part I
To 04/20/2022 Part II
To 04/20/202 Part II
To 04/20/202 Part II
To 04/20/202 Part II
To 04/20/202 Part II
To 0 Provi der No.: 315427

				T	06/30/2022		pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATION, MAINT. &	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	: 18 am
			REPAI RS				
	CENEDAL CEDVICE COCT CENTEDS	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	3, 201, 647					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	357, 122	1, 734, 516				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	38, 844	24, 966	213, 628			6. 00
7.00	00700 HOUSEKEEPI NG	191, 378	11, 348	0	940, 855		7. 00
8.00	00800 DI ETARY	573, 949	47, 662	2 0	26, 406	2, 861, 695	8. 00
9.00	00900 NURSING ADMINISTRATION	0	0	0	0	0	9. 00
10. 00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10. 00
11. 00	01100 PHARMACY	0	0	0	0	0	11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300 SOCIAL SERVICE	20, 572	5, 680	0	3, 147	0	13.00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	(O FF2)	27 224	0	15 000	0	14.00
15. 00 15. 01	01500   ACTI VI TI ES	69, 552	27, 236		15, 089	0	15. 00 15. 01
15. 01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	22, 425		<u> </u>	<u> </u>	0	13.01
30. 00	03000 SKILLED NURSING FACILITY	988, 928	293, 655	160, 221	162, 694	1, 113, 486	30. 00
31. 00	03100 NURSING FACILITY	0	0	l	0	0	31. 00
32. 00	03200   CF/IID	0	0	0	O	0	32.00
33.00	03300 OTHER LONG TERM CARE	766, 434	1, 316, 332	53, 407	729, 289	1, 748, 209	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	1, 501	0	0	0	0	40. 00
41. 00	04100 LABORATORY	3, 897	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	17, 391	0	0	0	0	43.00
44. 00	04400 PHYSI CAL THERAPY	57, 595	5, 367	0	2, 973	0	44.00
45. 00 46. 00	04500   OCCUPATI ONAL THERAPY   04600   SPEECH PATHOLOGY	45, 608 15, 189	0		0	0	45. 00 46. 00
47. 00	04700 SFEECH PATHOLOGY	13, 109	0		0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 611	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	21, 719	0	o o	o	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	o	o	0	50.00
51.00	05100 SUPPORT SURFACES	O	0	0	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	· ·	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62. 00	06200 FQHC						62. 00
70. 00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	0	Ol	0	70. 00
71.00	07100 AMBULANCE	0	0		- 1	0	70.00
73. 00	07300 CMHC	0	0	· -	- 1	0	73. 00
, 0. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u>,                                      </u>	91		70.00
80.00							80. 00
81.00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83.00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	3, 193, 715	1, 732, 246	213, 628	939, 598	2, 861, 695	89. 00
00.00	NONREI MBURSABLE COST CENTERS	7 722				0	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	7, 732	2, 270	0	-	0	90. 00 91. 00
91.00	09200 PHYSI CLANS PRI VATE OFFI CES	200	2, 270	0	l	0	91.00
93. 00	09300 NONPALD WORKERS		0	0	-	0	93.00
94. 00	09400 PATIENTS LAUNDRY		0	0	-	0	94. 00
98. 00		0	0	o o	ا	0	98. 00
99. 00	Negative Cost Centers		0	0	o	0	99. 00
100.00		3, 201, 647	1, 734, 516	213, 628	940, 855	2, 861, 695	100. 00

| Peri od: | Worksheet B | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared: | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/1

			To	06/30/2022	Date/Time Prep 11/29/2022 11:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	TO alli
odst denter beserverten	ADMI NI STRATI ON	SERVICES &	1 11/11/11/11/10	RECORDS &	SOUTHE SERVICE	
		SUPPLY		LI BRARY		
	9.00	10.00	11.00	12.00	13. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00   00200   CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00 00300 EMPLOYEE BENEFITS						3. 00
4.00   OO400   ADMINISTRATIVE & GENERAL						4. 00
5.00   00500   PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00   00600   LAUNDRY & LINEN SERVICE						6. 00
7. 00   00700   HOUSEKEEPI NG						7. 00
8. 00   00800   DI ETARY						8. 00
9.00 O0900 NURSING ADMINISTRATION	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   MEDI CAL RECORDS & LI BRARY	0	0	0	0		12. 00
13. 00   01300   SOCIAL SERVICE	0	0	0	0	108, 742	13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15. 00   01500   ACTIVITIES	0	0	0	0	0	15. 00
15. 01 01501 CHAPLAIN	0	U	0	0	0	15. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		ما	0	0	100 742	20.00
30. 00 03000 SKILLED NURSING FACILITY	0	0	0	0	108, 742	30.00
31. 00   03100   NURSI NG   FACILITY	0	0	0	0	0	31. 00
32. 00   03200   TEPL ONG TEPL CAPE	0	0	0	0	0	32.00
33.00 O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	l d	······································	U	U	U	33. 00
40. 00 04000 RADI OLOGY	l ol	ol	0	0	0	40. 00
41. 00   04100   LABORATORY		0	0	0	0	41. 00
42. 00   04200   NTRAVENOUS THERAPY		0	0	0	0	42. 00
43. 00   04300   0XYGEN (INHALATION) THERAPY		0	0	0	0	43. 00
44. 00 04400 PHYSI CAL THERAPY		0	0	0	0	44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	o o	0	0	0	0	45. 00
46. 00 04600 SPEECH PATHOLOGY		0	0	0	0	46. 00
47. 00 04700 ELECTROCARDI OLOGY		0	0	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS		0	0	0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	l ol	o	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	o	o	0	0	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
71. 00  07100 AMBULANCE	0	0	0	0	0	71. 00
73. 00 07300 CMHC	0	0	0	0	0	73. 00
SPECIAL PURPOSE COST CENTERS	1					
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00 08100 INTEREST EXPENSE						81. 00
82. 00   08200   UTILIZATION REVIEW - SNF	_	_		_	_	82. 00
83. 00   08300   HOSPI CE	0	0	0	0		83. 00
89. 00 SUBTOTALS (sum of lines 1-84)	0	0	0	0	108, 742	89. 00
NONREI MBURSABLE COST CENTERS	1 2	ام				00.00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92. 00   O9200   PHYSICIANS PRIVATE OFFICES 93. 00   O9300   NONPAID   WORKERS	0	0	0	0	0	92.00
		0	0	0	0	93. 00
94.00 O9400 PATIENTS LAUNDRY 98.00 Cross Foot Adjustments		0	O	O	0	94. 00 98. 00
98.00   Cross Foot Adjustments 99.00   Negative Cost Centers		0		0	0	98. 00 99. 00
100.00 TOTAL	0	0	0	0	-	
100.00   101AL	ı V	Ŋ	U	U	100, 742	100.00

| Peri od: | Worksheet B | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared: | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/10 | 11/1 Provi der No.: 315427

				To	06/30/2022	Date/Time Pre 11/29/2022 11	
			OTHER GENEI	RAL SERVICE		11/2//2022 11	10 am
	Cost Center Description	NURSING AND ALLIED HEALTH	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Stepdown	
		EDUCATION				Adjustments	
		14.00	15. 00	15. 01	16. 00	17. 00	
' <u></u>	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 4. 00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL						3. 00 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 13. 00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE						12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTIVITIES	0	380, 135				15. 00
15. 01	01501 CHAPLAI N	o	000, 100				15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	380, 135	34, 770	7, 056, 864	0	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31. 00
32. 00	03200   CF/IID	0	0	1	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	74, 146	7, 643, 896	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	0	7, 289	0	40. 00
41. 00	04100 LABORATORY	0	0	1	18, 927	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	o o	0	o o	0, 727	ő	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	84, 467	0	43. 00
44.00	04400 PHYSI CAL THERAPY	0	0	0	288, 074	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0	0	221, 513	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	73, 773	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	7 024	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0		7, 824 105, 489	0	48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		103, 469 N	0	50.00
51. 00	05100 SUPPORT SURFACES	o	0		0	Ö	51.00
	OUTPATIENT SERVICE COST CENTERS	-1	-		-		
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
70.00	OTHER REIMBURSABLE COST CENTERS			J			70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0	0	70. 00 71. 00
73.00	07300 CMHC	0	0		0		73.00
73.00	SPECIAL PURPOSE COST CENTERS	0		,			73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82. 00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	380, 135	108, 916	15, 508, 116	0	89. 00
90. 00	NONREIMBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	O	0		37, 553	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		4, 499	0	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	0		7, 477	0	92.00
93. 00	09300 NONPALD WORKERS		0	ol ol	0	Ö	93. 00
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	
100.00	D TOTAL	0	380, 135	108, 916	15, 550, 168	0	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS PI TMAN MANOR

| Peri od: | Worksheet B | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared: Provi der No.: 315427

			nte/Time Prepared: 1/29/2022 11:18 am
	Cost Center Description	Total	 72772022 11. 10 dill
	I	18. 00	
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 ADMI NI STRATI VE & GENERAL		4.00
5.00	· ·		
6. 00	OO5OO  PLANT OPERATION, MAINT. & REPAIRS   OO6OO  LAUNDRY & LINEN SERVICE		5. 00 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		9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		10.00
11. 00	01100 PHARMACY		11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		12. 00
	01300 SOCIAL SERVICE		13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION		14. 00
	01500 ACTIVITIES		15. 00
	01501 CHAPLAI N		15. 01
15.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		15.01
30. 00	03000 SKILLED NURSING FACILITY	7, 056, 864	30.00
31. 00	03100 NURSING FACILITY	7,030,004	31.00
	03200   CF/11D		32.00
	03300 OTHER LONG TERM CARE	7, 643, 896	33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS	7,043,070	33.00
40. 00	04000 RADI OLOGY	7, 289	40. 00
41. 00	04100 LABORATORY	18, 927	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	10, 727	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	84, 467	43. 00
	04400 PHYSI CAL THERAPY	288, 074	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	221, 513	45. 00
	04600 SPEECH PATHOLOGY	73, 773	46. 00
	04700 ELECTROCARDI OLOGY	75,775	47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 824	48. 00
	04900 DRUGS CHARGED TO PATIENTS	105, 489	49. 00
	05000 DENTAL CARE - TITLE XIX ONLY	0	50.00
	05100 SUPPORT SURFACES	l ol	51.00
	OUTPATIENT SERVICE COST CENTERS	-1	7 11 9 9
60.00	06000 CLI NI C	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	o	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
	SPECIAL PURPOSE COST CENTERS		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		80. 00
81. 00	08100 I NTEREST EXPENSE		81.00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF		82.00
83. 00		0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	15, 508, 116	89. 00
	NONREI MBURSABLE COST CENTERS		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	37, 553	90.00
91. 00	09100 BARBER AND BEAUTY SHOP	4, 499	91.00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	0	92. 00
93. 00	09300 NONPAI D 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	0	99.00
100.00	TOTAL	15, 550, 168	100. 00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315427

