This report is required by law (42 USC 1395g; 42 CFR 413. 20(b)). Failure to report can result in all interim

payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 315404

Period:
From 07/01/2021
To 06/30/2022

Worksheet S
Parts I, II & III
Date/Time Prepared:
11/29/2022 11:11 am

| PART I - COST | REPORT STATUS | |
|---------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Provi der | 1. [X] Electronically prepared cost rep | oort Date: 11/29/2022 Time: 11:11 a |
| use only | 2. [] Manually prepared cost report | |
| | 3. [0] If this is an amended report ent | er the number of times the provider resubmitted this cost report |
| | 3.01 [] No Medicare Utilization. Enter " | Y" for yes or leave blank for no. |
| Contractor | 4. [1] Cost Report Status | 6. Contractor No. |
| use only | (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended | 7.[N] First Cost Report for this Provider CCN |
| | | 8.[N] Last Cost Report for this Provider CCN |
| | | 9. NPR Date: |
| | | 10.[0]If line 4, column 1 is "4": Enter number of times reopened |
| | | 11. Contractor Vendor Code 4 |
| | 5. Date Received: | 12.[F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization. |
| | | TOT NO ULTITIZATION. |

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLLINGSWOOD MANOR (315404) for the cost reporting period beginning 07/01/2021 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 | 2 | 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 | 0 | 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 | 0 | 0 | 0 | 100.00 |
| Tho ab | over amounts represent "due to" or "due from" the applicable | program for th | o alamont of t | ho above compl | ov indicated | |

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

Health Financial Systems COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315404 Peri od: Worksheet S-2 From 07/01/2021 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:11 am 3.00 Skilled Nursing Facility and Skilled Nursing Facility Complex Address: 1.00 Street: 460 HADDON AVENUE PO Box: 1.00 2.00 Ci ty: COLLI NGSWOOD State: NJ Zi p Code: 08108 2.00 3.00 County: CAMDEN CBSA Code: 15804 Urban/Rural: U 3.00 CBSA Code: 3.01 3.01 Component Name Provi der Date Payment System (P, CCN Certi fi ed 0, or N) XVIII XIX 4.00 5.00 6.00 1.00 2.00 3. 00 SNF and SNF-Based Component Identification: 4.00 SNF COLLINGSWOOD MANOR 315404 12/01/1997 N Р 0 4.00 5.00 Nursing Facility 5.00 6.00 I CF/IID 6 00 7.00 SNF-Based HHA 7.00 8.00 SNF-Based RHC 8.00 9.00 SNF-Based FQHC 9.00 SNF-Based CMHC 10 00 10 00 11.00 SNF-Based OLTC 11.00 12.00 SNF-Based HOSPICE 12.00 13.00 SNF-Based CORF 13.00 From: To 1. 00 2.00 14.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2021 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 1, 097, 650 20.00 21.00 Declining Balance 21.00 22.00 Sum of the Year's Digits 22.00 Sum of line 20 through 22 1, 097, 650 23 00 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 34.00 SNF-Based FQHC 34.00 35.00 SNF-Based CMHC 35.00 Ν 36.00 SNF-Based OLTC <u>36. 0</u>0 Y/N 1.00 2.00 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF 37. 00 regardless of the level of care given for Titles V & XIX patients? (Y/N) Are you legally-required to carry malpractice insurance? (Y/N) Is the malpractice a "claims-made" or "occurrence" policy? If the policy is Ν 38.00 38, 00 39.00 1 39.00 <u>"claims-made" enter 1. If the policy is "occurrence", enter 2.</u> Self Insurance Premi ums Pai d Losses 1.00 2.00 3.00 41.00 List malpractice premiums and paid losses: 100 442 41 00

| Heal th | Financial Systems | COLLI NGSW | OOD MANOR | | In Li€ | eu of Form CMS- | 2540-10 |
|---------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------|-----------|-------------------|-----------------|---------|
| SKI LLE | D NURSING FACILITY AND SKILLED NURSING | FACILITY HEALTH CARE | Provi der No.: | | Peri od: | Worksheet S-2 | |
| COMPLE | X INDENTIFICATION DATA | | | | From 07/01/2021 | Part I | |
| | | | | | To 06/30/2022 | | |
| | | | | | | 11/29/2022 11 | :11 am |
| | | | | | | Y/N | |
| | | | | | | 1.00 | |
| 42.00 | Are malpractice premiums and paid loss | es reported in other | than the Administr | ative and | General cost | N | 42. 00 |
| | center? Enter Y or N. If yes, check bo | x, and submit suppor | ting schedule listi | na cost c | enters and | | |
| | amounts. | | 3 | 3 | | | |
| 43.00 | Are there any home office costs as def | ined in CMS Pub. 15-1 | 1, Chapter 10? | | | Υ | 43. 00 |
| 44.00 | If line 43 is yes, enter the home offi | ce chain number and e | enter the name and | address o | f 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 or | ganization, enter the | e name and address | of the ho | me office on the | e lines | |
| | bel ow. | | | | | | |
| 45. 00 | Name: UNITED METHODIST HOMES OF NJ | Contractor's Name: U | NITED METHODIST | Contracto | or's Number: 1200 | 01 | 45. 00 |
| | | Н | OMES OF NJ | | | | |
| 46.00 | Street: 3311 HIGHWAY 33 | PO Box: | | | | | 46.00 |
| 47.00 | City: NEPTUNE | State: N | J | Zip Code: | : 077! | 53 | 47. 00 |
| | 1.00 If this facility is part of a chain or below. Name: UNITED METHODIST HOMES OF NJ Street: 3311 HIGHWAY 33 | ganization, enter the Contractor's Name: U HPO Box: | e name and address NITED METHODIST OMES OF NJ | Contracto | or's Number: 1200 | 01 | |

| | Financial Systems | COLLI NGSWOOD MA | | | | eu of Form CMS- | |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------|----------------|---------------------------------------------|-----------------------|----------------|
| | D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE | IY HEALIH CARE | Provi der | | Period: From 07/01/2021 To 06/30/2022 | Date/Time Pre | epared: |
| | | | | L | Y/N | 11/29/2022 11 Date | 1:11 am |
| | | | 4 111/11 6 | V | 1.00 | 2.00 | |
| | General Instruction: For all column 1 responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation | ses enter in column | Ι, "Υ" ΤΟ | r yes or "N" 1 | FOR NO. FOR ALL | the date | |
| 1.00 | Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions) | | | | N | | 1.00 |
| | instructions) | | | Y/N | Date | V/I | |
| 2. 00 | Has the provider terminated participation in | the Medicare Progr | am? If | 1. 00 N | 2. 00 | 3. 00 | 2.00 |
| | column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary. | of termination and | in column | | | | |
| 3.00 | Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions) | ., chain home offic d to the provider o I, or members of th | es, drug r its e board | Y | | | 3.00 |
| | (See That dott only) | | | Y/N | Type | Date | |
| | Financial Data and Reports | | | 1. 00 | 2. 00 | 3. 00 | |
| 4.00 | Column 1: Were the financial statements preparcountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple | " for Audited, "C" te copy or enter da | for te | Y | A | 10/28/2022 | 4. 00 |
| 5.00 | available in column 3. (see instructions) If Are the cost report total expenses and total those on the filed financial statements? If reconciliation. | revenues different | from | Y | | | 5. 00 |
| | reconciliation. | | | | Y/N | Legal Oper. | |
| | Approved Educational Activities | | | | 1. 00 | 2. 00 | |
| 6.00 | Column 1: Were costs claimed for Nursing Scholegal operator of the program? (Y/N) | ool? (Y/N) Column 2 | : Is the | provi der the | N | N | 6. 00 |
| 7. 00 8. 00 | Were costs claimed for Allied Health Program: Were approvals and/or renewals obtained duri | ng the cost reporti | | for Nursing | N N | | 7. 00 8. 00 |
| | School and/or Allied Health Program? (Y/N) Si | ee Instructions. | | | | Y/N 1.00 | |
| 9. 00 | Bad Debts Is the provider seeking reimbursement for bar | d dehts? (V/N) see | instructio | ns | | N | 9.00 |
| 10.00 | If line 9 is "Y", did the provider's bad debperiod? If "Y", submit copy. | t collection policy | change du | ring this cos | , | N | 10.00 |
| 11. 00 | If line 9 is "Y", are patient deductibles and Bed Complement | d/or coinsurance wa | ived? If " | Y", see instr | ucti ons. | N | 11. 00 |
| 12. 00 | Have total beds available changed from prior | cost reporting per | iod? If "Y | | | N | 12. 00 |
| | | Descriptio | n | Y/N | rt A Date | Part B Y/N | |
| | DCAD D. | 0 | | 1. 00 | 2. 00 | 3. 00 | |
| 13. 00 | PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) | | | Y | 11/19/2022 | N | 13. 00 |
| 14.00 | Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. | | | N | | N | 14. 00 |
| 15. 00 | If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. | | | N | | N | 15. 00 |
| 16. 00 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. | | | N | | N | 16. 00 |
| 17. 00 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: | | | N | | N | 17. 00 |
| 18. 00 | Was the cost report prepared only using the | | | N | | N | 18. 00 |

| Heal th | Financial Systems COLLINGSV | OOD M | ANOR | In Lieu of Form CMS-2540-10 | | | |
|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------|----------------------|-----------------------------|------------------------|-----------------|---------|
| SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | | Ξ | Provider No.: 315404 | | rom 07/01/2021 Part II | | epared: |
| | | | | | | | |
| | | | 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- | 820-0301 | DEANDRA | . FALLON | BAKERTI LLY. CO | 21.00 |
| | report preparer in columns 1 and 2, respectively. | | | M | | | |

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

COLLINGSWOOD MANOR
In Lieu of Form CMS-2540-10
Provider No.: 315404
Period: Worksheet S-2
From 07/01/2021 Part II

| COMPLE | X REIMBURSEMENT QUESTIONNAIRE | | | To 06/30/2022 | Date/Time Prepared: 11/29/2022 11:11 am |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------|---------------|--------------------------------------------|
| | | Part B Date | | | 11/2//2022 11.11 dil |
| | DCOD D 1 | 4. 00 | | | |
| 12 00 | PS&R Data | | I | | 12.00 |
| 13. 00 | Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) | | | | 13.00 |
| 14. 00 | Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. | | | | 14.00 |
| 15. 00 | If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. | | | | 15. 00 |
| 16. 00 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions. | | | | 16. 00 |
| 17. 00 | If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: | | | | 17.00 |
| 18. 00 | Was the cost report prepared only using the provider's records? If "Y" see Instructions. | | | | 18. 00 |
| | | | 3. 00 | | |
| | Cost Report Preparer Contact Information | | | | |
| 19. 00 | Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively. | | CPA, SENIOR MANAGER | | 19.00 |
| 20. 00 | Enter the employer/company name of the cost r preparer. | eport | | | 20. 00 |
| 21. 00 | Enter the telephone number and email address report preparer in columns 1 and 2, respectiv | | | | 21. 00 |

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

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

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part I | Part I | Date/Time Prepared: | 11/20/1002-11/21/20

| | | | | T | 06/30/2022 | Date/Time Prep 11/29/2022 11: | |
|----------------|-------------------------------------|--------------------|-----------------------|------------------|-----------------------|----------------------------------|----------------|
| | | | | I npa | atient Days/Vis | | |
| | Component | Number of Beds | Bed Days Available | Title V | Title XVIII | Title XIX | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1.00 | SKILLED NURSING FACILITY | 60 | 21, 900 | 0 | 2, 740 | 4, 468 | 1. 00 |
| 2.00 | NURSING FACILITY | 0 | 0 | 0 | | 0 | 2. 00 |
| 3.00 | ICF/IID | 0 | 0 | | | 0 | 3. 00 |
| 4.00 | HOME HEALTH AGENCY COST | | | 0 | 0 | 0 | 4. 00 |
| 5.00 | Other Long Term Care | 128 | 46, 720 | | | | 5. 00 |
| 6.00 | SNF-Based CMHC | | | | | | 6. 00 |
| 7.00 | HOSPI CE | 0 | 0 | 0 | 0 740 | 0 | 7. 00 |
| 8. 00 | Total (Sum of lines 1-7) | 188 Inpatient D | 68, 620 | 0 | 2, 740 Di scharges | 4, 468 | 8. 00 |
| | | Impatrent L | ays/visits | | Di scharges | | |
| | Component | Other | Total | Title V | Title XVIII | Title XIX | |
| | | 6.00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 1.00 | SKILLED NURSING FACILITY | 8, 710 | 15, 918 | 0 | 110 | 5 | 1.00 |
| 2.00 | NURSING FACILITY | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 | ICF/IID | 0 | 0 | | | 0 | 3.00 |
| 4.00 | HOME HEALTH AGENCY COST | 0 | 0 | | | | 4.00 |
| 5.00 | Other Long Term Care | 29, 044 | 29, 044 | | | | 5. 00 |
| 6. 00 | SNF-Based CMHC | | | | | | 6. 00 |
| 7.00 | HOSPI CE | 0 | 0 | 0 | 0 | 0 | 7. 00 |
| 8. 00 | Total (Sum of lines 1-7) | 37, 754 | 44, 962 | 0 | 110 age Length of | 5 | 8. 00 |
| | | Di scha | ai yes | Avei | age Length of | Stay | |
| | Component | 0ther | Total | Title V | Title XVIII | Title XIX | |
| | | 11. 00 | 12. 00 | 13. 00 | 14. 00 | 15. 00 | |
| 1. 00 | SKILLED NURSING FACILITY | 61 | 176 | | 24. 91 | 893. 60 | 1. 00 |
| 2.00 | NURSING FACILITY | 0 | 0 | 0.00 | | 0.00 | 2. 00 |
| 3.00 | ICF/IID | 0 | 0 | | | 0. 00 | 3. 00 |
| 4.00 | HOME HEALTH AGENCY COST | 40 | 40 | | | | 4. 00 |
| 5.00 | Other Long Term Care | 43 | 43 | | | | 5. 00 |
| 6.00 | SNF-Based CMHC HOSPICE | | 0 | 0.00 | 0.00 | 0.00 | 6.00 |
| 7. 00 8. 00 | Total (Sum of lines 1-7) | 104 | 0 219 | 0. 00 0. 00 | 0. 00 24. 91 | 0. 00 893. 60 | 7. 00 8. 00 |
| 8.00 | Total (Suil of Titles 1-7) | Average Length | 217 | Admi s | | 073.00 | 0.00 |
| | | of Stay | | Adilii 3 | 31 0113 | | |
| | Component | Total | Title V | Title XVIII | Title XIX | 0ther | |
| | | 16. 00 | 17. 00 | 18. 00 | 19. 00 | 20. 00 | |
| 1.00 | SKILLED NURSING FACILITY | 90. 44 | 0 | 149 | 3 | 17 | 1. 00 |
| 2.00 | NURSING FACILITY | 0.00 | 0 | | 0 | 0 | 2.00 |
| 3.00 | ICF/IID | 0.00 | | | 0 | 0 | 3. 00 |
| 4.00 | HOME HEALTH AGENCY COST | | | | | | 4. 00 |
| 5.00 | Other Long Term Care | 675. 44 | | | | 40 | 5. 00 |
| 6.00 | SNF-Based CMHC | 0.00 | 0 | | | | 6. 00 |
| 7. 00 8. 00 | HOSPICE Total (Sum of lines 1-7) | 0. 00 205. 31 | 0 | 0 149 | 0 | 0 57 | 7. 00 8. 00 |
| 8.00 | Total (Suill Of Titles 1-7) | Admi ssi ons | Full Time | | ગ | 57 | 8.00 |
| | | T. I. I. | | | | | |
| | Component | Total | Employees on Payroll | Nonpai d | | | |
| | | 21. 00 | 22. 00 | Workers 23.00 | | | |
| 1. 00 | SKILLED NURSING FACILITY | 169 | 39. 82 | 0.00 | | | 1. 00 |
| 2.00 | NURSING FACILITY | ol | 0.00 | 0.00 | | | 2.00 |
| 3.00 | ICF/IID | 0 | 0.00 | | | ļ | 3. 00 |
| 4.00 | HOME HEALTH AGENCY COST | | 0.00 | | | ļ | 4.00 |
| 5.00 | Other Long Term Care | 40 | 38. 12 | 0.00 | | ļ | 5.00 |
| 6.00 | SNF-Based CMHC | | 0.00 | 0.00 | | ļ | 6.00 |
| 7.00 | HOSPI CE | 0 | 0.00 | | | | 7. 00 |
| 8.00 | Total (Sum of lines 1-7) | 209 | 77. 94 | 0.00 | | | 8. 00 |
| | | | | | | | |

SNF WAGE INDEX INFORMATION

Provi der No.: 315404 | Peri od: | Worksheet S-3 | From 07/01/2021 | Part II | Part (Time Provi

06/30/2022 Date/Time Prepared: 11/29/2022 11:11 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) 8, 097, 635 8, 097, 635 309, 422. 00 26, 17 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 0.00 4.00 0 0.00 4.00 Sum of lines 2 through 4 0.00 5.00 0 0 0 0.00 5.00 8, 097, 635 8, 097, 635 309, 422. 00 6.00 Revised wages (line 1 minus line 5) 26.17 6.00 7.00 Other Long Term Care 2, 100, 027 2, 100, 027 79, 292. 00 26.48 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 35, 438 35, 438 2, 063. 00 17. 18 11.00 Subtotal Excluded salary (Sum of lines 7 81, 355. 00 2, 135, 465 26. 25 12.00 12.00 2, 135, 465 through 11) Total Adjusted Salaries (line 6 minus line 13.00 5, 962, 170 C 5, 962, 170 228, 067. 00 26.14 13.00 OTHER WAGES & RELATED COSTS Contract Labor: Patient Related & Mgmt Contract Labor: Physician services-Part A 14.00 528, 468 528, 468 13, 236. 00 39. 93 14.00 15.00 16, 677 0 16, 677 104.00 160.36 15.00 788, 583 13, 670. 00 16.00 Home office salaries & wage related costs 788, 583 0 57.69 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1, 935, 735 1, 935, 735 17.00 Wage-related costs other (See Part IV) 3, 647 0 3, 647 18.00 18.00 Wage related costs (excluded units) 511, 443 0 511, 443 19.00 Physician Part A - WRC 0 20.00 20.00 21.00 Physician Part B - WRC Oı 21.00 22.00 Total Adjusted Wage Related cost (see 1, 427, 939 0 1, 427, 939 22.00 instructions)

