This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0463 Expi res: 12/31/2021 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provi der CCN: 315404 Worksheet S Parts I, II & III Peri od: From 07/01/2022 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/30/2023 1:51 pm PART I - COST REPORT STATUS Provi der [X] Electronically prepared cost report Date: 11/30/2023 Time: 1:51 pm use only] Manually prepared cost report 2 [0] If this is an amended report enter the number of times the provider resubmitted this cost report 3 No Medicare Utilization. Enter "Y" for yes or leave blank for no. Contractor 4. [1] Cost Report Status 6. Contractor No. use only (1) As Submitted 7.[N] First Cost Report for this Provider CCN (2) Settled without audit 8.[N] Last Cost Report for this Provider CCN

9. NPR Date:

11. Contractor Vendor Code

for no utilization.

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

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

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

(3) Settled with audit

(4) Reopened

(5) Amended

5. Date Received:

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLLINGSWOOD MANOR (315404) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		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	315	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	315	0	0	100. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10 SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315404 Peri od: Worksheet S-2 From 07/01/2022 COMPLEX INDENTIFICATION DATA Part I Date/Time Prepared: 06/30/2023 11/30/2023 1:51 pm 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: COLLINGSWOOD 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) 07/01/2022 06/30/2023 14.00 15.00 Type of Control (See Instructions) 15.00 Y/N 1.00 Type of Freestanding Skilled Nursing Facility 16.00 Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR N 16.00 section 483.5? 17.00 Is this a composite distinct part skilled nursing facility that meets the requirements set forth in Ν 17.00 42 CFR section 483.5? Are there any costs included in Worksheet A that resulted from transactions with related 18.00 18.00 organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1 Miscellaneous Cost Reporting Information 19.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N 19.00 19.01 If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 19.01 20.00 Straight Line 1, 073, 740 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, 073, 740 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: 130 500 41 00

Health Financial Systems	COLLI NGSWOOD	MANOR	In Lie	u of Form CMS-2	2540-10		
SKILLED NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 31540-		Worksheet S-2			
COMPLEX INDENTIFICATION DATA			From 07/01/2022				
			To 06/30/2023				
				11/30/2023 1:	51 pm		
				Y/N			
				1.00			
42.00 Are malpractice premiums and paid los	ses reported in other tha	n the Administrative a	and General cost	N	42.00		
center? Enter Y or N. If yes, check be	ox, and submit supporting	schedule listing cos	t centers and				
amounts.	amounts.						
43.00 Are there any home office costs as de	fined in CMS Pub. 15-1, (Chapter 10?		Υ	43.00		
44.00 If line 43 is yes, enter the home off	ice chain number and ente	er the name and address	s of the home	H53010	44. 00		
office on lines 45, 46 and 47.							
1.00	2. 00		3. 00				
If this facility is part of a chain o	rganization, enter the na	ame and address of the	home office on the	lines			
bel ow.							
45. 00 Name: UNITED METHODIST HOMES OF NJ	Contractor's Name: UNIT	ED METHODIST Contra	actor's Number: 1200)1	45. 00		
	HOME	S OF NJ					
46.00 Street: 3311 HIGHWAY 33	PO Box:				46. 00		
47.00 City: NEPTUNE	State: NJ	Zip Co	ode: 0775	2	47.00		

	Financial Systems	COLLI NGSWOOD MA				eu of Form CMS-	
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Provi der		Period: From 07/01/2022 Fo 06/30/2023	Date/Time Pre	epared:
					Y/N	11/30/2023 1: Date	31 pili
	General Instruction: For all column 1 responseresponses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column	1, "Y" for	r Yes or "N" 1	1.00 For No. For all	2.00 the date	
1. 00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter instructions)				N		1.00
				Y/N 1. 00	Date 2.00	V/I 3. 00	
2.00	Has the provider terminated participation in column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.			N			2. 00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are related officers, medical staff, management personner of directors through ownership, control, or relationships? (see instructions)	., chain home offic d to the provider o I, or members of the	es, drug rits e board	Y			3.00
				Y/N 1. 00	Type 2. 00	Date 3.00	
	Financial Data and Reports		5				
4. 00	Column 1: Were the financial statements prepared Accountant? (Y/N) Column 2: If yes, enter "A Compiled, or "R" for Reviewed. Submit comple available in column 3. (see instructions) If	" for Audited, "C" te copy or enter da	for te	Υ	A	12/31/2023	4. 00
5.00	Are the cost report total expenses and total those on the filed financial statements? If reconciliation.			Υ			5. 00
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2	Is the	provider the	N	N	6. 00
7. 00 8. 00	legal operator of the program? (Y/N) 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) s	ee mstructions.				Y/N 1.00	
9. 00 10. 00	Bad Debts Is the provider seeking reimbursement for bar If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.				t reporting	Y N	9. 00 10. 00
11. 00	If line 9 is "Y", are patient deductibles and Bed Complement	d/or coinsurance wa	ved? If "	Y", see instr	ucti ons.	N	11. 00
12. 00	Have total beds available changed from prior	cost reporting per	od? If "Y		ctions. rt A	N Part B	12. 00
		Descriptio	n	Y/N	Date	Y/N	
	PS&R Data	0		1. 00	2. 00	3. 00	
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)			Y	11/14/2023	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			N		N	17. 00
17.00	adjustments made to PS&R data for Other? Describe the other adjustments:						

Heal th F	Financial Systems COLLINGSW	OOD M	ANOR		Health Financial Systems COLLINGSWOOD MANOR In Lieu of Form CMS-2				
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE			Provi der No.: 315404		i od: om 07/01/2022	Worksheet S-2 Part II			
COMPLEX	REI MBURSEMENT QUESTI ONNAI RE			To		Date/Time Pre	pared:		
						11/30/2023 1:	51 pm		
			1. 00		2. (00			
Co	ost Report Preparer Contact Information								
19.00 E	Inter the first name, last name and the title/position	DEAN	DRA	F.A	ALLON		19. 00		
h	neld by the cost report preparer in columns 1, 2, and 3,								
r	respecti vel y.								
20. 00 E	Inter the employer/company name of the cost report	BAKE	R TILLY US, LLP				20. 00		
р	preparer.								
21. 00 E	Enter the telephone number and email address of the cost	570-	820-0301	DE	EANDRA. FALLON@	BAKERTI LLY. CO	21. 00		
r	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 Provider No.: 315404 Period:

SYSTEM OF THE PROPERTY OF THE PROPERTY

From 07/01/2022 To 06/30/2023 Part II Date/Time Prepared: COMPLEX REIMBURSEMENT QUESTIONNAIRE 11/30/2023 1:51 pm Part B Date 4.00 PS&R Data 13.00 Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to 13.00 prepare this cost report in cols. 2 and 4. (see Instructions.) 14.00 Was the cost report prepared using the PS&R 14.00 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 15.00 If line 13 or 14 is "Y", were adjustments 15.00 made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. 16.00 | If line 13 or 14 is "Y", then were 16.00 adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.

17.00 If line 13 or 14 is "Y", then were 17.00 adjustments made to PS&R data for Other? Describe the other adjustments:

		3. 00	
	Cost Report Preparer Contact Information		
19.00	Enter the first name, last name and the title/position	DI RECTOR	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		20. 00
	preparer.		
21.00	Enter the telephone number and email address of the cost		21. 00
	report preparer in columns 1 and 2, respectively.		

18.00

18.00 Was the cost report prepared only using the provider's records? If "Y" see Instructions.

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

Health Financial Systems COLLINGSWOOD SKILLED NURSING FACILITY HEALTH CARE Provi der No.: 315404 COMPLEX STATISTICAL DATA

				To	06/30/2023	Date/Time Prep 11/30/2023 1:5	
				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	3, 786	6, 744	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		0		0		6. 00
7.00	HOSPICE Total (Sum of lines 1-7)	0 188	0 68, 620	0	3, 786	0	7. 00
8. 00	Total (Suil of Titles 1-7)	Inpatient D		U	Di scharges	6, 744	8. 00
		Theatrent b	ays/ vrsi ts		Di Schai ges		
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	SKILLED NURSING FACILITY	7, 426	17, 956		155	11	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	36, 620	36, 620				5. 00
6.00	SNF-Based CMHC						6. 00
7. 00 8. 00	HOSPICE	0 44, 046	54, 576	0	0 155	0 11	7. 00 8. 00
0.00	Total (Sum of lines 1-7)	Di scha			age Length of		6.00
		Di Serie		7,1001	age Zength of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
	I	11.00	12. 00	13. 00	14. 00	15. 00	
1.00	SKILLED NURSING FACILITY	112	278		24. 43		1.00
2.00	NURSING FACILITY	0	0	0. 00		0.00	2.00
3.00	I CF/IID HOME HEALTH AGENCY COST	0	0			0. 00	3.00
4. 00 5. 00	Other Long Term Care	33	33				4. 00 5. 00
6.00	SNF-Based CMHC	33	33				6. 00
7. 00	HOSPI CE	0	0	0.00	0.00	0.00	7. 00
8.00	Total (Sum of lines 1-7)	145	311	0.00	24. 43		8. 00
0.00	Total (Sam St 111165 1 1)	Average Length	011	Admi s		010.07	0.00
		of Stay					
	Component	Total	Title V	Title XVIII	Title XIX	0ther	
	1	16. 00	17. 00	18. 00	19. 00	20. 00	
1.00	SKILLED NURSING FACILITY	64. 59	0	211	7	92	1. 00
2.00	NURSING FACILITY	0. 00	0		0	0	2. 00
3.00	ICF/IID	0. 00			O	0	3. 00
4.00	HOME HEALTH AGENCY COST	1 100 70				2.4	4. 00
5. 00 6. 00	Other Long Term Care SNF-Based CMHC	1, 109. 70				34	5. 00 6. 00
7. 00	HOSPI CE	0.00	0	0	0	О	7. 00
8. 00	Total (Sum of lines 1-7)	175. 49	0	211	7	126	8. 00
<u> </u>		Admi ssi ons	Full Time			.=-	2. 4.2
	Component	Total	Employees on	Nonpai d			
	Component	Total	Payrol I	Workers			
		21.00	22. 00	23. 00			
1. 00	SKILLED NURSING FACILITY	310	40. 15				1. 00
2.00	NURSING FACILITY	0	0.00	0.00			2.00
3.00	ICF/IID	0	0.00	0.00			3.00
4.00	HOME HEALTH AGENCY COST		0.00				4. 00
5.00	Other Long Term Care	34	39. 28				5. 00
6.00	SNF-Based CMHC		0. 00				6. 00
7.00	HOSPI CE	0	0.00				7. 00
8. 00	Total (Sum of lines 1-7)	344	79. 43	0.00			8. 00

Provi der No.: 315404

					o 06/30/2023	Date/Time Pre	
		Amount	Reclass. of	Adj usted	Pai d Hours	11/30/2023 1: Average Hourly	
		Reported		Sal ari es (col.		Wage (col. 3 ÷	
		Reported	Worksheet A-6		Salary in col.		
			WOI KSHEET A-0	1 ± CO1. 2)	3	COI . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	PART II - DIRECT SALARIES						
	SALARI ES						
1.00	Total salaries (See Instructions)	8, 813, 183	0	8, 813, 183	315, 089. 00	27. 97	1. 00
2.00	Physician salaries-Part A	0	0	C	0.00	0.00	2. 00
3.00	Physician salaries-Part B	0	0	C	0.00	0.00	3. 00
4.00	Home office personnel	0	0	C	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	C	0.00	0.00	5. 00
6.00	Revised wages (line 1 minus line 5)	8, 813, 183	0	8, 813, 183	315, 089. 00	27. 97	6. 00
7.00	Other Long Term Care	2, 318, 004	0	2, 318, 004	81, 693. 00	28. 37	7. 00
8.00	HOME HEALTH AGENCY COST	0	0	C	0.00	0.00	8. 00
9.00	CMHC	0	0	C	0.00	0.00	9. 00
10.00	HOSPI CE	0	0	C	0.00	0.00	10.00
11.00	Other excluded areas	39, 402	0	39, 402	2, 049. 00	19. 23	11. 00
12. 00	Subtotal Excluded salary (Sum of lines 7	2, 357, 406	0	2, 357, 406	83, 742. 00	28. 15	12. 00
12 00	through 11)	/ 455 777		/ 455 777	221 247 00	27.01	12.00
13. 00	Total Adjusted Salaries (line 6 minus line	6, 455, 777	0	6, 455, 777	231, 347. 00	27.91	13. 00
	12) OTHER WAGES & RELATED COSTS						
14. 00	Contract Labor: Patient Related & Mgmt	725, 169		725, 169	13, 600. 00	53. 32	14. 00
15. 00	Contract Labor: Physician services-Part A	18, 407		18, 407	· ·		
16. 00	Home office salaries & wage related costs	821, 693					
10.00	WAGE-RELATED COSTS	021,073		021,073	12, 704. 00	03. 27	10.00
17. 00	Wage-related costs core (See Part IV)	2, 078, 105	0	2, 078, 105			17. 00
18. 00	Wage-related costs other (See Part IV)	3, 667		3, 667			18. 00
19. 00	Wage related costs (excluded units)	556, 846		556, 846			19. 00
20. 00	Physician Part A - WRC	0	0	0.00			20. 00
21. 00	Physician Part B - WRC	0	0				21. 00
22. 00	Total Adjusted Wage Related cost (see	1, 524, 926	0	1, 524, 926			22. 00
	instructions)]				

Health Financial Systems
SNF WAGE INDEX INFORMATION COLLI NGSWOOD MANOR

| Peri od: | Worksheet S-3 | From 07/01/2022 | Part III | To 06/30/2023 | Date/Time Prepared: Provi der No.: 315404

				1	o 06/30/2023	Date/lime Prep 11/30/2023 1:	
		Amount	Reclass. of	Adj usted	Pai d Hours	Average Hourly	
		Reported	Salaries from	Salaries (col.	Related to	Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col . 4)	
					3		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0	0.00	0. 00	1. 00
2.00	Administrative & General	1, 229, 175	0	1, 229, 175	22, 892. 00	53. 69	2. 00
3.00	Plant Operation, Maintenance & Repairs	410, 509	0	410, 509	21, 883. 00	18. 76	3.00
4.00	Laundry & Li nen Servi ce	126, 410	0	126, 410	6, 659. 00	18. 98	4. 00
5.00	Housekeepi ng	320, 833	0	320, 833	18, 079. 00	17. 75	5.00
6.00	Di etary	841, 075	0	841, 075	48, 811. 00	17. 23	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	57, 238	0	57, 238	2, 056. 00	27. 84	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	257, 952	0	257, 952	12, 707. 00	20. 30	13. 00
14.00	Total (sum lines 1 thru 13)	3, 243, 192	0	3, 243, 192	133, 087. 00	24. 37	14. 00

Heal th	Financial Systems	COLLI NGSWOOD MANOR		In Lie	u of Form CMS-2	2540-10
SNF WA	GE RELATED COSTS	Provi	der No.: 315404	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part IV Date/Time Pre 11/30/2023 1:	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	on			0	2. 00