				<del> </del>	To 06/30/2022	Date/Time Pre 11/29/2022 11	pared:
			CAPI TAL REL	ATED COSTS		11/29/2022 11	: 18 alli
	Cost Center Description	Directly	BLDGS &	MOVABLE	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	FIXTURES	EQUI PMENT	Subtotal	BENEFI TS	
		Capi tal					
		Related Costs 0	1. 00	2. 00	2A	3. 00	
	GENERAL SERVICE COST CENTERS			2.00	271	0.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	0	(	o	0	2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL	0	26, 648		26, 648		4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	6, 951		6, 951	0	5. 00
6. 00 7. 00	O0600 LAUNDRY & LINEN SERVICE   O0700 HOUSEKEEPING	0	8, 496		8, 496 3, 862		6. 00 7. 00
7. 00 8. 00	00800 DI ETARY	0	3, 862 16, 219		3, 862 16, 219		8.00
9. 00	00900 NURSING ADMINISTRATION	O	0		0	Ö	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	10. 00
11.00	01100 PHARMACY	0	0	(	0	0	11.00
12. 00 13. 00	O1200   MEDICAL RECORDS & LIBRARY   O1300   SOCIAL SERVICE		1, 933		0 0 1, 933	0	12. 00 13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14. 00
15. 00	01500 ACTIVITIES	0	9, 268		9, 268		15. 00
15. 01	O1501   CHAPLAI N   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	[(	0	0	15. 01
30. 00	03000 SKILLED NURSING FACILITY	0	99, 929		99, 929	0	30.00
31. 00	03100 NURSING FACILITY	0	. 0		0		31. 00
32.00	03200   CF/11D	0	0		0	0	32.00
33. 00	03300  OTHER LONG TERM CARE   ANCILLARY SERVICE COST CENTERS	0	447, 940	[(	0 447, 940	0	33. 00
40. 00	04000 RADI OLOGY	0	0		0	0	40.00
41. 00	04100 LABORATORY	0	0		0	0	41. 00
42.00	04200 I NTRAVENOUS THERAPY	0	0	(	0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0 1, 826		1, 826	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	o	0		0 1, 020		45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0		0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	(	0	0	47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS		0			0	48. 00 49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	o	0		0	0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	(	0	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS  06000 CLINIC	O	0	,	o o	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0				61.00
62. 00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS						
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0 0	-	70. 00 71. 00
73.00	07300 CMHC	0	0				1
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81. 00 82. 00	O8100   INTEREST EXPENSE   O8200   UTI LI ZATI ON REVIEW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	o	0		o	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	623, 072	(	623, 072	0	89. 00
00.00	NONREI MBURSABLE COST CENTERS		0				00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 772		0 772	0	90. 00 91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES		0		0 0	Ő	1
93. 00	09300 NONPALD WORKERS	0	0		0	0	93. 00
94. 00 98. 00	O9400 PATIENTS LAUNDRY   Cross Foot Adjustments	0	0	(	0	0	94. 00 98. 00
98.00	Negative Cost Centers		Ω	(	0	0	1
100.00		0	623, 844		623, 844	-	100.00
			'		'		

Period: Worksheet B
From 07/01/2021 Part II
To 04/20/2022 Part III
To 04/20/2022 Part III
To 04/20/2022 Part III Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315427

				To	06/30/2022	Date/Time Pre 11/29/2022 11	pared:
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	. 10 alli
		& GENERAL	OPERATION, MAINT. &	LINEN SERVICE			
			REPAI RS				
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0, ,,,					3. 00
4. 00 5. 00	OO400 ADMINISTRATIVE & GENERAL OO500 PLANT OPERATION, MAINT. & REPAIRS	26, 648 2, 972	9, 923				4. 00 5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE	323	143				6.00
7.00	00700 HOUSEKEEPI NG	1, 593	65		5, 520		7. 00
8.00	00800 DI ETARY	4, 777	273		155	21, 424	8.00
9. 00 10. 00	O0900   NURSI NG   ADMI NI STRATI ON   O1000   CENTRAL   SERVI CES & SUPPLY		0	1	0	0	9. 00 10. 00
11. 00	01100 PHARMACY	O	0	Ö	Ö	0	11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12. 00
13. 00 14. 00	01300 SOCIAL SERVICE	171	32 0	0	18 0	0	13. 00 14. 00
15. 00	01400   NURSING AND ALLIED HEALTH EDUCATION   01500   ACTIVITIES	579	156	1	89	0	15. 00
15. 01	01501 CHAPLAI N	187	0		0	0	15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			1	1		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	8, 233	1, 680 0		955 0	8, 336 0	30. 00 31. 00
32. 00	03200   CF/11D	0	0		o	0	32.00
33.00	03300 OTHER LONG TERM CARE	6, 379	7, 530	2, 241	4, 279	13, 088	1
	ANCILLARY SERVICE COST CENTERS				_1		
40. 00 41. 00	04000   RADI OLOGY   04100   LABORATORY	12	0	1	0	0	40. 00 41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		o	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	145	0	0	o	0	43. 00
44.00	04400 PHYSI CAL THERAPY	479	31	0	17	0	44.00
45. 00 46. 00	04500   OCCUPATI ONAL THERAPY   04600   SPEECH PATHOLOGY	380 126	0	0	0	0	45. 00 46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	o	o	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	13	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	181	0	0	0	0	49. 00
50. 00 51. 00	05000   DENTAL CARE - TITLE XIX ONLY   05100   SUPPORT SURFACES	0	0	-	0	0	50. 00 51. 00
01.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<sub>I</sub>		01.00
60.00	06000 CLI NI C	0	0	-	0	0	60. 00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	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	
73. 00	O7300   CMHC   SPECI AL 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 I NTEREST EXPENSE						81. 00
82.00	08200 UTI LI ZATI ON REVI EW - SNF					0	82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	26, 582	9, 910	0 8, 962	0 5, 513	0 21, 424	
07.00	NONREI MBURSABLE COST CENTERS	20, 302	7, 710	0, 702	3, 313	21, 727	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	64	0		0	0	
91.00	09100 BARBER AND BEAUTY SHOP	2	13		7	0	1
92. 00 93. 00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS		0	1	0	0	
94. 00	09400 PATI ENTS LAUNDRY		0	Ö	o	0	94. 00
98. 00	Cross Foot Adjustments			0	0	0	98. 00
99. 00 100. 00	Negative Cost Centers   TOTAL	0 26, 648	9, 923	0 8, 962	0 5, 520	0 21, 424	99.00
100.00	, ITOTAL	20,040	7, 923	0, 902	5, 520	21, 424	1100.00

Provi der No.: 315427

	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	11/29/2022 11   SOCIAL   SERVICE	: 18 am
		9. 00	10.00	11. 00	12.00	13. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS - BLDGS & FIXTURES  00200 CAP REL COSTS - MOVABLE EQUIPMENT  00300 EMPLOYEE BENEFITS  00400 ADMINISTRATIVE & GENERAL  00500 PLANT OPERATION, MAINT. & REPAIRS  00600 LAUNDRY & LINEN SERVICE  00700 HOUSEKEEPING  00800 DIETARY  00900 NURSING ADMINISTRATION  01000 CENTRAL SERVICES & SUPPLY  01100 PHARMACY  01200 MEDICAL RECORDS & LIBRARY	0 0 0	0 0 0	0 0	0 0	2, 154	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 15. 01	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES 01501 CHAPLAIN	0 0	0 0 0	0 0	0 0 0	0 0	14. 00 15. 00 15. 01
30. 00 31. 00 32. 00 33. 00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0	0 0 0 0	0	0 0 0 0	2, 154 0 0 0	30. 00 31. 00 32. 00 33. 00
40. 00 41. 00 42. 00 43. 00 44. 00 45. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATIONAL THERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	40. 00 41. 00 42. 00 43. 00 44. 00 45. 00
46. 00 47. 00 48. 00 49. 00 50. 00 51. 00	04900 DRUGS CHARGED TO PATIENTS	0 0 0 0 0	0 0 0 0 0	0 0 0	0 0 0 0	0 0 0 0	46. 00 47. 00 48. 00 49. 00 50. 00 51. 00
60. 00 61. 00 62. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC OTHER REIMBURSABLE COST CENTERS	0	0		0	0	60. 00 61. 00 62. 00
70. 00 71. 00 73. 00		0 0 0	0 0 0	0	0 0 0	0 0 0	70. 00 71. 00 73. 00
80. 00 81. 00 82. 00 83. 00 89. 00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	0	0	0	0 2, 154	1
90. 00 91. 00 92. 00 93. 00 94. 00 98. 00 99. 00 100. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0 0	91. 00 92. 00 93. 00 94. 00 98. 00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/10/2020 | 11/ Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315427

				To	06/30/2022	Date/Time Pre 11/29/2022 11	
			OTHER GENER	PAL SERVICE		11/29/2022 11	10 alli
			OTTIER GENET	THE SERVICE			
	Cost Center Description	NURSING AND	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Step-Down	
	, , , , , , , , , , , , , , , , , , ,	ALLIED HEALTH				Adjustments	
		EDUCATI ON				,	
		14.00	15. 00	15. 01	16.00	17. 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 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						9.00
10. 00 11. 00	01000   CENTRAL SERVI CES & SUPPLY   01100   PHARMACY						10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY						12. 00
13. 00	01300 SOCIAL SERVICE						13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14. 00
15. 00	01500 ACTIVITIES		10, 092				15. 00
15. 01	01501 CHAPLAI N		0, 0, 2				15. 01
10.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u> </u>	107			10.01
30. 00	03000 SKILLED NURSING FACILITY	O	10, 092	60	138, 160	0	30. 00
31. 00	03100 NURSING FACILITY	o	0		C		31. 00
32. 00	03200   CF/IID	O	0		C	0	32. 00
33.00	03300 OTHER LONG TERM CARE	o	0	127	481, 584	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	0	12	0	40.00
41.00	04100 LABORATORY	0	0	0	32	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	0	C		42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	0	0	0	145	1	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	2, 353	1	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	380	1	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	0	0	126	1	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	12		47. 00
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	0	13 181		48. 00 49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	101	1	50.00
51. 00	05100 SUPPORT SURFACES		0		C	1	51. 00
01.00	OUTPATIENT SERVICE COST CENTERS	١	J	, , ,		,	01.00
60.00	06000 CLI NI C	O	0	0	C	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	o	0		C	1	61. 00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	C	0	70.00
71.00	07100 AMBULANCE	0	0	0	C	0	71.00
73.00	07300 CMHC	0	0	0	C	0	73.00
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF	_	_	_	_	_	82. 00
83. 00	08300 H0SPI CE	0	0		0		83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	10, 092	187	622, 986	0	89. 00
90. 00	NONREI MBURSABLE COST CENTERS  09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN		0			0	90. 00
	09100 BARBER AND BEAUTY SHOP		0	0	64 794	l .	90.00
91.00	09200 PHYSI CLANS PRI VATE OFFI CES		0	0	794	l .	91.00
93. 00	09300 NONPAID WORKERS		0	ا	0		93. 00
94. 00	09400 PATIENTS LAUNDRY		0	Ö	Č		94. 00
98. 00	Cross Foot Adjustments		0	Ö	Č	o o	98. 00
99. 00	Negative Cost Centers	0	0	0	C	0	99. 00
100.00		0	10, 092	187	623, 844	0	100. 00
		·		,			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315427