Health Financial Systems
SNF WAGE INDEX INFORMATION COLLI NGSWOOD MANOR

Provi der No.: 315404

| | | | | | o 06/30/2022 | Data/Time Dro | oorod. |
|-------|--------------------------------------------|-------------|---------------|----------------|----------------|---------------------------------|--------|
| | | | | ' | 0 00/30/2022 | Date/Time Prep 11/29/2022 11 | |
| | | Amount | Reclass. of | Adj usted | Pai d Hours | Average Hourly | |
| | | Reported | | Salaries (col. | | Wage (col. 3 ÷ | |
| | | opor tou | Worksheet A-6 | | Salary in col. | | |
| | | | | | 3 | ., | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - OVERHEAD COST - DIRECT SALARIES | | | • | | | |
| 1.00 | Employee Benefits | 0 | 0 | 0 | 0.00 | 0.00 | 1. 00 |
| 2.00 | Administrative & General | 1, 226, 341 | 0 | 1, 226, 341 | 29, 638. 00 | 41. 38 | 2. 00 |
| 3.00 | Plant Operation, Maintenance & Repairs | 387, 568 | 0 | 387, 568 | 18, 544. 00 | 20. 90 | 3. 00 |
| 4.00 | Laundry & Linen Service | 110, 799 | 0 | 110, 799 | 6, 374. 00 | 17. 38 | 4.00 |
| 5.00 | Housekeepi ng | 329, 629 | 0 | 329, 629 | 18, 017. 00 | 18. 30 | 5. 00 |
| 6.00 | Di etary | 692, 391 | 0 | 692, 391 | 44, 689. 00 | 15. 49 | 6. 00 |
| 7.00 | Nursing Administration | 0 | 0 | 0 | 0.00 | 0.00 | 7. 00 |
| 8.00 | Central Services and Supply | 0 | 0 | 0 | 0.00 | 0.00 | 8. 00 |
| 9.00 | Pharmacy | 0 | 0 | 0 | 0.00 | 0.00 | 9. 00 |
| 10.00 | Medical Records & Medical Records Library | 0 | 0 | 0 | 0.00 | 0.00 | 10.00 |
| 11.00 | Soci al Servi ce | 52, 621 | 0 | 52, 621 | 2, 275. 00 | 23. 13 | 11. 00 |
| 12.00 | Nursing and Allied Health Ed. Act. | | | | | | 12.00 |
| 13.00 | Other General Service | 233, 238 | 0 | 233, 238 | 11, 228. 00 | 20. 77 | 13.00 |
| 14.00 | Total (sum lines 1 thru 13) | 3, 032, 587 | 0 | 3, 032, 587 | 130, 765. 00 | 23. 19 | 14. 00 |

| Heal th | Financial Systems | COLLI NGSWOOD MANOR | | | In Lie | u of Form CMS-2 | 2540-10 |
|---------|---------------------------------------------------|---------------------|-------|-------------|----------------------------------------------|------------------------------------------------------------|---------|
| SNF W | AGE RELATED COSTS | Provi | der I | No.: 315404 | Peri od: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part IV Date/Time Pre 11/29/2022 11 | pared: |
| | | | | | | 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 | า | | | | 0 | 2. 00 |
| 3.00 | Qualified and Non-Qualified Pension Plan Cost | | | | | 133, 191 | 3. 00 |
| 4.00 | Prior Year Pension Service Cost | | | | | 0 | 4. 00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organ | ni zati on) | | | | | ĺ |
| 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 | 6 | | | | 0 | 7. 00 |
| | HEALTH AND INSURANCE COST | | | | | | 1 |
| 8.00 | Health Insurance (Purchased or Self Funded) | | | | | 882, 697 | 8.00 |
| 9.00 | Prescription Drug Plan | | | | | 0 | 9.00 |

| | | 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 | 133, 191 | 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) | 882, 697 | 8. 00 |
| 9.00 | Prescription Drug Plan | 0 | 9. 00 |
| 10.00 | Dental, Hearing and Vision Plan | 12, 574 | 10.00 |
| | Life Insurance (If employee is owner or beneficiary) | 0 | 11. 00 |
| | Accident Insurance (If employee is owner or beneficiary) | 0 | 12.00 |
| | Disability Insurance (If employee is owner or beneficiary) | 4, 149 | 13.00 |
| | Long-Term Care Insurance (If employee is owner or beneficiary) | l ol | 14.00 |
| | Workers' Compensation Insurance | 207, 213 | 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 | 594, 995 | 17.00 |
| | Medicare Taxes - Employers Portion Only | l ol | |
| | Unemployment Insurance | 100, 324 | 19. 00 |
| | State or Federal Unemployment Taxes | 0 | 20.00 |
| | OTHER | | |
| 21. 00 | Executive Deferred Compensation | 0 | 21. 00 |
| | Day Care Cost and Allowances | 0 | 22. 00 |
| | Tuition Reimbursement | 592 | 23. 00 |
| 24. 00 | | 1, 935, 735 | |
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | Part B - Other than Core Related Cost | | |
| 25 00 | OTHER WAGE RELATED COST | 3, 647 | 25. 00 |

Provi der No.: 315404

| | | | | T | o 06/30/2022 | | pared: |
|--------|--------------------------------------------|-------------|----------|------------------|----------------|----------------|--------|
| | Occupational Category | Amount | Fri nge | Adj usted | Pai d Hours | Average Hourly | |
| | occupational outegoly | Reported | | Sal ari es (col. | | Wage (col. 3 ÷ | |
| | | Nopol tou | Bonorres | | Salary in col. | col. 4) | |
| | | | | | 3 | ., | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | Di rect Sal ari es | | | | | | |
| | Nursing Occupations | | | | | | |
| 1.00 | Registered Nurses (RNs) | 915, 361 | 219, 229 | | | | 1.00 |
| 2.00 | Licensed Practical Nurses (LPNs) | 167, 553 | 40, 129 | | · | | 2. 00 |
| 3.00 | Certified Nursing Assistant/Nursing | 902, 402 | 216, 125 | 1, 118, 527 | 45, 415. 00 | 24. 63 | 3. 00 |
| | Assi stants/Ai des | | | | | | |
| 4.00 | Total Nursing (sum of lines 1 through 3) | 1, 985, 316 | 475, 483 | | · | | 4. 00 |
| 5.00 | Physical Therapists | 205, 814 | 49, 293 | · | · | | 5. 00 |
| 6.00 | Physical Therapy Assistants | 80, 031 | 19, 167 | 99, 198 | | | 6. 00 |
| 7.00 | Physical Therapy Aides | 0 | 0 | ľ | 0.00 | | 7. 00 |
| 8.00 | Occupational Therapists | 95, 499 | 22, 872 | | 2, 068. 00 | | 8. 00 |
| 9.00 | Occupational Therapy Assistants | 56, 896 | 13, 626 | 70, 522 | 1, 540. 00 | | 9. 00 |
| 10. 00 | Occupational Therapy Aides | 0 | 0 | ľ | 0. 00 | | |
| 11. 00 | Speech Therapists | 109, 800 | 26, 297 | · | 2, 089. 00 | | 11. 00 |
| 12.00 | Respi ratory Therapi sts | 77, 227 | 18, 496 | · | · | | 12.00 |
| 13. 00 | Other Medical Staff | 319, 001 | 76, 401 | 395, 402 | 8, 567. 00 | 46. 15 | 13.00 |
| | Contract Labor | | | | | | |
| | Nursing Occupations | , | | | | | |
| 14. 00 | Registered Nurses (RNs) | 20, 375 | | 20, 375 | | | |
| | Licensed Practical Nurses (LPNs) | 323, 233 | | 323, 233 | · | | |
| 16. 00 | Certified Nursing Assistant/Nursing | 184, 860 | | 184, 860 | 6, 162. 00 | 30. 00 | 16. 00 |
| 47.00 | Assi stants/Ai des | 500 440 | | 500 440 | 40.00/.00 | | 47.00 |
| | Total Nursing (sum of lines 14 through 16) | 528, 468 | | 528, 468 | | | |
| 18. 00 | Physi cal Therapi sts | 0 | | 0 | 0.00 | | |
| 19. 00 | Physical Therapy Assistants | 0 | | 0 | 0.00 | | |
| 20. 00 | Physical Therapy Aides | 0 | | 0 | 0. 00 | | |
| 21. 00 | Occupational Therapists | 0 | | 0 | 0. 00 | | |
| 22. 00 | Occupational Therapy Assistants | 0 | | 0 | 0.00 | | |
| 23. 00 | Occupational Therapy Aides | 0 | | 0 | 0.00 | | |
| 24. 00 | Speech Therapists | 0 | | 0 | | | |
| 25. 00 | Respiratory Therapists | 0 | | 0 | | | 25. 00 |
| 26. 00 | Other Medical Staff | 0 | | 0 | 0. 00 | 0.00 | 26. 00 |
| | | | | | | | |

Health Financial Systems COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10 PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider No.: 315404 Peri od: Worksheet S-7 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/29/2022 11:11 am Group Days 1. 00 2.00 1.00 RUX 1.00 2.00 RUL 2.00 3.00 RVX 3.00 4.00 RVL 4.00 5.00 RHX 5.00 6.00 RHL 6.00 7.00 RMX 7.00 8.00 RML 8.00 9.00 RLX 9.00 10.00 RUC 10.00 11.00 RUB 11.00 12.00 RUA 12.00 13.00 RVC 13.00 14.00 RVB 14.00 15.00 RVA 15.00 RHC 16.00 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE2 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC₂ 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38, 00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB₂ 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00

BA2

BA1

PF2

PE1

PD2

PD1

PC2

PC1

PB2

PB1

PA₂

65.00

66.00

67.00

68.00

69.00

70.00

71.00

72.00

73.00

74.00 75.00

65.00

66.00

67.00

68.00

69.00

70.00

71.00

72.00

73.00

74.00

75. 00

| Health Financial Systems | COLLINGSWOOD MANOR | | In Lie | u of Form CMS- | 2540-10 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------|--------------------|
| PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provi d | er No.: 315404 | Peri od: | Worksheet S- | 7 |
| | | | From 07/01/2021 To 06/30/2022 | Date/Time Pro 11/29/2022 1 | |
| | | | Group | Days | |
| | | | 1. 00 | 2. 00 | |
| 76. 00 | | | PA1 | | 76. 00 |
| 99. 00 | | | AAA | | 99. 00 |
| 100. 00 TOTAL | | | | | 100. 00 |
| | | Expenses | Percentage | Y/N | |
| | | 1. 00 | 2. 00 | 3. 00 | |
| A notice published in the Federal Register Vopayments beginning 10/01/2003. Congress experexpenses. For lines 101 through 106: Enter in column 2 the percentage of total expenses for line 1, column 3. Indicate in column 3 "Y" fowith direct patient care and related expenses (See instructions) | cted this increase to be us a column 1 the amount of the each category to total Sl or yes or "N" for no if the | ed for direct ne expense for NF revenue from e spending refl | patient care and each category. Er Worksheet G-2, F ects increases as | related nter in Part I, ssociated | |
| 101.00 Staffing | | | | | 101. 00 |
| 102.00 Recrui tment | | | | | 102.00 |
| 103.00 Retention of employees | | | | | 103.00 |
| 104. 00 Training | | | | | 104. 00 |
| 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, li | ne 1 column 3) | | | | 105. 00 106. 00 |
| 100.00 101a. 0 1010.100 (101K51100 t 0 2, 141 t 1, 111 | .5 ., 55 5) | 1 | I | | 1.00.00 |

| Health Financial Systems | COLLI NGSWOOD | MANOR | | In Lie | u of Form CMS-2 | 2540-10 |
|------------------------------------------------------------------------------------|---------------------------------------|-------------|---------------|-----------------------------------------------|---------------------|------------------|
| RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF | EXPENSES | Provi der | | Peri od: | Worksheet A | |
| | | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre | narod: |
| | | | | 00/30/2022 | 11/29/2022 11 | |
| Cost Center Description | Sal ari es | Other | Total (col. 1 | Reclassi fi cati | Reclassi fied | |
| | | | + col . 2) | ons | Trial Balance | |
| | | | | Increase/Decre | (col. 3 +- | |
| | | | | ase (Fr Wkst | col . 4) | |
| | | | | A-6) | | |
| | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES | | 1, 286, 557 | 1, 286, 557 | 7 0 | 1, 286, 557 | 1. 00 |
| 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | 0 | (| - | 0 | 2. 00 |
| 3.00 00300 EMPLOYEE BENEFITS | 0 | 1, 939, 382 | | | 1, 939, 382 | 3. 00 |
| 4.00 00400 ADMINISTRATIVE & GENERAL | 1, 226, 341 | 2, 467, 493 | | | 3, 693, 834 | 4. 00 |
| 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS | 387, 568 | 837, 646 | | | 1, 225, 214 | 5. 00 |
| 6.00 00600 LAUNDRY & LINEN SERVICE | 110, 799 | 29, 726 | | | 140, 525 | 6. 00 |
| 7. 00 00700 HOUSEKEEPI NG | 329, 629 | 245, 432 | | | 575, 061 | 7. 00 |
| 8. 00 00800 DI ETARY | 692, 391 | 1, 161, 352 | 1, 853, 743 | 0 | 1, 853, 743 | 8. 00 |
| 9. 00 00900 NURSI NG ADMINI STRATI ON | 0 | 0 | (| 0 | 0 | 9. 00 |
| 10. 00 01000 CENTRAL SERVICES & SUPPLY | 0 | 0 | 9 | 0 | 0 | 10.00 |
| 11. 00 01100 PHARMACY | 0 | 0 | | 0 | 0 | 11. 00 |
| 12. 00 01200 MEDI CAL RECORDS & LI BRARY | 0 | 0 | | 0 | 0 | 12. 00 |
| 13. 00 01300 SOCI AL SERVI CE | 52, 621 | 0 | 52, 62 | 0 | 52, 621 | 13.00 |
| 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | (| 0 | 0 | 14. 00 |
| 15. 00 01500 ACTI VI TI ES | 170, 655 | 32, 773 | | | 203, 428 | 15. 00 |
| 15. 01 01501 CHAPLAI N | 62, 583 | 1, 162 | 63, 745 | 0 | 63, 745 | 15. 01 |
| INPATIENT ROUTINE SERVICE COST CENTERS | 0.004.044 | | | | 0.054.400 | |
| 30. 00 03000 SKILLED NURSING FACILITY | 2, 304, 316 | 1, 049, 812 | | | -,, | 30.00 |
| 31. 00 03100 NURSING FACILITY | 0 | 0 | (| J | 0 | 31.00 |
| 32. 00 03200 ICF/IID | 0 100 007 | 100.000 | 0 000 01 | 0 | 0 | 32.00 |
| 33. 00 03300 OTHER LONG TERM CARE | 2, 100, 027 | 190, 889 | 2, 290, 916 | 0 | 2, 290, 916 | 33. 00 |
| ANCILLARY SERVICE COST CENTERS | | F 2/0 | F 2// | | F 2/0 | 40.00 |
| 40. 00 04000 RADI OLOGY | 0 | 5, 369 | | | 5, 369 13, 547 | 40.00 |
| 41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY | 0 | 13, 547 | 13, 547 | | 13,547 | 41.00 |
| 43. 00 04200 TNTRAVENOUS THERAPY 43. 00 04300 0XYGEN (INHALATION) THERAPY | 77, 227 | 170 | 77, 39 | 7 | _ | 42. 00 43. 00 |
| 44. 00 04400 PHYSI CAL THERAPY | 285, 845 | 122, 224 | | | 77, 397 286, 078 | 44. 00 |
| 45. 00 04500 OCCUPATIONAL THERAPY | 152, 395 | 122, 224 | 152, 395 | | 235, 723 | 45. 00 |
| 46. 00 04600 SPEECH PATHOLOGY | 109, 800 | 0 | 109, 800 | | 148, 463 | 46. 00 |
| 47. 00 04700 ELECTROCARDI OLOGY | 109, 800 | 0 | 107, 800 | 30,003 | 146, 403 | 47. 00 |
| 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 27, 667 | 27, 66 | 7 | 27, 667 | 48. 00 |
| 49. 00 04900 DRUGS CHARGED TO PATIENTS | | 138, 868 | | | 138, 868 | 49. 00 |
| 50. 00 05000 DENTAL CARE - TITLE XIX ONLY | l o | 130, 000 | 130,000 | | 0 | 50.00 |
| 51. 00 05100 SUPPORT SURFACES | l o | 0 | | | Ö | 51. 00 |
| OUTPATIENT SERVICE COST CENTERS | <u> </u> | | | <u>, </u> | | 01.00 |
| 60. 00 06000 CLINIC | 0 | 0 | | 0 | 0 | 60.00 |
| 61. 00 06100 RURAL HEALTH CLINIC | | 0 | | 0 | Ö | 61. 00 |
| 62. 00 06200 FQHC | | · · | Ì | 1 | | 62. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 70. 00 07000 HOME HEALTH AGENCY COST | O | 0 | (| 0 | 0 | 70.00 |
| 71. 00 07100 AMBULANCE | o | 0 | | 0 | 0 | |
| 73. 00 07300 CMHC | o | 0 | | o o | 0 | 73. 00 |
| SPECIAL PURPOSE COST CENTERS | · | | | | | |
| 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | 0 | | 0 | 0 | 80. 00 |
| 81.00 08100 INTEREST EXPENSE | | 0 | | 0 | 0 | 81. 00 |
| 82.00 08200 UTILIZATION REVIEW - SNF | o | 0 | | 0 | 0 | 82. 00 |
| 83. 00 08300 HOSPI CE | o | 0 | | 0 | 0 | 83. 00 |
| 89.00 SUBTOTALS (sum of lines 1-84) | 8, 062, 197 | 9, 550, 069 | 17, 612, 266 | 0 | 17, 612, 266 | 89. 00 |
| NONREI MBURSABLE COST CENTERS | · · · · · · · · · · · · · · · · · · · | | | | | |
| 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 35, 438 | 16, 971 | 52, 409 | 9 0 | 52, 409 | 90.00 |
| 91.00 09100 BARBER AND BEAUTY SHOP | o | 0 | (| 0 | 0 | 91. 00 |
| 92.00 09200 PHYSICIANS PRIVATE OFFICES | o | 0 | (| 0 | 0 | 92. 00 |
| 93. 00 09300 NONPALD WORKERS | 0 | 0 | (| 0 | 0 | 93. 00 |
| 94.00 09400 PATIENTS LAUNDRY | o | 0 | (| 0 | 0 | 94. 00 |
| 100. 00 TOTAL | 8, 097, 635 | 9, 567, 040 | 17, 664, 675 | 5 0 | 17, 664, 675 | 100. 00 |
| | | | | | | |

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

Health Financial Systems COLLII
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Peri od: Worksheet A From 07/01/2021 To 06/30/2022 Date/Time Prepared: Provi der No.: 315404

| | | | | | To 06/30/2022 | Date/Time Prepared: 11/29/2022 11:11 am |
|------------------|----------------------------------------------------------------------|----------------|------------------|---|---------------|-----------------------------------------|
| | Cost Center Description | Adjustments to | Net Expenses | | | 11/29/2022 11.11 dill |
| | | | For Allocation | | | |
| | | Wkst A-8) | (col. 5 +- | | | |
| | | | col . 6) | | | |
| | CENEDAL CEDALCE COCT CENTERS | 6. 00 | 7. 00 | | | |
| 1. 00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES | -197 | 1, 286, 360 | | | 1. 00 |
| 2. 00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | -177 | 1, 200, 300 | 1 | | 2.00 |
| 3. 00 | 00300 EMPLOYEE BENEFITS | -48, 558 | | | | 3.00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | -727, 374 | 1 | • | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | -8, 629 | 1, 216, 585 | | | 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | 0 | 140, 525 | • | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | 0 (72 | 575, 061 | • | | 7. 00 |
| 8. 00 9. 00 | 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON | -29, 673 | 1, 824, 070 0 | i | | 8. 00 9. 00 |
| 10. 00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 0 | • | | 10.00 |
| 11. 00 | 01100 PHARMACY | Ö | Ö | | | 11. 00 |
| 12.00 | 01200 MEDICAL RECORDS & LIBRARY | 0 | 0 | | | 12. 00 |
| 13. 00 | 01300 SOCIAL SERVICE | 0 | 52, 621 | | | 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | | | 14. 00 |
| 15. 00 | 01500 ACTIVITIES | 0 | 203, 428 | | | 15. 00 |
| 15. 01 | 01501 CHAPLAI N I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 0 | 63, 745 | | | 15. 01 |
| 30. 00 | | 0 | 3, 354, 128 | | | 30.00 |
| 31. 00 | 03100 NURSING FACILITY | 0 | 3, 334, 120 | | | 31.00 |
| 32. 00 | 03200 CF/IID | Ö | Ö | | | 32. 00 |
| 33. 00 | 1 1 | 0 | 2, 290, 916 | | | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 40. 00 | | 0 | 0,00, | 1 | | 40. 00 |
| 41.00 | | 0 | 13, 547 | 1 | | 41.00 |
| 42. 00 43. 00 | 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY | 0 | 0 77, 397 | | | 42. 00 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 0 | 286, 078 | • | | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 235, 723 | • | | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | 148, 463 | ı | | 46. 00 |
| 47.00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | | | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 27, 667 | • | | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 0 | 138, 868 | 1 | | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | | | 50.00 |
| 51. 00 | 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS | 0 | 0 | | | 51. 00 |
| 60. 00 | 06000 CLINIC | 0 | 0 | | | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | Ö | Ö | | | 61. 00 |
| 62.00 | 06200 FQHC | | | | | 62. 00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| 70. 00 | | 0 | | | | 70.00 |
| 71.00 | 07100 AMBULANCE 07300 CMHC | 0 | 1 | | | 71.00 |
| 73. 00 | SPECIAL PURPOSE COST CENTERS | 0 | 0 | | | 73. 00 |
| 80 00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | 0 | 0 | | | 80.00 |
| | 08100 NTEREST EXPENSE | 0 | Ö | | | 81. 00 |
| 82. 00 | | 0 | 0 | | | 82. 00 |
| 83. 00 | 1 1 | 0 | 0 | | | 83. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | -814, 431 | 16, 797, 835 | | | 89. 00 |
| 00.00 | NONREI MBURSABLE COST CENTERS | | F0 400 | | | 20.55 |
| 90.00 | | 0 | 52, 409 | 1 | | 90.00 |
| 91.00 | 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | | | 91.00 |
| | 09300 NONPALD WORKERS | 0 | 0 | | | 93. 00 |
| | 09400 PATIENTS LAUNDRY | 0 | Ö | | | 94. 00 |
| 100.00 | DTOTAL | -814, 431 | 16, 850, 244 | | | 100. 00 |

| Health Financial Systems | COLLI NGSWOOD MA | COLLI NGSWOOD MANOR | | | In Lieu of Form CMS-2540-10 | | |
|------------------------------|------------------------------|---------------------|-----------|----------------------------|-----------------------------|-----------|--|
| RECLASSI FI CATI ONS | Provi der No.: 315 | | | Period: From 07/01/2021 | Worksheet A-6 | | |
| | | | | | Date/Time Pre | pared: | |
| | | | Increases | | 1172772022 11 | 11 (3.11) | |
| | Cost Center | ſ | Li ne # | Sal ary | Non Salary | | |
| | 2.00 | | 3.00 | 4. 00 | 5. 00 | | |
| (1) A - TO RECLASS OT AND ST | | | | | | | |
| 1. 00 | OCCUPATIONAL THERAP | Υ | 45.0 | 0 39, 890 | 43, 438 | 1. 00 | |
| 2. 00 | SPEECH PATHOLOGY | | 46. 0 | 0 18, 508 | 20, 155 | 2. 00 | |
| TOTALS | | | | | | | |
| 100. 00 | Total Reclassifications (Sum | | | 58, 398 | 63, 593 | 100.00 | |
| | of columns 4 and 5 | must | | | | | |
| | equal sum of column | s 8 and | | | | | |
| | 9) | | | | | | |