PART IV - WAGE RELATED COSTS 1.00			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contribution 0 1.00 2.00 7.00 7.00 2.00 7.			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00	1.00	401K Employer Contributions	0	1.00
Prior Year Pension Service Cost 0 4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA PI an Admin istration Fees 0 0 0 0 0 0 0 0 0	3.00	Qualified and Non-Qualified Pension Plan Cost	125, 877	3. 00
5.00 401K/TSA Plan Administration fees 0 6.00 1.	4.00		0	4. 00
Column C		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
The column Taxes The column Taxes The column Taxes The column Taxes	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded) 903, 136 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 11,731 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 3,662 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 14.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 278, 204 15.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 00 16.00 1	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 11,731 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 3,662 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 278,204 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 0 16.00 0 16.00 17.00 FICA-Employers Portion Only 0 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 110,427 19.00 20.00 OTHER 0 20.00 07HER 0 21.00 22.00 20.078,105 24.00 Part B - Other than Core Related Cost 0		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 11,731 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 13.00 13.00 13.00 13.00 14.00 15.00 14.00 15	8.00	Health Insurance (Purchased or Self Funded)	903, 136	8. 00
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00 Accident Insurance (If employee is owner or beneficiary) 3, 662 13.00 13.00 15.30i 11.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 14.00 15.00 14.00 14.00 14.00 15.00 14.00 14.00 15.00 14.00	10.00	Dental, Hearing and Vision Plan	11, 731	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 3,662 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 278,204 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) 642,736 17.00 18.00 Modicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 110,427 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 2,332 23.00 23.00 Tuition Reimbursement 2,332 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 2,078,105 24.00 Part B - Other than Core Related Cost	11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00			_	
15. 00 Workers' Compensation Insurance 278, 204 15. 00 16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16. 00 16			3, 662	
Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 - 23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES TAX	15.00		278, 204	15. 00
TAXES 17.00 FI CA-Employers Portion Onl y 642,736 17.00 18.00 Medicare Taxes - Employers Portion Onl y 0 18.00 19.00 Unemployment Insurance 110,427 19.00 20.00	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17.00 FI CA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 110, 427 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 110, 427 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 2, 332 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 2, 078, 105 24.00 Amount Reported 1.00 - Part B - Other than Core Related Cost				
19.00 Unempl oyment Insurance 110, 427 19.00 20.00 State or Federal Unempl oyment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 2, 332 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 2, 078, 105 24.00 Amount Reported Reported 1.00 Part B - Other than Core Related Cost			642, 736	1
20.00 State or Federal Unemployment Taxes 0 0 0 0 0 0 0 0 0			_	
OTHER 21.00 Executive Deferred Compensation 0 21.00			110, 427	
21.00 Executive Deferred Compensation 0 21.00	20.00		0	20. 00
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 2, 332 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 - 23) 2, 078, 105 24. 00 Amount Reported 1. 00 1. 00				
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported 1.00 Part B - Other than Core Related Cost			_	
24. 00 Total Wage Related cost (Sum of lines 1 - 23) 2, 078, 105 24. 00 Amount Reported 1. 00 1. 00			_	
Amount Reported 1.00 Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost	24.00	Total Wage Related cost (Sum of lines 1 - 23)	2, 078, 105	24. 00
Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost				
			1. 00	
25. 00 OTHER WAGE RELATED COST 3, 667 25. 00				
	25. 00	OTHER WAGE RELATED COST	3, 667	25. 00

				Ť	o 06/30/2023	Date/Time Prep 11/30/2023 1:5	
	Occupational Category	Amount	Fri nge	Adjusted	Pai d Hours	Average Hourly	эт рііі
	g ,	Reported	Benefits	Salaries (col.		Wage (col. 3 ÷	
					Salary in col.	col . 4)	
				,	3	ŕ	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	918, 720	242, 634				1. 00
2.00	Licensed Practical Nurses (LPNs)	280, 794	74, 158	·			2.00
3.00	Certified Nursing Assistant/Nursing	103, 526	273, 398	376, 924	44, 018. 00	8. 56	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	1, 303, 040	590, 190		·		4.00
5.00	Physical Therapists	165, 600	43, 735				5.00
6.00	Physical Therapy Assistants	0	C	ή	0.00		6. 00
7.00	Physical Therapy Aides	64, 434	17, 017		1		7. 00
8.00	Occupational Therapists	94, 026	24, 832				8. 00
9.00	Occupational Therapy Assistants	0	C	ή			9. 00
10.00	Occupational Therapy Aides	64, 161	16, 945		·		10.00
11. 00	Speech Therapists	121, 869	32, 186				11. 00
12.00	Respiratory Therapists	72, 910	19, 256				12.00
13. 00	Other Medical Staff	394, 865	104, 284	499, 149	13, 265. 00	37. 63	13.00
	Contract Labor						
14.00	Nursing Occupations	27.202		27.202	F72.00	/F 04	14.00
14.00	Registered Nurses (RNs)	37, 203		37, 203			14. 00 15. 00
15.00	Licensed Practical Nurses (LPNs)	303, 475		303, 475	·		
16. 00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	384, 491		384, 491	7, 510. 00	51. 20	16. 00
17. 00	Total Nursing (sum of lines 14 through 16)	725, 169		725, 169	13, 600. 00	53. 32	17. 00
18. 00	Physical Therapists	723, 107		725, 107	0.00		18. 00
19. 00	Physical Therapy Assistants				0.00		19. 00
20. 00	Physical Therapy Aides				0.00		
21. 00	Occupational Therapists				0.00		21. 00
22. 00	Occupational Therapy Assistants				0.00		
23. 00	Occupational Therapy Aides				0.00		
24. 00	Speech Therapists				0.00		
25. 00	Respiratory Therapists	l ol			0.00		25. 00
	Other Medical Staff	l ol					26. 00
	1	-1					

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/30/2023 1:51 pm 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 16.00 RHC 16.00 17.00 RHB 17.00 18.00 RHA 18.00 19.00 RMC 19.00 RMB 20.00 20.00 21.00 RMA 21.00 22.00 RLB 22.00 23.00 RLA 23.00 24.00 ES3 24.00 25.00 ES2 25.00 26.00 ES1 26.00 27.00 HE₂ 27.00 28.00 HE1 28.00 29.00 HD2 29.00 30.00 30.00 HD1 31.00 HC2 31.00 32.00 HC1 32.00 33.00 HB2 33.00 34.00 HB1 34.00 35.00 LE2 35.00 36.00 LE1 36.00 37.00 LD2 37.00 38.00 LD1 38.00 39.00 LC2 39.00 40.00 LC1 40.00 41.00 LB2 41.00 42.00 LB1 42.00 43.00 CE2 43.00 44.00 44.00 CE1 45.00 CD2 45.00 46.00 CD1 46.00 47.00 CC2 47.00 48.00 CC1 48.00 49.00 CB₂ 49.00 50.00 CB1 50.00 51.00 CA2 51.00 52.00 52.00 CA1 53.00 SE3 53.00 54.00 SE2 54.00 55.00 SE1 55.00 56.00 SSC 56.00 57.00 SSB 57.00 58.00 SSA 58.00 59.00 1 B2 59.00 60.00 IB1 60.00 61.00 IA2 61.00 62.00 I A1 62.00 63.00 63.00 BB2 BB1 64.00 64.00 65.00 BA2 65.00 66.00 BA1 66.00 67.00 PF2 67.00 68.00 PE1 68.00 69.00 PD2 69.00 70.00 PD1 70.00 71.00 PC2 71.00 72.00 PC1 72.00 73.00 PB2 73.00 74.00 PB1 74.00 75.00 75. 00 PA₂

Health Financial Systems	COLLINGSWOOD MANOR		In Lie	ieu of Form CMS-2540-10		
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315404	Peri od: From 07/01/2022	Worksheet S-		
			To 06/30/2023	Date/Time Pro 11/30/2023 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 Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)						
101. 00 Staffing					101. 00	
102.00 Recrui tment					102. 00	
103.00 Retention of employees					103. 00	
104. 00 Trai ni ng					104. 00	
105. 00 OTHER (SPECIFY)					105. 00	
106.00 Total SNF revenue (Worksheet G-2, Part I, line 1,	column 3)				106. 00	

Health Financial Systems	COLLI NGSWO	OD MANOR		In Lie	eu of Form CMS-2	2540-10
RECLASSIFICATION AND ADJUSTMENT OF TRIA	BALANCE OF EXPENSES	Provi der	No.: 315404 F	Peri od:	Worksheet A	
				From 07/01/2022 o 06/30/2023		narod:
			'	0 00/30/2023	11/30/2023 1:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col . 2)	ons	Trial Balance	
				Increase/Decre	· `	
				ase (Fr Wkst	col . 4)	
	1.00	2. 00	3.00	A-6) 4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00 O0100 CAP REL COSTS - BLDGS & FIX	TURES	1, 256, 946	1, 256, 946	0	1, 256, 946	1.00
2.00 00200 CAP REL COSTS - MOVABLE EQU		0	,	o o	0	2. 00
3.00 00300 EMPLOYEE BENEFITS	o	2, 081, 772	2, 081, 772	0	2, 081, 772	3. 00
4.00 00400 ADMINISTRATIVE & GENERAL	1, 229, 175	2, 582, 417	3, 811, 592	0	3, 811, 592	4.00
5.00 00500 PLANT OPERATION, MAINT. & R	EPAI RS 410, 509	1, 129, 386	1, 539, 895	0	1, 539, 895	5. 00
6.00 00600 LAUNDRY & LINEN SERVICE	126, 410	46, 489			172, 899	6. 00
7. 00 00700 HOUSEKEEPI NG	320, 833	151, 892	1		472, 725	7. 00
8. 00 00800 DI ETARY	841, 075	1, 247, 095	2, 088, 170	0	2, 088, 170	8. 00
9. 00 00900 NURSI NG ADMI NI STRATI ON	0	0		0	0	9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY 11. 00 01100 PHARMACY	0	0		0	0	10. 00 11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY		0			0	12.00
13. 00 01200 MEDI CAE RECORDS & ELBRART	57, 238	0	57, 238	0	57, 238	1
14.00 01400 NURSING AND ALLIED HEALTH E		0	07,200		07,230	14.00
15. 00 01500 ACTIVITIES	193, 282	36, 543	229, 825	0	229, 825	15. 00
15. 01 01501 CHAPLAI N	64, 670	1, 025				15. 01
INPATIENT ROUTINE SERVICE COST CE	NTERS					
30.00 03000 SKILLED NURSING FACILITY	2, 629, 585	1, 188, 478	3, 818, 063	0	3, 818, 063	30. 00
31.00 03100 NURSING FACILITY	0	0	(0	0	31. 00
32. 00 03200 CF/ I D	0	0	(0	_	32. 00
33. 00 03300 OTHER LONG TERM CARE	2, 318, 004	140, 327	2, 458, 331	0	2, 458, 331	33. 00
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	0	13, 577	13, 577	7 0	12 577	40. 00
41. 00 04100 LABORATORY		27, 481	27, 481		13, 577 27, 481	41.00
42. 00 04200 I NTRAVENOUS THERAPY	0	27, 401	27, 401	0	27, 401	42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	72, 910	1, 210	74, 120	o o	74, 120	43. 00
44. 00 04400 PHYSI CAL THERAPY	230, 034	126, 924	1			44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	158, 187	0	158, 187	75, 438	233, 625	45. 00
46.00 04600 SPEECH PATHOLOGY	121, 869	0	121, 869	29, 534		
47. 00 04700 ELECTROCARDI OLOGY	0	0	C	0	0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO	PATI ENTS 0	25, 287	1		25, 287	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS 50.00 05000 DENTAL CARE - TITLE XIX ONL	0	161, 518	161, 518	0	161, 518	1
50. 00 05000 DENTAL CARE - TITLE XIX ONL 51. 00 05100 SUPPORT SURFACES	Y O	0			0	50. 00 51. 00
OUTPATIENT SERVICE COST CENTERS		U	1) 0	0	31.00
60. 00 06000 CLINIC	O	0		0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	O	0	d	Ö	ō	61. 00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST	0	0	C	0		70. 00
71. 00 07100 AMBULANCE	0	0	(0	0	71. 00
73. 00 07300 CMHC		0	1 (0	0	73. 00
SPECIAL PURPOSE COST CENTERS	LOCCEC	0				00.00
80. 00 08000 MALPRACTICE PREMIUMS & PAID 81. 00 08100 INTEREST EXPENSE	LUSSES	0			0	80. 00 81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF		0			0	82.00
83. 00 08300 HOSPI CE	0	0			ő	83. 00
89.00 SUBTOTALS (sum of lines 1-8	4) 8, 773, 781	10, 218, 367	18, 992, 148	o o	18, 992, 148	89. 00
NONREI MBURSABLE COST CENTERS		., .,		-		
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS	& CANTEEN 39, 402	23, 736	63, 138	0	63, 138	90. 00
91.00 09100 BARBER AND BEAUTY SHOP	0	0	(0	0	91. 00
92. 00 09200 PHYSICIANS PRIVATE OFFICES	0	0	(0	0	
93. 00 09300 NONPAI D WORKERS	0	0]	0	0	93. 00
94. 00 09400 PATI ENTS LAUNDRY	0 013 103	10 242 103	10.055.307	0	10 055 294	94.00
100. 00 TOTAL	8, 813, 183	10, 242, 103	19, 055, 286) U	19, 055, 286	1100.00

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 07/01/2022 To 06/30/2023 Date/Time Prepared: Provi der No.: 315404

				T	o 06/30/2023	Date/Time Prepared: 11/30/2023 1:51 pm
	Cost Center Description	Adjustments to	Net Expenses			11/30/2023 1.31 piii
	, , , , , , , , , , , , , , , , , , ,		For Allocation			
		Wkst A-8)	(col. 5 +-			
			col . 6)			
	GENERAL SERVICE COST CENTERS	6.00	7. 00			
1. 00	00100 CAP REL COSTS - BLDGS & FLXTURES	-832	1, 256, 114			1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT	0	0			2. 00
3.00	00300 EMPLOYEE BENEFITS	-60, 640	2, 021, 132			3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	-791, 917	3, 019, 675			4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	-2, 681	1, 537, 214			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	0	172, 899			6.00
7. 00 8. 00	00700 HOUSEKEEPI NG 00800 DI ETARY	-48, 564	472, 725 2, 039, 606			7.00
9. 00	00900 NURSI NG ADMI NI STRATI ON	-48, 504	2,034,000			9.00
10. 00	01000 CENTRAL SERVICES & SUPPLY	Ö	Ö			10.00
11. 00	01100 PHARMACY	O	O			11. 00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0			12. 00
13. 00	01300 SOCI AL SERVI CE	0	57, 238			13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			14. 00
15.00	01500 ACTIVITIES	0	229, 825			15. 00
15. 01	01501 CHAPLAIN I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l o	65, 695			15. 01
30. 00	03000 SKILLED NURSING FACILITY	0	3, 818, 063			30.00
31. 00	03100 NURSING FACILITY	o	0			31.00
32.00	03200 CF/IID	0	0			32. 00
33. 00	03300 OTHER LONG TERM CARE	0	2, 458, 331			33. 00
	ANCILLARY SERVICE COST CENTERS					
40.00	04000 RADI OLOGY	0	13, 577			40.00
41.00	04100 LABORATORY	0	27, 481 0			41.00
42. 00 43. 00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	74, 120			42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY		251, 986			44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	233, 625			45. 00
46.00	04600 SPEECH PATHOLOGY	O	151, 403			46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0			47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25, 287			48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	161, 518			49.00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	١	U			31.00
60. 00	06000 CLINIC	0	0			60.00
61. 00	06100 RURAL HEALTH CLINIC	O	O			61. 00
62.00	06200 FQHC					62. 00
	OTHER REIMBURSABLE COST CENTERS					
70.00	07000 HOME HEALTH AGENCY COST	0	0			70.00
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0			71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	U			73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES	0	0			80.00
	08100 INTEREST EXPENSE	o	0			81. 00
82.00	08200 UTILIZATION REVIEW - SNF	0	0			82. 00
83. 00	08300 H0SPI CE	0	0			83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	-904, 634	18, 087, 514			89. 00
00.00	NONREI MBURSABLE COST CENTERS		(0.400			00.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP		63, 138 0			90.00
	09200 PHYSICIANS PRIVATE OFFICES		0			92.00
	09300 NONPALD WORKERS		o			93. 00
	09400 PATIENTS LAUNDRY		o			94. 00
100.00	TOTAL	-904, 634	18, 150, 652			100.00