COST CORTOP DESCRIPTION   Total   18.00				11/29/2022 11	
CENTRAL SERVICE COST CENTERS   1.00   00100 CAP REL COSTS - BLOSS & FIXTURES   2.00   00200 CAP REL COSTS - BLOSS & FIXTURES   2.00   00200 CAP REL COSTS - BLOSS & FIXTURES   2.00   00200 CAP REL COSTS - BOVABLE EQUI PIENT   3.00   00300 CHEPLOVEE BERRY & GENERAL   4.00   00400 CH		Cost Center Description	Total		
1.00		'	18. 00		
1.00		GENERAL SERVICE COST CENTERS			
2.00   00200   CAP PEL COSTS - MOVABLE EQUIPMENT   2.00   4.00	1.00				1.00
3.0 0 00000   EMPLOYER BENEFITS					1
4.00					1
5.00   00500   PLANT OPERATION MAINT & REPAIRS   5.00   00700   LANDRY & LIEN SERVICE   6.60   00700   HOUSEKEEP ING   7.00   00700   HOUSEKEEP ING   8.00   00800   ETARY   8.00   00800   ETARY   10.00   10.00   10.00   CHARLA SERVICES & SUPPLY   10.00   CHARLA SERVICE		l ;			1
0.000   0.0000   LAINDRY & LI NEN SERVICE					1
7.00					1
8. 0. 0 0. 00600 DIFTARY 0. 01000 CHAPTAL SERVICES & SUPPLY 11. 00 11.00		l i			1
9.00 00000 NURSINK ADMINISTRATION		l i			1
10. 00   01000   CENTRAL SERVI (CES & SUPPLY   1.0. 00   11.0. 0		1			1
11.00   01100   PHARMACY   12.00   15.00   1		l i			1
12. 00   101200   MEDICAL RECORDS & LIBRARY		l i			1
13. 00   01300   SOCIAL SERVICE   14. 00   01400   NURSIN GAND ALLIED HEALTH EDUCATION   15. 00   01500   ACTIVITIES   15. 00   15. 00   01500   ACTIVITIES   15. 00   15. 00   15. 00   15. 00   15. 00   16. 0					1
14. 00   01400   AURSING AND ALLIED HEALTH EDUCATION   15. 01					1
15. 00   OTSOO   ACTIVITIES     15. 00		l i			1
15. 01   O1501   CHAPLAIN	14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION			14.00
IMPATI ENT ROUTINE SERVICE COST CENTERS   30 0 0 310 0 0 0 310 0 0 0 100 NURSING FACILITY   138, 160   32 00 0 320 0 127 / 10   0 0 32 00 0 320 0 167 / 10   0 0 32 00 0 320 0 167 / 10   0 0 0 32 00 0 33. 00 0 3300 OTHER LONG TERM CARE   481, 584   33. 00 0 3300 OTHER LONG TERM CARE   481, 584   480 0 140 0 140 0 140	15. 00	01500 ACTI VI TI ES			15. 00
30. 00   03000   SILLED NURSI NG FACILITY   138, 160   31. 00   32. 00   032.00	15. 01	01501 CHAPLAI N			15. 01
31.00   03100   NURSI NC FACILITY   0   32.00   03200   ICF/II D   0   0   32.00   033.00		INPATIENT ROUTINE SERVICE COST CENTERS			
32.00   03200   ICF/I ID   32.00   33.00   033.00   07HER LONG TERN CARE	30.00	03000 SKILLED NURSING FACILITY	138, 160		30.00
33.00	31.00	03100 NURSING FACILITY	o		31. 00
33.00	32.00	03200   CF/IID	o		32. 00
ANCILLARY SERVICE COST CENTERS   40, 00			481, 584		1
40.00   04000   RADIOLOGY			, , , , , , , , , , , , , , , , , , , ,		
41.00	40 00		12		40.00
42. 00   04200   INTRAVENOUS THERAPY   0   42. 00   43. 00   04300   OXYGEN (INHALATION) THERAPY   145   43. 00   43. 00   04300   OXYGEN (INHALATION) THERAPY   2, 353   44. 00   45. 00   04500   0CCUPATIONAL THERAPY   380   45. 00   46. 00   04600   SPECT PATHOLOGY   126   46. 00   47. 00   04700   ELECTROCARDIOLOGY   0   47. 00   48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   13   48. 00   49. 00   04900   DRUGS CHARGED TO PATIENTS   181   49. 00   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   60. 00   06000   CLINIC SERVICE COST CENTERS   60. 00   60. 00   06000   CLINIC COST   0   61. 00   61. 00   06000   CLINIC COST   0   61. 00   62. 00   06000   CLINIC COST   0   61. 00   63. 00   07000   MALPRACTICE PREMIUMS & PAID LOSSES   80. 00   60. 00   07000   MALPRACTICE PREMIUMS & PAID LOSSES   80. 00   81. 00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   81. 00   82. 00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   81. 00   83. 00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   81. 00   84. 00   09000   GITT, FLOWER, COFFEE SHOPS & CANTEEN   90. 00   85. 00   09000   GITT, FLOWER, COFFEE SHOPS & CANTEEN   90. 00   87. 00   09000   0700   ARBURASHLE COST CENTERS   90. 00   87. 00   09000   0700   ARBURASHLE COST CENTERS   90. 00   88. 00   09000   0700   0700   0700   0700   0700   0700   0700   89. 00   07000   070					1
43. 00 44. 00 44.00 46.0					1
44. 00   04400   PHYSI CAL THERAPY   2, 353   44. 00   45. 00   04500   OCCUPATI ONAL THERAPY   380   45. 00   04600   SPEECH PATHOLOGY   126   46. 00   04600   SPEECH PATHOLOGY   126   47. 00   04700   ELECTROCARDI OLOGY   0   47. 00   04700   ELECTROCARDI OLOGY   0   47. 00   04700   ELECTROCARDI OLOGY   0   47. 00   04900   DRUGS CHARGED TO PATIENTS   13   48. 00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   181   49. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05100   SUPPORT SURFACES   0   51. 00   00   00   00   00   00   00   00			-		1
45. 00   04500   OCCUPATI ONAL THERAPY   380   45. 00   04600   SPECH PATHOLOGY   126   47. 00   04700   ELECTROCARDI OLOGY   0   47. 00   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   13   48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   181   49. 00   05. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   60. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   05000   DENTAL CARE - TITLE XIX ONLY   0   0   0   0   0   0   0   0   0					1
46. 00 04500 SPECH PATHOLOGY 126 47. 00 47.00 61200 ELECTROCARDI OLOGY 0 0 47. 00 61700 ELECTROCARDI OLOGY 0 0 47. 00 6170 DELECTROCARDI OLOGY 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 13 48. 00 69. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50. 00 05100 SUPPORT SURFACES 0 0 51.00 DUTPATIENT SERVICE COST CENTERS 51.00 DELTAL CARE - TITLE XIX ONLY 0 0 50. 00 05100 SUPPORT SURFACES 0 0 51.00 DELTAL CARE - TITLE XIX ONLY 0 0 50. 00 05100 SUPPORT SURFACES 0 0 51.00 DELTAL CARE - TITLE XIX ONLY 0 0 60. 00 06.00 CLINI C 0 0 61.00 RURAL HEALTH CLINI C 0 0 61.00 RURAL HEALTH CLINI C 0 0 61.00 RURAL HEALTH AGENCY COST 0 0 05000 DELTAL CARE - TITLE XIX ONLY 0 0 0 07000 HOME HEALTH AGENCY COST 0 70. 00 71. 00 07000 HOME HEALTH AGENCY COST 0 0 07300 CMMC 0 733. 00 07300 CMMC 0 0 81.00 INTEREST EXPENSE 8 81.00 82. 00 08200 INTLEAST EXPENSE 8 81.00 82. 00 08200 INTLEAST EXPENSE 8 81.00 82. 00 08200 INTLEAST EXPENSE 8 82. 00 08200 INTLEAST EXPENSE 8 83. 00 83. 00 8000 HOSPI CE 0 0 83. 00 83. 00 HOSPI CE 0 0 83. 00 83. 00 HOSPI CE 0 0 83. 00 83. 00 HOSPI CE 0 0 90.00 FILE TOWNER INBURSABLE COST CENTERS 99.00 NONNEI INBURSABLE COST CENTERS 99.00 09000 GIFT. FLOWER, COFFEE SHOPS & CANTEEN 99.00 99.00 09000 GIFT. FLOWER, COFFEE SHOPS & CANTEEN 99.00 99.00 09000 FILE SHOPS & CANTEEN 99.00 99.00 09000 FILE SHOPS & CANTEEN 99.00 99.00 99.00 NORAL DEATH OF SHORT SHOPS & CANTEEN 99.00 99.00 PATIENTS LAUNDRY 0 99.00 PATI					1
47. 00   04700   LECTROCARDIOLOGY   0   47. 00     48. 00   04800   MEDI CAL SUPPLIES CHARGED TO PATIENTS   13   48. 00     49. 00   04900   DRUGS CHARGED TO PATIENTS   181   49. 00     50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   51. 00     51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   51. 00     51. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   51. 00     50. 00   05000   DENTAL CARE - TITLE XIX ONLY   0   51. 00     60. 00   05000   CLINI C   0   61. 00     61. 00   06100   RURAL HEALTH CLINI C   0   61. 00     62. 00   06200   FOHC   0   62. 00     70. 00   07000   HOME HEALTH AGENCY COST   0   71. 00     71. 00   07100   AMBULANCE   0   73. 00     73. 00   73. 00   73. 00   73. 00     73. 00   73. 00   73. 00   73. 00     74. 00   07100   AMBULANCE   0   73. 00     75. 00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   80. 00     80. 00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   80. 00     80. 00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   80. 00     80. 00   08000   MALPRACTICE PREMI UMS & PAID LOSSES   80. 00     80. 00   08000   UTILIZATION REVIEW - SNF   82. 00     80. 00   SUBTOTALS (Sum of Lines 1-84)   622, 986   89. 00     NONEE IMBURSABLE COST CENTERS   90. 00     90. 00   09000   GIFT, FLOWER. COFFEE SHOPS & CANTEEN   794   91. 00     90. 00   09000   PATIENTS LAUNDRY   0   94. 00     90. 00   09300   NORPAL TI CLINIS CONTENTS   0   92. 00     90. 00   09300   NORPAL TI CLINIS CONTENTS   0   94. 00     90. 00   09400   PATIENTS LAUNDRY   0   94. 00     90. 00   09400   P		l ;	1		
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 13 49. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 181 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 0000 DENTAL CARE - TITLE XIX ONLY 0 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 51. 00 0000 CLI NIC 0 60. 00 61. 00 06000 CLI NIC 0 60. 00 62. 00 06000 CLI NIC 0 60. 00 63. 00 06000 RURAL HEALTH CLI NIC 0 60. 00 64. 00 06000 RURAL HEALTH CLI NIC 0 70. 00 07000 HOME HEALTH AGENCY COST 0 70. 00 07000 HOME HEALTH AGENCY COST 0 70. 00 073. 00 07300 CMHC 0 71. 00 074. 00			1		1
49. 00   04900   DRUGS CHARGED TO PATIENTS   181   50. 00   50. 00   DENTAL CARE - TITLE XIX ONLY   0   50. 00   50. 00   DENTAL CARE - TITLE XIX ONLY   0   50. 00   50. 00   DENTAL CARE - TITLE XIX ONLY   0   50. 00   50. 00   DENTAL CARE - TITLE XIX ONLY   0   50. 00   50. 00   DENTAL CARE - TITLE XIX ONLY   0   50. 00   50. 00   DENTAL EACH - TITLE XIX ONLY   0   50. 00   50. 00   DENTAL EACH - COST CENTERS   0   0   60. 00		l i	1		1
50.00   05000   DENTAL CARE - TITLE XIX ONLY   0   51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0		l i	1		1
51.00   05100   SUPPORT SURFACES   0   0   0   0   0   0   0   0   0		l i	1		1
OUTPATIENT SERVICE COST CENTERS   60.00   06000   CLINIC   0   61.00   62.00   06200   CLINIC   0   61.00   62.00   06200   FOHC   0   62.00   O06200   FOHC   0   071.00   O7100   AMBURANCE   0   0   071.00   O7100   AMBURANCE   0   0   071.00   O7100   AMBURANCE   0   0   071.00   O7300   CMHC   O7300   CMHC   O7300   CMHC   O7300   CMHC   O7300   CMHC   O7300   CMHC   O7300   O7300   O7300   CMHC   O7300		1			1
60. 00	51.00		0		51.00
61. 00					4
62. 00    Officer   Color   Color   Color					1
OTHER REIMBURSABLE COST CENTERS   O   O7000   HOME HEALTH AGENCY COST   O   O70   O7100   AMBULANCE   O   O7300   O7100   AMBULANCE   O   O7300   OMHC   O   O   O   O   O   O   O   O   O		l i	0		1
70. 00	62. 00				62. 00
71. 00					
73. 00   07300   CMHC   0     73. 00     SPECIAL PURPOSE COST CENTERS   80. 00   08000   MALPRACTI CE PREMI UMS & PAI D LOSSES   81. 00   81. 00   81. 00   82. 00   08200   UTI LI ZATI ON REVI EW - SNF   82. 00   83. 00   08300   HOSPI CE   0   83. 00   89. 00   SUBTOTALS (sum of lines 1-84)   622, 986   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   09100   BARBER AND BEAUTY SHOP   794   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   94. 00   94. 00   09400   PATI ENTS LAUNDRY   0   98. 00   Negati ve Cost Centers   0   99. 00   Negati ve Cost Centers   0   99. 00   099. 00   Negati ve Cost Centers   0   99. 00   099. 00   099. 00   Negati ve Cost Centers   0   99. 00   099. 00					1
SPECIAL PURPOSE COST CENTERS   80.00   08000   MALPRACTICE PREMIUMS & PAID LOSSES   80.00   81.00   08100   INTEREST EXPENSE   81.00   82.00   08200   UTILIZATION REVIEW - SNF   82.00   83.00   08300   HOSPICE   50   50   50   50   50   50   50   5	71. 00	07100 AMBULANCE			71. 00
80. 00 81. 00 81. 00 82. 00 82. 00 82. 00 83. 00 88. 00 89. 00	73.00		0		73. 00
81.00   08100   INTEREST EXPENSE   81.00   82.00   08200   UTI LI ZATI ON REVI EW - SNF   82.00   83.00   08300   HOSPI CE   0   83.00   89.00   SUBTOTALS (sum of lines 1-84)   622,986   89.00   NONREI MBURSABLE COST CENTERS   90.00   90900   GI FT, FLOWER, COFFEE SHOPS & CANTEEN   91.00   9		SPECIAL PURPOSE COST CENTERS			
82. 00 83. 00 83. 00 89. 00  SUBTOTALS (sum of lines 1-84)  NONREI MBURSABLE COST CENTERS  90. 00 91. 00 91. 00 92. 00 99. 00 99. 00 99. 00 90	80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			80. 00
83. 00 89. 00    SUBTOTALS (sum of lines 1-84)   622,986   89. 00   NONREI MBURSABLE COST CENTERS   90. 00   9000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   91. 00   91. 00   92. 00   92.00   94. 00   92. 00   94. 00   94. 00   94. 00   94. 00   94. 00   94. 00   94. 00   96	81. 00	08100   NTEREST EXPENSE			81. 00
89. 00   SUBTOTALS (sum of lines 1-84)   622, 986   89. 00	82.00	08200 UTILIZATION REVIEW - SNF			82. 00
NONREI MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   64   91.00   09100   BARBER AND BEAUTY SHOP   794   91.00   92.00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   92.00   93.00   NONPAI D WORKERS   0   93.00   09400   PATI ENTS LAUNDRY   0   94.00   98.00   09400   PATI ENTS LAUNDRY   0   98.00   99.00   Negati ve Cost Centers   0   99.00   099.00	83.00		o		83. 00
NONREI MBURSABLE COST CENTERS   90.00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   64   91.00   09100   BARBER AND BEAUTY SHOP   794   91.00   92.00   09200   PHYSI CI ANS PRI VATE OFFI CES   0   92.00   93.00   NONPAI D WORKERS   0   93.00   09400   PATI ENTS LAUNDRY   0   94.00   98.00   09400   PATI ENTS LAUNDRY   0   98.00   99.00   Negati ve Cost Centers   0   99.00   099.00	89. 00	SUBTOTALS (sum of Lines 1-84)	622, 986		89. 00
90. 00   09000   GIFT, FLOWER, COFFEE SHOPS & CANTEEN   64   91. 00   09100   BARBER AND BEAUTY SHOP   794   91. 00   92. 00   09200   PHYSI CI AINS PRI VATE OFFI CES   0   92. 00   93. 00   09300   NONPAI D WORKERS   0   93. 00   09400   PATI ENTS LAUNDRY   0   94. 00   98. 00   Cross Foot Adjustments   0   09400   Negative Cost Centers   0   99. 00   00   00   00   00   00					1
91. 00   09100   BARBER AND BEAUTY SHOP   794   91. 00   92. 00   09200   PHYSI CI ANS PRI VATE OFFICES   0   92. 00   93. 00   09300   NONPAID WORKERS   0   93. 00   94. 00   09400   PATI ENTS LAUNDRY   0   94. 00   98. 00   Cross Foot Adjustments   0   099. 00   Negative Cost Centers   0   99. 00   099.	90 00		64		90.00
92. 00   92.00   94.00   95.00					
93. 00   93.00   09300   NONPALD WORKERS   0   93. 00   94. 00   98. 00   98. 00   99. 00   Negative Cost Centers   0   99. 00					
94. 00   94. 00   94. 00   98. 00     Cross Foot Adjustments   0   99. 00   Negative Cost Centers   0   99. 00			1		
98.00         Cross Foot Adjustments         0         98.00           99.00         Negative Cost Centers         0         99.00					
99.00   Negative Cost Centers   0   99.00					
100.00   101AL   023,844			1		
	100.00	IOTAL	023, 044		1100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | To 06/30/2022 | Date/Time Prepared: Provi der No.: 315427