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

| Health Financial Systems | COLLI NGSWOOD MAI | NOR | | In Lie | u of Form CMS-2 | 2540-10 |
|------------------------------|-------------------|----------------------|---------|-----------------|-----------------|---------|
| RECLASSI FI CATI ONS | | Provider No.: 315404 | | Peri od: | Worksheet A-6 | |
| | | | | From 07/01/2021 | D . (T) D | |
| | | | | To 06/30/2022 | | |
| | | | | | 11/29/2022 11 | 11 am |
| | Decreases | | | | | |
| | Cost Center | | 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. 0 | 00 58, 398 | 63, 593 | 1.00 |
| 2. 00 | | | 0.0 | 00 | 0 | 2.00 |
| TOTALS | | | | | | |
| 100.00 | | | | 58, 398 | 63, 593 | 100. 00 |
| | | | | | | |

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

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COLLI NGSWOOD MANOR Provi der No.: 315404

| | | | | | To 06/30/2022 | Date/Time Prep 11/29/2022 11: | |
|-------|-----------------------------------------------|------------------|--------------|-----------------|---------------|----------------------------------|-------|
| | | | | Acqui si ti ons | 5 | | |
| | Description | Begi nni ng | Purchases | Donati on | Total | Di sposal s and | |
| | | Bal ances | | | | Retirements | |
| | T | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES | | | Г | | | |
| 1.00 | Land | 257, 870 | 0 | | 0 | 0 | 1. 00 |
| 2.00 | Land Improvements | 0 | 0 | | 0 | 0 | 2. 00 |
| 3.00 | Buildings and Fixtures | 25, 534, 069 | 69, 227 | | 0 69, 227 | 0 | 3. 00 |
| 4.00 | Building Improvements | 0 | 0 | | 0 | 0 | 4. 00 |
| 5.00 | Fi xed Equi pment | 2, 237, 320 | 213, 738 | | 0 213, 738 | | 5.00 |
| 6.00 | Movable Equipment | 218, 670 | 0 | | 0 | 13, 540 | 6. 00 |
| 7.00 | Subtotal (sum of lines 1-6) | 28, 247, 929 | 282, 965 | | 0 282, 965 | 13, 540 | 7. 00 |
| 8.00 | Reconciling Items | 0 | 0 | | 0 | 0 | 8.00 |
| 9. 00 | Total (line 7 minus line 8) | 28, 247, 929 | 282, 965 | | 0 282, 965 | 13, 540 | 9. 00 |
| | Description | Endi ng Bal ance | Fully | | | | |
| | | | Depreci ated | | | | |
| | | | Assets | | | | |
| | | 6. 00 | 7. 00 | | | | |
| | ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES | | | | | | |
| 1.00 | Land | 257, 870 | 0 | | | | 1. 00 |
| 2.00 | Land Improvements | 0 | 0 | | | | 2. 00 |
| 3.00 | Buildings and Fixtures | 25, 603, 296 | 0 | | | | 3. 00 |
| 4.00 | Building Improvements | 0 | 0 | | | | 4.00 |
| 5.00 | Fixed Equipment | 2, 451, 058 | 0 | | | | 5.00 |
| 6.00 | Movable Equipment | 205, 130 | 0 | | | | 6.00 |
| 7.00 | Subtotal (sum of lines 1-6) | 28, 517, 354 | 0 | | | | 7. 00 |
| 8.00 | Reconciling Items | 0 | 0 | | | | 8.00 |
| 9. 00 | Total (line 7 minus line 8) | 28, 517, 354 | 0 | | | l | 9. 00 |

Provi der No.: 315404

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

| | | | | To 06/30/2022 | Date/Time Pre 11/29/2022 11 | |
|----------------|-----------------------------------------------------------------------------------|-----------------|---------------|--------------------------------------|-----------------------------|----------------|
| | | | | Expense Classification on | | . II alli |
| | | | | To/From Which the Amount is | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | Description (1) | (2) Basis For | Amount | Cost Center | Line No. | |
| | bescription (1) | Adjustment | Amount | Cost center | Little No. | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | |
| 1. 00 | Investment income on restricted funds | В | | CAP REL COSTS - BLDGS & | 1.00 | 1. 00 |
| | (chapter 2) | | | FI XTURES | | |
| 2. 00 | Trade, quantity, and time discounts (chapter | | O | | 0.00 | 2. 00 |
| 2 00 | Befunds and relates of synamose (shorter 0) | | 0 | | 0.00 | 2 00 |
| 3. 00 4. 00 | Refunds and rebates of expenses (chapter 8) Rental of provider space by suppliers | | 0 | | 0.00 | 3. 00 4. 00 |
| 4.00 | (chapter 8) | | 0 | , | 0.00 | 4.00 |
| 5.00 | Tel ephone services (pay stations excluded) | | 0 | | 0.00 | 5. 00 |
| | (chapter 21) | | | | | |
| 6.00 | Television and radio service (chapter 21) | В | -6, 728 | PLANT OPERATION, MAINT. & | 5. 00 | 6. 00 |
| 7.00 | | | | REPAI RS | 0.00 | 7.00 |
| 7.00 | Parking lot (chapter 21) | 400 | 0 | | 0.00 | 7.00 |
| 8. 00 | Remuneration applicable to provider-based physician adjustment | A-8-2 | U | , | | 8. 00 |
| 9. 00 | Home office cost (chapter 21) | | 0 | | 0.00 | 9. 00 |
| 10.00 | Sale of scrap, waste, etc. (chapter 23) | | O | | 0.00 | |
| 11. 00 | Nonallowable costs related to certain | | 0 | | 0.00 | 11. 00 |
| | Capital expenditures (chapter 24) | | | | | |
| 12. 00 | Adjustment resulting from transactions with | A-8-1 | -78, 892 | 2 | | 12. 00 |
| 13. 00 | related organizations (chapter 10) | | 0 | | 0.00 | 13. 00 |
| 14. 00 | Laundry and linen service Revenue - Employee meals | В | -29 546 | DI ETARY | 8.00 | |
| 15. 00 | Cost of meals - Guests | | 27, 540 |) | 0.00 | |
| 16. 00 | Sale of medical supplies to other than | | 0 | | 0.00 | ı |
| | patients | | | | | |
| 17. 00 | Sale of drugs to other than patients | | 0 | | 0.00 | |
| 18. 00 | Sale of medical records and abstracts | | 0 | | | 18. 00 |
| 19.00 | Vending machines | | 0 | | 0.00 | |
| 20. 00 | Income from imposition of interest, finance or penalty charges (chapter 21) | | U | , | 0.00 | 20. 00 |
| 21. 00 | Interest expense on Medicare overpayments | | 0 | | 0.00 | 21. 00 |
| 21.00 | and borrowings to repay Medicare | | Č | | 0.00 | 21.00 |
| | overpayments | | | | | |
| 22. 00 | Utilization reviewphysicians' compensation | | 0 | UTILIZATION REVIEW - SNF | 82.00 | 22. 00 |
| | (chapter 21) | | | 0.15 DEL 000TO DI 500 0 | | |
| 23. 00 | Depreciationbuildings and fixtures | | O | CAP REL COSTS - BLDGS & | 1.00 | 23. 00 |
| 24. 00 | Depreciationmovable equipment | | 0 | FIXTURES CAP REL COSTS - MOVABLE | 2.00 | 24. 00 |
| 24.00 | bepreciationmovabre equipment | | O | EQUI PMENT | 2.00 | 24.00 |
| 25. 00 | MI SCELLANEOUS I NCOME | В | -6, 345 | ADMINISTRATIVE & GENERAL | 4.00 | 25. 00 |
| 25. 01 | MARKETI NG SAL/OTHER | A | -409, 457 | ADMINISTRATIVE & GENERAL | 4.00 | 25. 01 |
| 25. 02 | NON-ALLOWABLE EXPENSE | A | | ADMINISTRATIVE & GENERAL | 4.00 | |
| 25. 03 | | A | | ADMI NI STRATI VE & GENERAL | | 25. 03 |
| | MARKETING BENEFITS | A | | EMPLOYEE BENEFITS | l . | 25. 04 |
| 25. 05 | ELECTRI C REVENUE | В | -1, 171 | PLANT OPERATION, MAINT. & REPAIRS | 5. 00 | 25. 05 |
| 25. 06 | MAINTENANCE SERVICES | В | _730 | | 5.00 | 25. 06 |
| 20.00 | SERVI GEO | | 730 | REPAIRS | 3.00 | 20.00 |
| 25. 07 | FOOD | A | -127 | DI ETARY | 8.00 | 25. 07 |
| 100.00 | Total (sum of lines 1 through 99) (Transfer | | -814, 431 | | | 100. 00 |
| | to Worksheet A, col. 6, line 100) | | | | | |
| (1) De | scription - all chapter references in this co | lumn pertain to | CMS Pub. 15-1 | 1. | | |

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

COLLI NGSWOOD MANOR

Health Financial Systems COLLINGSWOOD
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der No.: 315404 OFFICE COSTS

| 011102 00313 | | | Ť | o 06/30/2022 | Date/Time Pre | |
|--------------------------------------------------------------------------|----------------|-------------------|---------------|---------------------|---------------|----------------|
| | Li ne No. | Cost (| Center | Expense | Items | |
| | 1.00 | 2. | 00 | 3. 0 | 00 | |
| PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS: | | | | D ORGANIZATIONS | OR | |
| 1. 00 2. 00 | 4. 00 0. 00 | ADMI NI STRATI VE | & GENERAL | HOME OFFICE COS | ΣT | 1. 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 | 0.00 | | | | | 10.00 |
| 6, line 100 to Worksheet A-8, column 3, line | | | | | | |
| 12. | | | | | | |
| | Amount | Amount | Adjustments | | | |
| | Allowable In | Included in | (col. 4 minus | | | |
| | Cost | Wkst. A, col. | col . 5) | | | |
| | | 5 | | | | |
| DART L. COCTO LNOUDDED AND AD HICTMENTS DECILIA | 4.00 | 5.00 | 6.00 | D. ODGANII ZATI ONG | 0.0 | |
| PART I. COSTS INCURRED AND ADJUSTMENTS REQUII CLAIMED HOME OFFICE COSTS: | | | | | UR | |
| 1.00 | 1, 036, 101 | 1, 114, 993 | -78, 892 | | | 1. 00 |
| 2. 00 | 0 | 0 | C | | | 2. 00 |
| 3. 00 | 0 | 0 |) C | | | 3. 00 |
| 4. 00 | 0 | 0 | 9 | | | 4. 00 |
| 5. 00 | 0 | 0 | | | | 5. 00 |
| 6.00 | 0 | 0 | | | | 6. 00 |
| 7. 00 8. 00 | 0 | 0 | | | | 7. 00 8. 00 |
| 9.00 | 0 | 0 | | | | 9.00 |
| 10.00 TOTALS (sum of lines 1-9). Transfer column | 1, 036, 101 | 1, 114, 993 | -78, 892 | | | 10.00 |
| 6, line 100 to Worksheet A-8, column 3, line | | 1, 114, 993 | -70,092 | | | 10.00 |
| 12. | | | | | | |

Provider No.: 315404 Worksheet A-8-1 From 07/01/2021 Parts I-II Date/Time Prepared: 11/29/2022 11:11 am OFFICE COSTS 06/30/2022

Symbol (1) Name Percentage of Ownershi p 1.00 2.00 3.00

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

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

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

| 1.00 | G | UNITED METHODIST HOMES OF NJ | 100.00 | 1.00 |
|----------------------------------------------|---|------------------------------|--------|---------|
| 2.00 | | | 0.00 | 2.00 |
| 3.00 | | | 0.00 | 3.00 |
| 4.00 | | | 0.00 | 4.00 |
| 5. 00 | | | 0.00 | 5. 00 |
| 6. 00 | | | 0.00 | 6. 00 |
| 7. 00 | | | 0.00 | 7. 00 |
| 8. 00 | | | 0.00 | 8. 00 |
| 9. 00 | | | 0.00 | 9. 00 |
| 10. 00 | | | 0.00 | 10.00 |
| 100.00 G. Other (financial or non-financial) | | | 0.00 | 100. 00 |
| speci fy: | | | | |

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

| Rel ated Organi | zation(s) and/ | or Home Office | |
|-----------------|-------------------------|------------------|--|
| Name | Percentage of Ownership | Type of Business | |
| 4.00 | 5. 00 | 6. 00 | |

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

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

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

| 1.00 | UNITED METHODIST HOMES OF NJ | 100. 00 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.

COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315404 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:11 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDGS & MOVABLE EMPLOYEE Subtotal for Cost **FLXTURES FOUL PMENT** BENEFITS Allocation (from Wkst A col. 7) 1.00 2.00 3. 00 ЗА GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1 00 1 00 1, 286, 360 1, 286, 360 2.00 0 2.00 3.00 00300 EMPLOYEE BENEFITS 1, 890, 824 0 1, 890, 824 3.00 00400 ADMINISTRATIVE & GENERAL 0 3, 270, 364 4 00 2 966 460 55, 820 248 084 4 00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 1, 216, 585 17, 033 0 92,657 1, 326, 275 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 140, 525 20, 810 26, 489 187, 824 6.00 7.00 00700 HOUSEKEEPI NG 575,061 9, 461 78, 805 663, 327 7.00 00800 DI FTARY 1,824,070 39, 732 2, 029, 334 8 00 8 00 165, 532 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 4,730 0 12, 580 69, 931 13.00 52, 621 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 0 14.00 01500 ACTI VI TI ES 0 40, 799 266, 934 15.00 203.428 15.00 22, 707 01501 CHAPLAI N 15.01 63, 745 0 14, 962 78, 707 15.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 3, 354, 128 239, 421 0 550, 900 4, 144, 449 30.00 03100 NURSING FACILITY 31.00 0 31.00 0 0 32.00 03200 | CF/IID Λ 32.00 03300 OTHER LONG TERM CARE 2, 290, 916 0 33.00 861, 642 502,060 3, 654, 618 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40.00 5.369 0 0 5.369 0 41.00 04100 LABORATORY 13, 547 C 0 13, 547 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 77, 397 0 18.463 95, 860 43.00 0 44.00 04400 PHYSI CAL THERAPY 286, 078 15,004 54, 376 355, 458 44.00 04500 OCCUPATIONAL THERAPY 235, 723 45, 970 45.00 281, 693 45.00 46.00 04600 SPEECH PATHOLOGY 148, 463 0 0 30, 675 179, 138 46.00 04700 ELECTROCARDI OLOGY 0 47 00 C 47 00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 27,667 C 0 27, 667 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 49.00 138, 868 138, 868 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 0 05100 SUPPORT SURFACES O 51.00 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 16, 797, 835 0 1, 882, 352 16, 789, 363 89.00 89.00 1, 286, 360 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 52, 409 0 8, 472 60, 881 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 Ω 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 92 00 0 0 0 92 00 Ω 0 0 93.00 09300 NONPALD WORKERS 0 0 0 93.00 09400 PATIENTS LAUNDRY 0 0 0 94.00 94.00 0 98.00 98.00 Cross Foot Adjustments 0 0 0 0 0 99 00 99.00 Negative Cost Centers 0

16, 850, 244

1, 286, 360

0

1, 890, 824

16, 850, 244 100. 00

TOTAL

100.00

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 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315404

| | | | | To | 06/30/2022 | | pared: |
|------------------|------------------------------------------------------------|-------------------|-------------|---------------|---------------|---------------------------|------------------|
| | Cost Center Description | ADMI NI STRATI VE | PLANT | LAUNDRY & | HOUSEKEEPI NG | 11/29/2022 11 DI ETARY | : II am |
| | cost conto. Bood ptron | & GENERAL | OPERATION, | LINEN SERVICE | HOUSENEE! I'M | 5.2.7 | |
| | | | MAINT. & | | | | |
| | | 4.00 | REPAI RS | / 00 | 7.00 | 0.00 | |
| | GENERAL SERVICE COST CENTERS | 4.00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| 1. 00 | 00100 CAP REL COSTS - BLDGS & FLXTURES | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUI PMENT | | | | | | 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | | | | 3. 00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | 3, 270, 364 | | | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 319, 399 | 1, 645, 674 | 1 | | | 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | 45, 233 | 28, 221 | | | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | 159, 745 | 12, 830 | 0 | 835, 902 | 0 500 005 | 7. 00 |
| 8. 00 9. 00 | 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON | 488, 712 | 53, 881 | | 28, 068 | 2, 599, 995 0 | 8. 00 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 11. 00 | 01100 PHARMACY | 0 | 0 | | 0 | 0 | 11. 00 |
| 12. 00 | 01200 MEDICAL RECORDS & LIBRARY | o | 0 | ő | o | 0 | 12. 00 |
| 13.00 | 01300 SOCIAL SERVICE | 16, 841 | 6, 415 | 0 | 3, 342 | 0 | 13.00 |
| 14.00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | 0 | 0 | 0 | 14. 00 |
| 15. 00 | 01500 ACTI VI TI ES | 64, 284 | 30, 794 | 0 | 16, 042 | 0 | 15. 00 |
| 15. 01 | 01501 CHAPLAI N | 18, 955 | 0 | 0 | 0 | 0 | 15. 01 |
| 00.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 000 005 | 204 (0) | 1 000 000 | 4/0 440 | 4 444 054 | 00.00 |
| 30.00 | 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY | 998, 085 | 324, 686 | 1 | 169, 140 | 1, 114, 354 | 30.00 |
| 31. 00 32. 00 | 03200 CF/IID | 0 | 0 | 0 | 0 | 0 | 31. 00 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 880, 120 | 1, 168, 499 | 52, 256 | 608, 710 | 1, 485, 641 | 33. 00 |
| 33. 00 | ANCILLARY SERVICE COST CENTERS | 000, 120 | 1, 100, 477 | 32, 230 | 000, 710 | 1, 400, 041 | 33.00 |
| 40.00 | 04000 RADI OLOGY | 1, 293 | 0 | 0 | 0 | 0 | 40. 00 |
| 41.00 | 04100 LABORATORY | 3, 262 | 0 | О | 0 | 0 | 41. 00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 42. 00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 23, 085 | 0 | 0 | 0 | 0 | 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 85, 603 | 20, 348 | 0 | 10, 600 | 0 | 44.00 |
| 45. 00 | 04500 OCCUPATIONAL THERAPY | 67, 838 | 0 | 0 | 0 | 0 | 45. 00 |
| 46. 00 47. 00 | 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY | 43, 141 | 0 | 0 | 0 | 0 | 46. 00 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 6, 663 | 0 | | 0 | 0 | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 33, 443 | 0 | ő | o | 0 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | o | 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 | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC 06200 FOHC | 0 | 0 | 0 | 0 | 0 | 61.00 |
| 62. 00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 62. 00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 | 07100 AMBULANCE | O | 0 | | o | 0 | 71. 00 |
| 73. 00 | 07300 CMHC | 0 | 0 | | o | 0 | 73. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 80.00 | | | | | | | 80. 00 |
| 81. 00 | | | | | | | 81. 00 |
| 82. 00 | 08200 UTILIZATION REVIEW - SNF | | _ | _ | _ | _ | 82. 00 |
| 83.00 | 08300 H0SPI CE | 0 | 0 | 0 | 0 | 0 | 83. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS | 3, 255, 702 | 1, 645, 674 | 261, 278 | 835, 902 | 2, 599, 995 | 89. 00 |
| 90. 00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 14, 662 | 0 | 0 | 0 | 0 | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 0 | 0 | _ | - | 0 | 91. 00 |
| 92. 00 | 09200 PHYSI CI ANS PRI VATE OFFI CES | 0 | 0 | ō | o | 0 | 92.00 |
| 93.00 | 09300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 93. 00 |
| 94. 00 | 09400 PATIENTS LAUNDRY | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 98. 00 | | 0 | 0 | 0 | 0 | 0 | 98. 00 |
| 99.00 | | 2 270 2/4 | 1 / 45 / 74 | 0 | 0 | 2 500 005 | 99.00 |
| 100.00 | D TOTAL | 3, 270, 364 | 1, 645, 674 | 261, 278 | 835, 902 | 2, 599, 995 | 100.00 |