Health Financial Systems	COLLINGSWOOD MANOR In Lieu of				u of Form CMS-2	2540-10
RECLASSI FI CATI ONS				Peri od:	Worksheet A-6	
				From 07/01/2022 To 06/30/2023	Date/Time Pre 11/30/2023 1:	
			Increases			
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	2. 00		3.00	4. 00	5. 00	
(1) A - TO RECLASS OT AND ST	·					
1. 00	OCCUPATIONAL THERAF	γ	45. 0	20, 518	54, 920	1.00
2. 00	SPEECH PATHOLOGY		46. 0	00 8, 033	21, 501	2. 00
TOTALS	·					
100. 00	Total Reclassificat	tions (Sum		28, 551	76, 421	100. 00
	of columns 4 and 5	must				
	equal sum of column	ns 8 and				
	9)					

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

Health Financial Systems	COLLI NGSWOOD MA	ANOR		In Lie	u of Form CMS-2	2540-10
RECLASSI FI CATI ONS		Provi der		Peri od:	Worksheet A-6	
				From 07/01/2022 To 06/30/2023		narod:
				10 00/30/2023	11/30/2023 1:	
	Decreases					
	Cost Cente	r	Li ne #	Sal ary	Non Salary	
	6.00		7. 00	8. 00	9. 00	
(1) A - TO RECLASS OT AND ST						
1.00	PHYSI CAL THERAPY		44. C	0 28, 551	76, 421	1.00
2. 00			0. 0	0 0	0	2.00
TOTALS						
100. 00				28, 551	76, 421	100. 00

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

ANOR In Lieu of Form CMS-2540-10
Provider No.: 315404 | Period: From 07/01/2022 | Worksheet A-7 Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COLLI NGSWOOD MANOR

					To 06/30/2023	Date/Time Prep 11/30/2023 1:5	
	<u> </u>		•	Acqui si ti ons	5		
	Description	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	257, 870	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2.00
3.00	Buildings and Fixtures	25, 603, 297	349, 969		0 349, 969	0	3.00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fixed Equipment	2, 451, 058	314, 752		0 314, 752	0	5.00
6.00	Movable Equipment	205, 130	0		0	0	6. 00
7.00	Subtotal (sum of lines 1-6)	28, 517, 355	664, 721		0 664, 721	0	7. 00
8.00	Reconciling Items	0	0		0	0	8. 00
9. 00	Total (line 7 minus line 8)	28, 517, 355	664, 721		0 664, 721	0	9. 00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	257, 870	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	25, 953, 266	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5. 00	Fi xed Equipment	2, 765, 810	0				5. 00
6.00	Movable Equipment	205, 130	0				6. 00
7.00	Subtotal (sum of lines 1-6)	29, 182, 076	0				7. 00
8.00	Reconciling Items	0	0				8.00
9. 00	Total (line 7 minus line 8)	29, 182, 076	0				9. 00

Provi der No.: 315404

Peri od:

From 07/01/2022
To 06/30/2023 Date/Time Prepared:

				10 00/30/2023	11/30/2023 1:	
				Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
	D(1)	(2) P!- F	A	Cook Cooks	1 : N-	
	Description (1)	(2) Basis For Adjustment	Amount	Cost Center	Li ne No.	
		1.00	2.00	3.00	4.00	
1. 00	Investment income on restricted funds	B B		CAP REL COSTS - BLDGS &	1.00	1.00
1.00	(chapter 2)		032	FI XTURES	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter		0		0.00	2. 00
	8)					
3.00	Refunds and rebates of expenses (chapter 8)		0	ol .	0.00	3.00
4.00	Rental of provider space by suppliers		0		0.00	4.00
	(chapter 8)					
5.00	Telephone services (pay stations excluded)		0		0.00	5. 00
	(chapter 21)					
6.00	Television and radio service (chapter 21)	В	-1, 480	PLANT OPERATION, MAINT. &	5.00	6. 00
7.00				REPAIRS	0.00	7.00
7.00	Parking lot (chapter 21)	4.0.0	0		0.00	7. 00
8. 00	Remuneration applicable to provider-based	A-8-2	0			8. 00
9. 00	physician adjustment Home office cost (chapter 21)		0		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	
11. 00	Nonallowable costs related to certain		0	1	0.00	11. 00
11.00	Capital expenditures (chapter 24)		O		0.00	11.00
12. 00	Adjustment resulting from transactions with	A-8-1	-97, 236			12. 00
	related organizations (chapter 10)		, ====			
13.00	Laundry and Linen service		0	ol .	0.00	13. 00
14.00	Revenue - Employee meals	В	-46, 322	DI ETARY	8.00	14. 00
15.00	Cost of meals - Guests		0		0.00	15. 00
16.00	Sale of medical supplies to other than		0		0.00	16. 00
	patients					
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	18. 00
19. 00	Vendi ng machi nes		0		0.00	19. 00
20. 00	Income from imposition of interest, finance		0		0.00	20. 00
04.00	or penalty charges (chapter 21)				0.00	04 00
21. 00	Interest expense on Medicare overpayments		0		0.00	21. 00
	and borrowings to repay Medicare overpayments					
22. 00	Utilization reviewphysicians' compensation		0	UTILIZATION REVIEW - SNF	82.00	22. 00
22.00	(chapter 21)		O	JOTTET ZATTON KEVTEW SIN	02.00	22.00
23. 00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS &	1.00	23. 00
20.00	boprooratron barrarnge and rextance		· ·	FI XTURES		20.00
24.00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE	2.00	24. 00
	· ·			EQUI PMENT		
25.00	MI SCELLANEOUS I NCOME	В	-12, 020	ADMINISTRATIVE & GENERAL	4.00	25. 00
25. 01	MARKETI NG SAL/OTHER	A	-450, 256	ADMINISTRATIVE & GENERAL	4.00	25. 01
25. 02	NON-ALLOWABLE EXPENSE	A		ADMINISTRATIVE & GENERAL	4.00	
25. 03	BED TAX	A		ADMINISTRATIVE & GENERAL	4.00	
25. 04	MARKETING BENEFITS	Α		EMPLOYEE BENEFITS	3.00	25. 04
25. 05	ELECTRI C REVENUE	В	-1, 201	PLANT OPERATION, MAINT. &	5.00	25. 05
			_	REPAI RS		
25. 06	5000		0		0.00	25. 06
25. 07	FOOD	A	-2, 242	DIETARY	8.00	
29.00	Total (cum of lines 1 through 00) (Transfer		004 434	<u>'</u>	0.00	29.00
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-904, 634	1		100. 00
(1) Do	scription - all chapter references in this co	lump portain to	CMC Dub 1E 1	1	I	I

⁽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

Heal th Financial Systems COLLINGSWOOL STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provi der No.: 315404

OFFICI	E COSTS				o 06/30/2023		
		Li ne No.	Cost (Center	Expense		. 51 pili
		1. 00	2.		3. (
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELATE	D ORGANI ZATI ONS	OR OR	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	4. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00		& GENERAL	HOME OFFICE COS	ST	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
	PART I. COSTS INCURRED AND ADJUSTMENTS REQUIR	Amount Allowable In Cost 4.00	Amount Included in Wkst. A, col. 5 5.00	Adjustments (col. 4 minus col. 5) 6.00	D. ODCANI ZATI ONS	· op	
	CLAIMED HOME OFFICE COSTS:	ED AS A RESULT	UF TRANSACTIO	NS WITH KELATE	D ORGANIZATIONS	O UK	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	1, 074, 308 0 0 0 0 0 0 0 0 0 0 1, 074, 308	0 0 0 0 0 0 0	0 0 0 0 0 0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00

OFFICE COSTS

2.00

06/30/2023

Name Percentage of Ownershi p

3.00

Parts I-II Date/Time Prepared: 11/30/2023 1:51 pm

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.

Symbol (1)

1.00

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.
- 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.
- 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	Type of Business	
		Ownershi p	3.	
	4.00	5. 00	6.00	1
DADT II. INTERDELATIONSHIP TO BELATER ORGANIE	14T1 011 (0) 411D (0D 11011E 0EEL 0E			_

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

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

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

1.00	UNITED METHODIST HOMES OF NJ	100.00 SUPPORT SERVICES	1.00
2. 00		0. 00	2.00
3. 00		0.00	3.00
4. 00		0.00	4. 00
5. 00		0.00	5. 00
6.00		0.00	6.00
7. 00		0.00	7.00
8.00		0.00	8.00
9. 00		0.00	9.00
10. 00		0.00	10.00
100.00 G. Other (financial or non-financial)		0. 00	100.00
speci fy:			

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

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

Health Financial Systems COLLI NGSWOOD MANOR In Lieu of Form CMS-2540-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider No.: 315404 Peri od: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/30/2023 1:51 pm 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, 256, 114 1, 256, 114 2.00 0 2.00 3.00 00300 EMPLOYEE BENEFITS 2, 021, 132 0 2, 021, 132 3.00 00400 ADMINISTRATIVE & GENERAL 3, 019, 675 0 3, 309, 545 4 00 54 507 235, 363 4 00 00500 PLANT OPERATION, MAINT. & REPAIRS 5.00 1, 537, 214 16, 632 0 96, 661 1, 650, 507 5.00 6.00 00600 LAUNDRY & LINEN SERVICE 172, 899 20, 321 29, 765 222, 985 6.00 7.00 00700 HOUSEKEEPI NG 472, 725 9, 238 0 75, 545 557, 508 7.00 00800 DI FTARY 2, 039, 606 38, 797 198.044 2, 276, 447 8 00 8 00 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 57, 238 0 13, 478 75, 335 13.00 4,619 01400 NURSING AND ALLIED HEALTH EDUCATION 14.00 14.00 01500 ACTI VI TI ES 0 15.00 229, 825 45, 511 297, 510 15.00 22, 174 01501 CHAPLAI N 15.01 65, 695 0 15, 228 80, 923 15.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 SKILLED NURSING FACILITY 3, 818, 063 233, 791 0 619, 174 4, 671, 028 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 0 33.00 2, 458, 331 841, 384 545, 809 3, 845, 524 33.00 ANCILLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 40.00 13.577 0 13.577 0 41.00 04100 LABORATORY 27, 481 C 0 27, 481 41.00 04200 I NTRAVENOUS THERAPY 0 42.00 0 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 74, 120 0 17. 168 91, 288 43.00 0 44.00 04400 PHYSI CAL THERAPY 251, 986 14,651 47, 442 314, 079 44.00 04500 OCCUPATIONAL THERAPY 42, 079 275, 704 45.00 233, 625 45.00 46.00 04600 SPEECH PATHOLOGY 151, 403 0 0 30, 587 181, 990 46.00 04700 ELECTROCARDI OLOGY 0 47 00 C Ω 47 00 0 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 25, 287 C 0 25, 287 48.00 04900 DRUGS CHARGED TO PATIENTS 0 0 49.00 49.00 161, 518 161, 518 05000 DENTAL CARE - TITLE XIX ONLY 0 0 50.00 50.00 0 05100 SUPPORT SURFACES O 51.00 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLI NI C 0 0 60.00 61 00 06100 RURAL HEALTH CLINIC 0 0 0 ol 0 61 00 62.00 06200 FQHC 62.00 OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 70.00 0 07100 AMBULANCE 0 0 71 00 Ω 71 00 0 73.00 07300 CMHC 0 0 0 73.00 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 08300 H0SPI CE 83.00 83.00 SUBTOTALS (sum of lines 1-84)
NONREIMBURSABLE COST CENTERS 18, 087, 514 0 2, 011, 854 18, 078, 236 89.00 89.00 1, 256, 114 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 63, 138 0 9, 278 72, 416 90.00 09100 BARBER AND BEAUTY SHOP 0 91.00 0 Ω 0 Ω 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

18, 150, 652

1, 256, 114

0

0

2, 021, 132

99 00

0

18, 150, 652 100. 00

Negative Cost Centers

TOTAL

99.00

100.00

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

				To	06/30/2023	Date/Time Pre 11/30/2023 1:	
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J I DIII
		& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	/ 00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & 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	3, 309, 545					4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	368, 061	2, 018, 568	1			5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	49, 725	34, 616				6. 00
7.00	00700 HOUSEKEEPI NG	124, 324	15, 737	1	697, 569	0.070.405	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	507, 645	66, 090		23, 423	2, 873, 605 0	8. 00
10.00	01000 CENTRAL SERVICES & SUPPLY		0	0	0	0	9. 00 10. 00
11. 00	01100 PHARMACY		0		0	0	11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY		0	Ö	Ö	0	12. 00
13. 00	01300 SOCIAL SERVICE	16, 800	7, 869	ō	2, 789	0	13. 00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	О	0	0	14. 00
15.00	01500 ACTI VI TI ES	66, 344	37, 772	0	13, 387	0	15.00
15. 01	01501 CHAPLAI N	18, 046	0	0	0	0	15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 SKILLED NURSING FACILITY	1, 041, 628	398, 257		141, 149	1, 365, 191	30. 00
31. 00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 TUFP LONG TERM CARE	057 540	1 422 240	(1.445	FO7 07E	1 500 414	32.00
33. 00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	857, 548	1, 433, 269	61, 465	507, 975	1, 508, 414	33. 00
40. 00	04000 RADI OLOGY	3, 028	0	0	O	0	40. 00
41. 00	04100 LABORATORY	6, 128	0		0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0, 120	0	Ö	Ö	0	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	20, 357	0	ō	O	0	43. 00
44.00	04400 PHYSI CAL THERAPY	70, 039	24, 958	О	8, 846	0	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	61, 482	0	0	0	0	45. 00
46. 00	04600 SPEECH PATHOLOGY	40, 584	0	0	0	0	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	0	0	0	0	47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 639	0	0	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	36, 018	0	0	0	0	49. 00
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0	0	0	0	50. 00 51. 00
31.00	OUTPATIENT SERVICE COST CENTERS	l d	0	ıj U	U	U	31.00
60. 00	06000 CLINIC	0	0	0	0	0	60. 00
61. 00	06100 RURAL HEALTH CLINIC	o	0	ő	Ö	0	61. 00
62.00	06200 FQHC						62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	71. 00
73. 00	07300 CMHC	0	0	0	0	0	73. 00
00.00	SPECIAL PURPOSE COST CENTERS						00.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE		0	0	O	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	3, 293, 396	2, 018, 568	307, 326	697, 569		89. 00
07.00	NONREI MBURSABLE COST CENTERS	0,270,070	2,010,000	007,020	077,007	2,070,000	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	16, 149	0	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	О	0	0	91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93. 00	09300 NONPALD WORKERS	0	0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94. 00
98. 00	Cross Foot Adjustments	0	0	0	0	0	98. 00
99.00	Negative Cost Centers	0	0 010 540	0	(07.5(0	0	99.00
100.00	D TOTAL	3, 309, 545	2, 018, 568	307, 326	697, 569	2, 873, 605	100.00