					T	o 06/30/2022	Date/Time Pre 11/29/2022 11	
			CAPITAL REL	ATED COSTS			111/2//2022 11	. TO aiii
		Cost Center Description	BLDGS & FLXTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE	
				(SQUARE FEET)	(GROSS		& GENERAL (ACCUM COST)	
			(SQUARE FEET)	(SQUARE TELT)	SALARI ES)		(ACCOM COST)	
			1.00	2.00	3.00	4A	4. 00	
		AL SERVICE COST CENTERS	1		T	1	ı	
1.00	1	CAP REL COSTS - BLDGS & FIXTURES	163, 969					1. 00 2. 00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	0	0   0		,		3.00
4.00		ADMINISTRATIVE & GENERAL	7,004	0			12, 348, 521	4. 00
5.00		PLANT OPERATION, MAINT. & REPAIRS	1, 827	0	413, 325		1, 377, 394	5. 00
6.00		LAUNDRY & LINEN SERVICE	2, 233	0	96, 316		149, 818	6. 00
7.00		HOUSEKEEPI NG	1, 015		519, 639		738, 129	7. 00
8. 00 9. 00		DIETARY NURSING ADMINISTRATION	4, 263	0	825, 518	0	2, 213, 678 0	8. 00 9. 00
10.00		CENTRAL SERVICES & SUPPLY	0	0			0	10.00
11. 00		PHARMACY	0	Ö	d	Ö	0	11. 00
12.00		MEDICAL RECORDS & LIBRARY	0	0	C	0	0	12. 00
13.00		SOCIAL SERVICE	508	0	63, 055	0	79, 343	
14.00		NURSING AND ALLIED HEALTH EDUCATION	0	0   0	1	0	240 250	14.00
15. 00 15. 01		ACTIVITIES CHAPLAIN	2, 436	0			268, 258 86, 491	15. 00 15. 01
10.01		I ENT ROUTINE SERVICE COST CENTERS			70,100		00, 171	10.01
30. 00		SKILLED NURSING FACILITY	26, 265	0	2, 370, 621	0	3, 814, 233	30. 00
31.00	1	NURSING FACILITY	0	0			-	31. 00
32.00		I CF/II D	0	0				32. 00
33. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	117, 735	0	1, 931, 004	. 0	2, 956, 079	33. 00
40. 00		RADI OLOGY	1 0	0		0	5, 788	40. 00
41.00	1	LABORATORY	0	0	C	0	15, 030	•
42.00		I NTRAVENOUS THERAPY	0	0	C	0	0	42. 00
43. 00		OXYGEN (INHALATION) THERAPY	0	0	50, 532		67, 076	•
44. 00 45. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	480	0	1,		222, 139 175, 905	
46. 00		SPEECH PATHOLOGY	0	0			58, 584	
47. 00		ELECTROCARDI OLOGY	0	Ö	07, 187	0	0	47. 00
48. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	6, 213	48. 00
49. 00	1	DRUGS CHARGED TO PATIENTS	0	0	C	0	83, 770	
50.00		DENTAL CARE - TITLE XIX ONLY	0	0		_	0	50.00
51. 00		SUPPORT SURFACES TIENT SERVICE COST CENTERS	0	0		0	0	51. 00
60. 00		CLINIC	0	0	C	0	0	60.00
61.00		RURAL HEALTH CLINIC	0	0	C	0	0	61. 00
62.00	06200							62. 00
70.00		REIMBURSABLE COST CENTERS	1	0		0	1 0	70.00
70. 00 71. 00	1	HOME HEALTH AGENCY COST AMBULANCE	0	0			0	70. 00 71. 00
73. 00	07300			Ö	•		Ö	73. 00
		AL PURPOSE COST CENTERS				1		
80.00	1	MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81.00		INTEREST EXPENSE  UTILIZATION REVIEW - SNF						81. 00
82. 00 83. 00	1	HOSPICE	0	0		0	0	82. 00 83. 00
89. 00	00300	SUBTOTALS (sum of lines 1-84)	163, 766		•	-3, 201, 647		
	NONRE	IMBURSABLE COST CENTERS						
90.00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	-	1		29, 821	90. 00
91.00		BARBER AND BEAUTY SHOP	203	0	C	0	772	
92. 00 93. 00		PHYSICIANS PRIVATE OFFICES NONPAID WORKERS	0	0		0	0	
94. 00	1	PATIENTS LAUNDRY	0	Ö	Ö	Ö	Ö	94. 00
98. 00	1	Cross Foot Adjustments						98. 00
99. 00		Negative Cost Centers						99. 00
102.00	)	Cost to be allocated (per Wkst. B,	623, 844	0	1, 772, 305	1	3, 201, 647	102. 00
103.00		Part   )  Unit cost multiplier (Wkst. B, Part   )	3. 804646	0. 000000	0. 227661		0. 259274	103 00
103.00		Cost to be allocated (per Wkst. B,	3. 304040	5. 500000	0. 227001		26, 648	•
. , ,		Part II)						
105.00	)	Unit cost multiplier (Wkst. B, Part			0.000000		0. 002158	105. 00
	1	11)	1	I	I	ĺ	I	I