Peri od: Worksheet B
From 07/01/2021 Part I
To 06/30/2022 Date/Time Prepared: 11/29/2022 11:11 am Provi der No.: 315404

| | Cost Center Description | | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | SOCIAL SERVICE | . TT GIII |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------|---------------------------------|----------|-----------------------------------|----------------|----------------------------------|
| | | 9. 00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 2. 00 3. 00 4. 00 | 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL | | | | | | 1. 00 2. 00 3. 00 4. 00 |
| 5. 00 6. 00 7. 00 8. 00 | 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY | | | | | | 5. 00 6. 00 7. 00 8. 00 |
| 9.00 | 00900 NURSI NG ADMI NI STRATI ON | 0 | | | | | 9. 00 |
| 10. 00 11. 00 | 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY | 0 | 0 | 0 | | | 10. 00 11. 00 |
| 12. 00 | 01200 MEDICAL RECORDS & LIBRARY | 0 | 0 | 0 | 0 | | 12. 00 |
| 13. 00 14. 00 | 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | 0 | 0 | 96, 529 0 | 13. 00 14. 00 |
| 15. 00 | 01500 ACTI VI TI ES | 0 | 0 | 0 | 0 | 0 | 15. 00 |
| 15. 01 | O1501 CHAPLAIN INPATIENT ROUTINE SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 15. 01 |
| 30.00 | 03000 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 96, 529 | 30. 00 |
| | 03100 NURSING FACILITY | O | Ö | ő | o | | 31. 00 |
| 32.00 | 03200 CF/IID 03300 OTHER LONG TERM CARE | 0 | 0 | 0 | 0 | _ | 32. 00 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | 0 | 0 | | | | 33.00 |
| | 04000 RADI OLOGY 04100 LABORATORY | 0 | 0 | 0 | 0 | | 40. 00 41. 00 |
| | 04200 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 41.00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | 0 | 0 | 0 | 43. 00 |
| | 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 0 | 0 | 44. 00 45. 00 |
| 46. 00 | | 0 | 0 | 0 | | 0 | 46. 00 |
| | 04700 ELECTROCARDI OLOGY | 0 | 0 | Ō | 0 | 0 | 47. 00 |
| | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 48. 00 |
| 49. 00 50. 00 | O4900 DRUGS CHARGED TO PATIENTS O5000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | 0 | | 0 | 49. 00 50. 00 |
| 51. 00 | 05100 SUPPORT SURFACES | o o | 0 | ő | 0 | | |
| 60. 00 | OUTPATIENT SERVICE COST CENTERS 06000 CLINIC | 0 | 0 | 0 | 0 | 0 | 60. 00 |
| 61. 00 | i i | 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 | 0 | 0 | 70. 00 |
| | 07100 AMBULANCE | 0 | 0 | | _ | | 71.00 |
| 73. 00 | 07300 CMHC | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| 80 00 | SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81. 00 | 08100 NTEREST EXPENSE | | | | | | 81. 00 |
| | 08200 UTILIZATION REVIEW - SNF | | | | | | 82. 00 |
| 83.00 | 08300 HOSPICE SUBTOTALS (sum of lines 1-84) | 0 | 0 | | | | |
| 89.00 | NONREI MBURSABLE COST CENTERS | 0 | 0 | 0 | | 70, 327 | 09.00 |
| | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | | 0 | _ | |
| 91. 00 92. 00 | 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 0 | 0 | | |
| 93. 00 | 09300 NONPALD WORKERS | | 0 | 0 | 0 | _ | 92. 00 93. 00 |
| 94.00 | 09400 PATIENTS LAUNDRY | 0 | 0 | Ō | 0 | | 94. 00 |
| 98. 00 | Cross Foot Adjustments | 0 | 0 | | | | 98. 00 |
| 99. 00 100. 00 | Negative Cost Centers TOTAL | 0 | 0 | 0 | 0 | | |
| . 50. 50 | 1 | 1 | J | ' | ' | , 5, 52, | |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| | | | | | To 06/30/2022 | | |
|------------------|--------------------------------------------------------------------------|------------------------------|---------------|-------------|-----------------------|---------------------------|-------------------|
| | | | OTHER GENER | RAL SERVICE | | 11/29/2022 11 | : II am |
| | | | | | | | |
| | Cost Center Description | NURSING AND ALLIED HEALTH | ACTI VI TI ES | CHAPLAI N | Subtotal | Post Stepdown Adjustments | |
| | | EDUCATION | | | | Auj us tillerits | |
| | | 14. 00 | 15. 00 | 15. 01 | 16.00 | 17. 00 | |
| | GENERAL SERVICE COST CENTERS | I | | T. | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FLXTURES | | | | | | 1.00 |
| 2. 00 3. 00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS | | | | | | 2. 00 3. 00 |
| 4. 00 | 00400 ADMINISTRATIVE & GENERAL | | | | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | | | | 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | | | | | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | | | | | | 7. 00 |
| 8. 00 9. 00 | 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON | | | | | | 8. 00 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | | | | | | 10.00 |
| 11. 00 | 01100 PHARMACY | | | | | | 11. 00 |
| 12.00 | 01200 MEDICAL RECORDS & LIBRARY | | | | | | 12. 00 |
| 13.00 | 01300 SOCI AL SERVI CE | | | | | | 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | | | | | 14. 00 |
| 15. 00 15. 01 | 01500 ACTIVITIES | 0 | 378, 054 | | () | | 15.00 |
| 15.01 | 01501 CHAPLAIN I NPATI ENT ROUTI NE SERVI CE COST CENTERS | U | 0 | 97, 6 | 02 | | 15. 01 |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 0 | 378, 054 | 31, 2 | 7, 465, 570 | 0 | 30.00 |
| 31.00 | 03100 NURSING FACILITY | 0 | 0 | | 0 0 | 1 | 31. 00 |
| 32. 00 | 03200 CF/IID | 0 | 0 | | 0 0 | 1 | 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 0 | 0 | 66, 4 | 11 7, 916, 255 | 5 0 | 33. 00 |
| 40. 00 | ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY | | 0 | | 0 6, 662 | 2 0 | 40. 00 |
| 41. 00 | 04100 LABORATORY | 0 | 0 | • | 0 6, 662 0 16, 809 | 1 | 41.00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | | 0 0 | Ö | 42. 00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | | 0 118, 945 | 0 | 43. 00 |
| 44.00 | 04400 PHYSI CAL THERAPY | 0 | 0 | | 0 472, 009 | 1 | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 349, 531 | | 45. 00 |
| 46. 00 47. 00 | 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY | 0 | 0 | | 0 222, 279 | 1 | 46. 00 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 34, 330 | 1 | 48.00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 172, 311 | 1 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | | 0 0 | 1 | 50. 00 |
| 51. 00 | 05100 SUPPORT SURFACES | 0 | 0 | | 0 0 | 0 | 51. 00 |
| | OUTPATIENT SERVICE COST CENTERS | 1 0 | | T | | | |
| 60. 00 61. 00 | 06000 CLINIC 06100 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | | 60. 00 61. 00 |
| | 06200 FQHC | | U | | | | 62.00 |
| 02.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 02.00 |
| 70.00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | | 0 0 | 0 | 70. 00 |
| 71. 00 | 07100 AMBULANCE | 0 | 0 | • | 0 0 | | 71. 00 |
| 73. 00 | 07300 CMHC |] 0 | 0 | | 0 0 | 0 | 73. 00 |
| 80. 00 | SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81.00 | 08100 NTEREST EXPENSE | | | | | | 81.00 |
| 82. 00 | 08200 UTILIZATION REVIEW - SNF | | | | | | 82. 00 |
| 83.00 | 08300 H0SPI CE | 0 | 0 | | 0 0 | | 83. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 0 | 378, 054 | 97, 6 | 62 16, 774, 701 | 0 | 89. 00 |
| 90. 00 | NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | | 0 | | 0 75, 543 | 0 | 90. 00 |
| 90.00 | 09100 BARBER AND BEAUTY SHOP | 0 | 0 | 1 | 0 75, 543 | 1 | 90.00 |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | | 0 | | o o | | 92.00 |
| 93. 00 | 09300 NONPAI D WORKERS | 0 | Ö | | 0 0 | o o | 93. 00 |
| 94.00 | 09400 PATIENTS LAUNDRY | 0 | 0 | | 0 0 | 0 | 94. 00 |
| 98. 00 | Cross Foot Adjustments | 0 | 0 | | 0 0 | 1 | 98. 00 |
| 99.00 | Negative Cost Centers | 0 | 270 054 | 97, 6 | 0 14 950 244 | 0 | 99. 00 100. 00 |
| 100.00 |) TOTAL | ı o | 378, 054 | J 97, 6 | 62 16, 850, 244 | 1 | 1100.00 |

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der No.: 315404

| | | | 10 06/30/2022 Date/Time Pre | |
|--------|--------------------------------------------|-------------------------|-----------------------------|------------|
| | Cost Center Description | Total | 1172772022 113 | i i i dili |
| | oost conton boson per on | 18. 00 | | |
| | GENERAL SERVICE COST CENTERS | 10.00 | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUI PMENT | | | 2. 00 |
| 3. 00 | 00300 EMPLOYEE BENEFITS | | | 3. 00 |
| 4. 00 | 00400 ADMINISTRATIVE & GENERAL | | | 4. 00 |
| 5. 00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | 5. 00 |
| | 1 | | | |
| 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 | 01000 CENTRAL SERVICES & SUPPLY | | | 10. 00 |
| 11. 00 | 01100 PHARMACY | | | 11. 00 |
| 12. 00 | 01200 MEDICAL RECORDS & LIBRARY | | | 12. 00 |
| 13.00 | 01300 SOCIAL SERVICE | | | 13. 00 |
| 14.00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | | | 14.00 |
| 15.00 | 01500 ACTI VI TI ES | | | 15. 00 |
| 15. 01 | 01501 CHAPLAI N | | | 15. 01 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | 1 |
| 30.00 | 03000 SKILLED NURSING FACILITY | 7, 465, 570 | | 30.00 |
| 31.00 | 03100 NURSING FACILITY | o | | 31.00 |
| 32.00 | 03200 CF/IID | o | | 32. 00 |
| 33. 00 | | 7, 916, 255 | | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | .,, | | 1 |
| 40. 00 | | 6, 662 | | 40. 00 |
| 41. 00 | 1 | 16, 809 | | 41. 00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | 10,007 | | 42. 00 |
| 43. 00 | | 118, 945 | | 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 472, 009 | | 44. 00 |
| 45. 00 | 1 | 349, 531 | | 45. 00 |
| | 1 | 1 | | 1 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 222, 279 | | 46. 00 |
| 47. 00 | 1 | 0 | | 47. 00 |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 34, 330 | | 48. 00 |
| 49. 00 | 1 | 172, 311 | | 49. 00 |
| 50.00 | 1 | 0 | | 50.00 |
| 51. 00 | | 0 | | 51. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | |
| 60. 00 | 06000 CLI NI C | 0 | | 60.00 |
| 61. 00 | 1 | 0 | | 61. 00 |
| 62. 00 | | | | 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 INTEREST EXPENSE | | | 81.00 |
| 82.00 | 08200 UTILIZATION REVIEW - SNF | | | 82. 00 |
| 83.00 | 08300 HOSPI CE | o | | 83. 00 |
| 89. 00 | | 16, 774, 701 | | 89. 00 |
| 230 | NONREI MBURSABLE COST CENTERS | , , , , , , , , , , , , | | 1 |
| 90. 00 | | 75, 543 | | 90. 00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 1 0 | | 91.00 |
| 92. 00 | 09200 PHYSI CI ANS PRI VATE OFFI CES | | | 92.00 |
| 93. 00 | 09300 NONPALD WORKERS | | | 93.00 |
| 94. 00 | 09400 PATIENTS LAUNDRY | | | 94.00 |
| 98. 00 | Cross Foot Adjustments | | | 98.00 |
| 98.00 | Negative Cost Centers | | | 99.00 |
| 100.00 | | | | 100.00 |
| 100.00 | ן וטואב | 16, 850, 244 | | 1100.00 |

| 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.: 315404

| | | | | To | 06/30/2022 | Date/Time Pre 11/29/2022 11 | pared: |
|------------------|---------------------------------------------------------------------------|--------------------------|-----------------------------------------|-----------------------|--------------------|--------------------------------|------------------|
| | | | CAPI TAL REL | ATED COSTS | | 11/29/2022 11 | : II alli |
| | Cost Center Description | Directly Assigned New | BLDGS & FIXTURES | MOVABLE EQUI PMENT | Subtotal | EMPLOYEE BENEFITS | |
| | | Capi tal | | | | | |
| | | Related Costs 0 | 1.00 | 2. 00 | 2A | 3. 00 | |
| | GENERAL SERVICE COST CENTERS | | | 2.00 | | 0.00 | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | | | | | | 1. 00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | _ | _ | _ | _ | _ | 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | 0 | 0 | 0 | 0 | 0 | |
| 4. 00 5. 00 | 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS | 0 | 55, 820 17, 033 | 0 | 55, 820 17, 033 | 0 | |
| 6. 00 | 00600 LAUNDRY & LINEN SERVICE | 0 | 20, 810 | 0 | 20, 810 | 0 | |
| 7. 00 | 00700 HOUSEKEEPI NG | 0 | 9, 461 | Ō | 9, 461 | 0 | 1 |
| 8.00 | 00800 DI ETARY | 0 | 39, 732 | 0 | 39, 732 | 0 | 8. 00 |
| 9.00 | 00900 NURSI NG ADMI NI STRATI ON | 0 | 0 | 0 | 0 | 0 | |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 11. 00 12. 00 | O1100 PHARMACY O1200 MEDI CAL RECORDS & LI BRARY | 0 | 0 | 0 | O O | 0 | 11. 00 12. 00 |
| | 01300 SOCIAL SERVICE | 0 | 4, 730 | 0 | 4, 730 | 0 | 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0, 730 | 0 | 0 | 0 | 1 |
| 15. 00 | 01500 ACTIVITIES | 0 | 22, 707 | 0 | 22, 707 | 0 | 1 |
| 15. 01 | 01501 CHAPLAI N | 0 | 0 | 0 | 0 | 0 | 15. 01 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | тг | | | | | |
| 30.00 | 03000 SKILLED NURSING FACILITY | 0 | 239, 421 0 | 0 | 239, 421 0 | 0 | |
| 31. 00 32. 00 | 03100 NURSING FACILITY 03200 CF/IID | | 0 | 0 | 0 | 0 | 31. 00 32. 00 |
| | 03300 OTHER LONG TERM CARE | 0 | 861, 642 | Ö | 861, 642 | 0 | 1 |
| | ANCILLARY SERVICE COST CENTERS | | *************************************** | -, | 33.7 3.2 | | 1 |
| 40.00 | 04000 RADI OLOGY | 0 | 0 | 0 | 0 | 0 | 40. 00 |
| 41. 00 | 04100 LABORATORY | 0 | 0 | 0 | 0 | 0 | |
| 42. 00 43. 00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 42. 00 43. 00 |
| 44. 00 | 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY | 0 | 15, 004 | 0 | 15, 004 | 0 | 1 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 0 | 0 | 1 |
| 46.00 | 04600 SPEECH PATHOLOGY | 0 | 0 | 0 | 0 | 0 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | |
| 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | |
| 49. 00 | 04900 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | |
| 50. 00 51. 00 | O5000 DENTAL CARE - TITLE XIX ONLY O5100 SUPPORT SURFACES | 0 | 0 | 0 | 0 | 0 | 50. 00 51. 00 |
| 31.00 | OUTPATIENT SERVICE COST CENTERS | 0 | | 0 | <u> </u> | | 31.00 |
| 60.00 | 06000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 60.00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 61. 00 |
| 62. 00 | 06200 FOHC | | | | | | 62. 00 |
| 70. 00 | OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST | l ol | ol | O | ol | 0 | 70. 00 |
| 71.00 | 07100 AMBULANCE | 0 | 0 | 0 | 0 | 0 | |
| 73. 00 | 07300 CMHC | o | o | 0 | Ö | 0 | 73. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 80.00 | 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | | | | 80.00 |
| 81. 00 | 08100 NTEREST EXPENSE | | | | | | 81.00 |
| 82. 00 83. 00 | 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE | o | 0 | 0 | | 0 | 82. 00 83. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 0 | 1, 286, 360 | 0 | 1, 286, 360 | 0 | 1 |
| 07.00 | NONREI MBURSABLE COST CENTERS | <u> </u> | 1, 200, 000 | 51 | 17 2007 000 | | 07.00 |
| 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 | |
| 92.00 | 09200 PHYSI CLANS PRI VATE OFFI CES | 0 | 0 | 0 | 0 | 0 | |
| 93. 00 94. 00 | 09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY | 0 | 0 | 0 | 0 | 0 | |
| 98.00 | Cross Foot Adjustments | | ٩ | U | 0 | U | 98.00 |
| 99. 00 | Negative Cost Centers | | ol | 0 | ol | 0 | 1 |
| 100.00 | | 0 | 1, 286, 360 | 0 | 1, 286, 360 | | 100. 00 |
| | | | · · | , | | | |