Provi der No.: 315404

					00/30/2023	11/30/2023 1:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4. 00
5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
6.00	00600 LAUNDRY & LINEN SERVICE						6. 00
7. 00	00700 HOUSEKEEPI NG						7. 00
8. 00	00800 DI ETARY						8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0					9. 00
10.00	1	0	0				10.00
11.00	1 1	0	0	0			11.00
12.00	1 1	0	0	0	0	100 700	12.00
13.00	1 1	0	0	0	0	102, 793	•
14. 00	1 1	0	0	0	0	0	
15. 00 15. 01	1	0	0	-	0	0	
15.01	01501 CHAPLAIN INPATIENT ROUTINE SERVICE COST CENTERS	0	U	l o	U	0	15.01
30. 00			0	0	0	102, 793	30.00
31. 00		0	0		0	102, 743	31.00
32. 00		0	0	-	0	0	32.00
33. 00	1	0	0		0	0	33. 00
33.00	ANCI LLARY SERVI CE COST CENTERS		0	<u> </u>	0	0	33.00
40. 00		0	0	0	0	0	40. 00
41. 00		0	0		0	Ö	41. 00
42. 00		0	0	Ö	0	l ő	42. 00
43. 00		0	0	Ö	0	l ő	43. 00
44. 00		0	0	Ö	0	0	44. 00
45. 00		0	0	Ö	0	0	45. 00
46. 00		0	0	Ō	0	0	46. 00
47. 00		0	0	Ö	0	o o	47. 00
48. 00		0	0	0	0	0	48. 00
49. 00	1	0	0	0	0	0	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50. 00
51.00		0	0	О	0	0	51. 00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	0	0	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61. 00
62.00							62. 00
	OTHER REIMBURSABLE COST CENTERS						
70. 00		0	0		0	l .	
71. 00		0	0		0	l	
73. 00		0	0	0	0	0	73. 00
	SPECIAL PURPOSE COST CENTERS	T		ı		I	
80.00	1						80.00
81. 00	1						81.00
82. 00	1		0		0	_	82.00
83.00		0			0		
89. 00		0	0	0	0	102, 793	89. 00
00 00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	00.00
90. 00 91. 00		0	0		0	0	90. 00 91. 00
91.00			0		0		91.00
93.00			0		0	0	93.00
94. 00			0		0	0	94. 00
98. 00			0		Ü		98. 00
99. 00			0		0	0	
100.00		0	0		0		
			_		_		

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

				To	06/30/2023	Date/Time Pre 11/30/2023 1:	pared:
			OTHER GENER	RAL SERVICE		11/30/2023 1.	31 pili
			OTTIER OFFICE	OE OE			
	Cost Center Description	NURSI NG AND	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Stepdown	
		ALLI ED HEALTH				Adjustments	
		EDUCATION 14.00	15. 00	15. 01	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	15.01	10.00	17.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS						3. 00
4.00	00400 ADMINISTRATIVE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						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 12. 00	01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY						11. 00 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	415, 013				15. 00
15. 01	01501 CHAPLAI N	0	0				15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS		-				
30.00	03000 SKILLED NURSING FACILITY	0	415, 013	32, 562	8, 413, 482	0	30.00
31.00	03100 NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200 CF/IID	0	0	0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0	66, 407	8, 280, 602	0	33.00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	0	0	-	16, 605		40.00
41.00	04100 LABORATORY	0	0	-	33, 609		41. 00
42. 00 43. 00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0	0	0	111 445	0 0	42. 00 43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0	0	111, 645 417, 922	0	44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	0	337, 186	_	45. 00
46. 00	04600 SPEECH PATHOLOGY	0	Ö	0	222, 574	Ö	46. 00
47. 00	04700 ELECTROCARDI OLOGY	0	Ö	0	0	Ö	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	30, 926	0	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	197, 536	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		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	O6200 FOHC OTHER REIMBURSABLE COST CENTERS						62. 00
70. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0		71. 00
	07300 CMHC	0	Ö	-	0		73. 00
	SPECIAL PURPOSE COST CENTERS		-	-,	<u> </u>		
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
81. 00	08100 I NTEREST EXPENSE						81. 00
82. 00	08200 UTILIZATION REVIEW - SNF						82.00
83. 00	08300 HOSPI CE	0	0	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	415, 013	98, 969	18, 062, 087	0	89. 00
00.00	NONREI MBURSABLE COST CENTERS		ما		00 5/5	^	00.00
90. 00 91. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0		88, 565	0	90. 00 91. 00
91.00	09200 PHYSICIANS PRIVATE OFFICES		0	0	0	0	91.00
93.00	09300 NONPALD WORKERS		0	0	0	0	93. 00
94. 00	09400 PATIENTS LAUNDRY		n	0	0	0	94. 00
98. 00	Cross Foot Adjustments	0	ő	o	0	Ö	98. 00
99. 00	Negative Cost Centers	0	o	0	0	0	99. 00
100.00		0	415, 013	98, 969	18, 150, 652	0	100. 00

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

Provi der No.: 315404

			10 06/30/2023 Date/Time Pre	
	Cost Center Description	Total	117 007 2020 1.	J I PIII
	555 551161 B5561 F11 511	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
				1
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 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	8, 413, 482		30.00
31. 00		0		31. 00
32. 00	03200 CF/11D			32.00
33. 00		8, 280, 602		33.00
33.00	ANCILLARY SERVICE COST CENTERS	0, 200, 002		33.00
40.00		1/ /05		40.00
40.00		16, 605		40.00
41. 00	1	33, 609		41.00
42. 00	04200 I NTRAVENOUS THERAPY	0		42.00
43. 00		111, 645		43. 00
44. 00	04400 PHYSI CAL THERAPY	417, 922		44. 00
45. 00	1	337, 186		45. 00
46. 00	04600 SPEECH PATHOLOGY	222, 574		46. 00
47. 00	04700 ELECTROCARDI OLOGY	0		47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 926		48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS	197, 536		49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0		50. 00
51.00	05100 SUPPORT SURFACES	o		51.00
	OUTPATIENT SERVICE COST CENTERS	'		
60.00	06000 CLI NI C	0		60.00
61.00	06100 RURAL HEALTH CLINIC	ol		61.00
62. 00				62.00
	OTHER REIMBURSABLE COST CENTERS			
70. 00	07000 HOME HEALTH AGENCY COST	0		70. 00
71. 00	07100 AMBULANCE			71.00
73. 00				73.00
70.00	SPECIAL PURPOSE COST CENTERS	١		70.00
80. 00				80. 00
81. 00				81. 00
82. 00				1
	08200 UTI LI ZATI ON REVI EW - SNF			82.00
83. 00		0		83. 00
89. 00		18, 062, 087		89. 00
0.5	NONREI MBURSABLE COST CENTERS			
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	88, 565		90.00
91. 00	09100 BARBER AND BEAUTY SHOP	0		91. 00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00	09300 NONPALD WORKERS	0		93. 00
94.00	09400 PATIENTS LAUNDRY	0		94. 00
98. 00	Cross Foot Adjustments	0		98. 00
99. 00	Negative Cost Centers	o		99. 00
100.00		18, 150, 652		100.00
	I I			

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315404

				7	Γο 06/30/2023	3 Date/Time Pre 11/30/2023 1:	pared:
			CAPI TAL REI	ATED COSTS		1173072023 1.	3 i pili
	Cook Cooks Decoriation	D:+1	DI DOC 0	MOVADLE	C	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDGS & FLXTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFITS	
		Capi tal		240112111		32.12.1.10	
		Related Costs				0.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	3. 00	
1. 00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	00300 EMPLOYEE BENEFITS	0	0		-	0	
4. 00 5. 00	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	54, 507 16, 632		54, 50 16, 63	I	
6. 00	00600 LAUNDRY & LINEN SERVICE		20, 321		20, 32	I	
7.00	00700 HOUSEKEEPI NG	0	9, 238		9, 23		1
8.00	00800 DI ETARY	0	38, 797	1	38, 79		8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		_	0	9.00
10. 00 11. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	0	0			0 0	10. 00 11. 00
12. 00	01200 MEDI CAL RECORDS & LI BRARY	0	0		Ď	o o	
13.00	01300 SOCI AL SERVI CE	0	4, 619	(4, 61	9 0	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0			0	
15. 00 15. 01	01500 ACTI VI TI ES 01501 CHAPLAI N	0	22, 174 0		22, 17	4 0 0 0	
15.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		<u> </u>	0 0	13.01
30.00	03000 SKILLED NURSING FACILITY	0	233, 791	(233, 79	1 0	30. 00
31. 00	03100 NURSING FACILITY	0	0			0	
32. 00 33. 00	03200 CF/IID 03300 OTHER LONG TERM CARE	0	0 0 1 1 20 4		-	0 4 0	
33.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	841, 384		841, 38	4] 0	33.00
40.00	04000 RADI OLOGY	0	0	(0 0	40. 00
41. 00	04100 LABORATORY	0	0		_	0	
42. 00 43. 00	04200 I NTRAVENOUS THERAPY	0	0	·		0 0	
44. 00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	14, 651	·	14, 65	-	43. 00 44. 00
45. 00	04500 OCCUPATI ONAL THERAPY	0	0	·		0 0	1
46. 00	04600 SPEECH PATHOLOGY	0	0	()	0	
47. 00 48. 00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0 0	
49. 00	04900 DRUGS CHARGED TO PATIENTS		0				1
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			0 0	50.00
51. 00	05100 SUPPORT SURFACES	0	0	(O .	0 0	51. 00
40.00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	l ,		0 0	40.00
60. 00 61. 00	06100 RURAL HEALTH CLINIC	0	0			0 0	1
62. 00	06200 FQHC			·			62. 00
	OTHER REIMBURSABLE COST CENTERS						
70.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			0 0	
71. 00 73. 00	07100 AMBULANCE 07300 CMHC	0	0			0 0	
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			×1	<u> </u>	70.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 INTEREST EXPENSE						81.00
82. 00 83. 00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE	0	0	(0 0	82. 00 83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	0	1, 256, 114		1, 256, 11		1
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0			0	1
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES		0			0 0	
93. 00	09300 NONPAI D WORKERS		0			0 0	1
94.00	09400 PATIENTS LAUNDRY	0	0	(0	0 0	94. 00
98. 00	Cross Foot Adjustments		^			0	98.00
99. 00 100. 00	Negative Cost Centers TOTAL	0	0 1, 256, 114		1, 256, 11	0 0	99. 00 100. 00
100.00	1.000	١	1, 200, 114	1	1,200,11	.,	1.00.00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLLI NGSWOOD MANOR Provi der No.: 315404

				T	0 06/30/2023	Date/Time Prep 11/30/2023 1:	pared: 51 pm
	Cost Center Description	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	от ріп
	·	& GENERAL	OPERATI ON,	LINEN SERVICE			
			MAINT. &				
		4.00	REPAI RS	/ 00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4.00	5. 00	6.00	7. 00	8. 00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT					 -	2. 00
3.00	00300 EMPLOYEE BENEFITS					 -	3. 00
4.00	00400 ADMINISTRATIVE & GENERAL	54, 507				 -	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	6, 062	22, 694			 -	5. 00
6.00	00600 LAUNDRY & LINEN SERVICE	819	389	21, 529		 -	6. 00
7.00	00700 HOUSEKEEPI NG	2, 048	177		11, 463	 -	7. 00
8.00	00800 DI ETARY	8, 361	743	1	385	48, 286	8. 00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0	1	0	0	9. 00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
11.00	01100 PHARMACY	0	0	0	0	0	11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	0	1	0	0	12.00
13. 00 14. 00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	277	88 0	1	46 0	0	13. 00 14. 00
15. 00	01500 ACTIVITIES	1, 093	425	1	220	0	15. 00
	01501 CHAPLAI N	297	423		0	0	15. 00
13.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	277		,, ,	<u> </u>	0	13.01
30. 00	03000 SKILLED NURSING FACILITY	17, 152	4, 477	17, 223	2, 319	22, 940	30. 00
31.00	03100 NURSING FACILITY	0	0		0	0	31. 00
32.00	03200 CF/IID	0	0	0	О	0	32. 00
33.00	03300 OTHER LONG TERM CARE	14, 125	16, 114	4, 306	8, 348	25, 346	33. 00
	ANCILLARY SERVICE COST CENTERS						
40.00	04000 RADI OLOGY	50	0	0	0	0	40. 00
41. 00	04100 LABORATORY	101	0	1	0	0	41. 00
42. 00	04200 I NTRAVENOUS THERAPY	0	0	1	0	01	42. 00
43. 00	04300 OXYGEN (INHALATION) THERAPY	335	0	1	0	0	43. 00
44. 00	04400 PHYSI CAL THERAPY	1, 154	281	1	145	0	44. 00
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	1, 013	0	1	U	0	45. 00
46.00	04700 ELECTROCARDI OLOGY	668	0		0	0	46. 00 47. 00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	93	0		0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	593	0		0	Ö	49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	Ö		o	0	50.00
51. 00	05100 SUPPORT SURFACES	o	0	Ö	o	0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00	06000 CLI NI C	0	C	0	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62. 00	06200 FQHC						62. 00
70.00	OTHER REIMBURSABLE COST CENTERS				ما		70.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	70.00
71. 00 73. 00	07100 AMBULANCE	0	0		0	0	71. 00 73. 00
73.00	SPECIAL PURPOSE COST CENTERS	j U		<u> </u>	U	U	73.00
80 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
	08100 I NTEREST EXPENSE					 -	81. 00
	08200 UTILIZATION REVIEW - SNF					 -	82. 00
83. 00	08300 H0SPI CE	0	Ō	0	0	0	83. 00
89. 00	SUBTOTALS (sum of lines 1-84)	54, 241	22, 694	21, 529	11, 463	48, 286	89. 00
	NONREI MBURSABLE COST CENTERS				,		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	266	C	0	0	0	90. 00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91. 00
	09200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92. 00
93. 00	09300 NONPALD WORKERS	0	0	1	0	0	93. 00
	09400 PATIENTS LAUNDRY	0	0	0	0	0	
98. 00	Cross Foot Adjustments		-] 0	0	0	98. 00
99. 00	Negative Cost Centers	[0 E4 E07	22.404	0	11 4(2)	49 294	99.00
100.00	TOTAL	54, 507	22, 694	21, 529	11, 463	48, 286	100.00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Provi der No.: 315404

