	I Systems required by Law (42 USC 1395g; 42 CFR 413.: since the beginning of the cost reporting po		re to report can resul	t in all interim	u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021	
	KILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider CCN: 315427 Period: From 07/01/2022 To 06/30/2023 ART I - COST REPORT STATUS Provider Status Date: 11/30/20 "ovider" 1. [X] Electronically prepared cost report Date: 11/30/20 Se only 2. [] Manually prepared cost report Date: 11/30/20 3. [] 0] If this is an amended report enter the number of times the provider resubmitted this 3.01 [] No Medicare Utilization. Enter "Y" for yes or leave blank for no.					
PART I - COST F	REPORT STATUS					
Provi der use only	1. [X] Electronically prepared cost report Date: 11/30/2023 Time: 1:54 p 2. [] Manually prepared cost report 3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report					
Contractor use only	 4. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 	8.[N] Last 9.NPR Date: 10.[0]If I 11.Contracto	t Cost Report for this Cost Report for this ine 4, column 1 is "4" r Vendor Code	Provider CCN 	·	
	5. Date Received:		care Utilization. Ente no utilization.	er "⊦" for full, '	"L" for low, or "N"	

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PITMAN MANOR (315427) 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	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Robe	ert Peterson	ř	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	20, 071	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	20, 071	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.

Image: state in the second s	SKI LLE	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILI X INDENTIFICATION DATA		I TMAN MANOR I CARE		No.: 315427	 Period: From 07/01/ To 06/30/	2022	u of Form CM Worksheet Part I Date/Time	S-2
Skilled Nursing Facility and Skilled Nursing Facility Complex Address: Zip Code: 08071 OB City P170A4 Street Skill Zip Code: 08071 Discover Skill Component Name Component Name Component Name Component Skill SMF and SMF-Bused Component Identification: 1.00 2.00 3.00 4.00 5.00 SMF and SMF-Bused Component Identification: 1.00 2.00 3.00 4.00 5.00 SMF and SMF-Bused Component Identification: 1.00 2.00 3.00 4.00 5.00 SMF and SMF-Bused Component Identification: 1.00 2.00 3.00 4.00 5.00 SMF and SMF-Bused Component Identification: 1.00 2.00 3.15427 11/30/1993 N P Color SMF-Bused Color 1.00 2.00 3.15427 11/30/1993 N P Color SMF-Bused Color 1.00 2.00 0.00 3.00 4.00 2.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <								2020	11/30/2023	
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42 CFR section 483.5? N N N 6.00 Are there any costs included in Worksheet A that resulted from transactions with related yr granizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1. Y Miscel Laneous Cost Reporting Information N N N 9.00 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N N 9.01 If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no. N N 9.01 If this is a low Medicare utilization cost report the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 0.00 Straight Line 5 9.00 Sum of the Year's Digits 5 5 5 9.00 Ware there any disposal of capital assets during the cost reporting period? N N 9.00 Ware there a ubstantial decrease in health insurance proportion of allowable cost from prior cost N N 8.00 Ware there a ubstantial decrease in non-public provider that qualifies for an exemption from the applies? N N 9.00 Killed Nursing Facility N N N N 9.00 Silled V/N Part Apart B N N N 9.00 Sille V/N N N N N N <td>7 00</td> <td colspan="7">section 483.5?</td> <td>N</td> <td>17.00</td>	7 00	section 483.5?							N	17.00
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Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22. 000 Straight Line 5 21.00 Declining Balance 5 22.00 Sum of the Year's Digits 5 22.00 Sum of Line 20 through 22 5 22.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N) N 26.00 Was accelerated depreciation claimed on any assets in the current or any prior cost report applies? (Y/N) N 27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N) N 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) N 29.00 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 N N 30.00 Nursing Facility N N 30.00 SWF-Based HIA N N 30.00 SWF-Based CMHC N N 31.00 IS the skilled nursing facility locc		If line 19 is yes, does this cost report meet	your cor	ntractor's	criteria f			e		19.00
20.00 Straight Line 5 21.00 Declining Balance 5 22.00 Sum of the Year's Digits 5 23.00 Sum of the Year's Digits 5 23.00 Sum of the Year's Digits 5 23.00 Were there any disposal of capital assets during the cost reporting period? (Y/N) N 26.00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N) N 27.00 Did you cease to participate in the Medicare program at end of the period to which this cost report applica? (Y/N) N 28.00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 29.00 Skilled Nursing 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. N N 29.00 Skilled Nursing Facility N N N N 30.00 CY/NI N N N N N 20.00 Skilled Nursing Facility N N N N N N 31.00 IC/1ID N						the method i	ndicated on	lines	20 - 22	
21:00 Dectifing Balance 5 22:00 Sum of the Year's Digits 5 22:00 If depreciation is funded, enter the balance as of the end of the period. N 24:00 If depreciation is funded, enter the balance as of the end of the period. N 25:00 Were there any disposal of capital assets during the cost reporting period? (Y/N) N 26:00 Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? N (Y/N) 20:00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 28:00 Was there a substantial decrease in health insurance proportion of allowable cost from prior cost N 29:00 Skilled Nursing 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. N N 20:00 Skilled Nursing Facility N N N N 30:00 SWF-Based HHA N N N N 30:00 SWF-Based CMHC N N N N 31:00 ICF/11D N N N N	20. 00		0.1 1 0 0 0 1					2		182 20.00
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Part APart B 1.00 2.00 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 0.00 Nursing Facility 1.00 LCF/ID 0.00 SNF-Based HHA 0.00 SNF-Based FMC 32.00 SNF-Based FMC 33.00 SNF-Based CMHC 36.00 SNF-Based CMHC 37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) 38.00 Are you legally-required to carry malpractice insurance? (Y/N) 39.00 Is the malpractice a "claims-made" or "occurrence", enter 2. Premiums Paid Losses Self Insurance	28.00	Was there a substantial decrease in health in	nsurance p	proportion	of allowab	le cost from	n prior cost		N	28.00
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86.00 SNF-Based OLTC Y/N 1.00 2.00 87.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 88.00 Are you legally-required to carry malpractice insurance? (Y/N) N 99.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "ccurrence", enter 2. Premiums Paid Losses Self Insurance	34.00	SNF-Based FQHC								34.00
37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) 1.00 2.00 38.00 Are you legally-required to carry malpractice insurance? (Y/N) N N 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insu									N	35.00
1.00 2.00 1.00	36.00	SNF-Based OLIC								36.00
37.00 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N) Y 38.00 Are you legally-required to carry malpractice insurance? (Y/N) N 39.00 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is 1 N "claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses Self Insu									2.00	
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"claims-made" enter 1. If the policy is "occurrence", enter 2. Premiums Paid Losses SelfInsutation		Are you legally-required to carry malpractice	i nsurano	ce? (Y/N)						38.00
Premiums Paid Losses SelfInsu	39.00				e policy i	S	1			39.00
		<u>rclaims-made" enter 1. If the policy is "occu</u>	irrence",	enter 2.		Promiumo	Paid Los	SPS	Self Insurar	
						1.00	2.00	303	3.00	
41.00 List malpractice premiums and paid losses: 169,393 0 0	41.00	List malpractice premiums and paid losses:								41.00