NNOR In Lieu of Form CMS-2540-10
Provider No.: 315404 Period: Worksheet B
From 07/01/2021 Part II
Provider No.: 315404 Period: Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLLI NGSWOOD MANOR

| | | | To | 06/30/2022 | Date/Time Pre 11/29/2022 11 | pared: | |
|-------------------------------------------|--------------------------------------------------------------------------|--------------------------------|--------------------------------------------|----------------------------|--------------------------------|--------------|-------------------------------------------|
| | Cost Center Description | ADMI NI STRATI VE & GENERAL | PLANT OPERATION, MAINT. & REPAIRS | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | DI ETARY | . II dili |
| | | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 | O0100 CAP REL COSTS - BLDGS & FIXTURES | 55, 820 5, 451 | 22, 484 | | | | 1. 00 2. 00 3. 00 4. 00 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | 772 | 386 | | | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | 2, 726 | 175 | 1 | 12, 362 | 40.224 | 7.00 |
| 8. 00 9. 00 | 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON | 8, 341 | 736 0 | | 415 0 | 49, 224 0 | 8. 00 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 0 | | o | 0 | 10. 00 |
| 11. 00 | 01100 PHARMACY | 0 | 0 | 0 | o | 0 | 11. 00 |
| 12.00 | 01200 MEDICAL RECORDS & LIBRARY | 0 | 0 | _ | 0 | 0 | 12. 00 |
| 13.00 | 01300 SOCIAL SERVICE | 287 | 88 | | 49 | 0 | 13. 00 |
| 14.00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 1 007 | 0 | | 0 | 0 | 14.00 |
| 15. 00 15. 01 | 01500 ACTI VI TI ES | 1, 097 323 | 421 0 | | 237 | 0 | 15. 00 15. 01 |
| 13.01 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 323 | | 1 0 | <u>ا</u> | | 13.01 |
| 30.00 | | 17, 041 | 4, 436 | 17, 574 | 2, 501 | 21, 097 | 30. 00 |
| 31.00 | | 0 | 0 | 0 | 0 | 0 | 31. 00 |
| 32. 00 | 03200 CF/IID | 0 | 0 | _ | 0 | 0 | 32. 00 |
| 33. 00 | | 15, 020 | 15, 964 | 4, 394 | 9, 003 | 28, 127 | 33. 00 |
| 40. 00 | ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY | 22 | 0 | 0 | ol | 0 | 40. 00 |
| 41. 00 | 04100 LABORATORY | 56 | 0 | | | 0 | 41.00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | | Ö | 0 | 42.00 |
| 43.00 | | 394 | 0 | 0 | o | 0 | 43.00 |
| 44.00 | | 1, 461 | 278 | 0 | 157 | 0 | 44.00 |
| 45. 00 | • | 1, 158 | 0 | | 0 | 0 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY | 736 | 0 | 0 | 0 | 0 | 46. 00 47. 00 |
| 47. 00 48. 00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 114 | 0 | 0 | | 0 | 47.00 |
| 49. 00 | l l | 571 | 0 | | | 0 | 49. 00 |
| 50. 00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | ő | o | 0 | 50. 00 |
| 51.00 | 05100 SUPPORT SURFACES | 0 | 0 | 0 | 0 | 0 | 51. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60.00 | | 0 | 0 | 1 | 0 | 0 | 60.00 |
| 61. 00 62. 00 | 06100 RURAL HEALTH CLINIC 06200 FOHC | O O | 0 | 0 | 0 | 0 | 61. 00 62. 00 |
| 02.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 02.00 |
| 70.00 | | 0 | 0 | 0 | 0 | 0 | 70. 00 |
| 71. 00 | • • • • • • • • • • • • • • • • • • • | 0 | 0 | 1 | 0 | 0 | 71. 00 |
| 73. 00 | | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| 00.00 | SPECIAL PURPOSE COST CENTERS 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | | | | 00.00 |
| 80. 00 81. 00 | | | | | | | 80. 00 81. 00 |
| 82. 00 | | | | | | | 82. 00 |
| 83. 00 | 08300 HOSPI CE | 0 | 0 | 0 | o | 0 | |
| 89. 00 | SUBTOTALS (sum of lines 1-84) | 55, 570 | 22, 484 | 21, 968 | 12, 362 | 49, 224 | 89. 00 |
| | NONRE MBURSABLE COST CENTERS | | | | | | |
| 90.00 | | 250 | 0 | | 0 | 0 | |
| 91. 00 92. 00 | | 0 | 0 | | 0 | 0 | 91. 00 92. 00 |
| 92.00 | | | 0 | _ | | 0 | 92.00 |
| 94. 00 | • | | 0 | | | 0 | 94. 00 |
| 98. 00 | | | · · | 0 | o | 0 | 98. 00 |
| 99. 00 | Negative Cost Centers | 0 | 0 | 0 | О | 0 | 99. 00 |
| 100.00 | 0 TOTAL | 55, 820 | 22, 484 | 21, 968 | 12, 362 | 49, 224 | 100. 00 |
| | | | | | | | |

Provi der No.: 315404

In Lieu of Form CMS-2540-10

| Period: | Worksheet B | From 07/01/2021 | Part II |
| To 06/30/2022 | Date/Time Prepared: | 11/29/2022 | 11:11 am

| | | | | '' | 00/30/2022 | 11/29/2022 11 | |
|--------|-------------------------------------------------------------|-------------------|------------|----------|------------|----------------|---------|
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | SOCIAL SERVICE | |
| | | ADMI NI STRATI ON | SERVICES & | | RECORDS & | | |
| | | | SUPPLY | | LI BRARY | | |
| | | 9. 00 | 10. 00 | 11. 00 | 12. 00 | 13. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FLXTURES | | | | | | 1. 00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | | | | | 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | | | | 3. 00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | | | | | | 4.00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | | | | 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 | 0 | | | | | 9. 00 |
| 10.00 | 01000 CENTRAL SERVICES & SUPPLY | o | o | | | | 10.00 |
| 11. 00 | 01100 PHARMACY | o | o | 0 | | | 11. 00 |
| 12. 00 | 01200 MEDICAL RECORDS & LIBRARY | o | o | 0 | 0 | | 12. 00 |
| 13. 00 | 1 1 | o | o | 0 | 0 | 5, 154 | 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | o | o | 0 | 0 | 0 | 14. 00 |
| 15. 00 | 01500 ACTI VI TI ES | 0 | o | 0 | 0 | l . | 15. 00 |
| 15. 01 | 01501 CHAPLAI N | 0 | ol | 0 | 0 | 0 | 15. 01 |
| | I NPATIENT ROUTI NE SERVI CE COST CENTERS | <u> </u> | <u>~</u> | | | | |
| 30. 00 | 03000 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 5, 154 | 30. 00 |
| 31. 00 | 1 1 | o | o | ő | 0 | 1 | 31. 00 |
| 32. 00 | 1 | | Ö | ő | 0 | Ö | 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | | 0 | ő | 0 | l | 33. 00 |
| 33.00 | ANCI LLARY SERVI CE COST CENTERS | <u> </u> | <u> </u> | | | | 33.00 |
| 40. 00 | 04000 RADI OLOGY | 0 | ol | 0 | 0 | 0 | 40. 00 |
| 41. 00 | 04100 LABORATORY | | 0 | 0 | 0 | | 41. 00 |
| 42. 00 | 04200 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 42. 00 |
| 43. 00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | 0 | 0 | 0 | 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | | 0 | 0 | 0 | 0 | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | | 0 | 0 | 0 | 0 | 45. 00 |
| 46. 00 | | | 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 | | 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATTENTS | | 0 | 0 | 0 | 0 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | | 0 | 0 | 0 | | 50.00 |
| 51. 00 | 05100 SUPPORT SURFACES | | 0 | 0 | 0 | | 51. 00 |
| 51.00 | OUTPATIENT SERVICE COST CENTERS | <u> </u> | υ | U | 0 | 0 | 31.00 |
| 60. 00 | | O | ol | 0 | 0 | 0 | 60. 00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | | 0 | 0 | 0 | 1 | 61. 00 |
| 62. 00 | 06200 FQHC | ١ | ٩ | U | 0 | 0 | 62. 00 |
| 02.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 02.00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | l ol | ol | 0 | 0 | 0 | 70. 00 |
| 71.00 | 07100 AMBULANCE | 0 | 0 | 0 | 0 | | 70.00 |
| 73.00 | 1 | | 0 | 0 | 0 | ł | 73.00 |
| 73.00 | SPECIAL PURPOSE COST CENTERS | ı y | υ | U | U | U | 73.00 |
| 80. 00 | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | | | | 80. 00 |
| 81. 00 | 1 | | | | | | 81. 00 |
| | | | | | | | |
| | 08200 UTI LI ZATI ON REVI EW - SNF | | | | 0 | _ | 82.00 |
| 83. 00 | 08300 HOSPI CE | 0 | 0 | - | 0 | | 83. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 5, 154 | 89. 00 |
| 00.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | | ما | | 0 | | 00 00 |
| 90.00 | | 0 | 0 | 0 | - | | 90.00 |
| 91.00 | 09100 BARBER AND BEAUTY SHOP | 0 | U | 0 | 0 | | 91.00 |
| 92. 00 | 1 | 0 | 0 | 0 | 0 | 0 | 92.00 |
| 93. 00 | 09300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 93. 00 |
| 94.00 | 1 | 0 | 0 | 0 | 0 | 0 | 94.00 |
| 98. 00 | | 0 | 0 | 0 | _ | _ | 98. 00 |
| 99.00 | 1 3 | 0 | 0 | 0 | 0 | 0 | 99.00 |
| 100.00 | D TOTAL | 0 | 0 | 0 | 0 | 5, 154 | 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.: 315404

| | | | | | To 06/30/2022 | Date/Time Pre 11/29/2022 11 | pared: |
|-------------------|----------------------------------------------------------------------|------------------------------|---------------|-------------|----------------------------|-----------------------------------------------|-------------------|
| | | | OTHER GENER | RAL SERVICE | | 11/29/2022 11 | . II alli |
| | | | | | | | |
| | Cost Center Description | NURSING AND | ACTI VI TI ES | CHAPLAI N | Subtotal | Post Step-Down | |
| | | ALLI ED HEALTH EDUCATI ON | | | | Adjustments | |
| | | 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 00700 HOUSEKEEPING | | | | | | 6.00 |
| 7. 00 8. 00 | 00800 DI ETARY | | | | | | 7. 00 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 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 | 0 | 24, 462 | | | | 15. 00 |
| 15. 01 | 01501 CHAPLAI N | 0 | 0 | 32 | 3 | | 15. 01 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 SKILLED NURSING FACILITY | 0 | 24, 462 | 10 | 331, 789 | 0 | 30. 00 |
| 31. 00 | 03100 NURSING FACILITY | 0 | 0 | | 0 0 | 0 | 31. 00 |
| 32. 00 | 03200 I CF/I I D | 0 | 0 | | O C | 1 | 32. 00 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 0 | 0 | 22 | 0 934, 370 | 0 | 33. 00 |
| | ANCILLARY SERVICE COST CENTERS | | al | | | | |
| 40.00 | 04000 RADI OLOGY | 0 | 0 | | 0 22 | | 40.00 |
| 41. 00 | 04100 LABORATORY | 0 | 0 | | 0 56 | 1 | 41.00 |
| 42. 00 43. 00 | 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | | 0 0 394 | 1 | 42. 00 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 0 | 0 | | 0 16, 900 | 1 | 44. 00 |
| 45. 00 | 04500 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 1, 158 | 1 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | 0 | | 736 | 1 | 46. 00 |
| 47. 00 | 04700 ELECTROCARDI OLOGY | 0 | Ö | | 0 0 | 1 | 47. 00 |
| 48.00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 114 | 0 | 48. 00 |
| 49.00 | 04900 DRUGS CHARGED TO PATIENTS | 0 | О | | 0 571 | 0 | 49. 00 |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | 0 | | 0 0 | 0 | 50. 00 |
| 51.00 | 05100 SUPPORT SURFACES | 0 | 0 | | 0 0 | 0 | 51. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60. 00 | 06000 CLI NI C | 0 | 0 | | 0 0 | 1 | 60. 00 |
| 61. 00 | 06100 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 61. 00 |
| 62. 00 | 06200 FOHC | | | | | | 62. 00 |
| 70.00 | OTHER REIMBURSABLE COST CENTERS | | ٥ | | | | 70.00 |
| 70. 00 71. 00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | | O | 1 | 70.00 |
| 71.00 | 07100 AMBULANCE | 0 | 0 | | 0 0 | 1 | 71. 00 73. 00 |
| 73.00 | SPECIAL PURPOSE COST CENTERS | 0 | U | | 0 0 | <u>, </u> | 73.00 |
| 80. 00 | 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | | | | 80. 00 |
| 81. 00 | 08100 INTEREST EXPENSE | | | | | | 81. 00 |
| 82. 00 | 08200 UTI LI ZATI ON REVI EW - SNF | | | | | | 82. 00 |
| 83. 00 | 08300 HOSPI CE | 0 | 0 | | o c | 0 | • |
| 89.00 | SUBTOTALS (sum of lines 1-84) | 0 | 24, 462 | 32 | 1, 286, 110 | 0 | 89. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | | 0 250 | 0 | 90. 00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 0 | 0 | | 0 0 | 1 | 91. 00 |
| 92.00 | 09200 PHYSI CI ANS PRI VATE OFFI CES | 0 | 0 | | 0 0 | 0 | 92.00 |
| 93. 00 | 09300 NONPAI D WORKERS | 0 | 0 | | O C | 0 | 93. 00 |
| 94.00 | 09400 PATIENTS LAUNDRY | 0 | 0 | | U C | 0 | 94. 00 |
| 98. 00 | Cross Foot Adjustments | 0 | 0 | | | 0 | 98. 00 |
| 99. 00 100. 00 | Negative Cost Centers TOTAL | | 24, 462 | | 0 3 1, 286, 360 | 0 | 99. 00 100. 00 |
| 100.00 | , IOIAL | ı | 24, 402 | 32 | J ₁ 1, 200, 300 | ′I U | 1100.00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLLI NGSWOOD MANOR

Provi der No.: 315404

| | | | 11/29/2022 11 | |
|--------|--------------------------------------------|-------------|---------------|---------|
| | Cost Center Description | Total | 1172772022 11 | T Gill |
| | · | 18. 00 | | |
| | GENERAL SERVICE COST CENTERS | | | |
| 1.00 | 00100 CAP REL COSTS - BLDGS & FIXTURES | | | 1. 00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUIPMENT | | | 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | | | 3. 00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | | | 5. 00 |
| 6.00 | 00600 LAUNDRY & LINEN SERVICE | | | 6. 00 |
| 7.00 | 00700 HOUSEKEEPI NG | | | 7. 00 |
| 8.00 | 00800 DI ETARY | | | 8. 00 |
| 9.00 | 00900 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 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | |
| 30.00 | 03000 SKILLED NURSING FACILITY | 331, 789 | | 30.00 |
| | 03100 NURSING FACILITY | 0 | | 31. 00 |
| | 03200 CF/IID | 0 | | 32. 00 |
| | 1 | 934, 370 | | 33. 00 |
| 00.00 | ANCI LLARY SERVI CE COST CENTERS | 7017070 | | 00.00 |
| 40 00 | 04000 RADI OLOGY | 22 | | 40. 00 |
| | 04100 LABORATORY | 56 | | 41. 00 |
| | 04200 I NTRAVENOUS THERAPY | 0 | | 42. 00 |
| | 04300 OXYGEN (INHALATION) THERAPY | 394 | | 43. 00 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 16, 900 | | 44. 00 |
| | 04500 OCCUPATI ONAL THERAPY | 1, 158 | | 45. 00 |
| | 04600 SPEECH PATHOLOGY | 736 | | 46. 00 |
| | 04700 ELECTROCARDI OLOGY | 0 | | 47. 00 |
| | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 114 | | 48. 00 |
| | 04900 DRUGS CHARGED TO PATIENTS | 571 | | 49. 00 |
| | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | | 50.00 |
| | 05100 SUPPORT SURFACES | | | 51.00 |
| 31.00 | OUTPATIENT SERVICE COST CENTERS | UU | | 31.00 |
| 60. 00 | 06000 CLINIC | 0 | | 60.00 |
| | 06100 RURAL HEALTH CLINIC | | | 61.00 |
| 62. 00 | 06200 FQHC | | | 62.00 |
| 02.00 | OTHER REIMBURSABLE COST CENTERS | | | 02.00 |
| 70. 00 | 07000 HOME HEALTH AGENCY COST | 0 | | 70. 00 |
| 71. 00 | 07100 AMBULANCE | | | 71.00 |
| 73.00 | 07300 CMHC | | | 73.00 |
| 73.00 | SPECIAL PURPOSE COST CENTERS | U U | | 73.00 |
| 80 OO | 08000 MALPRACTICE PREMIUMS & PAID LOSSES | | | 80.00 |
| | 08100 I NTEREST EXPENSE | | | 81.00 |
| 82. 00 | 08200 UTILIZATION REVIEW - SNF | | | 82. 00 |
| | l l | | | 83. 00 |
| 89. 00 | I I | 1, 286, 110 | | 89. 00 |
| 09.00 | | 1, 200, 110 | | 1 09.00 |
| 00 00 | NONREI MBURSABLE COST CENTERS | 250 | | 00.00 |
| 90.00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 250 | | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | 0 | | 91.00 |
| 92. 00 | 09200 PHYSI CLANS PRI VATE OFFI CES | 0 | | 92.00 |
| 93. 00 | 09300 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 | 1, 286, 360 | | 100. 00 |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10 Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: Provi der No.: 315404

| | | | | ' | 0 00/30/2022 | 11/29/2022 11 | |
|------------------|---------------------------------------------------------------------------|------------------|------------|----------------------|----------------|----------------------|------------------|
| | | CAPI TAL REI | ATED COSTS | | | | |
| | Cost Center Description | BLDGS & | MOVABLE | EMPLOYEE | Reconciliation | ADMINISTRATIVE | |
| | cost center bescription | FIXTURES | EQUI PMENT | BENEFITS | Reconciliation | & GENERAL | |
| | | (SQUARE FEET) | | (GROSS | | (ACCUM COST) | |
| | | | | SALARI ES) | | , , | |
| | CENEDAL CEDALCE COCT CENTEDO | 1.00 | 2.00 | 3. 00 | 4A | 4. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS - BLDGS & FIXTURES | 147, 118 | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS - MOVABLE EQUI PMENT | 117,110 | 0 | | | | 2. 00 |
| 3.00 | 00300 EMPLOYEE BENEFITS | 0 | 0 | 7, 908, 986 | , | | 3. 00 |
| 4.00 | 00400 ADMINISTRATIVE & GENERAL | 6, 384 | l | 1, 037, 692 | | | 4. 00 |
| 5.00 | 00500 PLANT OPERATION, MAINT. & REPAIRS | 1, 948 | | 387, 568 | | 1, 326, 275 | 1 |
| 6. 00 7. 00 | 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING | 2, 380 1, 082 | l . | 110, 799 329, 629 | | 187, 824 663, 327 | 6. 00 7. 00 |
| 8. 00 | 00800 DI ETARY | 4, 544 | l . | 692, 391 | | 2, 029, 334 | 8.00 |
| 9. 00 | 00900 NURSING ADMINISTRATION | 0 | Ö | C | | 0 | 9. 00 |
| 10. 00 | 01000 CENTRAL SERVICES & SUPPLY | 0 | 0 | C | 0 | 0 | 10. 00 |
| 11. 00 | 01100 PHARMACY | 0 | 0 | O | 0 | 0 | 11.00 |
| 12. 00 13. 00 | 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE | 541 | 0 | C 52, 621 | _ | 0 69, 931 | 12. 00 13. 00 |
| 14. 00 | 01400 NURSING AND ALLIED HEALTH EDUCATION | 0 | 0 | 32, 021 | 0 | 09, 931 | 14. 00 |
| 15. 00 | 01500 ACTI VI TI ES | 2, 597 | Ö | 170, 655 | 0 | 266, 934 | 1 |
| 15. 01 | 01501 CHAPLAI N | 0 | 0 | 62, 583 | 0 | 78, 707 | 15. 01 |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 07.000 | | | 1 | | |
| 30. 00 31. 00 | 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY | 27, 382 | 0 | , | | | 30.00 |
| 32. 00 | 03200 CF/IID | 0 | | - | | - | 1 |
| 33. 00 | 03300 OTHER LONG TERM CARE | 98, 544 | Ö | _ | _ | - | 1 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 40.00 | 04000 RADI OLOGY | 0 | 0 | _ | | | |
| 41. 00 42. 00 | 04100 LABORATORY 04200 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 13, 547 0 | 41. 00 42. 00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 0 | 0 | 77, 227 | 0 | 95, 860 | 1 |
| 44. 00 | 04400 PHYSI CAL THERAPY | 1, 716 | Ö | 227, 447 | | 355, 458 | |
| 45.00 | 04500 OCCUPATI ONAL THERAPY | 0 | 0 | 192, 285 | 0 | 281, 693 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | 0 | 0 | 128, 308 | | 179, 138 | |
| 47. 00 48. 00 | 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 0 | | 0 | 0 27, 667 | 47. 00 48. 00 |
| 49. 00 | 04900 DRUGS CHARGED TO PATTENTS | 0 | 0 | | 0 | 138, 868 | |
| 50.00 | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | Ö | o c | - | | 50.00 |
| 51.00 | 05100 SUPPORT SURFACES | 0 | 0 | C | 0 | 0 | 51.00 |
| | OUTPATIENT SERVICE COST CENTERS | | _ | _ | 1 | | |
| 60. 00 61. 00 | 06000 CLINIC 06100 RURAL HEALTH CLINIC | 0 | 0 | _ | | | 60. 00 61. 00 |
| | 06200 FQHC | 0 | 0 | | 0 | 0 | 62.00 |
| 02.00 | OTHER REIMBURSABLE COST CENTERS | | | | II. | | 02.00 |
| 70.00 | 07000 HOME HEALTH AGENCY COST | 0 | 0 | C | 0 | 0 | 70. 00 |
| 71. 00 | 07100 AMBULANCE | 0 | 0 | _ | | | 71.00 |
| 73. 00 | 07300 CMHC SPECIAL PURPOSE COST CENTERS | 0 | 0 | C | 0 | 0 | 73.00 |
| 80. 00 | 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | | | | | | 80.00 |
| 81.00 | 08100 NTEREST EXPENSE | | | | | | 81.00 |
| 82. 00 | 08200 UTILIZATION REVIEW - SNF | | | | | | 82. 00 |
| 83.00 | 08300 H0SPI CE | 0 | 0 | _ | 0 | | |
| 89. 00 | SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS | 147, 118 | 0 | 7, 873, 548 | -3, 270, 364 | 13, 518, 999 | 89. 00 |
| 90. 00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 0 | 0 | 35, 438 | 0 | 60, 881 | 90.00 |
| 91.00 | 09100 BARBER AND BEAUTY SHOP | 0 | Ö | | | | 1 |
| 92. 00 | 09200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | C | 0 | 0 | |
| 93. 00 | 09300 NONPAI D WORKERS | 0 | 0 | C | 0 | 0 | 93. 00 |
| 94. 00 98. 00 | 09400 PATIENTS LAUNDRY Cross Foot Adjustments | | " | | 1 | 0 | 94. 00 98. 00 |
| 99. 00 | Negative Cost Centers | | | | | | 99.00 |
| 102.00 | | 1, 286, 360 | О | 1, 890, 824 | | 3, 270, 364 | |
| | Part I) | | | | | | |
| 103.00 | | 8. 743730 | 0. 000000 | 0. 239073 | | 0. 240824 | |
| 104.00 | Cost to be allocated (per Wkst. B, Part II) | | | | 1 | 55, 820 | 104. 00 |
| 105.00 | 1 1 1 | | | 0. 000000 | | 0. 004110 | 105. 00 |
| | | | | | | | |
| | | | | | | | |