COSET CENTER DESCRIPTION ADMINISTRATION SOCIAL SERVICE SOCIAL SE				To	06/30/2023	Date/Time Pre	
SEMINAL SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00	Cost Center Description	NURSLNG	CENTRAL	PHARMACY	MEDI CAL		J I DIII
SUPPLY	odst denter beserretten			1 11/11/11/11/10 1		SOUTHE SERVICE	
CENERAL SERVICE COST CENTERS							
1.00		9.00		11. 00		13. 00	
2.00 00200 CAP PEL COSTS - MOVABLE COLIPMENT 2.00 3.00 00300 CHEVEYE BERKET IS REAL 3.00 00300 CHEVEYE BERKET IS REAL 5.00 00500 CANDRUY & CHEVE SERVICE 5.00 00500 CHEVAL SERVICE 5.00 00500 CHEVAL SERVICE CHEVE SERVICE 5.00 00500 CHEVAL SERVICE 5.00 00500 CHEVAL SERVICE 5.00 CHEVAL SERVI	GENERAL SERVICE COST CENTERS						
3.00 003000 EMPLOYEE BENEFITS	1.00 00100 CAP REL COSTS - BLDGS & FIXTURES						1. 00
4.00	2.00 O0200 CAP REL COSTS - MOVABLE EQUIPMENT						2.00
5.00	3.00 00300 EMPLOYEE BENEFITS						3. 00
0.000 0.0000 LAINDRY & LI NEN SERVICE 0.000	4.00 OO400 ADMINISTRATIVE & GENERAL						4. 00
7. 0.0 00700 HOUSEKEEPING	5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5. 00
8.00 000000 NETARY NETATION 0 9.00 0.							6. 00
9.00 00000 NURSING ADMINISTRATION 0 0 0 0 110.00 110.00 110.00 11000 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 110.00 110.00 1110.							7. 00
10.00 01000 CENTRAL SERVICES & SUPPLY 0							
11.00 01100 PHARMACY		0					
12.00 01200 MEDICAL RECORDS & LIBRARY 0	l +	0	0				
13.00 O1300 SOCIAL SERVICE O O O O 5,030 13.00	l +	0	0	0			
14.00 01400 AURSING AND ALLIED HEALTH EDUCATION 0 0 0 0 0 15.00 15.01 01501 CHAPLAIN 0 0 0 0 0 0 0 15.01 101501 CHAPLAIN 0 0 0 0 0 0 0 17.01 101501 CHAPLAIN 0 0 0 0 0 0 0 17.01 101501 CHAPLAIN 0 0 0 0 0 0 0 18.01 101501 CHAPLAIN 0 0 0 0 0 0 0 19.01 101501 CHAPLAIN 0 0 0 0 0 0 0 0 19.01 100 100 00 0 0 0 0 0	l	0	0	0	0		
15.00 O1500 ACTIVITIES O O O O O D 15.00		0	0	0	0		
15. 01 01501 CHAPLAIN 0 0 0 0 0 0 15. 01		0	0	0	0		
IMPATIENT ROUTINE SERVICE COST CENTERS		1	0	-	0		
30. 00 03000 SILLED NURSING FACILITY		0	0	0	0	0	15. 01
33.00 03100 NURSI NG FACILITY 0 0 0 0 0 0 0 32.00 03.20 07.711 0 0 0 0 0 0 0 0 32.00 03.20 07.711 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	al		al		
32.00 03200 10F/I I D 0 0 0 0 0 0 32.00		1		-	0		
33.00 03300 0714FR LONG TERM CARE		1	ĭ	-	-1		
ANCILLARY SERVICE COST CENTERS		1	ĭ	-	0		
40.00		0	0	0	0	0	33.00
41.00			ما		ما		40.00
42. 00 04200 INTRAVENOUS THERAPY 0 0 0 0 0 0 42. 00 43. 00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 0 0 0 43. 00 04300 OXYGEN (INHALATION) THERAPY 0 0 0 0 0 0 44. 00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 46. 00 04600 SPECER PATHOLOGY 0 0 0 0 0 0 47. 00 04700 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 ORUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 ORUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 ORUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 ORUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 ORUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 49. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 49. 00 05000 ODENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 49. 00 04900 OLINIC SERVICE COST CENTERS 0 0 0 0 0 0 0 0 40. 00 06000 CLINIC COST CENTERS 0 0 0 0 0 0 0 0 40. 00 06000 CLINIC COST 0 0 0 0 0 0 0 0 0 40. 00 06000 MALPRASABLE COST CENTERS 0 0 0 0 0 0 0 0 0 40. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0		1		-			
43. 00 04300 0XYGEN (I NHALATION) THERAPY 0 0 0 0 0 0 0 43. 00 44. 00 04400 PHYSICAL THERAPY 0 0 0 0 0 0 0 45. 00 04500 0CCUPATIONAL THERAPY 0 0 0 0 0 0 0 46. 00 04500 0CCUPATIONAL THERAPY 0 0 0 0 0 0 0 46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 0 0 0 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 51. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 60. 00 06000 CLINIC 0 0 0 0 0 0 0 0 61. 00 06000 CLINIC 0 0 0 0 0 0 0 0 61. 00 06000 CLINIC 0 0 0 0 0 0 0 0 0 61. 00 05000 DENTAL HEALTH CLINIC 0 0 0 0 0 0 0 0 61. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 71. 00 07100 AMBULANCE 0 0 0 0 0 0 0 0 0		0	0	0	0		
44. 00 04400 PHYSI CAL THERAPY 0 0 0 0 0 0 44. 00 45. 00 04500 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 45. 00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 0 0 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 61. 00 06000 CLINIC C COST CENTERS 0 0 0 0 0 0 62. 00 06000 CLINIC C COST CENTERS 0 0 0 0 0 0 63. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 64. 00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 73. 00 07000 CHINC C C C CENTERS 0 0 0 0 0 0 0 74. 00 07000 MBULANCE 0 0 0 0 0 0 0 0 75. 00 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 81. 00 82.0		0	U	0	0	-	
45. 00 04500 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 45. 00 46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 0 0 0 46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 0 0 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 48. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 00 00 00		0	U	0	0		
46. 00 04600 SPEECH PATHOLOGY 0 0 0 0 0 0 0 46. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 47. 00 47. 00 04700 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 47. 00 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 48. 00 49. 00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 49. 00 50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 50. 00 51. 00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 0 51. 00 UITPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0		
47. 00 04700 ELECTROCARDIOLOGY			0	0	0	-	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 50.00 51.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 51.00 51.00 05100 SUPPORT SURFACES 0 0 0 0 0 0 0 0 51.00 OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLINIC 0 0 0 0 0 0 0 0 61.00 61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 61.00 62.00 06200 FOHC 0 0 0 0 0 0 0 0 61.00 OTHER REI MBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 70.00 71.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 73.00 73.00 07300 CMHC 0 0 0 0 0 0 73.00 SPECI AL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMI UMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE 82.00 82.00 08200 UTILLIZATION REVIEW - SNF 82.00 83.00 08300 HOMSPICE 0 0 0 0 0 0 0 83.00 89.00 SUBTOTALS (SUM OF I I INES 1-84) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0		
49,00			0	0	0		
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 50.00			0	0	0		
51.00			0	0	0		
OUTPATIENT SERVICE COST CENTERS O		1	0	-	0		
60. 00 06000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		<u> </u>	<u> </u>	0	<u> </u>		31.00
61. 00		n	O	0	0	0	60 00
62. 00 06200 FOHC OTHER REI MBURSABLE COST CENTERS 70. 00 O7000 HOME HEALTH AGENCY COST O O O O O O O O O O O O O O O O O O		1	0	-	0		
OTHER REIMBURSABLE COST CENTERS O	1 I		Ĭ	J	Ŭ	· ·	
70. 00							02.00
71. 00		0	0	0	0	0	70. 00
73.00 07300 CMHC 0 0 0 0 0 0 0 0 0		1	-		-		
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTIL LI ZATI ON REVIEW - SNF 82.00 83.00 08300 HOSPI CE 80.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	o	0	Ö		
81. 00			-,	- "	-,		
82.00	80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80. 00
83. 00 08300 HOSPI CE 0 0 0 0 0 0 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 0 0 0 5,030 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 98. 00 Cross Foot Adjustments 0 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0	81.00 08100 INTEREST EXPENSE						81. 00
83. 00 08300 HOSPI CE 0 0 0 0 0 0 83. 00 89. 00 SUBTOTALS (sum of lines 1-84) 0 0 0 0 5,030 NONREI MBURSABLE COST CENTERS 90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 91. 00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 0 92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 0 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 98. 00 Cross Foot Adjustments 0 0 0 0 99. 00 Negati ve Cost Centers 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0	82.00 08200 UTILIZATION REVIEW - SNF						82. 00
NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 0 0 0		0	o	0	0	0	83. 00
90. 00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 92. 00 93. 00 09300 NONPAID WORKERS 0 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 94. 00 98. 00 Cross Foot Adjustments 0 0 0 0 99. 00 0 99. 00 0 0 0 0 0 0 99. 00 0 0 0 0 0 0 0 0 0	89.00 SUBTOTALS (sum of lines 1-84)	0	o	0	0	5, 030	89. 00
91.00 09100 BARBER AND BEAUTY SHOP 0 0 0 0 0 91.00 92.00 92.00 93.00 09300 NONPAI D WORKERS 0 0 0 0 0 0 93.00 94.00 94.00 94.00 PATIENTS LAUNDRY 0 0 0 0 0 94.00 98.00 Negative Cost Centers 0 0 0 0 0 99.00		·					
92. 00 09200 PHYSI CIANS PRI VATE OFFICES 0 0 0 0 92. 00 93. 00 09300 NONPAI D WORKERS 0 0 0 0 0 93. 00 94. 00 09400 PATI ENTS LAUNDRY 0 0 0 0 0 94. 00 98. 00 Cross Foot Adjustments 0 0 0 0 0 98. 00 99. 00 Negati ve Cost Centers 0 0 0 0 0 99. 00	90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
93. 00 09300 NONPAI D WORKERS 0 0 0 0 93. 00 94. 00 94. 00 98. 00 0 0 0 0 0 94. 00 98. 00 99. 00 Negative Cost Centers 0 0 0 0 0 99. 00 0 0 99. 00 0 0 0 0 0 0 0 0 0	91.00 09100 BARBER AND BEAUTY SHOP	0	o	0	o	0	91.00
94. 00 09400 PATIENTS LAUNDRY 0 0 0 0 94. 00 98. 00 99. 00 Negative Cost Centers 0 0 0 0 99. 00 0 0 99. 00 0 0 0 0 0 0 0 0 0	92.00 09200 PHYSICIANS PRIVATE OFFICES	0	o	0	o	0	92.00
98.00 Cross Foot Adjustments	93. 00 09300 NONPALD WORKERS	0	o	0	O	0	93.00
99.00 Negative Cost Centers 0 0 0 99.00	94.00 09400 PATIENTS LAUNDRY	0	O	0	0	0	94.00
		0	o	0			
100. 00 TOTAL 0 0 0 5, 030 100. 00		1	0		0		
	100. 00 TOTAL	0	0	0	0	5, 030	100. 00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der No.: 315404

					То	06/30/2023	Date/Time Pre 11/30/2023 1:	pared:
			OTHER GENER	RAL SERVICE			11/30/2023 1.	31 pili
	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							6. 00
7. 00 8. 00	00700 HOUSEKEEPI NG 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 ACTI VI TI ES	0	23, 912					15. 00
15. 01	01501 CHAPLAI N	0	0	2	97			15. 01
	INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000 SKILLED NURSING FACILITY	0	23, 912	1	98	326, 942	0	30. 00
31. 00	03100 NURSING FACILITY	0	0		0	0	0	31. 00
32. 00	03200 CF/IID	0	0		0	0	0	32. 00
33. 00	03300 OTHER LONG TERM CARE	0	0	1	99	909, 822	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0	l	0	50	0	40. 00
41. 00	04100 LABORATORY	0	0		0	101	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	335	-	43. 00
44. 00	04400 PHYSI CAL THERAPY	0	0		0	16, 231	Ö	44. 00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	1, 013	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0	668	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	93	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0		0	593		49. 00
50. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	•	0	0		50. 00
51. 00	05100 SUPPORT SURFACES	0	0		0	0	0	51. 00
60. 00	OUTPATIENT SERVICE COST CENTERS 06000 CLINIC	0	0	Ι	0	0	0	60. 00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0		61. 00
62. 00	06200 FQHC		J		U	O		62. 00
02.00	OTHER REIMBURSABLE COST CENTERS				_			02.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	70. 00
71. 00	07100 AMBULANCE	0	0		0	0	0	71. 00
73.00	07300 CMHC	0	0		0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS							
	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80. 00
	08100 I NTEREST EXPENSE							81. 00
82.00	08200 UTILIZATION REVIEW - SNF							82. 00
83. 00 89. 00	08300 HOSPI CE	0	22.012	,	97	1 255 040	0	83. 00
07.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS		23, 912		71	1, 255, 848	0	89. 00
90. 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	266	0	90. 00
91. 00	09100 BARBER AND BEAUTY SHOP		0	l	0	0		91. 00
92. 00	09200 PHYSI CI ANS PRI VATE OFFI CES	l ő	Ö		0	0	Ö	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	Cross Foot Adjustments	0	0		0	0	0	98. 00
99. 00	Negative Cost Centers	0	0		0	0	0	99. 00
100.00	TOTAL	0	23, 912	2	97	1, 256, 114	0	100. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLLI NGSWOOD MANOR

In Lieu of Form CMS-2540-10

| Period: | Worksheet B | From 07/01/2022 | Part II |
| To 06/30/2023 | Date/Time Prepared: | 11/30/2023 1:51 pm Provi der No.: 315404