Provi der No.: 315427

				'	0 06/30/2022	Date/IIme Pre 11/29/2022 11	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	10 4
		OPERATI ON,	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. &	(POUNDS OF			(0) 0507	
		REPAI RS	LAUNDRY)			(DI RECT	
		(SQUARE FEET) 5.00	6. 00	7. 00	8. 00	NURSI NG) 9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	155, 138	0.00				5. 00
6.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	2, 233	262, 800	i			6.00
7. 00 8. 00	00800 DI ETARY	1, 015 4, 263	0	151, 890 4, 263	1		7. 00 8. 00
9. 00	00900 NURSI NG ADMI NI STRATI ON	4, 203	0	4, 203	130, 430	0	9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY	ő	Ö		ol ol	0	10.00
11. 00	01100 PHARMACY	0	0		o	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	) c	0	0	12.00
13. 00	I I	508	0	508	0	0	13. 00
14. 00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. 00
15. 00	01500 ACTIVITIES	2, 436	0	2, 436		0	15. 00
15. 01	01501 CHAPLAIN	0	0	<u> </u>	)  ()	0	15. 01
30. 00	NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	26, 265	197, 100	26, 265	61, 842	0	30.00
31. 00	1 1	20, 203	197, 100	20, 200		0	31.00
32. 00	03200   CF/11D	o o	0			0	32.00
33. 00	1 1	117, 735	65, 700	117, 735	97, 094	0	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	C	0	0	40. 00
41. 00	+ + +	0	0	C	0	0	41.00
42. 00	04200 I NTRAVENOUS THERAPY	0	0		0	0	42.00
43. 00 44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0 480	0	480	-	0	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	400	0	400		0	45.00
46. 00	1 1	o o	0			0	46.00
47. 00	04700 ELECTROCARDI OLOGY	O	0	d	Ö	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ol c	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	) c	0	0	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	0	0	50. 00
51. 00	05100 SUPPORT SURFACES	0	0	<u> </u> C	)  0	0	51.00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	C	1	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0			0	61.00
62. 00	1 1					, , ,	62.00
	OTHER REIMBURSABLE COST CENTERS	•		•	· · · · · · · · · · · · · · · · · · ·		
70.00	07000 HOME HEALTH AGENCY COST	0	0	C	0	0	70. 00
71. 00		0	0	C	0	0	71. 00
73. 00		0	0	<u> </u>	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			00.00
80.00							80. 00 81. 00
82. 00	08200 UTI LI ZATI ON REVI EW - SNF			•			82.00
83. 00		0	0		o	0	83.00
89. 00	1 1	154, 935	262, 800	151, 687	158, 936		89. 00
	NONREI MBURSABLE COST CENTERS						
90.00		0	0			0	90. 00
91. 00	· ·	203	0		1	0	91.00
92.00		0	0	C	0	0	92.00
93. 00 94. 00		0	0			0	93. 00 94. 00
98. 00	I I		0	1		0	98.00
99. 00							99.00
102. 0		1, 734, 516	213, 628	940, 855	2, 861, 695	0	102.00
	Part I)						
103.0		11. 180472	0. 812892	1		0. 000000	
104. 0		9, 923	8, 962	5, 520	21, 424	0	104. 00
10F 0	Part II) Unit cost multiplier (Wkst. B, Part	0.042042	0 024102	0 024242	0 124704	0. 000000	105 00
105. 0		0. 063962	0. 034102	0. 036342	0. 134796	0.000000	105.00
	1.17	1		I	1	l	1

		ici ai Systellis	PI IWAN W				tu OI FOIII CNS-2	
COST A	LLOCA	FION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
						From 07/01/2021	D-+- /T: D	
						To 06/30/2022	Date/Time Pre	
		C+ C+	CENTRAL	DITA DIMA CV	MEDICAL	COCLAL CEDVICE	11/29/2022 11	: 18 alli
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
			SERVICES &	(COSTED	RECORDS &	(0.171.5117.0.110)	ALLI ED HEALTH	
			SUPPLY	REQUIS)	LI BRARY	(PATIENT DAYS)	EDUCATI ON	
			(COSTED		(TIME SPENT)		(ASSI GNED	
			REQUIS)				TIME)	
			10.00	11. 00	12.00	13. 00	14. 00	
	<b>GENER</b>	AL 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		EMPLOYEE BENEFITS						3.00
4. 00	1	ADMINISTRATIVE & GENERAL					İ	4. 00
5. 00		PLANT OPERATION, MAINT. & REPAIRS						5.00
	1	LAUNDRY & LINEN SERVICE						6.00
6.00	1	l .						
7. 00	1	HOUSEKEEPI NG						7. 00
8.00		DI ETARY						8. 00
9.00		NURSING ADMINISTRATION						9. 00
10.00	01000	CENTRAL SERVICES & SUPPLY	0					10.00
11.00	01100	PHARMACY	0	0	)			11. 00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	(	)		12. 00
		SOCIAL SERVICE	0	0	(	20, 614		13.00
		NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	14.00
15. 00		ACTIVITIES	0	0		o o	ا م	15.00
		CHAPLAI N	0	0			0	
15.01			U	0	1	J 0		15.01
		I ENT ROUTI NE SERVI CE COST CENTERS						
		SKILLED NURSING FACILITY	0	0	1	20, 614		
		NURSING FACILITY	0	0	1	0		
32.00	03200	I CF/I I D	0	0	(	0	0	32. 00
33.00	03300	OTHER LONG TERM CARE	0	0	(	0	0	33. 00
	ANCI L	LARY SERVICE COST CENTERS						
40.00	04000	RADI OLOGY	0	0	(	0	0	40.00
	1	LABORATORY	0	0	1	0	0	1
	1	I NTRAVENOUS THERAPY	0	0	1	0	0	1
	1	OXYGEN (INHALATION) THERAPY	0	0		0	0	1
		PHYSI CAL THERAPY	0	0				
	1	l .	U	0	1	-	0	44. 00
	1	OCCUPATI ONAL THERAPY	0	0	1	0	0	
		SPEECH PATHOLOGY	0	0	(	0	0	10.00
		ELECTROCARDI OLOGY	0	0	(	0	0	47. 00
48. 00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	48. 00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	(	0	0	49. 00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	(	0	0	50.00
51.00		SUPPORT SURFACES	0	0		0	0	51.00
		TIENT SERVICE COST CENTERS	-			-		
60.00		CLINIC	0		1 (	0	0	60.00
		RURAL HEALTH CLINIC	0	0	1			
	06200		o l	Ü	1		ĺ	62.00
02.00		REIMBURSABLE COST CENTERS						02.00
70.00			اه					
	1	HOME HEALTH AGENCY COST	0	0	1	0		
	1	AMBULANCE	0	0	1	0		
73. 00			0	0	(	0	0	73. 00
	SPECI	AL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW - SNF						82. 00
83.00	1	HOSPI CE	o	0	(	0	0	1
89. 00		SUBTOTALS (sum of lines 1-84)	0	0		20, 614	-	
07.00	NONDE	IMBURSABLE COST CENTERS	<u> </u>		`	20,011		07.00
90. 00		GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	J	0	0	90.00
	1	1		-	1		1	
		BARBER AND BEAUTY SHOP	0	0		0	-	
		PHYSICIANS PRIVATE OFFICES	0	0	1	) 0	0	
93.00	1	NONPALD WORKERS	0	0		0	0	
94.00	09400	PATI ENTS LAUNDRY	0	0	(	0	0	
98.00		Cross Foot Adjustments						98. 00
99. 00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B,	o	0		108, 742	0	102.00
		Part I)	1				1	
103.00		Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	5. 275153	0. 000000	103.00
104.00	1	Cost to be allocated (per Wkst. B,	n	0. 000000 N	1 2. 500000	2, 154		104. 00
104.00		Part II)	٩	0	1	2, 134	l	1.5 7. 00
105.00		Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 104492	0. 000000	105 00
100.00	]		0.000000	5. 000000	3.000000	0. 104472	0.000000	1.00.00
	1	1117	1		I	ı l	1	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS PITMAN MANOR In Lieu of Form CMS-2540-10