COST ALLOCATION - STATISTICAL BASIS

Provider No.: 315404 | Period:

Period: Worksheet B-1 From 07/01/2021

06/30/2022 Date/Time Prepared: 11/29/2022 11:11 am Cost Center Description PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG (SQUARE FEET) (MEALS SERVED) ADMINISTRATION OPERATI ON, LINEN SERVICE MAINT. & (POUNDS OF REPAI RS LAUNDRY) (DI RECT (SQUARE FEET) NURSI NG) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FLXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 1.00 1.00 2.00 2.00 00300 EMPLOYEE BENEFITS 3.00 3.00 00400 ADMINISTRATIVE & GENERAL 4.00 4.00 00500 PLANT OPERATION, MAINT. & REPAIRS 138, 786 5.00 5.00 00600 LAUNDRY & LINEN SERVICE 6.00 2, 380 378, 505 6.00 7.00 00700 HOUSEKEEPI NG 1,082 135, 324 7.00 8.00 00800 DI ETARY 4,544 4,544 111, 419 8.00 00900 NURSING ADMINISTRATION 9 00 0 C 0 0 9 00 10.00 01000 CENTRAL SERVICES & SUPPLY 0 0 0 0 10.00 11.00 01100 PHARMACY 0 C 0 0 11.00 01200 MEDICAL RECORDS & LIBRARY 0 12.00 0 0 0 12.00 01300 SOCIAL SERVICE 13 00 541 13 00 541 0 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION C C 0 0 14.00 01500 ACTI VI TI ES 15.00 2,597 2, 597 0 0 15.00 01501 CHAPLAI N 15 01 0 15 01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 27, 382 302, 804 27, 382 47, 754 0 30.00 03100 NURSING FACILITY 31.00 0 31.00 03200 | CF/IID 32 00 32 00 0 0 0 0 03300 OTHER LONG TERM CARE 33.00 98, 544 75, 701 98, 544 63, 665 0 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY Э 0 0 О 0 40.00 04100 LABORATORY 0 0 0 41.00 41.00 Ω 0 42.00 04200 I NTRAVENOUS THERAPY 0 0 0 0 0 42.00 04300 OXYGEN (INHALATION) THERAPY 0 43.00 43.00 0 0 04400 PHYSI CAL THERAPY 44.00 1,716 1,716 0 44.00 04500 OCCUPATIONAL THERAPY 45.00 0 0 0 45.00 46.00 04600 SPEECH PATHOLOGY 0 0 0 0 0 0 46.00 04700 ELECTROCARDI OLOGY 0 47.00 0 47.00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 48.00 0 0 04900 DRUGS CHARGED TO PATIENTS 0 0 49 00 C Λ 49 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 05100 SUPPORT SURFACES 51.00 0 0 ol 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 n O Λ 60.00 61.00 06100 RURAL HEALTH CLINIC 0 C 0 0 0 61.00 06200 FQHC 62.00 62.00 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 07300 CMHC 73.00 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 08200 UTILIZATION REVIEW - SNF 82.00 82.00 83.00 08300 H0SPI CE 0 83.00 SUBTOTALS (sum of lines 1-84) 89.00 138, 786 378, 505 135, 324 111, 419 0 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 90.00 91.00 09100 BARBER AND BEAUTY SHOP 0 C 0 0 0 91.00 09200 PHYSICIANS PRIVATE OFFICES 0 92.00 0 0 0 92.00 0 0 o 93 00 09300 NONPALD WORKERS 0 93.00 Ω 0 09400 PATIENTS LAUNDRY 94.00 0 0 0 0 94.00 98.00 Cross Foot Adjustments 98.00 99.00 Negative Cost Centers 99.00 102.00 Cost to be allocated (per Wkst. B, 1, 645, 674 261, 278 835, 902 2, 599, 995 0 102 00 Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 11.857637 0.690289 6. 177042 23. 335293 0.000000 103.00 104.00 Cost to be allocated (per Wkst. B, 22, 484 21, 968 12, 362 49, 224 0 104.00 Part II) 0.162005 0.058039 0.000000 105.00 105 00 Unit cost multiplier (Wkst. B, Part 0.091351 0 441792 II)

| | ALLOCATION STATISTICAL DAGLE | COLLINGSWOO | | No . 215404 | | Washabaat D 1 | |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------|-------------------------------------------------|-------------------------------|-----------------------------------------------------------------|------------------|
| | ALLOCATION - STATISTICAL BASIS | | | Į. | | Worksheet B-1 Date/Time Pre 11/29/2022 11 | pared: |
| | Cost Center Description | CENTRAL SERVI CES & SUPPLY (COSTED REQUI S) | PHARMACY (COSTED REQUIS) | MEDICAL RECORDS & LIBRARY (TIME SPENT) | SOCIAL SERVICE (PATIENT DAYS) | NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME) | |
| | | 10.00 | 11. 00 | 12. 00 | 13. 00 | 14. 00 | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 15. 00 15. 00 | 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY | 0 0 0 0 0 | 000000000000000000000000000000000000000 | | 15, 918 0 0 0 0 0 | 0 | 15. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 31. 00 32. 00 | 03200 ICF/IID 03300 OTHER LONG TERM CARE | 0 0 0 0 | 0 0 0 0 | | 0 15, 918 0 0 0 0 | 0 0 0 0 | 31. 00 32. 00 |
| 40. 00 | ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY | | 0 | | ol o | 0 | 40.00 |
| 41. 00 | 1 | | 0 | | | 0 | |
| | 04200 I NTRAVENOUS THERAPY | 0 | 0 | 1 | 0 | 0 | 1 00 |
| 43. 00 44. 00 | | 0 | 0 | | 0 | 0 | 43. 00 44. 00 |
| 45. 00 | | | 0 | | | 0 | 45. 00 |
| 46. 00 | 04600 SPEECH PATHOLOGY | O | 0 | | 0 | 0 | 46. 00 |
| | 04700 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 47. 00 |
| 48.00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 0 | 48. 00 49. 00 |
| 50.00 | + I | | 0 | | | 0 | 1 |
| 51.00 | 05100 SUPPORT SURFACES | O | 0 |) (| 0 | 0 | 51.00 |
| (0.00 | OUTPATIENT SERVICE COST CENTERS | | | 1 , | | | (0.00 |
| 60. 00 61. 00 | 1 1 | 0 | 0 | | 0 0 | | |
| 62. 00 | 1 1 | | Ö | Ì | | | 62. 00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 70.00 | 07000 HOME HEALTH AGENCY COST 07100 AMBULANCE | 0 | 0 | | 0 0 | 0 | |
| | 07300 CMHC | | 0 | 1 | | | 73.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 80. 00 81. 00 | | | | | | | 80. 00 81. 00 |
| 82. 00 | I I | | | | | | 82.00 |
| 83. 00 | 08300 HOSPI CE | o | 0 | | 0 | 0 | 83. 00 |
| 89. 00 | SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS | 0 | 0 |) (| 15, 918 | 0 | 89. 00 |
| 90. 00 | 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN | O | 0 | | 0 0 | 0 | 90.00 |
| 91. 00 | 09100 BARBER AND BEAUTY SHOP | o | 0 |) (| 0 | 0 | 91. 00 |
| 92.00 | · · · · · · · · · · · · · · · · · · · | 0 | 0 | | 0 | 0 | 1 |
| 93. 00 94. 00 | · · · · · · · · · · · · · · · · · · · | | 0 | | | 0 | |
| 98. 00 | | | | | | _ | 98. 00 |
| 99.00 | | | 0 | | 0/ 520 | 0 | 99.00 |
| 102.00 | Cost to be allocated (per Wkst. B, Part I) | | 0 | | 96, 529 | 0 | 102. 00 |
| 103.00 | Unit cost multiplier (Wkst. B, Part I) | 0. 000000 | 0. 000000 | 0.000000 | | 0. 000000 | 1 |
| 104.00 | Cost to be allocated (per Wkst. B, Part II) | 0 | 0 | | 5, 154 | 0 | 104. 00 |
| 105.00 | Unit cost multiplier (Wkst. B, Part | 0. 000000 | 0. 000000 | 0.000000 | 0. 323784 | 0. 000000 | 105. 00 |
| | 11) | | | I | | | I |
| | | | | | | | |

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared: Provi der No.: 315404

| 11/29/2022 OTHER GENERAL SERVICE | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| (PATIENT DAYS) (PATIENT DAYS) | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 |
| (PATIENT DAYS) (PATIENT DAYS) | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 |
| GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS - BLDGS & FIXTURES 2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 |
| 1. 00 00100 CAP REL COSTS - BLDGS & FLXTURES 2. 00 00200 CAP REL COSTS - MOVABLE EQUIPMENT | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 |
| 2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 |
| 3.00 00300 EMPLOYEE BENEFITS | 4. 00 5. 00 6. 00 7. 00 8. 00 |
| | 5. 00 6. 00 7. 00 8. 00 |
| 4. 00 00400 ADMINI STRATI VE & GENERAL | 6. 00 7. 00 8. 00 |
| 5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE | 7. 00 8. 00 |
| 7. 00 00700 HOUSEKEEPI NG | 8. 00 |
| 8. 00 00800 DI ETARY | |
| 9. 00 00900 NURSI NG ADMI NI STRATI ON | 9. 00 |
| 10. 00 01000 CENTRAL SERVI CES & SUPPLY 11. 00 01100 PHARMACY | 10.00 |
| 12. 00 01200 MEDI CAL RECORDS & LI BRARY | 12.00 |
| 13. 00 01300 SOCI AL SERVI CE | 13. 00 |
| 14.00 01400 NURSING AND ALLIED HEALTH EDUCATION | 14. 00 |
| 15. 00 01500 ACTIVITIES 15, 918 15, 01 01501 CHAPLAIN 0 49, 745 | 15.00 |
| 15. 01 01501 CHAPLAI N 0 49, 745 I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 15. 01 |
| 30. 00 03000 SKI LLED NURSI NG FACI LI TY 15, 918 15, 918 | 30.00 |
| 31. 00 03100 NURSI NG FACI LI TY 0 0 | 31. 00 |
| 32. 00 03200 I CF/I I D | 32.00 |
| 33. 00 03300 0THER LONG TERM CARE 0 33, 827 ANCI LLARY SERVI CE COST CENTERS | 33. 00 |
| 40. 00 04000 RADI OLOGY 0 0 | 40. 00 |
| 41. 00 04100 LABORATORY 0 0 | 41. 00 |
| 42. 00 04200 I NTRAVENOUS THERAPY 0 0 0 | 42. 00 |
| 43. 00 04300 0XYGEN (I NHALATI ON) THERAPY 0 0 0 440. 00 04400 PHYSI CAL THERAPY 0 0 0 | 43. 00 44. 00 |
| 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 | 45. 00 |
| 46. 00 04600 SPEECH PATHOLOGY 0 0 | 46. 00 |
| 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 | 47. 00 48. 00 |
| 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 49. 00 |
| 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 | 50.00 |
| 51. 00 05100 SUPPORT SURFACES 0 0 | 51. 00 |
| OUTPATIENT SERVICE COST CENTERS | 60.00 |
| 61. 00 06100 RURAL HEALTH CLINIC 0 0 | 61.00 |
| 62. 00 06200 FOHC | 62. 00 |
| OTHER REIMBURSABLE COST CENTERS | 70.00 |
| 70. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 | 70. 00 71. 00 |
| 73. 00 07300 CMHC 0 0 | 73.00 |
| SPECIAL PURPOSE COST CENTERS | |
| 80. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES | 80.00 |
| 81. 00 08100 INTEREST EXPENSE 82. 00 08200 UTI LI ZATI ON REVI EW - SNF | 81. 00 82. 00 |
| 83. 00 08300 HOSPI CE 0 0 | 83. 00 |
| 89.00 SUBTOTALS (sum of lines 1-84) 15,918 49,745 | 89. 00 |
| NONREI MBURSABLE COST CENTERS 90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 | |
| 90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 91. 00 09100 BARBER AND BEAUTY SHOP 0 0 | 90.00 |
| 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 | 92. 00 |
| 93. 00 09300 NONPALD WORKERS 0 0 | 93. 00 |
| 94. 00 09400 PATI ENTS LAUNDRY 0 0 | 94.00 |
| 98.00 Cross Foot Adjustments 99.00 Negative Cost Centers | 98. 00 99. 00 |
| 102.00 Cost to be allocated (per Wkst. B, 378,054 97,662 | 102. 00 |
| Part I) | |
| 103.00 Unit cost multiplier (Wkst. B, Part I) 23.750094 1.963253 | 103.00 |
| 104.00 Cost to be allocated (per Wkst. B, 24,462 323 | 104. 00 |
| 105.00 Unit cost multiplier (Wkst. B, Part 1.536751 0.006493 | 105. 00 |
| | |

| Heal th | Fi nanci al | Systems | | | COL | LI NGSWOOD | MANOR | | In Lie | eu of Form CMS-2 | 2540-10 |
|---------|-------------|---------------|--------------|----------------|------|------------|-----------|---------------|-----------------|------------------|---------------|
| RATI 0 | OF COST TO | CHARGES FOR | ANCI LLARY A | AND OUTPATIENT | COST | CENTERS | Provi der | | Peri od: | Worksheet C | |
| | | | | | | | | I . | From 07/01/2021 | | |
| | | | | | | | | | To 06/30/2022 | Date/Time Pre | pared: |
| | | | | | | | | | | 11/29/2022 11 | <u>:11 am</u> |
| | Cost | Center Desci | ription | | | | | Total (from | Total Charges | Ratio (col. 1 | |
| | | | | | | | | Wkst. B, Pt I | , | di vi ded by | |
| | | | | | | | | col . 18) | | col. 2 | |
| | | | | | | | | 1.00 | 2. 00 | 3. 00 | |
| | ANCI LLARY | SERVI CE COST | CENTERS | | | | | | | | |
| 40.00 | 04000 RADI | OLOGY | | | | | | 6, 66 | 2 5, 369 | 1. 240827 | 40.00 |
| 41.00 | 04100 LABC | RATORY | | | | | | 16, 80 | 9 16, 793 | 1. 000953 | 41.00 |
| 42.00 | 04200 I NTR | AVENOUS THER | APY | | | | | | o c | 0.000000 | 42.00 |
| 43.00 | 04300 0XYG | EN (INHALATIO | ON) THERAPY | | | | | 118, 94 | 5 77, 397 | 1. 536817 | 43.00 |

| Health Financial Systems | | COLLI NGSWO | OD MANOR | | In Li∈ | eu of Form CMS- | 2540-10 |
|-------------------------------------|-------------------------|----------------------------------------------------------|-----------------|----------------|----------------------------------------------|---------------------------------------------------------|-------------------|
| APPORTIONMENT OF ANCILLARY A | ND OUTPATIENT COSTS | | Provi der | No.: 315404 | Peri od: From 07/01/2021 To 06/30/2022 | Worksheet D Part I Date/Time Pre 11/29/2022 11 | epared: :11 am |
| | | | Title | XVIII (1) | Skilled Nursing Facility | | |
| | | | Heal th Care Pr | rogram Charge: | | Program Cost | |
| | | Ratio of Cost to Charges (Fr. Wkst. C Column 3) | Part A | Part B | Part A (col. 1 x col. 2) | Part B (col. 1 x col. 3) | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | OF ANCILLARY AND OUTPAT | TENT COST | | | | | |
| ANCILLARY SERVICE COST | Γ CENTERS | | | | | | |
| 40. 00 04000 RADI OLOGY | | 1. 240827 | 3, 316 | | 0 4, 115 | | |
| 41. 00 04100 LABORATORY | | 1. 000953 | 15, 522 | | 0 15, 537 | 0 | 1 |
| 42.00 04200 I NTRAVENOUS THEF | | 0. 000000 | 0 | | 0 | 0 | 1 .2.00 |
| 43.00 04300 0XYGEN (I NHALATI | | 1. 536817 | 0 | | 0 | 0 | 1 .0.00 |
| 44.00 04400 PHYSI CAL THERAPY | | 1. 299398 | 212, 725 | | 0 276, 414 | | 44. 00 |
| 45. 00 04500 OCCUPATI ONAL THE | | 1. 298517 | 177, 582 | | 0 230, 593 | l . | 45. 00 |
| 46.00 04600 SPEECH PATHOLOGY | | 1. 779941 | 81, 300 | | 0 144, 709 | 0 | 46. 00 |
| 47. 00 04700 ELECTROCARDI OLOG | | 0. 000000 | 0 | | 0 | 0 | 47. 00 |
| 48. 00 04800 MEDI CAL SUPPLI ES | | 1. 240828 | 0 | | 0 | 0 | 48. 00 |
| 49. 00 04900 DRUGS CHARGED TO | | 1. 240817 | 129, 937 | | 0 161, 228 | 0 | 49. 00 |
| 50. 00 05000 DENTAL CARE - TI | | 0. 000000 | 0 | | 0 | _ | 50.00 |
| 51. 00 05100 SUPPORT SURFACES | | 0. 000000 | 0 | | 0 0 | 0 | 51.00 |
| OUTPATIENT SERVICE COS | ST CENTERS | | | | | | |
| 60. 00 06000 CLINIC | NII O | 0. 000000 | 0 | | 0 | 0 | |
| 61. 00 06100 RURAL HEALTH CLI | NIC | | | | | | 61.00 |
| 62. 00 06200 FQHC | | 0.000000 | | | | | 62.00 |
| 71. 00 07100 AMBULANCE (2) | 71) | 0. 000000 | | | 0 022 504 | l | 71.00 |
| 100.00 Total (Sum of Ii | • | 1 | 620, 382 | I | 0 832, 596 | l 0 | 100. 00 |
| (1) For title V and XIX use | columns 1, 2, and 4 onl | у. | | | | | |