		11/30/2023 1:	
Cost Center Description	Total		
	18. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES			1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT	1		2. 00
3.00 00300 EMPLOYEE BENEFITS	1		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	1		8. 00
9. 00 00900 NURSING ADMINISTRATION			9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY			10.00
11. 00 01100 PHARMACY			11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY			12.00
13. 00 01300 SOCI AL SERVI CE	1		13. 00
14. 00 01400 NURSING AND ALLIED HEALTH EDUCATION	1		14. 00
15. 00 01500 ACTIVITIES			15. 00
15. 01 01501 CHAPLAI N			15. 01
I NPATIENT ROUTINE SERVICE COST CENTERS			13.01
30. 00 03000 SKILLED NURSING FACILITY	326, 942		30.00
31. 00 03100 NURSI NG FACILITY	320, 442		31.00
32. 00 03200 CF/IID	0		32.00
33. 00 03300 OTHER LONG TERM CARE	909, 822		33.00
ANCI LLARY SERVI CE COST CENTERS	909, 022		33.00
	FO		40.00
40. 00 04000 RADI OLOGY	50		40.00
41. 00 04100 LABORATORY	101		41.00
42. 00 04200 I NTRAVENOUS THERAPY	0		42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY	335		43.00
44. 00 04400 PHYSI CAL THERAPY	16, 231		44. 00
45. 00 04500 OCCUPATI ONAL THERAPY	1, 013		45. 00
46. 00 04600 SPEECH PATHOLOGY	668		46. 00
47. 00 04700 ELECTROCARDI OLOGY	0		47. 00
48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	93		48. 00
49. 00 04900 DRUGS CHARGED TO PATIENTS	593		49. 00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0		50.00
51. 00 05100 SUPPORT SURFACES	0		51. 00
OUTPATIENT SERVICE COST CENTERS	T al		
60. 00 06000 CLI NI C	0		60.00
61. 00 06100 RURAL HEALTH CLINIC	0		61.00
62. 00 06200 FQHC			62. 00
OTHER REIMBURSABLE COST CENTERS			
70. 00 07000 HOME HEALTH AGENCY COST	0		70.00
71. 00 07100 AMBULANCE	0		71. 00
73. 00 07300 CMHC	0		73. 00
SPECIAL PURPOSE COST CENTERS			
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES			80.00
81. 00 08100 I NTEREST EXPENSE			81. 00
82. 00 08200 UTI LI ZATI ON REVI EW - SNF			82. 00
83. 00 08300 HOSPI CE	0		83. 00
89.00 SUBTOTALS (sum of lines 1-84)	1, 255, 848		89. 00
NONREI MBURSABLE COST CENTERS			
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	266		90.00
91.00 09100 BARBER AND BEAUTY SHOP	0		91. 00
92.00 09200 PHYSICIANS PRIVATE OFFICES	0		92. 00
93. 00 09300 NONPALD WORKERS	0		93. 00
94. 00 09400 PATIENTS LAUNDRY	0		94. 00
98.00 Cross Foot Adjustments	0		98. 00
99.00 Negative Cost Centers	0		99. 00
100. 00 TOTAL	1, 256, 114		100.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

						o 06/30/2023	Date/Time Pre	
			CAPITAL REL	ATED COSTS			117 307 2023 1.	J I pili
		Cost Center Description	BLDGS &	MOVABLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
			FIXTURES (SQUARE FEET)	EQUI PMENT (SQUARE FEET)	BENEFITS (GROSS		& GENERAL (ACCUM COST)	
			,		SALARI ES)			
	GENER	AL SERVICE COST CENTERS	1.00	2.00	3. 00	4A	4. 00	
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	147, 118					1. 00
2. 00 3. 00		CAP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	0	0		ı		2. 00 3. 00
4.00	00400	ADMINISTRATIVE & GENERAL	6, 384	O	999, 566	-3, 309, 545		4. 00
5. 00 6. 00	1	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE	1, 948 2, 380		410, 509 126, 410		1, 650, 507 222, 985	5. 00 6. 00
7. 00		HOUSEKEEPI NG	1, 082	O	1		557, 508	7. 00
8.00	1	DI ETARY NURSI NG ADMI NI STRATI ON	4, 544	0	1		2, 276, 447 0	8.00
9. 00 10. 00	1	CENTRAL SERVICES & SUPPLY	0	0		0	0	9. 00 10. 00
11.00	1	PHARMACY	0	0		0	0	11.00
12. 00 13. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	541		57, 238) 3	75, 335	12. 00 13. 00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14. 00
15. 00 15. 01		ACTIVITIES CHAPLAIN	2, 597 0	0			297, 510 80, 923	
	I NPAT	ENT ROUTINE SERVICE COST CENTERS		-				
30. 00 31. 00		SKILLED NURSING FACILITY NURSING FACILITY	27, 382	0	1		4, 671, 028 0	30. 00 31. 00
32. 00	03200	ICF/IID	0	O		1	ő	32. 00
33. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	98, 544	0	2, 318, 004	0	3, 845, 524	33. 00
40. 00		RADI OLOGY	0	O	(0	13, 577	40. 00
41. 00 42. 00	1	LABORATORY I NTRAVENOUS THERAPY	0	0	(-	27, 481 0	41. 00 42. 00
43. 00	1	OXYGEN (INHALATION) THERAPY	0	0	72, 910	-	91, 288	
44. 00	1	PHYSI CAL THERAPY	1, 716	0			314, 079	44.00
45. 00 46. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0		178, 705 129, 902		275, 704 181, 990	
47. 00	04700	ELECTROCARDI OLOGY	0	0		0	0	47. 00
48. 00 49. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0			0	25, 287 161, 518	48. 00 49. 00
50. 00	05000	DENTAL CARE - TITLE XIX ONLY	0	O	_	o o	0	
51. 00		SUPPORT SURFACES TIENT SERVICE COST CENTERS	0	0		0	0	51. 00
60. 00	06000	CLINIC	0	O	1		0	60. 00
61. 00 62. 00	06100 06200	RURAL HEALTH CLINIC	0	O	C	0	0	61. 00 62. 00
02.00		REIMBURSABLE COST CENTERS						02.00
70.00		HOME HEALTH AGENCY COST AMBULANCE	0	0	1			
71. 00 73. 00	07300		0	0			l .	
00.00		AL PURPOSE COST CENTERS						00.00
80. 00 81. 00		MALPRACTICE PREMIUMS & PAID LOSSES INTEREST EXPENSE						80. 00 81. 00
82. 00	08200	UTILIZATION REVIEW - SNF						82. 00
83. 00 89. 00	08300	HOSPICE SUBTOTALS (sum of lines 1-84)	147, 118	0	1	0 2 -3, 309, 545	0 14, 768, 691	83. 00 89. 00
		IMBURSABLE COST CENTERS						
90. 00 91. 00	1	GIFT, FLOWER, COFFEE SHOPS & CANTEEN BARBER AND BEAUTY SHOP	0	0	1	0	72, 416 0	90. 00 91. 00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	Ò	o o	0	92. 00
93. 00 94. 00		NONPALD WORKERS PATIENTS LAUNDRY	0	0		0	0	93. 00 94. 00
98. 00	07400	Cross Foot Adjustments				,		98. 00
99.00		Negative Cost Centers	1, 256, 114		2 021 12		3, 309, 545	99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	1, 250, 114			-	3, 307, 345	102.00
103.00 104.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	8. 538139	0. 000000	0. 235465	5	0. 222999 54 507	
104.00	Ί	Part II)				΄	54, 507	104.00
105.00)	Unit cost multiplier (Wkst. B, Part			0.000000	D	0. 003673	105. 00
	1	11)	I	ı	I	I	I	I

Provi der No.: 315404

				o 06/30/2023		
Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	11/30/2023 1: NURSI NG	51 pm
cost center bescription	OPERATION,	LI NEN SERVI CE				
	MAINT. &	(POUNDS OF	(Ì		
	REPAI RS	LAUNDRY)			(DI RECT	
	(SQUARE FEET)	6.00	7. 00	8. 00	NURSI NG) 9. 00	
GENERAL SERVICE COST CENTERS	5. 00	0.00	7.00	8.00	9.00	
1.00 O0100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00 00300 EMPLOYEE BENEFITS						3. 00
4. 00 00400 ADMI NI STRATI VE & GENERAL	400 70/					4. 00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS 6.00 00600 LAUNDRY & LINEN SERVICE	138, 786	ł .				5. 00 6. 00
7. 00 00700 LAUNDRY & LINEN SERVICE	2, 380 1, 082		1			7. 00
8. 00 00800 DI ETARY	4, 544	l o	4, 544			8. 00
9.00 00900 NURSING ADMINISTRATION	0	0	C	0	0	9. 00
10. 00 01000 CENTRAL SERVICES & SUPPLY	0	0	C	O	0	10.00
11. 00 01100 PHARMACY	0	0	C C	0	0	11. 00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	0	0	[C	0	0	12.00
13.00 O1300 SOCIAL SERVICE 14.00 O1400 NURSING AND ALLIED HEALTH EDUCATION	541		541		0	13. 00 14. 00
15. 00 01500 ACTIVITIES	2, 597		2, 597	Ö	0	15. 00
15. 01 01501 CHAPLAI N	0	Ö	2,0,7	o	0	15. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 SKILLED NURSING FACILITY	27, 382	249, 524	27, 382	53, 808	0	30. 00
31.00 03100 NURSING FACILITY	0	0	C	0	0	31.00
32. 00 03200 TEPL LONG TEPM CAPE	98, 544	(42 201	98, 544	59, 453	0	32. 00 33. 00
33.00 O3300 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	98, 544	62, 381	98, 544	39, 453	U	33.00
40. 00 04000 RADI OLOGY	0	0	C	o	0	40. 00
41. 00 04100 LABORATORY	0	0	d	o	0	41.00
42.00 04200 INTRAVENOUS THERAPY	0	0	C	0	0	42. 00
43. 00 04300 OXYGEN (INHALATION) THERAPY	0	0	C	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	1, 716	0	1, 716	0	0	44.00
45.00 04500 OCCUPATI ONAL THERAPY 46.00 04600 SPEECH PATHOLOGY	0	0			0 0	45. 00 46. 00
47. 00 04700 SELECT FATHOLOGY	0				0	47. 00
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	Ö	i c	o	Ö	48. 00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	c	0	0	49. 00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	0	0	50. 00
51. 00 05100 SUPPORT SURFACES	0	0	<u> </u>	0	0	51.00
60.00 OUTPATIENT SERVICE COST CENTERS	0	0	l c	1	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	0					61.00
62. 00 06200 FQHC						62. 00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000 HOME HEALTH AGENCY COST	0		C			70. 00
71. 00 07100 AMBULANCE	0				-	71.00
73. 00 O7300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>) ()	0	73. 00
80. 00 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 08100 I NTEREST EXPENSE						81. 00
82.00 08200 UTILIZATION REVIEW - SNF						82. 00
83. 00 08300 HOSPI CE	0		C	١	0	83. 00
89.00 SUBTOTALS (sum of lines 1-84)	138, 786	311, 905	135, 324	113, 261	0	89. 00
NONREI MBURSABLE COST CENTERS 90. 00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	l c	ol	0	90.00
91. 00 09100 BARBER AND BEAUTY SHOP						91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0			-	ő	92.00
93. 00 09300 NONPALD WORKERS	0	0	d	o	0	93. 00
94.00 09400 PATIENTS LAUNDRY	0	0	(c	o	0	94. 00
98.00 Cross Foot Adjustments						98. 00
99.00 Negative Cost Centers 102.00 Cost to be allocated (per Wkst. B,	2 010 540	207 224	697, 569	2 072 405	_	99.00
102.00 Cost to be allocated (per Wkst. B, Part I)	2, 018, 568	307, 326	097, 209	2, 873, 605		102. 00
103.00 Unit cost multiplier (Wkst. B, Part I)	14. 544464	0. 985319	5. 154806	25. 371531	0. 000000	103. 00
104.00 Cost to be allocated (per Wkst. B,	22, 694		1	1		104. 00
Part II)						
105.00 Unit cost multiplier (Wkst. B, Part	0. 163518	0. 069024	0. 084708	0. 426325	0. 000000	105. 00
11)	I	I	I	1 1	I	I

	rindicial systems	CULLINGSWUC				u or Form CW3	
COST	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2022	Worksheet B-1	
					o 06/30/2023		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11/30/2023 1: NURSI NG AND	51 pm
	oost denter bescription	SERVICES &	(COSTED	RECORDS &	SOOTAL SERVICE	ALLI ED HEALTH	
		SUPPLY	REQUIS)	LI BRARY	(PATIENT DAYS)		
		(COSTED		(TIME SPENT)		(ASSI GNED	
		REQUIS) 10.00	11. 00	12.00	13.00	TI ME) 14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT						2. 00
3.00	OO300						3.00
4. 00 5. 00	00500 PLANT OPERATION, MAINT. & REPAIRS						4. 00 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 10. 00	00900 NURSI NG ADMI NI STRATI ON						9.00
11. 00	O1000 CENTRAL SERVI CES & SUPPLY O1100 PHARMACY		0				10. 00 11. 00
12. 00	01200 MEDICAL RECORDS & LIBRARY	0	0	C)		12. 00
13.00	01300 SOCIAL SERVICE	0	0	C	17, 956		13. 00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	
15.00	01500 ACTIVITIES	0	0	_	-	0	
15. 01	O1501 CHAPLAI N I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0		ıl U	0	15. 01
30. 00	03000 SKILLED NURSING FACILITY	0	0	C	17, 956	0	30.00
31.00	03100 NURSING FACILITY	0	0	C		0	31. 00
32. 00	03200 CF/IID	0	0	-	-	0	
33. 00	03300 OTHER LONG TERM CARE	0	0	0	0	0	33. 00
40. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	0	0		ol	0	40.00
41. 00	04100 LABORATORY		0	1	-	0	
42.00	04200 I NTRAVENOUS THERAPY	o	0	o c	0	0	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	O.	0	0	
44.00	04400 PHYSI CAL THERAPY	0	0		0	0	
45. 00 46. 00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	0	0		0	0	
47. 00	04700 ELECTROCARDI OLOGY	0	0	ď	Ö	ő	ı
48. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	o c	0	0	48. 00
49. 00	04900 DRUGS CHARGED TO PATIENTS	0	0	O.	0	0	
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	-	1		
31.00	O5100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	l O	0	1	ıl U	0	31.00
60.00	06000 CLINIC	0		С	0	0	60.00
61. 00	06100 RURAL HEALTH CLINIC	0	0	C	0	0	61. 00
62. 00	06200 FOHC						62.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0	C	O	0	70.00
70. 00 71. 00	07100 AMBULANCE		0	1			
	07300 CMHC	l o	0	1	1		1
	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81. 00 82. 00
83. 00	08300 HOSPI CE	0	0		0	0	1
89. 00	SUBTOTALS (sum of lines 1-84)	0	0	1	1		1
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		-		
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFICES		0	C	0	0	
93. 00	09300 NONPAID WORKERS		0		o	0	
94.00	09400 PATIENTS LAUNDRY	O	0	d	O	0	1
98. 00	Cross Foot Adjustments						98. 00
99.00	Negative Cost Centers		0		100 700		99.00
102.00	Cost to be allocated (per Wkst. B, Part I)		0	C	102, 793		102. 00
103.00		0. 000000	0. 000000	0.000000	5. 724716	0. 000000	103. 00
104.00	Cost to be allocated (per Wkst. B,	0	0	C	5, 030		104. 00
105 00	Part II)	0.000000	0.000000	0.000000	0.000100	0.00000	105 00
105.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.000000	0. 280129	0. 000000	105.00
	1 17	1 I		1	1	1	1

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der No.: 315404

Peri od: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				10 00/30/2023	11/30/2023 1:51	
		OTHER GENER	AL SERVICE			
	Cost Center Description	ACTIVITIES	CHAPLAI N			
	cost center bescription	(PATIENT DAYS)				
		15. 00	15. 01			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				l	1. 00
2. 00 3. 00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS				1	2. 00 3. 00
4. 00	00400 ADMI NI STRATI VE & GENERAL				1	4. 00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				1	5. 00
6. 00	00600 LAUNDRY & LINEN SERVICE				1	5. 00
7.00	00700 HOUSEKEEPI NG				1	7. 00
8. 00 9. 00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON					3. 00 9. 00
10. 00					1	0. 00
11. 00					1	1. 00
12. 00					ı	2. 00
13.00					ı	3. 00
14. 00 15. 00		17, 956			ı	4. 00 5. 00
15. 00		17, 730	54, 576		l l	5. 01
	I NPATIENT ROUTINE SERVICE COST CENTERS	, ,				
30. 00		17, 956	17, 956		l	0. 00
31. 00		0	0		l	1. 00
32. 00 33. 00		0	36, 620		l l	2. 00 3. 00
33.00	ANCILLARY SERVICE COST CENTERS	١	30, 020). 00
40. 00		0	0		40	0. 00
41. 00		0	0		ı	1. 00
42. 00		0	0		l l	2. 00
43. 00 44. 00		0	0		l	3. 00 4. 00
45. 00			0		1	4. 00 5. 00
46. 00		o	o		1	5. 00
47.00		0	O		47	7. 00
48. 00		0	0		1	3. 00
49. 00		0	0		1	9. 00
50. 00 51. 00		0	0			0. 00 1. 00
01.00	OUTPATIENT SERVICE COST CENTERS	9	<u> </u>		01	. 00
60.00		0	0		60	0. 00
61. 00		0	0		ı	1. 00
62. 00	06200 FQHC OTHER REIMBURSABLE COST CENTERS				62	2. 00
70. 00		0	0		70	0. 00
71. 00		o	Ö		ı	1. 00
73. 00		0	O		73	3. 00
00.00	SPECIAL PURPOSE COST CENTERS					
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE				l	0. 00 1. 00
82. 00					l	2. 00
83. 00		0	o		l l	3. 00
89. 00	SUBTOTALS (sum of lines 1-84)	17, 956	54, 576		89	9. 00
	NONREI MBURSABLE COST CENTERS					
90. 00 91. 00		0	0			0. 00 1. 00
91.00			0		l l	2. 00
93. 00		0	o		1	3. 00
94.00		0	O			4. 00
98. 00						3.00
99.00	1 1 9	41E 013	00 060		1	9.00
102. 0	O Cost to be allocated (per Wkst. B, Part I)	415, 013	98, 969		102	2. 00
103.0		23. 112776	1. 813416		103	3. 00
104.0		23, 912	297		104	4. 00
105.0	Part II)	4 004700	0.005440		4.5-	- 00
105. 0	O Unit cost multiplier (Wkst. B, Part	1. 331700	0. 005442		105	5. 00
	1 1	ı	1		1	