Provi der No.: 315427

Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11: 18 am

					11/29/2022 11:1	18 am
		OTHER GENER	AL SERVICE			
		40TIVII TI FO	OLIA DI ALAI			
	Cost Center Description	ACTI VI TI ES	CHAPLAIN			
		(PATIENT DAYS)	15. 01			
C	GENERAL SERVICE COST CENTERS	13.00	13.01			
	00100 CAP REL COSTS - BLDGS & FLXTURES					1. 00
	00200 CAP REL COSTS - MOVABLE EQUIPMENT					2. 00
	00300 EMPLOYEE BENEFITS					3.00
4.00	00400 ADMINISTRATIVE & GENERAL					4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS					5.00
1	00600 LAUNDRY & LINEN SERVICE					6. 00
	00700 HOUSEKEEPI NG					7. 00
	DO800 DI ETARY					8. 00
	DO900 NURSI NG ADMI NI STRATI ON					9. 00
	01000 CENTRAL SERVICES & SUPPLY					10.00
	D1100 PHARMACY D1200 MEDICAL RECORDS & LIBRARY					11.00
	01300 SOCIAL SERVICE				I	12. 00 13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION					14. 00
	01500 ACTIVITIES	20, 614				15. 00
4	D1501 CHAPLAI N	20,014	64, 573			15. 01
<u> </u>	NPATIENT ROUTINE SERVICE COST CENTERS		2.72.2			
	03000 SKILLED NURSING FACILITY	20, 614	20, 614		3	30. 00
31.00	03100 NURSING FACILITY	0	O		3	31. 00
32.00	03200   CF/IID	0	0		3	32. 00
33.00	03300 OTHER LONG TERM CARE	0	43, 959		3	33. 00
_	ANCILLARY SERVICE COST CENTERS					
	04000 RADI OLOGY	0	0		I	40. 00
1	04100 LABORATORY	0	0		1	41. 00
1	04200 I NTRAVENOUS THERAPY	0	0		I	42. 00
1	04300 OXYGEN (INHALATION) THERAPY	0	0			43.00
	04400 PHYSI CAL THERAPY	0	0			44. 00
	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0			45. 00 46. 00
	04700 ELECTROCARDI OLOGY		0		· · · · · · · · · · · · · · · · · · ·	46. 00 47. 00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			48. 00
	04900 DRUGS CHARGED TO PATIENTS	0	o			49. 00
1	05000 DENTAL CARE - TITLE XIX ONLY	0	o		I	50. 00
1	05100 SUPPORT SURFACES	0	O			51. 00
C	OUTPATIENT SERVICE COST CENTERS		,			
	06000 CLI NI C	0	0		$\epsilon$	60. 00
	06100 RURAL HEALTH CLINIC	0	0			61. 00
	06200 FQHC				<i>\epsilon</i>	62. 00
	OTHER REIMBURSABLE COST CENTERS	1				
	07000 HOME HEALTH AGENCY COST	0	0			70.00
	07100 AMBULANCE	0 0	0			71.00
	D7300 CMHC SPECIAL PURPOSE COST CENTERS	U U	U			73. 00
	08000 MALPRACTICE PREMIUMS & PAID LOSSES				5	80. 00
	08100 INTEREST EXPENSE					81. 00
	08200 UTILIZATION REVIEW - SNF					82. 00
	08300 HOSPI CE	o	o			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	20, 614	64, 573		8	89. 00
N	NONREI MBURSABLE COST CENTERS					
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		;	90. 00
	09100 BARBER AND BEAUTY SHOP	0	0		l .	91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		I	92. 00
	09300 NONPALD WORKERS	0	0			93. 00
	09400 PATIENTS LAUNDRY		0			94. 00
98. 00	Cross Foot Adjustments				· · · · · · · · · · · · · · · · · · ·	98. 00
99. 00	Negative Cost Centers	200 125	100 01/		· · · · · · · · · · · · · · · · · · ·	99. 00
102.00	Cost to be allocated (per Wkst. B,	380, 135	108, 916		110	02. 00
103.00	Part     Unit cost multiplier (Wkst. B, Part	18. 440623	1. 686711		11	03. 00
103.00	Cost to be allocated (per Wkst. B,	10, 092	187			04. 00
10 1.00	Part II)	10,072	107			2 1. 00
105.00	Unit cost multiplier (Wkst. B, Part	0. 489570	0. 002896		10	05. 00
	[11]					
		·			·	

Heal th Financial	Systems					PITMAN MANO	R		In Lie	u of Form CMS-2540-10
RATIO OF COST TO	CHARGES	FOR ANCILLARY	AND (	OUTPATI ENT	COST	CENTERS	Provi der No.	: 315427	Peri od: From 07/01/2021	Worksheet C
										Date/Time Prepared

		rom 0//01/2021		
	1	o 06/30/2022		
	T 1 1 (6	T	11/29/2022 11:	18 am
Cost Center Description	Total (from		Ratio (col. 1	
	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	7, 289		1. 510987	40. 00
41. 00  04100  LABORATORY	18, 927	15, 030	1. 259281	41.00
42. 00  04200  I NTRAVENOUS THERAPY	C	0	0.000000	42.00
43.00 O4300 OXYGEN (INHALATION) THERAPY	84, 467	55, 572	1. 519956	43.00
44. 00 04400 PHYSI CAL THERAPY	288, 074	225, 301	1. 278618	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	221, 513	208, 997	1. 059886	45.00
46. 00 04600 SPEECH PATHOLOGY	73, 773	54, 475	1. 354254	46.00
47. 00 04700 ELECTROCARDI OLOGY	C	o	0.000000	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 824	6, 213	1. 259295	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	105, 489	83, 722	1. 259991	49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	C	o	0. 000000	50.00
51. 00 05100 SUPPORT SURFACES		ol	0. 000000	51.00
OUTPATIENT SERVICE COST CENTERS				
60. 00 06000 CLINIC	C	0	0.000000	60.00
61. 00 06100 RURAL HEALTH CLINIC				61. 00
62. 00   06200 FQHC				62. 00
71. 00   07100   AMBULANCE	1	ار	0. 000000	71. 00
100. 00 Total	807, 356	654, 134		100.00
100.00	007, 330	054, 154		100.00

Health Financial Systems	PI TMAN	MANOR		In Lie	eu of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Pre 11/29/2022 11	pared: :18 am
		Title	XVIII (1)	Skilled Nursing	PPS	
			01	Facility		
		Heal th Care Pr			Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1	Part B (col. 1	
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2. 00	3. 00	4. 00	5. 00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	I ENT COST					
ANCILLARY SERVICE COST CENTERS		T	T			
40. 00   04000   RADI OLOGY	1. 510987			0 7, 090	•	
41. 00   04100   LABORATORY	1. 259281			0 8, 987	0	
42.00 04200 I NTRAVENOUS THERAPY	0. 000000			0	0	1
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 519956			0	0	
44. 00 O4400 PHYSI CAL THERAPY	1. 278618			0 149, 844	0	
45. 00 04500 OCCUPATI ONAL THERAPY	1. 059886			0 134, 142		
46. 00 04600 SPEECH PATHOLOGY	1. 354254			0 52, 615	•	
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 259295			0	0	
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 259991		•	0 99, 450	0	
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50. 00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51. 00
OUTPATIENT SERVICE COST CENTERS						
60. 00  06000   CLI NI C	0. 000000	0		0	0	
61.00   06100   RURAL HEALTH CLINIC						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)		373, 365		0 452, 128	0	100. 00
(1) For title V and XIX use columns 1, 2, and 4 onl	у.					

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

Heal th	Financial Systems	PI TMAN	MANOR		In Lie	u of Form CMS-2	2540-10
APPORT	TONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315427	Period: From 07/01/2021 To 06/30/2022	Worksheet D Parts II-III Date/Time Pre 11/29/2022 11	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1, 00	
	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C. column 3	line 49)	1. 259991	1.00
2.00	Program vaccine charges (From your reco			•	,	0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS pro	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
			Allied Health		Cost (From	& Allied	
		The state of the s	(From Wkst. B,			Heal th Costs	
		18	·	Costs to Tota		for Pass	
			14)	Costs - Part (Col. 2 / Col		Through (Col. 3 x Col. 4)	
				1)	•	3 X COI. 4)	
		1, 00	2.00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH	•			
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	7, 289	C	0.00000	7, 090	0	40. 00
41.00	04100 LABORATORY	18, 927	C	0.00000		0	
42.00	04200 I NTRAVENOUS THERAPY	0	١	0.00000		0	
43.00	04300 OXYGEN (INHALATION) THERAPY	84, 467		0.00000		0	
44. 00	04400 PHYSI CAL THERAPY	288, 074		0.00000			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	221, 513		0.00000			45. 00
46. 00	04600 SPEECH PATHOLOGY	73, 773		0.00000			46. 00
47. 00	04700 ELECTROCARDI OLOGY	7 024		0.00000		0	
48. 00 49. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	7, 824 105, 489		0. 00000 0. 00000		0	1 .0.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	105, 489		0.00000		0	
	05100 SUPPORT SURFACES			0.00000		0	
100.00		807, 356		•	452, 128	_	100.00
100.00	1 1.023. (Sam St 111103 10 02)	007,000	1	1	102, 120	۰	1.50.00

Provider No.::		Peri od: From 07/01/2021 To 06/30/2022	Worksheet D-1 Parts I-II Date/Time Pre	
Title XVI	H		11/29/2022 11	
		Skilled Nursing Facility	PPS	
			1. 00	
			0	1 -
3				
the Program			_	1
			7, 056, 864	5
			9 094 047	6
(Line 5 divided by Line 6	)			
(2 5 a a.a. 2) 5	,		0.770707	1
8.00   Enter private room charges from your records 9.00   Average private room per diem charge (Private room charges line 8 divided by private room days, line				
3 .				
			9, 094, 047	
vate room charges line 10,	di vi de	d by	441. 16	11
ino O minus Lino 11)			0.00	12
•			0.00	
,	Line 5	minus line 14)	_	1
			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1
ne 15 divided by line 1)			342. 33	16
			690, 137	17
	e 13)		0	1
			-	
	B, Par	t II column 18,	138, 160	20
•			4 70	21
			-	
			0	
` '	e 23 miı	nus line 24)	676, 630	
`		,	· · · · · · · · · · · · · · · · · · ·	26
mes the per diem limitatio	n line :	26) (1)		27
	25 or I	ine 27)		28
•				1
i t i t	charges line 8 divided by provided room charges line 10, Line 9 minus line 11) ne 7 times line 12) mes line 13) te room cost differential ( line 15 divided by line 1) program (line 4 times line 17 plus line 18) service costs (From Wkst. //IID) line 1) 22) (From provider records) to the cost limitation (Line 18) limes the per diem limitation (22 plus the lesser of line tructions)	(Line 5 divided by line 6)  charges line 8 divided by private in vate room charges line 10, divided by private in vate room charges line 10, divided by line 9 minus line 11)  ne 7 times line 12)  mes line 13)  te room cost differential (Line 5  ine 15 divided by line 1)  program (line 4 times line 13)  t (Line 17 plus line 18)  service costs (From Wkst. B, Parrivill)  line 1)  22)  (From provider records)  to the cost limitation (Line 23 minumes the per diem limitation line 22 plus the lesser of line 25 or litructions)	(Line 5 divided by line 6)  charges line 8 divided by private room days, line  ivate room charges line 10, divided by  Line 9 minus line 11)  ne 7 times line 12)  imes line 13)  te room cost differential (Line 5 minus line 14)  line 15 divided by line 1)  program (line 4 times line 13)  t (Line 17 plus line 18)  service costs (From Wkst. B, Part II column 18, /IID)  line 1)  22)  (From provider records)  to the cost limitation (Line 23 minus line 24)  limes the per diem limitation line 26) (1)  limes the per diem limitation line 25 or line 27)	2, 016

		1. 00	
<u>-</u>	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	20, 614	1.00
2.00	Program inpatient days (see instructions)	2, 016	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. 097798	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5. 00