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

| Heal th | Financial Systems | COLLI NGSWO | OOD MANOR | | In Lie | u of Form CMS-2 | 2540-10 |
|---------|----------------------------------------------|----------------|----------------|----------------|----------------------------------------------|-----------------------------|---------|
| | IONMENT OF ANCILLARY AND OUTPATIENT COSTS | | Provi der | No.: 315404 | Peri od: From 07/01/2021 To 06/30/2022 | Worksheet D Parts II-III | pared: |
| | | | Ti tl | e XVIII | Skilled Nursing Facility | PPS | |
| | Cost Center Description | | | | | 1. 00 | |
| | PART II - APPORTIONMENT OF VACCINE COST | | | | | 11.00 | |
| 1.00 | Drugs charged to patients - ratio of co | st to charges | (From Workshee | t C. column 3 | . line 49) | 1. 240817 | 1.00 |
| 2.00 | Program vaccine charges (From your reco | | | , | , | 0 | |
| 3.00 | Program costs (Line 1 x line 2) (Title | | | 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 | Part A Nursing | |
| | · | (From Wkst. B, | Allied Health | Nursing & | Cost (From | & Allied | |
| | | Part I, Col. | (From Wkst. B, | Allied Healt | h Wkst. D Part | Health Costs | |
| | | 18 | Part I, Col. | Costs to Tota | , , , , , , , , , , , , , , , , , , , , | for Pass | |
| | | | 14) | Costs - Part | | Through (Col. | |
| | | | | (Col . 2 / Col | | 3 x Col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - CALCULATION OF PASS THROUGH COSTS | | | 0.00 | | 0.00 | |
| | ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 40.00 | 04000 RADI OLOGY | 6, 662 | C | 0.0000 | 00 4, 115 | 0 | 40.00 |
| 41.00 | 04100 LABORATORY | 16, 809 | l c | 0. 00000 | | 0 | 41.00 |
| 42.00 | 04200 I NTRAVENOUS THERAPY | 0 | l c | 0. 00000 | 00 | 0 | 42. 00 |
| 43.00 | 04300 OXYGEN (INHALATION) THERAPY | 118, 945 | l c | 0. 00000 | 00 | 0 | 43.00 |
| 44.00 | 04400 PHYSI CAL THERAPY | 472, 009 | C | 0. 00000 | 276, 414 | 0 | 44. 00 |
| 45.00 | 04500 OCCUPATI ONAL THERAPY | 349, 531 | C | 0.0000 | 230, 593 | 0 | 45. 00 |
| 46.00 | 04600 SPEECH PATHOLOGY | 222, 279 | C | 0.0000 | 144, 709 | 0 | 46. 00 |
| 47.00 | 04700 ELECTROCARDI OLOGY | 0 | C | 0. 00000 | 00 | 0 | 47. 00 |
| 48.00 | 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS | 34, 330 | C | 0.00000 | | 0 | |
| 49.00 | 04900 DRUGS CHARGED TO PATIENTS | 172, 311 | [C | 0.00000 | | 0 | 49. 00 |
| | 05000 DENTAL CARE - TITLE XIX ONLY | 0 | C | 0.0000 | | 0 | 50.00 |
| | 05100 SUPPORT SURFACES | 0 | C | 0.0000 | | 0 | 51.00 |
| 100. 00 | Total (Sum of lines 40 - 52) | 1, 392, 876 | [c | P | 832, 596 | 0 | 100. 00 |

| eal th | Financial Systems COLLI | NGSWOOD MANOR | In Lie | eu of Form CMS- | 2540-1 |
|---------|------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------|-----------------|--------|
| COMPUTA | ATION OF INPATIENT ROUTINE COSTS | Provi der No.: 31540 | 4 Period: From 07/01/2021 To 06/30/2022 | | pared: |
| | | Title XVIII | Skilled Nursing Facility | | |
| | | | | 1.00 | |
| | PART I CALCULATION OF INPATIENT ROUTINE COSTS | | | 1.00 | |
| Ī | I NPATI ENT DAYS | | | | 1 |
| | Inpatient days including private room days | | | 15, 918 | |
| | Private room days | | | 0 | |
| | Inpatient days including private room days applicable | | | 2, 740 | |
| | Medically necessary private room days applicable to the | ne Program | | 0 | l |
| | Total general inpatient routine service cost | | | 7, 465, 570 | 5.0 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges | | | 9, 210, 883 | 6.0 |
| | General inpatient routine service charges General inpatient routine service cost/charge ratio | (line 5 divided by line 6) | | 0. 810516 | |
| | Enter private room charges from your records | (Erric o di vi ded by Title o) | | 0.010010 | |
| | Average private room per diem charge (Private room cha | arges line 8 divided by privat | e room davs. line | 0.00 | |
| | 2) | | | | |
| | | | | | |
| 1. 00 | | | | | |
| 2 00 | semi -private room days) | as O minus line 11) | | 0.00 | 12 (|
| | Average per diem private room charge differential (Lin Average per diem private room cost differential (Line | | | 0.00 | 12. (|
| | Private room cost differential adjustment (Line 2 time | | | 0.00 | |
| 1 | General inpatient routine service cost net of private | · · | 5 minus line 14) | 7, 465, 570 | |
| | PROGRAM INPATIENT ROUTINE SERVICE COSTS | <u> </u> | | ., | 1 |
| | Adjusted general inpatient service cost per diem (Line | e 15 divided by line 1) | | 469.00 | 16. (|
| | Program routine service cost (Line 3 times line 16) | | | 1, 285, 060 | 1 |
| | Medically necessary private room cost applicable to pr | <i>,</i> | | 0 | |
| | Total program general inpatient routine service cost | | | 1, 285, 060 | |
| 0. 00 | Capital related cost allocated to inpatient routine so line 30 for SNF; line 31 for NF, or line 32 for ICF/II | | art II column 18, | 331, 789 | 20. (|
| 1. 00 | Per diem capital related costs (Line 20 divided by li | • | | 20. 84 | 21. (|
| | Program capital related costs (Line 3 times line 21) | ne i) | | 57, 102 | 1 |
| | Inpatient routine service cost (Line 19 minus line 22 | 2) | | 1, 227, 958 | |
| | Aggregate charges to beneficiaries for excess costs | | | 0 | 1 |
| . 00 | Total program routine service costs for comparison to | the cost limitation (Line 23 | minus line 24) | 1, 227, 958 | 25. |
| | Enter the per diem limitation (1) | | | | 26. |
| | Inpatient routine service cost limitation (Line 3 time | | | | 27. |
| 3. 00 | Reimbursable inpatient routine service costs (Line 22 | | r line 27) | | 28. |
| | (Transfer to Worksheet E, Part II, line 4) (See instrumes 26 and 27 are not applicable for title XVIII, but it | • | | I | I |

| | | 1. 00 | |
|------|----------------------------------------------------------------------------------------------|-----------|-------|
| | PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH | | |
| 1.00 | Total SNF inpatient days | 15, 918 | 1.00 |
| 2.00 | Program inpatient days (see instructions) | 2, 740 | 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. 172132 | 4. 00 |
| 5.00 | Program nursing & allied health costs for pass-through. (line 3 times line 4) | 0 | 5. 00 |
| | | | |

| PART I CALCULATION OF INPATIENT ROUTINE COSTS PART I CALCULATION OF INPATIENT ROUTINE COSTS | | Period: From 07/01/2021 To 06/30/2022 | W 1 1 1 5 5 | 2540- |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------|---------------------------------------------------------------|-------|
| PART I CALCULATION OF INPATIENT ROUTINE COSTS INPATIENT DAYS Inpatient days including private room days Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by 2) Enter semi-private room charges from your records Average semi-private room charges from your records Average semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost per diem (Line 15 divided by line 1) Program routine service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) B. 00 Medically necessary private room cost applicable to program (line 4 times line 30 for SNF: line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 20 divided by line 1) Program capital related costs (Line 31 times line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service cost (Line 22 plus the lesser | XI X | 10 00/30/2022 | Worksheet D-1 Parts I-II Date/Time Pre 11/29/2022 11 | pare |
| INPATIENT DAYS Inpatient days including private room days Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by 2) D.O. Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10 semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capital related cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Cotal program routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capital related cost (Line 20 divided by line 1) Program capi | | Skilled Nursing Facility | Cost | |
| INPATIENT DAYS | | | 1. 00 | |
| Inpatient days including private room days Private room days Inpatient days including private room days applicable to the Program Medically necessary private room days applicable to the Program Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges General inpatient routine service cost/charge ratio (Line 5 divided by line Enter private room charges from your records Average private room per diem charge (Private room charges line 8 divided by 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10 semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related cost (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 17 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service cost sorts (From provider records) Total program routine service cost (Line 3 times line 21) Inpatient routine service cost (Line 3 times the per diem limitation (Line 10 times to the cost limitation (Line 11 program routine service cost (Line 22 plus the lesser of line (Line 15 times the per diem limitation (Line 16 times to worksheet E, Part II, Iine 4) (See instructions) | | | 11 00 | |
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| Average private room per diem charge (Private room charges line 8 divided by 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10 semi-private room days) Average per diem private room charge differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times li Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Program capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service cost for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | e 6) | | 0. 810516 | |
| 2) Enter semi-private room charges from your records Average semi-private room per diem charge (Semi-private room charges line 10 semi-private room days) Average per diem private room cost differential (Line 9 minus line 11) Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 10) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service cost for comparison to the cost limitation (Line 10 linpatient routine service cost limitation (Line 20 line 22 plus the lesser of line (Transfer to Worksheet E, Part II, line 4) (See instructions) | , | | 0 | 8 |
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| Average per diem private room cost differential (Line 7 times line 12) Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times li Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | 0.00 | 12 |
| Private room cost differential adjustment (Line 2 times line 13) General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times line 10) Capital program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 20 times the per diem limitation (Line 21 times line 22) Inpatient routine service cost limitation (Line 3 times the per diem limitation (Line 22 plus the lesser of line (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | | |
| General inpatient routine service cost net of private room cost differential PROGRAM INPATIENT ROUTINE SERVICE COSTS Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times li Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | | |
| Adjusted general inpatient service cost per diem (Line 15 divided by line 1) Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times li Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | (Line 5 | minus line 14) | 7, 465, 570 | 15 |
| Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to program (line 4 times li Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) |) | | 469.00 | 16 |
| Total program general inpatient routine service cost (Line 17 plus line 18) Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | , | | 2, 095, 492 | |
| Capital related cost allocated to inpatient routine service costs (From Wkst line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | ine 13) | | 0 | 18 |
| line 30 for SNF; line 31 for NF, or line 32 for ICF/IID) Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Line 20) Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitation (Reimbursable inpatient routine service costs (Line 22 plus the lesser of limitation (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | 2, 095, 492 | |
| ON Per diem capital related costs (Line 20 divided by line 1) Program capital related cost (Line 3 times line 21) Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | st. B, Par | t II column 18, | 331, 789 | 20 |
| Inpatient routine service cost (Line 19 minus line 22) Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | 20. 84 | 21 |
| Aggregate charges to beneficiaries for excess costs (From provider records) Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | 93, 113 | |
| Total program routine service costs for comparison to the cost limitation (Li Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | 2, 002, 379 | |
| OD Enter the per diem limitation (1) Inpatient routine service cost limitation (Line 3 times the per diem limitati Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | 0 2, 002, 379 | |
| OU Inpatient routine service cost limitation (Line 3 times the per diem limitati OU Reimbursable inpatient routine service costs (Line 22 plus the lesser of lir (Transfer to Worksheet E, Part II, line 4) (See instructions) | | | | |
| OO Reimbursable inpatient routine service costs (Line 22 plus the lesser of line (Transfer to Worksheet E, Part II, line 4) (See instructions) | ine 23 mi | 24) (1) | 0. 00 0 | 1 |
| (Transfer to Worksheet E, Part II, line 4) (See instructions) | | , , , | 2, 095, 492 | |
| | ion line | 11116 27) | 2,073,472 | 20 |
| | ion line | itle XIX | | |
| | ion line ne 25 or | | 1. 00 | |
| PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-T | ion line ne 25 or | | | |
| Total SNF inpatient days | ion line ne 25 or / and or t | | 15, 918 | |
| Program inpatient days (see instructions) | ion line ne 25 or / and or t | | | 2 |
| Total nursing & allied health costs. (see instructions)(Do not complete for t | ion line ne 25 or / and or t | | 4, 468 | |
| ON Nursing & allied health ratio. (line 2 divided by line 1) ON Program nursing & allied health costs for pass-through. (line 3 times line 4) | ion line ne 25 or / and or t | or XIX) | | 1 ~ |

| Health Financial Systems | COL | LINGSWOOD MANOR | | In Lieu | u of Form CMS-2540-10 |
|------------------------------|----------------------------|-----------------|--------|-----------------|------------------------------------------------------------|
| CALCULATION OF REIMBURSEMENT | SETTLEMENT FOR TITLE XVIII | Provi der No. : | 315404 | From 07/01/2021 | Worksheet E Part I Date/Time Prepared: 11/29/2022 11:11 am |

| | | | | 11/29/2022 11: | <u>:11 am</u> |
|--------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------|----------------|------------------|
| | | 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) | LIVILINI | | 1, 652, 736 | 1.00 |
| | Nursing and Allied Health Education Activities (pass through pa | vments) | | 1, 032, 730 | 1 |
| 1 | Subtotal (Sum of lines 1 and 2) | yments) | | 1, 652, 736 | 1 |
| 1 | Primary payor amounts | | | 1, 032, 730 | 1 |
| - 1 | Coi nsurance | | | 164, 778 | |
| | Allowable bad debts (From your records) | | | 0 | |
| | Allowable Bad debts for dual eligible beneficiaries (See instru | ctions) | | 0 | |
| | Adjusted reimbursable bad debts. (See instructions) | 011 01.07 | | 0 | |
| | Recovery of bad debts - for statistical records only | | | 0 | 1 |
| 1 | Utilization review | | | 0 | 1 |
| | Subtotal (See instructions) | | | 1, 487, 958 | 11.00 |
| | Interim payments (See instructions) | | | 1, 484, 571 | |
| | Tentati ve adjustment | | | 0 | 1 |
| 14. 00 | OTHER adjustment (See instructions) | | | 0 | 14. 00 |
| 14. 50 | Demonstration payment adjustment amount before sequestration | | | 0 | 14. 50 |
| 14. 55 | Demonstration payment adjustment amount after sequestration | | | 0 | 14. 55 |
| 14. 75 | Sequestration for non-claims based amounts (see instructions) | | | 0 | 14. 75 |
| 14. 99 | Sequestration amount (see instructions) | | | 3, 387 | 14. 99 |
| 15. 00 | Balance due provider/program (see Instructions) | | | 0 | 15. 00 |
| | Protested amounts (Nonallowable cost report items in accordance | | | 0 | 16. 00 |
| | PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER | OF COST OR CHARGES - T | TITLE XVIII ONLY | | |
| | Ancillary services Part B | | | 0 | |
| | Vaccine cost (From Wkst D, Part II, line 3) | | | 0 | 1 |
| | Total reasonable costs (Sum of lines 17 and 18) | | | 0 | |
| | Medicare Part B ancillary charges (See instructions) | | | 0 | |
| | Cost of covered services (Lesser of line 19 or line 20) | | | 0 | |
| | Primary payor amounts | | | 0 | |
| | Coinsurance and deductibles | | | 0 | |
| | Allowable bad debts (From your records) Allowable Bad debts for dual eligible beneficiaries (see instru | ctions) | | 0 | 24. 00 24. 01 |
| | Adjusted reimbursable bad debts (see instructions) | Ctrons) | | 0 | 1 |
| | Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) | | | 0 | |
| | Interim payments (See instructions) | | | 0 | |
| | | | | 0 | 1 |
| | Tentative adjustment Output Adjustments (See instructions) Specify | | | 0 | |
| | 0 Other Adjustments (See instructions) Specify 0 Demonstration payment adjustment amount before sequestration | | | 0 | 1 |
| | Demonstration payment adjustment amount after sequestration | | | 0 | |
| | Sequestration amount (see instructions) | | | 0 | 1 |
| | Balance due provider/program (see instructions) | | | 0 | |
| | Balance due provider/program (see instructions) Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2 | | | | |

| Health Financial Systems | COLLI NGSWOOD MA | ANOR | In Lie | u of Form CMS-2540-10 |
|-----------------------------------------|----------------------------|-----------------------|-----------------|-------------------------------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | TITLE V and TITLE XIX ONLY | Provi der No.: 315404 | From 07/01/2021 | Worksheet E Part II Date/Time Prepared: 11/29/2022 11:11 am |
| | | Title XIX | Skilled Nursing | Cost |

| | | Title XIX | Skilled Nursing | Cost | |
|------------------|--------------------------------------------------------------------------|------------------------|------------------|-------------|--------|
| | | | Facility | | |
| | | | - | 1. 00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | 1.00 | |
| 1.00 | Inpatient ancillary services (see Instructions) | | | 0 | 1.00 |
| 2.00 | Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line | 5) | | 0 | |
| 3.00 | Outpatient services | 3) | | 0 | 3.00 |
| 4. 00 | Inpatient routine services (see instructions) | | | 2, 095, 492 | |
| 5. 00 | Utilization reviewphysicians' compensation (from provider rec | ords) | | 0 | ł |
| 6. 00 | Cost of covered services (Sum of lines 1 - 5) | | | 2, 095, 492 | |
| 7. 00 | Differential in charges between semiprivate accommodations and | less than semiprivate | accommodations | 0 | 1 |
| 8.00 | SUBTOTAL (Line 6 minus line 7) | , | | 2, 095, 492 | |
| 9.00 | Primary payor amounts | | | 0 | 1 |
| 10.00 | Total Reasonable Cost (Line 8 minus line 9) | | | 2, 095, 492 | 10.00 |
| | REASONABLE CHARGES | | <u>'</u> | , , | |
| 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 | Aggregate amount actually collected from patients liable for pa | | | 0 | 16. 00 |
| 17. 00 | Amounts that would have been realized from patients liable for | payment for services o | n a charge basis | 0 | 17. 00 |
| | had such payment been made in accordance with 42 CFR 413.13(e) | | | | |
| 18. 00 | Ratio of line 16 to line 17 (not to exceed 1.000000) | | | 0. 000000 | 1 |
| 19. 00 | Total customary charges (see instructions) | | | 0 | 19. 00 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 20.00 | Cost of covered services (see Instructions) | | | 0 | |
| 21. 00 | Deductibles | | | 0 | |
| 22. 00 | Subtotal (Line 20 minus line 21) | | | 0 | |
| 23. 00 | Coinsurance | | | 0 | |
| 24. 00 25. 00 | Subtotal (Line 22 minus line 23) Allowable bad debts (from your records) | | | 0 | |
| 26. 00 | Subtotal (sum of lines 24 and 25) | | | 0 | |
| 27. 00 | Unrefunded charges to beneficiaries for excess costs erroneousl | v collected based on c | orrection of | 0 | |
| 27.00 | cost limit | y corrected based on c | orrection or | Ü | 27.00 |
| 28. 00 | Recovery of excess depreciation resulting from provider termina | tion or a decrease in | program | 0 | 28. 00 |
| 20.00 | lutilization | | program | Ü | 20.00 |
| 29. 00 | Other Adjustments (see instructions) Specify | | | 0 | 29. 00 |
| 30.00 | Amounts applicable to prior cost reporting periods resulting fr | om disposition of depr | eciable assets (| 0 | 30.00 |
| | if minus, enter amount in parentheses) | | `\ | | |
| 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 | heses) (see | 0 | 33. 00 |
| | Instructions) | | | | |
| | | | | | |