Heal th	Financial Systems COLI	LINGSWOOD MANOR		In Lie	u of Form CMS-2	2540-10
RATI 0	OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST	CENTERS Provi der		Peri od:	Worksheet C	
				From 07/01/2022	5	
				To 06/30/2023	Date/Time Pre	
	Cost Center Description		Total (from	Total Charges	11/30/2023 1: Ratio (col. 1	o i pili
	cost center bescription		Wkst. B, Pt I			
			· ·	•	di vi ded by	
			col . 18)	2. 00	col . 2	
	ANOLUL ADV. CEDVI CE. COCT. CENTEDO		1.00	2.00	3. 00	
	ANCILLARY SERVICE COST CENTERS			- 40	4 000004	
	04000 RADI OLOGY		16, 60		1. 223024	40.00
	04100 LABORATORY		33, 60	9 25, 840		
42. 00	04200 I NTRAVENOUS THERAPY			0	0. 000000	42. 00
43.00	04300 OXYGEN (INHALATION) THERAPY		111, 64	5 74, 120	1. 506274	43.00
44.00	04400 PHYSI CAL THERAPY		417, 92	2 326, 696	1. 279238	44.00
45.00	04500 OCCUPATI ONAL THERAPY		337, 18	5 355, 300	0. 949018	45. 00
46.00	04600 SPEECH PATHOLOGY		222, 57	4 142, 254	1. 564624	46. 00
47.00	04700 ELECTROCARDI OLOGY			0	0.000000	47. 00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		30, 92	6 25, 287	1. 223000	48. 00
49.00	04900 DRUGS CHARGED TO PATIENTS		197, 53	6 141, 024	1. 400726	49. 00
50.00	05000 DENTAL CARE - TITLE XIX ONLY			0	0.000000	50.00
51.00	05100 SUPPORT SURFACES			0	0.000000	51.00
	OUTPATIENT SERVICE COST CENTERS		•	•		
60.00	06000 CLINIC			n n	0.000000	60 00

0.000000

0.000000

0

0

1, 104, 098

0

1, 368, 003

60.00

61.00

62.00

71.00

100.00

60. 00 | 06000 | CLI NI C | 61. 00 | 06100 | RURAL | HEALTH | CLI NI C

62. 00 06200 FOHC 71. 00 07100 AMBULANCE 100. 00 Total

Health Financial Systems	COLLI NGSWO	OD MANOR		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315404	Peri od: From 07/01/2022 To 06/30/2023		pared: 51 pm
		Title	XVIII (1)	Skilled Nursing Facility	PPS	•
		Health Care Pr	rogram Charge	s Health Care	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	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	LENT COST					
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	1. 223024	4, 435		0 5, 424	0	
41. 00 04100 LABORATORY	1. 300658			0 33, 609	0	
42. 00 04200 I NTRAVENOUS THERAPY	0. 000000	0		0	0	
43.00 04300 OXYGEN (INHALATION) THERAPY	1. 506274	0		0	0	
44. 00 04400 PHYSI CAL THERAPY	1. 279238			0 351, 605	0	
45. 00 04500 OCCUPATI ONAL THERAPY	0. 949018	295, 521		0 280, 455	0	1 .0.00
46. 00 04600 SPEECH PATHOLOGY	1. 564624	142, 254		0 222, 574	0	1 .0.00
47. 00 04700 ELECTROCARDI OLOGY	0. 000000			0	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 223000			0	0	
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 400726			0 197, 536	0	1
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0		50.00
51. 00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS		_		_	_	
60. 00 06000 CLI NI C	0. 000000	0		0 0	0	
61. 00 06100 RURAL HEALTH CLINIC						61.00
62. 00 06200 FQHC				_		62. 00
71. 00 07100 AMBULANCE (2)	0. 000000			0	0	
100.00 Total (Sum of Lines 40 - 71)	1	883, 929		0 1, 091, 203		100.00

⁽¹⁾ For title V and XIX use columns 1, 2, and 4 only.

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

APPORTI (Financial Systems	COLLINGSWO	OD MANOR		In Lie	u of Form CMS-2	2540-10
	ONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315404	Peri od: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/30/2023 1:	
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description					1. 00	
P	PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00	Drugs charged to patients - ratio of co	st to charges	(From Workshee	t C, column 3	, line 49)	1. 400726	1.00
2.00	Program vaccine charges (From your reco	rds, or the PS	&R)			0	2. 00
3.00	Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	er this amoun	t to Worksheet	0	3. 00
	E, Part I, line 18)						
	Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
		(From Wkst. B,	(From Wkst. B,		Cost (From h Wkst. D Part	& Allied Health Costs	
		18		Costs to Tota		for Pass	
		10		Costs - Part		Through (Col.	
			1 17	(Col. 2 / Col		3 x Col . 4)	
				1)		,	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
	NCILLARY SERVICE COST CENTERS			1			
	04000 RADI OLOGY	16, 605				0	40.00
	04100 LABORATORY	33, 609	0	0.0000		0	41.00
	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	111, 645	0	0. 00000 0. 00000		0	42. 00 43. 00
	04400 PHYSI CAL THERAPY	417, 922		0.0000		0	44.00
	04500 OCCUPATIONAL THERAPY	337, 186	0	0.0000		0	45. 00
	04600 SPEECH PATHOLOGY	222, 574		0.0000		0	
	04700 ELECTROCARDI OLOGY	0	Ö	0. 00000		Ö	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 926	O	0.0000		0	48. 00
49.00 C	04900 DRUGS CHARGED TO PATIENTS	197, 536	0	0. 00000	00 197, 536	0	49. 00
	D5000 DENTAL CARE - TITLE XIX ONLY	0	0	0. 00000		0	
	05100 SUPPORT SURFACES	0	0	0.0000		0	
100.00	Total (Sum of lines 40 - 52)	1, 368, 003	0	1	1, 091, 203	0	100. 00

	Financial Systems COLLINGSWOOD M TATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315404	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2022 To 06/30/2023	Parts I-II Date/Time Pre 11/30/2023 1:	pared 51 pr
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	INPATIENT DAYS				
00	Inpatient days including private room days			17, 956	1.
00	Private room days			0	2
00	Inpatient days including private room days applicable to the Pr	ogram		3, 786	3
0	Medically necessary private room days applicable to the Program			0	4
0	Total general inpatient routine service cost			8, 413, 482	5
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				1
0	General inpatient routine service charges			10, 019, 240	
0	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		0. 839733	
0	Enter private room charges from your records			0	8
0	Average private room per diem charge (Private room charges line 2)	8 divided by private	room days, line	0. 00	9
00	Enter semi-private room charges from your records			10, 019, 240	10
00	Average semi-private room per diem charge (Semi-private room c semi-private room days)	harges line 10, divide	d by	557. 99	11
00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12
00	Average per diem private room cost differential (Line 7 times I			0.00	13
00	Private room cost differential adjustment (Line 2 times line 13			0	14
00	General inpatient routine service cost net of private room cost PROGRAM INPATIENT ROUTINE SERVICE COSTS	differential (Line 5	minus line 14)	8, 413, 482	15
00	Adjusted general inpatient service cost per diem (Line 15 divi	ded by line 1)		468. 56	16
00	Program routine service cost (Line 3 times line 16)	ded by Title T)		1, 773, 968	
00	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		1, 773, 700	18
00	Total program general inpatient routine service cost (Line 17)			1, 773, 968	
00	Capital related cost allocated to inpatient routine service cos		t II column 18.	326, 942	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			,	
00	Per diem capital related costs (Line 20 divided by line 1)			18. 21	21
00	Program capital related cost (Line 3 times line 21)			68, 943	22
00	Inpatient routine service cost (Line 19 minus line 22)			1, 705, 025	23
00	Aggregate charges to beneficiaries for excess costs (From prov	ider records)		0	24
00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	1, 705, 025	25
00	Enter the per diem limitation (1)				26
00	Inpatient routine service cost limitation (Line 3 times the per				27
00	Reimbursable inpatient routine service costs (Line 22 plus the (Transfer to Worksheet E, Part II, line 4) (See instructions)	lesser of line 25 or	line 27)		28
Li	nes 26 and 27 are not applicable for title XVIII, but may be use	d for title V and or t	itle XIX		
				1. 00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		00	
0	Total SNF inpatient days			17, 956	1
· ·					

2. 00 3. 00 4. 00 5. 00

3, 786

Program inpatient days (see instructions)
Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)
Nursing & allied health ratio. (line 2 divided by line 1)
Program nursing & allied health costs for pass-through. (line 3 times line 4)

2.00

4. 00 5. 00

Ilth Financial Systems	COLLI NGSWOOD MAN			u of Form CMS-2	
MPUTATION OF INPATIENT ROUTINE COSTS	F	Provi der No. : 315404	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-1 Parts I-II Date/Time Pre 11/30/2023 1:	pare
		Title XIX	Skilled Nursing Facility	Cost	
PART I CALCULATION OF INPATIENT ROUTINE COS	272			1. 00	
I NPATI ENT DAYS	513				1
Inpatient days including private room days				17, 956	1
O Private room days				0	2
On Inpatient days including private room days	applicable to the Prog	ram		6, 744	3
Medically necessary private room days appl				0	4
Total general inpatient routine service co	st			8, 413, 482	5
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				10, 019, 240	6
O General inpatient routine service charges General inpatient routine service cost/cha	rgo ratio (Lino E divi	dod by Lino 6)		0. 839733	
O Enter private room charges from your record		ded by Title 0)		0.037733	
O Average private room per diem charge (Private		divided by private	room days line	0.00	
2)	g				
00 Enter semi-private room charges from your	records			10, 019, 240	
00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by				557. 99	11
semi -pri vate room days)					
Average per diem private room charge differential (Line 9 minus line 11)				0.00	
Average per diem private room cost differential (Line 7 times line 12)				0.00	1
O Private room cost differential adjustment (Line 2 times line 13) O General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)				8, 413, 482	
PROGRAM INPATIENT ROUTINE SERVICE COSTS	or private room cost a	TTTCTCTTTTTT (ETTIC 5	mirius irric i+/	0, 413, 402	'
00 Adjusted general inpatient service cost pe	r diem (Line 15 divide	d by line 1)		468. 56	16
00 Program routine service cost (Line 3 times	s line 16)	,		3, 159, 969	
00 Medically necessary private room cost appl				0	1
00 Total program general inpatient routine se				3, 159, 969	
00 Capital related cost allocated to inpatien		(From Wkst. B, Par	t II column 18,	326, 942	20
line 30 for SNF; line 31 for NF, or line 3.				10 01	
00 Per diem capital related costs (Line 20 d 00 Program capital related cost (Line 3 time				18. 21 122, 808	
00 Inpatient routine service cost (Line 3 time)				3, 037, 161	
00 Aggregate charges to beneficiaries for exc		er records)		0,037,101	
OD Total program routine service costs for co			nus line 24)	3, 037, 161	
00 Enter the per diem limitation (1)	•	•	, i	0.00	26
00 Inpatient routine service cost limitation				0	
00 Reimbursable inpatient routine service cos		esser of line 25 or	line 27)	3, 159, 969	28
(Transfer to Worksheet E, Part II, line 4)					
Lines 26 and 27 are not applicable for title	XVIII, but may be used	for title V and or t	itle XIX		
				1. 00	
PART II CALCULATION OF INPATIENT NURSING &	ALLIED HEALTH COSTS FO	R PPS PASS-THROUGH			
O Total SNF inpatient days				17, 956	1
Program inpatient days (see instructions)				6, 744	
Total nursing & allied health costs. (see	, ,	mplete for titles V	or XIX)	0	
Nursing & allied health ratio. (line 2 div	,			0. 375585	
O Program nursing & allied health costs for	pass-inrough. (line 3 t	rmes rine 4)		0	!