	Financial Systems P TATION OF INPATIENT ROUTINE COSTS	PITMAN MANOR	Provi der No.: 315427	In Lie	u of Form CMS-2 Worksheet D-1	
COMPU	ATTON OF THEATTENT ROUTINE COSTS	ľ	10VI dei No 313427	From 07/01/2021 To 06/30/2022	Parts I-II	pared:
			Title XIX	Skilled Nursing Facility	Cost	
					1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS					
	I NPATI ENT DAYS					٠
1.00	Inpatient days including private room days				20, 614	
2. 00 3. 00	Private room days Inpatient days including private room days applicable	a ta tha Dram	rom.		0 8. 409	
1. 00	Medically necessary private room days applicable to t		I dili		0, 409	
5. 00	Total general inpatient routine service cost	the rrogram			7, 056, 864	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				7,000,001	1 0.0
. 00	General inpatient routine service charges				9, 094, 047	6.0
7.00	General inpatient routine service cost/charge ratio	(Line 5 divi	ded by line 6)		0. 775987	7. 0
3. 00	Enter private room charges from your records				0	1
. 00	Average private room per diem charge (Private room ch	charges line 8	divided by private	room days, line	0. 00	9. 0
0. 00	2)   Enter semi-private room charges from your records				9, 094, 047	10.0
1. 00	Average semi -pri vate room per diem charge (Semi -pri v	vate room cha	rges line 10, divide	d by	441. 16	
2. 00	semi-private room days) Average per diem private room charge differential (Li	ino O minus I	ino 11)		0. 00	12. 0
	Average per diem private room cost differential (Line					13. 0
4. 00			C 12)		0.00	
5. 00	1		ifferential (Line 5	minus line 14)	7, 056, 864	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS					
6. 00	1 3		d by line 1)		342. 33	
7.00	Program routine service cost (Line 3 times line 16)		- 4		2, 878, 653	1
8. 00 9. 00	Medically necessary private room cost applicable to protal program general inpatient routine service cost		,		0 2, 878, 653	
0.00	Capital related cost allocated to inpatient routine service cost			t II column 18	138, 160	
0. 00	line 30 for SNF; line 31 for NF, or line 32 for ICF/I		(TTOIII WKSt. D, Tai	t 11 cordiiii 10,	130, 100	20.0
1. 00	Per diem capital related costs (Line 20 divided by I				6. 70	21.0
2. 00	Program capital related cost (Line 3 times line 21)	ŕ			56, 340	22. 0
	Inpatient routine service cost (Line 19 minus line 2				2, 822, 313	23. 0
	Aggregate charges to beneficiaries for excess costs	, ,	,		0	
	Total program routine service costs for comparison to	to the cost li	mitation (Line 23 mi	nus line 24)	2, 822, 313	
	Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times)	mos the ner d	iom limitation lima	26) (1)	0.00	
	Reimbursable inpatient routine service costs (Line 22				2, 878, 653	
5. 00	(Transfer to Worksheet E, Part II, line 4) (See instr		COSCI OI ITHE ZU UI	11110 21)	2,070,000	20.0
1) Li	nes 26 and 27 are not applicable for title XVIII, but		for title V and or t	itle XIX		'
					1. 00	

		1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	20, 614	1.00
2.00	Program inpatient days (see instructions)	8, 409	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. 407927	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	PI TMAN MANOI	?	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	TITLE XVIII	Provi der No.: 315427	Peri od:	Worksheet E
			From 07/01/2021	Part I
			To 06/30/2022	Date/Time Prepared:
				11/20/2022 11:18 am

				11/29/2022 11:	18 am
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1. 00	Inpatient PPS amount (See Instructions)			1, 272, 068	1. 00
2.00	Nursing and Allied Health Education Activities (pass through page 1)	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)			1, 272, 068	3. 00
4.00	Primary payor amounts			0	4. 00
5. 00	Coinsurance			208, 546	5. 00
6. 00	Allowable bad debts (From your records)			6, 678	6. 00
7. 00	Allowable Bad debts for dual eligible beneficiaries (See instru	ctions)		6, 493	7. 00
8. 00	Adjusted reimbursable bad debts. (See instructions)			4, 341	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, 067, 863	11. 00
12. 00	Interim payments (See instructions)			1, 059, 444	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)			11	14. 75
14. 99	Sequestration amount (see instructions)			4, 078	
15. 00	Balance due provider/program (see Instructions)			4, 330	15. 00
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
47.00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES -	ITTLE XVIII ONLY		47.00
17. 00	Ancillary services Part B			0	17. 00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18. 00
19. 00	Total reasonable costs (Sum of lines 17 and 18)			0	19. 00
20.00	Medicare Part B ancillary charges (See instructions)			0	20.00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21. 00
22. 00	Primary payor amounts			0	22. 00
23. 00	Coinsurance and deductibles			0	23. 00
24. 00	Allowable bad debts (From your records)			0	24. 00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ctions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)			0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26. 00
27. 00	Tentati ve adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)	a with CMC Dub 15 3	continu 11F 2	0	29. 00 30. 00
30.00	Protested amounts (Nonallowable cost report items) in accordance	# WI LII CMS PUD. 15-2,	Section 115.2	υĮ	30.00

Health Financial Systems					PI TI	MAN MANO	₹			In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT	SETTLEMENT	TITLE V	and and	TITLE	XIX	ONLY	Provider No	).: 315427	Perion From To	07/01/2021	Worksheet E Part II Date/Time Prepared: 11/29/2022 11:18 am

		Title XIX	Skilled Nursing Facility	Cost	. 10 diii
			-	1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	1. 00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2. 00
3.00	Outpatient services	•		0	3. 00
4.00	Inpatient routine services (see instructions)			2, 878, 653	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			2, 878, 653	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)	·		2, 878, 653	8. 00
9.00	Primary payor amounts			0	9. 00
10.00	Total Reasonable Cost (Line 8 minus line 9)			2, 878, 653	10.00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges			0	11. 00
12.00	Outpati ent servi ce charges			0	12.00
13.00	Inpatient routine service charges			0	13.00
14.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	14.00
15. 00	Total reasonable charges			0	15.00
	CUSTOMARY CHARGES				
16. 00				0	16. 00
17. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR 413.13(e)	payment for services o	on a charge basis	0	17. 00
18. 00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0. 000000	18. 00
19. 00	·			0.000000	19. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				17.00
20. 00	Cost of covered services (see Instructions)			0	20. 00
21. 00	Deductibles			0	21. 00
22. 00	Subtotal (Line 20 minus line 21)			0	22. 00
23. 00	Coi nsurance			0	23. 00
24. 00	Subtotal (Line 22 minus line 23)			0	24. 00
25. 00	Allowable bad debts (from your records)			0	25. 00
26. 00	Subtotal (sum of lines 24 and 25)			0	26. 00
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	v collected based on o	correction of	0	27. 00
	cost limit			· ·	
28. 00	Recovery of excess depreciation resulting from provider termina utilization	tion or a decrease in	program	0	28. 00
29. 00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of den	reciable assets (	0	30.00
30.00	if minus, enter amount in parentheses)	om draposi tron or depi	cci abi c assets (	O	30.00
31. 00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines	27 and 28)		0	31. 00
32. 00	Interim payments			0	32. 00
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	theses) (see	0	33. 00
	Instructions)	1.7 . 22 [2.01]	, , , , , , , , , , , , , , , , ,	, and the second	

Provi der No.: 315427 Peri od: Worksheet E-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared: 11/29/2022 11:18 am Title XVIII Skilled Nursing PPS

		11 (1	e AVIII	Facility	PPS	
		I npati en	t Part A		t 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, 059, 444		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, enter 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				T	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02 3. 03			0		0	
3. 03			0		0	
3. 05			0		0	
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	
3. 52			0		0	
3.53			0		0	
3. 54 3. 99	Subtatal (Sum of Lines 2.01 2.40 minus sum of Lines 2.50		0		0	
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50   -3.98)		U		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 059, 444		0	4. 00
	(Transfer to Wkst. E, Part I line 12 for Part A, and line					
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR				l .	
5. 00	List separately each tentative settlement payment after 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
	Provi der to Program				1	
5. 50 5. 51	TENTATIVE TO PROGRAM		0		0	
5. 51			0		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	1
0. , ,	- 5. 98)		Ŭ			0. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		4, 330		0	
6. 02	PROVI DER TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		1, 063, 774 Contract	or Name	Contractor	7. 00
			Contract	.or Name	Number	
			1.	00	2. 00	
8. 00	Name of Contractor					8. 00
	linos 2 5 and 6 whore an amount is due provider to progr	om chow the o	mount and data	on which the	provi dor	

<sup>(1)</sup> 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

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

Provi der No.: 315427 | Peri od: From 07/01/2021 To 06/30/2022

Peri od: From 07/01/2021 To 06/30/2022 Worksheet G Date/Time Prepared: 11/29/2022 11: 18 am

ini y)		Conoral Fund	Specific E	Indowment Fund	11/29/2022 11	: 18 a
		General Fund	Purpose Fund	Indowment Fund	Plant Fund	
	Assets	1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
. 00	Cash on hand and in banks	86, 218		0	0	
. 00	Temporary investments	0	0	0	0	
. 00	Notes recei vabl e Accounts recei vabl e	1, 896, 089	0	0	0	
. 00	Other recei vables	30, 611		o	0	
. 00	Less: allowances for uncollectible notes and accounts	-436, 100	0	0	0	
	recei vabl e				_	
. 00	Inventory	120, 959		0	0	
i. 00 i. 00	Prepaid expenses Other current assets	85, 256	0	0	0	
0. 00	Due from other funds	0	Ö	ő	0	
1. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 783, 033	0	0	0	11. (
	FIXED ASSETS					
2.00	Land	39, 437	0	0	0	
3. 00 4. 00	Land improvements Less: Accumulated depreciation	0	0	0	0	
5. 00	Buildings	14, 555, 117	0	0	0	1
6. 00	Less Accumulated depreciation	-12, 207, 020	Ö	o	0	
7. 00	Leasehold improvements	0	0	0	0	17. (
8. 00	Less: Accumulated Amortization	0	0	0	0	
9. 00	Fixed equipment	2, 173, 071	0	0	0	1
0.00	Less: Accumulated depreciation Automobiles and trucks	-1, 474, 229 171, 892		0	0	
2. 00	Less: Accumulated depreciation	-171, 892		0	0	
3. 00	Major movable equipment	0	o	o	0	
4. 00	Less: Accumulated depreciation	0	0	0	0	24. (
5. 00	Mi nor equipment - Depreciable	0	0	0	0	
6. 00	Mi nor equi pment nondepreci abl e	0	0	0	0	1
7. 00 8. 00	Other fixed assets	3, 086, 376	0	0	0	
0.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)  OTHER ASSETS	3,000,370	<u> </u>	UU	0	20.
9. 00	Investments	0	0	0	0	29.
0.00	Deposits on Leases	0	0	O	0	30.
1. 00	Due from owners/officers	0	0	0	0	
2.00	Other assets	1, 038, 637		0	0	1
3. 00 4. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32) TOTAL ASSETS (Sum of lines 11, 28, and 33)	1, 038, 637 5, 908, 046		0	0	
4. 00	Liabilities and Fund Balances	3, 700, 040	9	<u> </u>		34.
	CURRENT LIABILITIES	_				
5. 00	Accounts payable	789, 203		0	0	
6.00	Salaries, wages, and fees payable	1, 179, 055	0	0	0	1
7. 00 8. 00	Payroll taxes payable Notes & Loans payable (Short term)	0	0	0	0	
9. 00	Deferred income	12, 500	0	0	0	
0.00	Accel erated payments	0				40.
1. 00	Due to other funds	36	0	0	0	
2. 00	Other current liabilities	0	0	0	0	1
3. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	1, 980, 794	0	0	0	43.
4. 00	LONG TERM LIABILITIES  Mortgage payable	0	0	0	0	44.
5. 00	Notes payable		o	o	0	1
6. 00	Unsecured Loans	0	0	o	0	
7. 00	Loans from owners:	0	0	0	0	1
8. 00	Other long term liabilities	1, 794, 741	0	0	0	
9.00	OTHER (SPECIFY)	1 704 741	0	0	0	1
0. 00 1. 00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 TOTAL LIABILITIES (Sum of lines 43 and 50)	1, 794, 741 3, 775, 535		0	0	
1. 00	CAPITAL ACCOUNTS	3,773,333	<u> </u>	<u> </u>		31.
2. 00	General fund balance	2, 132, 511				52.
3. 00	Specific purpose fund		0			53.
1. 00	Donor created - endowment fund balance - restricted			0		54.
5. 00	Donor created - endowment fund balance - unrestricted			0		55.
6. 00 7. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			٩	0	56. 57.
,	Plant fund balance - reserve for plant improvement,				0	
	1				O	55.
8. 00	replacement, and expansion					
	replacement, and expansion TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	2, 132, 511	0	o	0	