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der No.: 315404 Peri od: Worksheet E-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared: 11/29/2022 11:11 am Title XVIII Skilled Nursing PPS

| | | 11.61 | e AVIII | Facility | PPS | |
|----------------|----------------------------------------------------------------------------------------------|------------|-------------|------------|------------|----------------|
| | | Inpatien | t Part A | | t B | |
| | | | | | | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| 1 00 | Total interim normente poid to providen | 1. 00 | 2.00 | 3. 00 | 4.00 | 1 00 |
| 1. 00 2. 00 | Total interim payments paid to provider Interim payments payable on individual bills, either | | 1, 484, 571 | | 0 | 1. 00 2. 00 |
| 2.00 | submitted or to be submitted to the contractor for | | U | | 0 | 2.00 |
| | services rendered in the cost reporting period. If none, | | | | | |
| | enter zero | | | | | |
| 3.00 | List separately each retroactive lump sum adjustment | | | | | 3. 00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each | | | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | , | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | | 0 | | 0 | 3. 01 |
| 3. 02 | | | 0 | | 0 | 3. 02 |
| 3.03 | | | 0 | | 0 | 3. 03 |
| 3. 04 3. 05 | | | 0 | | 0 | 3. 04 3. 05 |
| 3.05 | Provider to Program | | U | | 0 | 3.03 |
| 3. 50 | ADJUSTMENTS TO PROGRAM | | 0 | | 0 | 3. 50 |
| 3. 51 | ABSOSTIMENTS TO TROOM III | | 0 | | l ő | 3. 51 |
| 3. 52 | | | 0 | | l o | 3. 52 |
| 3. 53 | | | 0 | | 0 | 3. 53 |
| 3.54 | | | 0 | | 0 | 3. 54 |
| 3.99 | Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 | | 0 | | 0 | 3. 99 |
| | - 3.98) | | | | | |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 1, 484, 571 | | 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 | | | | | |
| 5. 00 | List separately each tentative settlement payment after | | | | | 5. 00 |
| 3.00 | desk review. Also show date of each payment. If none, | | | | | 3.00 |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | • | |
| 5.01 | TENTATI VE TO PROVI DER | | 0 | | 0 | 5. 01 |
| 5.02 | | | 0 | | 0 | 5. 02 |
| 5.03 | | | 0 | | 0 | 5. 03 |
| | Provider to Program | | | | _ | |
| 5.50 | TENTATIVE TO PROGRAM | | 0 | | 0 | 5. 50 |
| 5. 51 | | | 0 | | 0 | 5. 51 |
| 5. 52 5. 99 | Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 | | 0 | | 0 | 5. 52 5. 99 |
| 5. 99 | - 5. 98) | | U | | 0 | 5. 99 |
| 6. 00 | Determined net settlement amount (balance due) based on | | | | | 6. 00 |
| 0.00 | the cost report. (1) | | | | | 0.00 |
| 6. 01 | PROGRAM TO PROVI DER | | 0 | | 0 | 6. 01 |
| 6.02 | PROVI DER TO PROGRAM | | 0 | | 0 | 6. 02 |
| 7.00 | Total Medicare program liability (see instructions) | | 1, 484, 571 | | 0 | 7. 00 |
| | | | Contract | or Name | Contractor | |
| | | | | | Number | |
| 0.00 | News of Combination | | 1. | 00 | 2. 00 | 0.00 |
| | Name of Contractor | | | | ١ | 8. 00 |

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

Health Financial Systems

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

| | | Conoral Fund | Coosi fi o | Indowment Fund | 11/29/2022 11: | : 11 ar |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------|----------------|----------------|---------|
| | | General Fund | Purpose Fund | Endowment Fund | Plant Fund | |
| As | ssets | 1.00 | 2. 00 | 3. 00 | 4. 00 | |
| | JRRENT ASSETS | | | | | |
| 1 | ash on hand and in banks | 61, 490 | 1 | 0 | 0 | |
| 1 | emporary investments | 0 | 0 | 0 | 0 | |
| | otes recei vabl e ccounts recei vabl e | 3, 690, 773 | 0 | 0 | 0 | |
| | ther receivables | 3,070,773 | | Ö | 0 | |
| | ess: allowances for uncollectible notes and accounts | -806, 300 | 0 | o | 0 | |
| 1 | ecei vabl e | | _ | | _ | l |
| 1 | nventory repai dexpenses | 90, 992 | 1 | 0 | 0 | |
| 1 | ther current assets | 127, 940 | 0 | 0 | 0 | |
| 1 | ue from other funds | 33, 054, 642 | 0 | ő | 0 | |
| 11. 00 TC | OTAL CURRENT ASSETS (Sum of lines 1 - 10) | 36, 219, 537 | 0 | o | 0 | 11. 0 |
| | XED ASSETS | | | | | |
| | and | 257, 870 | 1 | 0 | 0 | 1 |
| 1 | and improvements ess: Accumulated depreciation | 0 | 0 | 0 | 0 | |
| 1 | uildings | 25, 603, 297 | _ | 0 | 0 | 1 |
| | ess Accumulated depreciation | -15, 376, 161 | i o | o | 0 | |
| 17. 00 Le | easehold improvements | 0 | 0 | O | 0 | 17.0 |
| | ess: Accumulated Amortization | 0 | 0 | 0 | 0 | |
| | ixed equipment | 2, 451, 057 | | 0 | 0 | 1 |
| 1 | ess: Accumulated depreciation utomobiles and trucks | -1, 529, 969 | 1 | 0 | 0 | |
| 1 | ess: Accumulated depreciation | 205, 130 -187, 310 | | 0 | 0 | |
| | ajor movable equipment | 0 | ő | o | 0 | |
| 1 | ess: Accumulated depreciation | 0 | O | ō | 0 | |
| | inor equipment - Depreciable | 0 | 0 | O | 0 | |
| 1 | i nor equi pment nondepreci abl e | 0 | 0 | 0 | 0 | 1 |
| 1 | ther fixed assets | 0 | 0 | 0 | 0 | |
| | OTAL FIXED ASSETS (Sum of lines 12 - 27) THER ASSETS | 11, 423, 914 | 0 | U | 0 | 28.0 |
| | nvestments | 1 0 | 0 | ol | 0 | 29. 0 |
| 1 | eposits on leases | Ō | o | Ö | 0 | |
| 31. 00 Du | ue from owners/officers | 0 | 0 | o | 0 | 31.0 |
| | ther assets | 320, 144 | 1 | 0 | 0 | 1 |
| 1 | OTAL OTHER ASSETS (Sum of lines 29 - 32) | 320, 144 | | 0 | 0 | |
| _ | OTAL ASSETS (Sum of lines 11, 28, and 33) abilities and Fund Balances | 47, 963, 595 | ıl U | U | U | 34.0 |
| | JRRENT LI ABI LI TI ES | | | | | 1 |
| | ccounts payable | 678, 247 | 0 | 0 | 0 | 35. C |
| | alaries, wages, and fees payable | 963, 858 | 0 | 0 | 0 | 1 |
| | ayroll taxes payable | 0 | 0 | 0 | 0 | |
| | otes & loans payable (Short term) eferred income | 0 | | 0 | 0 | |
| | ccel erated payments | | | ٩ | O | 40.0 |
| | ue to other funds | 0 | О | o | 0 | |
| 42. 00 Ot | ther current liabilities | 1, 000 | 0 | O | 0 | |
| | OTAL CURRENT LIABILITIES (Sum of lines 35 - 42) | 1, 643, 105 | 0 | 0 | 0 | 43.0 |
| _ | ONG TERM LIABILITIES | 1 127 500 | | ما | 0 | 1,, , |
| 1 | ortgage payable otes payable | 1, 127, 599 2, 742, 117 | 1 | 0 | 0 | 1 |
| 1 | nsecured Loans | 2, 742, 117 | | 0 | 0 | |
| 1 | pans from owners: | Ö | Ö | o | 0 | |
| 48. 00 Ot | ther long term liabilities | 6, 726, 562 | 0 | o | 0 | 48.0 |
| 1 | THER (SPECIFY) | 0 | 0 | 0 | 0 | 1 |
| 4 | OTAL LONG TERM LIABILITIES (Sum of lines 44 - 49 | 10, 596, 278 | | 0 | 0 | |
| | OTAL LIABILITIES (Sum of lines 43 and 50) APITAL ACCOUNTS | 12, 239, 383 | 0 | U | U | 31.0 |
| | eneral fund balance | 35, 724, 212 | | | | 52. 0 |
| | pecific purpose fund | | O | | | 53. 0 |
| 1 | onor created - endowment fund balance - restricted | | | o | | 54. (|
| 1 | onor created - endowment fund balance - unrestricted | | | 0 | | 55.0 |
| | overning body created - endowment fund balance | | | 0 | 0 | 56.0 |
| 1 | lant fund balance - invested in plant lant fund balance - reserve for plant improvement, | | | | 0 | |
| 57. 00 PI | | | 1 | | O | 50. (|
| 57. 00 PI 58. 00 PI | eplacement, and expansion | | | 1 | | 1 |
| 57. 00 PI 58. 00 PI re | | 35, 724, 212 | 0 | 0 | 0 | |
| 57. 00 PI 58. 00 PI re 59. 00 TO | eplacement, and expansion OTAL FUND BALANCES (Sum of lines 52 thru 58) OTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and | 35, 724, 212 47, 963, 595 | 1 | 0 | 0 | |

| Peri od: | Worksheet G-1 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES COLLI NGSWOOD MANOR

Provi der No.: 315404

| | | | | | To 06/30/2022 | Date/Time Prep 11/29/2022 11 | pared: |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------|----------|---------------|---------------------------------|------------------|
| | | General | Fund | Speci al | Purpose Fund | Endowment Fund | . II alli |
| | | | | | | | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 1.00 | Fund balances at beginning of period | | 37, 488, 218 | | 0 | | 1. 00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 31) | | -1, 764, 002 | | | | 2.00 |
| 3. 00 4. 00 | Total (sum of line 1 and line 2) Additions (credit adjustments) | | 35, 724, 216 | | 0 | | 3. 00 4. 00 |
| 5. 00 | INTERCOMPANY RECONCILIATION | 0 | | | 0 | 0 | 5. 00 |
| 6. 00 | ROUNDI NG | | | | 0 | 0 | 6. 00 |
| 7. 00 | | o | | | 0 | Ō | 7. 00 |
| 8.00 | | 0 | | | 0 | 0 | 8. 00 |
| 9.00 | | 0 | | | 0 | 0 | 9. 00 |
| 10. 00 | Total additions (sum of line 5 - 9) | | 0 | | 0 | | 10. 00 |
| 11.00 | Subtotal (line 3 plus line 10) | | 35, 724, 216 | | 0 | | 11.00 |
| 12. 00 13. 00 | Deductions (debit adjustments) ROUNDING | | | | 0 | 0 | 12. 00 13. 00 |
| 14. 00 | ROUNDING | 0 | | | 0 | 0 | 14. 00 |
| 15. 00 | | | | | 0 | ٥ | 15. 00 |
| 16. 00 | | o | | | 0 | Ö | 16. 00 |
| 17.00 | | 0 | | | 0 | 0 | 17. 00 |
| 18. 00 | Total deductions (sum of lines 13 - 17) | | 4 | | 0 | | 18. 00 |
| 19. 00 | Fund balance at end of period per balance | | 35, 724, 212 | | 0 | | 19. 00 |
| | sheet (Line 11 - line 18) | Endowment Fund | PI ant | Fund | | | |
| | | | | | | | |
| | | 6.00 | 7. 00 | 8. 00 | | | |
| 1.00 | Fund balances at beginning of period | 0 | | | 0 | | 1.00 |
| 2. 00 3. 00 | Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) | 0 | | | 0 | | 2. 00 3. 00 |
| 4. 00 | Additions (credit adjustments) | 9 | | | O O | | 4. 00 |
| 5. 00 | INTERCOMPANY RECONCILIATION | | 0 | | | | 5. 00 |
| 6.00 | ROUNDI NG | | 0 | | | | 6. 00 |
| 7.00 | | | 0 | | | | 7. 00 |
| 8.00 | | | 0 | | | | 8. 00 |
| 9.00 | T | | 0 | | | | 9. 00 |
| 10. 00 11. 00 | Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) | 0 | | | 0 | | 10. 00 11. 00 |
| 12.00 | Deductions (debit adjustments) | ٩ | | | U | | 12. 00 |
| 13. 00 | ROUNDI NG | | 0 | | | | 13. 00 |
| 14. 00 | THE STATE OF THE S | | 0 | | | | 14. 00 |
| 15. 00 | | | 0 | | | | 15. 00 |
| 16. 00 | | | 0 | | | | 16. 00 |
| 17. 00 | | | 0 | | | | 17. 00 |
| 18.00 | Total deductions (sum of lines 13 - 17) | 0 | | | 0 | | 18.00 |
| 19. 00 | Fund balance at end of period per balance sheet (Line 11 - line 18) | 0 | | | 0 | | 19. 00 |
| | Silect (Line II - IIIle Io) | | | I | l . | ļ | 1 |

| Health Financial Systems | COLLI NGSWOOD MAN | IOR | In Lieu | ı of Form CMS-2540-10 |
|---------------------------------------------|-------------------|-----------------------|-----------------|-----------------------|
| STATEMENT OF PATIENT REVENUES AND OPERATING | G EXPENSES I | Provi der No.: 315404 | | Worksheet G-2 |
| | | | From 07/01/2021 | |
| | | | To 06/30/2022 | Date/Time Prepared: |

| | ENT OF PATIENT REVENUES AND OPERATING EXPENSES | | No.: 315404 | | riod: om 07/01/2021 06/30/2022 | Worksheet G-2 Parts I-II Date/Time Pre 11/29/2022 11 | pared: |
|--------|-----------------------------------------------------------------------|------|-------------|----|--------------------------------------|---------------------------------------------------------------|---------|
| | Cost Center Description | | I npati ent | | Outpati ent | Total | |
| | | | 1.00 | | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | | | | |
| | General Inpatient Routine Care Services | | _ | | | | |
| 1.00 | SKILLED NURSING FACILITY | | 9, 210, 88 | 33 | | 9, 210, 883 | 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, 519, 39 | 97 | | 8, 519, 397 | 4. 00 |
| 5.00 | Total general inpatient care services (Sum of lines 1 - 4) | | 17, 730, 28 | 30 | | 17, 730, 280 | 5. 00 |
| | All Other Care Services | | | | | | |
| 6.00 | ANCI LLARY SERVI CES | | 936, 04 | 46 | 0 | 936, 046 | 6.00 |
| 7.00 | CLINIC | | | | 0 | 0 | 7. 00 |
| 8.00 | HOME HEALTH AGENCY COST | | | | 0 | 0 | 8. 00 |
| 9.00 | AMBULANCE | | | | 0 | 0 | 9. 00 |
| 10.00 | RURAL HEALTH CLINIC | | | | 0 | 0 | 10.00 |
| 10. 10 | FQHC | | | | 0 | 0 | 10. 10 |
| 11.00 | CMHC | | | | 0 | 0 | 11. 00 |
| 12.00 | HOSPI CE | | | 0 | 0 | 0 | 12.00 |
| | OTHER (SPECIFY) | | | 0 | 0 | 0 | 13. 00 |
| | Total Patient Revenues (Sum of Lines 5 - 13) (Transfer column 3 | 3 to | 18, 666, 32 | 26 | 0 | 18, 666, 326 | 1 |
| | 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) | | | | | 17, 664, 675 | 1.00 |
| 2.00 | Add (Specify) | | | | 0 | | 2.00 |
| 3.00 | | | | | 0 | | 3.00 |
| 4.00 | | | | | 0 | | 4. 00 |
| 5.00 | | | | | 0 | | 5. 00 |
| 6.00 | | | | | 0 | | 6.00 |
| 7.00 | | | | | 0 | | 7.00 |
| 8.00 | Total Additions (Sum of lines 2 - 7) | | | | - | 0 | 8. 00 |
| 9.00 | Deduct (Specify) | | | | 0 | | 9. 00 |
| 10.00 | | | | | 0 | | 10.00 |
| 11. 00 | | | | | 0 | | 11. 00 |
| 12. 00 | | | | | 0 | | 12. 00 |
| 13. 00 | | | | | 0 | | 13. 00 |
| | Total Deductions (Sum of Lines 9 - 13) | | | | O | 0 | • |
| | Total Operating Expenses (Sum of lines 1 and 8, minus line 14) | | | | | 17, 664, 675 | |
| 13.00 | Trotal operating Expenses (Julii of Trines I and G, Illinus Trine 14) | | | I | l | 17,004,075 | 1 10.00 |

| Health Financial Systems | COLLINGSWOOD MANOR In Lie | | u of Form CMS-2 | 540-10 |
|------------------------------------------------------|---------------------------|-----------------|---------------------------------------------|--------|
| STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provi der No.: 315404 | From 07/01/2021 | Worksheet G-3 Date/Time Prep 11/29/2022 11: | pared: |
| | | | | |

| STATEM | ENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provi der No.: 315404 | Peri od: | Worksheet G-3 | |
|-----------------------------------------------------------|------------------------------------------------------------------|-----------------------|----------------------------------|----------------------------------|------------------|
| | | | From 07/01/2021 To 06/30/2022 | Date/Time Prep 11/29/2022 11: | |
| | | | | | |
| 1. 00 | Total patient revenues (From Wkst. G-2, Part I, col. 3, line 1 | 1.4.) | | 1. 00 | 1. 00 |
| | Less: contractual allowances and discounts on patients accounts | | | 18, 666, 326 3, 027, 877 | 2. 00 |
| 3.00 | · | | | 15, 638, 449 | 3. 00 |
| 4. 00 | | | | | 4. 00 |
| 5.00 Net income from service to patients (Line 3 minus 4) | | | | | 5. 00 |
| | Other income: | | | -2, 026, 226 | |
| 6.00 | Contributions, donations, bequests, etc | | | 124, 380 | 6.00 |
| 7.00 | | | | | 7.00 |
| 8.00 | Revenues from communications (Telephone and Internet service) | | | 0 | 8. 00 |
| 9.00 | Revenue from television and radio service | | | 6, 728 | |
| 10.00 | Purchase di scounts | | | 0 | |
| 11. 00 12. 00 | Rebates and refunds of expenses Parking Lot receipts | | | 0 | 11. 00 12. 00 |
| 13. 00 | Revenue from Laundry and Linen service | | | 0 | 13. 00 |
| 14. 00 | Revenue from meals sold to employees and guests | | | 29, 546 | |
| 15. 00 | Revenue from rental of living quarters | | | 4, 200 | |
| 16. 00 | Revenue from sale of medical and surgical supplies to other that | an patients | | 0 | 16. 00 |
| 17. 00 | Revenue from sale of drugs to other than patients | · | | 0 | 17.00 |
| 18. 00 | Revenue from sale of medical records and abstracts | | | 0 | 18.00 |
| 19. 00 | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | |
| 20. 00 | | | | | 20. 00 |
| | 21.00 Rental of vending machines | | | | 21. 00 |
| 22. 00 | Rental of skilled nursing space | | | 0 | 22. 00 |
| 23. 00 | Governmental appropriations | | | 4 700 | 23. 00 24. 00 |
| 24. 00 24. 01 | INSURANCE REVENUE CATERING / COUNTRY STORE | | | 4, 700 32, 660 | |
| 24. 01 | TRANS - RESIDENTIAL | | | 4, 511 | |
| 24. 03 | MI SCELLANEOUS I NCOME | | | 6, 345 | |
| 24. 04 | INVESTMENT SETTLEMENT | | | 102 | 24. 04 |
| 24. 05 | GRANT REVENUE | | | 46, 954 | 24. 05 |
| 24.06 | MAINTENANCE SERVICES | | | 730 | 24.06 |
| 24. 07 | ELECTRI C I NCOME | | | 1, 171 | 24. 07 |
| 24. 50 | COVI D-19 PHE Fundi ng | | | 0 | 24. 50 |
| 25. 00 | Total other income (Sum of lines 6 - 24) | | | 262, 224 | |
| 26. 00 | Total (Line 5 plus line 25) | | | -1, 764, 002 0 | |
| 27. 00 27. 01 | | | | | 27. 00 |
| 28. 00 | | | | | 27. 01 28. 00 |
| 29. 00 | | | | 0 | 29. 00 |
| 30. 00 | Total other expenses (Sum of Lines 27 - 29) | | | 0 | 30. 00 |
| | Net income (or loss) for the period (Line 26 minus line 30) | | | -1, 764, 002 | |
| | | | ' | | |