Heal th	Financial Systems		COLLI NGSWOOD MA	ANOR	In Lie	u of Form CMS-2540-10
CALCUL	ATION OF REIMBURSEMENT SE	ETTLEMENT FOR TITLE XVIII		Provi der No.: 315404	From 07/01/2022	Worksheet E Part I Date/Time Prepared: 11/30/2023 1:51 pm
•				Title XVIII	Skilled Nursing	PPS

				11/30/2023 1.	o i piii
		Title XVIII	Skilled Nursing Facility	PPS	
	T			1. 00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURS	EMENT			
1.00	Inpatient PPS amount (See Instructions)	_		2, 360, 823	1.00
2.00	Nursing and Allied Health Education Activities (pass through pa	yments)		0	2. 00
3.00	Subtotal (Sum of lines 1 and 2)			2, 360, 823	3.00
4.00	Pri mary payor amounts			0	4.00
5.00	Coinsurance			283, 069	5. 00
6.00	Allowable bad debts (From your records)			494	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instru	ictions)		0	7. 00
8.00	Adjusted reimbursable bad debts. (See instructions)			321	
9. 00	Recovery of bad debts - for statistical records only			0	9. 00
10.00	Utilization review			0	10.00
11. 00	Subtotal (See instructions)			2, 078, 075	
12.00	Interim payments (See instructions)			2, 036, 199	
13.00	Tentati ve adj ustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14. 50	Demonstration payment adjustment amount before sequestration			0	14. 50
14. 55	Demonstration payment adjustment amount after sequestration			0	14. 55
14. 75	Sequestration for non-claims based amounts (see instructions)			6	14. 75
14. 99	Sequestration amount (see instructions)			41, 555	1
15.00	Balance due provider/program (see Instructions)	CMC Dub 15 0		315	1
16. 00	Protested amounts (Nonallowable cost report items in accordance			0	16. 00
17 00	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	UF CUST UR CHARGES -	TITLE XVIII UNLY	0	17 00
17. 00 18. 00	Ancillary services Part B Vaccine cost (From Wkst D, Part II, line 3)			0	17. 00 18. 00
19. 00	Total reasonable costs (Sum of Lines 17 and 18)			0	19.00
20. 00	Medicare Part B ancillary charges (See instructions)			0	20.00
21. 00	Cost of covered services (Lesser of line 19 or line 20)			0	21.00
22. 00	Primary payor amounts			0	22.00
23. 00	Coinsurance and deductibles			0	23.00
24. 00	Allowable bad debts (From your records)			0	24.00
24. 01	Allowable Bad debts for dual eligible beneficiaries (see instru	ictions)		0	24. 01
24. 02	Adjusted reimbursable bad debts (see instructions)	10113)		0	24. 02
25. 00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25. 00
26. 00	Interim payments (See instructions)			0	26.00
27. 00	Tentative adjustment			0	27. 00
28. 00	Other Adjustments (See instructions) Specify			0	28. 00
28. 50	Demonstration payment adjustment amount before sequestration			0	28. 50
28. 55	Demonstration payment adjustment amount after sequestration			0	28. 55
28. 99	Sequestration amount (see instructions)			0	28. 99
29. 00	Balance due provider/program (see instructions)			0	29. 00
	Protested amounts (Nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	section 115.2	0	30.00
30.00	Trotested amounts (Nonarrowable cost report remis) in accordance	e with cws rub. 15-2,	36011011 113. 2	O ₁	J 30. 0

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 07/01/2022	Worksheet E Part II Date/Time Prepared: 11/30/2023 1:51 pm
		Title XIX	Skilled Nursing Facility	Cost

		litle XIX	Skilled Nursing Facility	Cost	
			Facility		
			-	1. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)			0	1.00
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	1
3.00	Outpati ent servi ces	•		0	3. 00
4.00	Inpatient routine services (see instructions)			3, 159, 969	4. 00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5. 00
6.00	Cost of covered services (Sum of lines 1 - 5)			3, 159, 969	6. 00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate a	accommodations	0	7. 00
8.00	SUBTOTAL (Line 6 minus line 7)			3, 159, 969	8. 00
9.00	Primary payor amounts			0	9. 00
10.00	Total Reasonable Cost (Line 8 minus line 9)			3, 159, 969	10.00
	REASONABLE CHARGES				
11. 00	Inpatient ancillary service charges			0	11. 00
12.00	Outpati ent servi ce charges			0	12. 00
13.00	Inpatient routine service charges			0	
14. 00	Differential in charges between semiprivate accommodations and	less than semiprivate a	accommodations	0	
15. 00	Total reasonable charges			0	15. 00
	CUSTOMARY CHARGES				
16. 00	Aggregate amount actually collected from patients liable for pa			-	16. 00
17. 00	Amounts that would have been realized from patients liable for	payment for services or	n a charge basis	0	17. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	40.00
18.00	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.000000	
19. 00	Total customary charges (see instructions)			0	19. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Cost of covered services (see Instructions)			0	20.00
20. 00 21. 00	Deductibles			0	
21.00	Subtotal (Line 20 minus line 21)			0	
23. 00	Coinsurance			0	
24. 00	Subtotal (Line 22 minus line 23)			0	
25. 00	Allowable bad debts (from your records)			0	
26. 00	Subtotal (sum of lines 24 and 25)			0	
27. 00	Unrefunded charges to beneficiaries for excess costs erroneousl	v collected based on co	orrection of	0	
27.00	cost limit	y corrected based on ea	511 00 11 011 01	· ·	27.00
28. 00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in p	orogram	0	28. 00
	utilization	·			
29.00	Other Adjustments (see instructions) Specify			0	29. 00
30.00	Amounts applicable to prior cost reporting periods resulting fr	om disposition of depre	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	
32. 00	Interim payments			0	
33. 00	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parenth	neses) (see	0	33. 00
	Instructions)				1

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider No.: 315404 | Period: From 07/01/2022 To 06/30/2023 | Date/Time Prepared: 11/30/2023 1:51 pm |

Title XVIII | Skilled Nursing | PPS

		11 (1	e XVIII S	Facility	PPS	
		Innation	t Part A		t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 036, 199		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, lenter zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			<u>I</u>		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	
3.53			0		0	
3.54			0		0	
3. 99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 036, 199		0	4. 00
4.00	(Transfer to Wkst. E, Part I line 12 for Part A, and line		2,030,177			7.00
	26 for Part B)					
	TO BE COMPLETED BY CONTRACTOR					ĺ
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03	District date to District		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM					
5. 52			0		0	
5. 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50		0		0	
5. 77	- 5. 98)					3. //
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	PROGRAM TO PROVIDER		315		0	6. 01
6.02	PROVI DER TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 036, 514		0	7. 00
			Contract	tor Name	Contractor	
					Number	
0.00			1.	00	2. 00	0.00
	Name of Contractor		l			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 only)

Provi der No.: 315404 | Peri od: From 07/01/2022 | To 06/30/2023

| Period: | Worksheet G | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/30/2023 1:51 pm |

oni y)			6 : 6:		11/30/2023 1:	51 pm
		General Fund	Specific En Purpose Fund	idowment Fund	Plant Fund	
	Accets	1.00	2. 00	3. 00	4. 00	
	Assets CURRENT ASSETS					1
1. 00	Cash on hand and in banks	61, 490	0	0	0	1.0
2.00	Temporary investments	0	0	0	0	
3.00	Notes recei vable	0	0	0	0	1
4.00	Accounts receivable	4, 256, 565	0	0	0	
5. 00 6. 00	Other receivables Less: allowances for uncollectible notes and accounts	-1, 174, 250	0	0	0	5. 0 6. 0
6.00	recei vabl e	-1, 174, 230	٥	٩	U	0.0
7. 00	Inventory	57, 381	o	o	0	7.0
8. 00	Prepai d expenses	141, 508	0	О	0	8.0
9.00	Other current assets	0	O	o	0	9. 0
10.00	Due from other funds	33, 054, 642		0	0	
11. 00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	36, 397, 336	0	0	0	11. C
10.00	FI XED ASSETS	257.070		ما	0	1 12 0
12. 00 13. 00	Land improvements	257, 870	0	0	0	12. 0 13. 0
14. 00	Less: Accumulated depreciation			0	0	14.0
15. 00	Bui I di ngs	25, 953, 266	-	0	0	15. C
16. 00	Less Accumulated depreciation	-16, 235, 499		Ö	0	16. C
17. 00	Leasehold improvements	0	O	o	0	17. C
18. 00	Less: Accumulated Amortization	0	0	О	0	18.0
19. 00	Fi xed equipment	2, 765, 809	0	0	0	19.0
20. 00	Less: Accumulated depreciation	-1, 726, 551	0	0	0	20.0
21. 00	Automobiles and trucks	205, 130		0	0	21.0
22. 00	Less: Accumulated depreciation	-205, 130	0	0	0	22.0
23. 00	Major movable equipment	0	0	0	0	23.0
24. 00	Less: Accumulated depreciation	0	0	0	0	24.0
25. 00 26. 00	Mi nor equi pment - Depreci abl e		0	U O	0	25. C
27. 00	Minor equipment nondepreciable Other fixed assets			0	0	27.0
28. 00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	11, 014, 895		0	0	28.0
20.00	OTHER ASSETS	11,011,070	<u> </u>	<u> </u>	0	20.0
29. 00	Investments	0	0	0	0	29.0
30. 00	Deposits on Leases	0	0	o	0	30.0
31. 00	Due from owners/officers	0	0	0	0	31.0
32. 00	Other assets	490, 852	0	0	0	32. 0
33. 00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	490, 852	0	0	0	33.0
34. 00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	47, 903, 083	0	0	0	34.0
	Liabilities and Fund Balances CURRENT LIABILITIES					-
35. 00	Accounts payable	1, 115, 376	0	0	0	35.0
36. 00	Salaries, wages, and fees payable	1, 018, 443		ol	0	36. 0
37. 00	Payroll taxes payable	0	O	o	0	37.0
38. 00	Notes & Loans payable (Short term)	0	0	О	0	38.0
39. 00	Deferred income	0	0	0	0	39.0
40. 00	Accel erated payments	0				40.0
41. 00	Due to other funds	0	0	0	0	
42.00	Other current liabilities	18, 403		0	0	
43. 00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	2, 152, 222	0	0	0	43.0
44. 00	LONG TERM LIABILITIES		0	0	0	144 0
44. 00 45. 00	Mortgage payable Notes payable	3, 545, 522	0	0	0	1
46. 00	Unsecured Loans	3, 343, 322	١	0	0	
47. 00	Loans from owners:	0		ol Ol	0	
48. 00	Other long term liabilities	8, 642, 451	Ö	o	0	
49. 00	OTHER (SPECIFY)	0	0	o	0	49.0
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	12, 187, 973	0	O	0	50.0
51. 00	TOTAL LIABILITIES (Sum of lines 43 and 50)	14, 340, 195	0	0	0	51.0
	CAPI TAL ACCOUNTS					
52.00	General fund balance	33, 562, 888	1			52.0
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0			53. 0 54. 0
55.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			O		55. 0
56. 00	Governing body created - endowment fund balance			0		56. (
57. 00	Plant fund balance - invested in plant			J	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.0
	repl acement, and expansi on				-	
59. 00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	33, 562, 888		o	0	1
37.00						1 (0 (
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	47, 903, 083	0	0	0	60.0

Health Financial Systems COLLINGSWOOD MANOR In Lieu of Form CMS-2540-10

STATEMENT OF CHANGES IN FUND BALANCES

Provi der No.: 315404 | Peri od: From 07/01/2022

od: Worksheet G-1

06/30/2023 Date/Time Prepared: 11/30/2023 1:51 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 35, 724, 212 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 31) -2, 161, 321 2.00 Total (sum of line 1 and line 2) 3.00 33, 562, 891 0 3.00 4.00 Additions (credit adjustments) 4.00 5.00 INTERCOMPANY RECONCILIATION 0 5.00 0000 6.00 ROUNDI NG 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 10.00 Subtotal (line 3 plus line 10) 33, 562, 891 0 11.00 11.00 12.00 Deductions (debit adjustments) 12.00 13.00 ROUNDI NG 3 0 0 0 0 13.00 14.00 0 14.00 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 Fund balance at end of period per balance 33, 562, 888 19.00 19.00 sheet (Line 11 - line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 31) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 Additions (credit adjustments) 4.00 4.00 INTERCOMPANY RECONCILIATION 5.00 5.00 ROUNDI NG 0 6.00 6.00 7.00 0 7 00 8.00 8.00 9.00 9.00 10.00 Total additions (sum of line 5 - 9) 0 0 10.00 0 0 11.00 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 12.00 ROUNDI NG 13.00 13.00 14.00 0 14.00 15.00 0 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 13 - 17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00 sheet (Line 11 - line 18)

Heal th	Financial Systems COLLINGSWOOD M.	ANOR		In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der		Peri od: From 07/01/2022 To 06/30/2023	Worksheet G-2 Parts I-II Date/Time Pre 11/30/2023 1:	pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Care Services					
1. 00	SKILLED NURSING FACILITY		10, 019, 24	10	10, 019, 240	1
2.00	NURSING FACILITY			0	0	2. 00
3.00	ICF/IID			0	0	3. 00
4.00	OTHER LONG TERM CARE		9, 747, 52	21	9, 747, 521	4. 00
5.00	Total general inpatient care services (Sum of lines 1 - 4)		19, 766, 76	51	19, 766, 761	5. 00
	All Other Care Services					
6.00	ANCI LLARY SERVI CES		993, 55	59 0	993, 559	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	12. 00
13.00	OTHER (SPECIFY)			0	0	13. 00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	20, 760, 32	20 0	20, 760, 320	14. 00

11.00	CMHC		U	U	11.00
12.00	HOSPI CE	0	0	0	12.00
13. 00	OTHER (SPECIFY)	0	0	0	13.00
14. 00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to	20, 760, 320	0	20, 760, 320	14.00
	Worksheet G-3, Line 1)				
	Cost Center Description				
			1. 00	2. 00	
	PART II - OPERATING EXPENSES				
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			19, 055, 286	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7. 00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9. 00	Deduct (Specify)		0		9.00
10.00			0		10.00
11. 00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of Lines 9 - 13)			ol	14.00
15. 00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			19, 055, 286	15.00

Heal th	Health Financial Systems COLLINGSWOOD MANOR		In Lie	Lieu of Form CMS-2540-10	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der No.: 315404		Worksheet G-3	
			From 07/01/2022 To 06/30/2023	Date/Time Prep 11/30/2023 1:5	pared: 51 pm
				1. 00	
1.00	1.00 Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)			20, 760, 320	1. 00
2.00	2.00 Less: contractual allowances and discounts on patients accounts			4, 156, 545	2.00
3.00	3.00 Net patient revenues (Line 1 minus line 2)		16, 603, 775	3.00	
4.00	4.00 Less: total operating expenses (From Worksheet G-2, Part II, line 15)			19, 055, 286	4.00
5.00	Net income from service to patients (Line 3 minu	ıs 4)		-2, 451, 511	5.00

		11/30/2023 1:	51 pm_
		1. 00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	20, 760, 320	1.00
2.00	Less: contractual allowances and discounts on patients accounts	4, 156, 545	2. 00
3.00	Net patient revenues (Line 1 minus line 2)	16, 603, 775	3. 00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	19, 055, 286	4. 00
5.00	Net income from service to patients (Line 3 minus 4)	-2, 451, 511	5. 00
	Other income:		
6.00	Contributions, donations, bequests, etc	102, 361	6. 00
7.00	Income from investments	139, 882	7. 00
8.00	Revenues from communications (Telephone and Internet service)	0	8. 00
9.00	Revenue from television and radio service	1, 480	9. 00
10.00	Purchase discounts	0	10. 00
11. 00	Rebates and refunds of expenses	0	11. 00
12.00	Parking Lot receipts	0	12. 00
13.00	Revenue from laundry and linen service	0	13. 00
14.00	Revenue from meals sold to employees and guests	46, 322	14. 00
15.00	Revenue from rental of living quarters	0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17.00	Revenue from sale of drugs to other than patients	0	17. 00
18.00	Revenue from sale of medical records and abstracts	0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20. 00
21.00	Rental of vending machines	0	21. 00
22.00	Rental of skilled nursing space	0	22. 00
23.00	Governmental appropriations	0	23. 00
24.00	I NSURANCE REVENUE	4, 781	24. 00
24. 01	CATERING / COUNTRY STORE	41, 660	24. 01
24. 02	TRANS - RESIDENTIAL	2, 378	24. 02
24. 03	MISCELLANEOUS INCOME	12, 020	24. 03
24.04	INVESTMENT SETTLEMENT	224	24. 04
24.05	GRANT REVENUE	0	24. 05
24.06	MAINTENANCE SERVICES	0	24. 06
24.07	ELECTRIC INCOME	1, 201	24. 07
24. 50	COVI D-19 PHE Fundi ng	0	24. 50
25.00	Total other income (Sum of lines 6 - 24)	352, 309	25. 00
26.00	Total (Line 5 plus line 25)	-2, 099, 202	26. 00
27.00	LOSS ON REFINANCING	62, 119	27. 00
27. 01	BARBER AND BEAUTY	0	27. 01
28.00		0	28. 00
29.00		0	29. 00
30.00	Total other expenses (Sum of lines 27 - 29)	62, 119	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-2, 161, 321	31.00
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