Ceneral Fund   Special Purpose Fund   Endowment Fund						То	06/30/2022	Date/Time Prep 11/29/2022 11:	
1.00			General	Fund	Speci al	Pur	pose Fund		
1.00									
1.00			1 00	2 00	2 00		4 00	5.00	
2.00 Not income (loss) (from Wist. G-3, line 31) 3.00 Total (sum of line 1 and line 2) 4.00 Add tions (credit adjustments) 5.00 INTERCOMPANY RECONCILIATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00	Fund halances at beginning of period	1.00						1 00
Total (sum of line 1 and line 2)							O		
Additions (credit adjustments)							0		
S. 00				_,,			_		
7.00 8.00 9.00 10.00 10.00 10.100 11.			o			0		o	
8.00   9.00   10.00   Total additions (sum of line 5 - 9)	6.00		O			0		o	6. 00
9.00   0.00   10.00	7.00		0			0		0	7. 00
10.00   Total additions (sum of line 5 - 9)	8.00		0			0		0	8.00
11.00   Deductions (debit adjustments)   2,132,513   0   11.00   12.00   12.00   13.00   14.00   0   0   0   0   0   0   14.00   0   0   0   0   0   0   0   0   0	9.00		0			0		0	9.00
12. 00	10.00	Total additions (sum of line 5 - 9)		0			0		10.00
13.00   ROUNDING	11. 00			2, 132, 513			0		11.00
14.00   15.00   16.00   0   0   0   0   0   0   0   15.00   16.00   17.00   0   0   0   0   0   0   16.00   17.00   18.00   Total deductions (sum of lines 13 - 17)   2   2   0   0   18.00   19.00									
15.00		ROUNDI NG	2			0		0	
16.00     17.00			0			0			
17.00			0			0			
18.00   Total deductions (sum of lines 13 - 17)   Fund balance at end of period per balance			0			0			
19.00   Fund balance at end of period per balance sheet (Line 11 - line 18)   19.00			0	_		0	_	0	
Sheet (Line 11 - line 18)				2			-		
Endowment Fund	19.00			2, 132, 511			0		19.00
1.00		Sheet (Line II - Iine 18)	Endowment Fund	PI ant	Fund				
1.00   Fund balances at beginning of period   0   0   0   0   0   0   0   0   0			Ziidoiiiioiit i diid						
2.00			6. 00	7. 00	8. 00				
3.00   Total (sum of line 1 and line 2)   0   3.00   4.00   4.00   5.00   1NTERCOMPANY RECONCILIATION   0   6.00   7.00   8.00   9.00   10.00   Total additions (sum of line 5 - 9)   0   0   11.00   Deductions (debit adjustments)   12.00   13.00   14.00   15.00   16.00   17.00   18.00   Total deductions (sum of lines 13 - 17)   0   0   18.00   Total deductions (sum of lines 13 - 17)   0   0   18.00			0			0			
4.00 5.00 INTERCOMPANY RECONCILIATION  0 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 ROUNDING  0 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 18.00 Total deductions (sum of lines 13 - 17)									
5.00   INTERCOMPANY RECONCILIATION   5.00   6.00   7.00   8.00   7.00   8.00   9.00   0   9.00   10.00   Total additions (sum of line 5 - 9)   0   9.00   11.00   Subtotal (line 3 plus line 10)   0   0   11.00   12.00   Deductions (debit adjustments)   12.00   13.00   14.00   15.00   16.00   17.00   16.00   17.00   18.00   Total deductions (sum of lines 13 - 17)   0   0   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   10.00   18.00   18.00   18.00   18.00   10.00   18.00   18.00   18.00   18.00   10.00   18.00   18.00   18.00   10.00   10.00   18.00   18.00   18.00   18.00   18.00   19.00			0			0			
6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 ROUNDING 0 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_					
7.00 8.00 9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 ROUNDING 0 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		INTERCOMPANY RECONCILIATION		0					
8.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 Subtotal (line 3 plus line 10) 0 Deductions (debit adjustments) 13.00 ROUNDING 0 PODE TOTAL ADDITIONS 10.00 PODE TOTAL ADDITIONS 11.00 PODE TOTAL ADDITIONS				0					
9.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 ROUNDING 0 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0					
10.00   Total additions (sum of line 5 - 9)   0   10.00   11.00   Subtotal (line 3 plus line 10)   0   11.00   12.00   Deductions (debit adjustments)   12.00   13.00   ROUNDING   0   13.00   14.00   15.00   16.00   0   17.00   18.00   Total deductions (sum of lines 13 - 17)   0   0   18.00				0					
11.00   Subtotal (line 3 plus line 10)   0   11.00   12.00   13.00   ROUNDING   0   13.00   14.00   15.00   16.00   17.00   18.00   Total deductions (sum of lines 13 - 17)   0   0   18.00		Total additions (sum of line F 0)		U		0			
12.00   Deductions (debit adjustments)   12.00   13.00   14.00   15.00   16.00   17.00   18.00   Total deductions (sum of lines 13 - 17)   0   18.00   18.00   18.00   10   10   10   10   10   10   10						0			
13.00 ROUNDING 0 13.00 14.00 15.00 0 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 0 18.00						U			
14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 14.00 15.00 16.00 17.00 18.00				0					
15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 15.00 16.00 17.00 18.00		NOOND! NO		0					
16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 0 16.00 18.00				0					
17.00 18.00 Total deductions (sum of lines 13 - 17) 0 17.00 18.00			1	0					
18.00 Total deductions (sum of lines 13 - 17) 0 18.00			1	0				İ	
		Total deductions (sum of lines 13 - 17)	o			0		İ	
17. 00   Tunia barance at cha or period per barance   O    O    O	19. 00	Fund balance at end of period per balance	0			0			19. 00
sheet (Line 11 - line 18)		sheet (Line 11 - line 18)						ļ	

Health Financial Systems	PITMAN MANOR	In Lie	u of Form CMS-2540-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENS	Provi der No.: 315427	Peri od:	Worksheet G-2

Heal th	Financial Systems	PITMAN MANOF	?		In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315427	Peri od:	Worksheet G-2	
					From 07/01/2021	Parts I-II	
					To 06/30/2022		pared:
						11/29/2022 11	: 18 am
	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			9, 094, 04	17	9, 094, 047	1. 00
2.00	NURSING FACILITY				0	0	2.00
3.00	ICF/IID				0	0	3. 00
4. 00	OTHER LONG TERM CARE			8, 231, 60	)4	8, 231, 604	4. 00
5. 00	Total general inpatient care services (Sum of lin	es 1 - 4)		17, 325, 65		17, 325, 651	5. 00
0.00	All Other Care Services	,		177020700	, . <u></u>	1770207001	0.00
6. 00	ANCI LLARY SERVI CES			592, 52	22 0	592, 522	6. 00
7. 00	CLINIC			372, 32	0	0	7. 00
8. 00	HOME HEALTH AGENCY COST				0	0	
9.00	AMBULANCE				0	0	9. 00
10. 00	RURAL HEALTH CLINIC				0	0	
					0	-	
10. 10	FQHC				0	0	
	CMHC				0	0	11.00
12. 00	HOSPI CE				0	0	12. 00
	OTHER (SPECIFY)				0	0	
14.00	Total Patient Revenues (Sum of Lines 5 - 13) (Tra	nsfer column 3	to	17, 918, 17	73 0	17, 918, 173	14. 00
	Worksheet G-3, Line 1)						
	Cost Center Description						
					1. 00	2. 00	
	PART II - OPERATING EXPENSES						
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line	100)				16, 402, 348	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	
9.00	Deduct (Specify)				0	U	9.00
	beduct (specify)				0		
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, m	inus line 14)				16, 402, 348	15. 00
	•	•			•		•

Heal th	Financial Systems PITMA	AN MANOR			In Lie	u of Form CMS-2	2540-10
STATEM	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	1	Provi der	No.: 315427	Peri od:	Worksheet G-3	
					From 07/01/2021		
					To 06/30/2022	Date/Time Prep	
						11/29/2022 11	18 am
						1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3,	line 14)	)			17, 918, 173	1. 00
2.00 Less: contractual allowances and discounts on patients accounts				3, 065, 735	2.00		
3.00 Net patient revenues (Line 1 minus line 2)				14, 852, 438	3.00		
4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)					16, 402, 348	4.00	
5.00	Net income from service to patients (Line 3 minus 4)					-1, 549, 910	5. 00

	10 06/30/2022	11/29/2022 11	pareu: ·18 am
		1172772022 11	10 4
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	17, 918, 173	1. 00
2.00	Less: contractual allowances and discounts on patients accounts	3, 065, 735	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	14, 852, 438	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	16, 402, 348	4. 00
5.00	Net income from service to patients (Line 3 minus 4)	-1, 549, 910	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	121, 399	6. 00
7.00	Income from investments	1, 874	7. 00
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	20, 000	9. 00
10.00	Purchase discounts	0	10.00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from Laundry and Linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15. 00	Revenue from rental of living quarters	0	15. 00
16. 00		0	16. 00
17. 00		0	17. 00
18. 00	Revenue from sale of medical records and abstracts	0	18. 00
19. 00	Ultion (fees, sale of textbooks, uniforms, etc.)		19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00
21. 00		0	21. 00
22. 00	Rental of skilled nursing space	0	22. 00
23. 00	Governmental appropriations	0	23. 00
24. 00	GRANT REVENUE	43, 810	
24. 01	CATERING / COUNTRY STORE	18, 865	24. 01
24. 02	TRANS - RESIDENTIAL	5, 619	
24. 03	UTILITY INCOME	540	
24. 04	MI SCELLANEOUS I NCOME	6, 097	24. 04
24. 06	HOUSEKEEPI NG	432	ł
24. 50		0	24. 50
25. 00	Total other income (Sum of lines 6 - 24)	218, 636	1
26. 00	Total (Line 5 plus line 25)	-1, 331, 274	26. 00
27. 00	MISCELLANEOUS	0	
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)	-1, 331, 274	31.00