Health Financial Systems PITMAN MANOR	In Lieu	of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE Provider No.: 315427 Period:		Worksheet S-2	
COMPLEX INDENTIFICATION DATA		Part I	nored
To 06/30		Date/Time Pre 11/30/2023 1:	
		Y/N	
		1.00	1
42.00 Are malpractice premiums and paid losses reported in other than the Administrative and General co	ost	N	42.00
center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and			
amounts.			
43.00 Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?		Y	43.00
44.00 If line 43 is yes, enter the home office chain number and enter the name and address of the home	H	153010	44.00
office on lines 45, 46 and 47.			
1.00 2.00 3	. 00		
If this facility is part of a chain organization, enter the name and address of the home office	on the	lines	
bel ow.			
45.00 Name: UNITED METHODIST HOMES OF NJ Contractor's Name: UNITED METHODIST Contractor's Number	r: 12001		45.00
HOMES OF NJ			
46.00 Street: 3311 HI GHWAY 33 PO Box:			46.00
47.00 City: NEPTUNE State: NJ Zip Code:	07753		47.00

WPLE	D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE Provider	No.: 315427	Period: From 07/01/2022	Worksheet S-2 Part II	2
	X REIMBURSEMENT QUESTIONNAIRE			To 06/30/2023	Date/Time Pre	
				Y/N	11/30/2023 1: Date	54 p
				1.00	2.00	
	General Instruction: For all column 1 respons	ses enter in column 1, "Y" fo	or Yes or "N"	for No. For all	the date	
	responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites					-
	Provider Organization and Operation					
00	Has the provider changed ownership immediate reporting period? If column 1 is "Y", enter			N		1.
	instructions)	the date of the change in co				
			Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program? If	1.00 N	2.00	3.00	2
50	column 1 is yes, enter in column 2 the date					2.
	3, "V" for voluntary or "I" for involuntary.					
00	Is the provider involved in business transac contracts, with individuals or entities (e.g		Y			3
	or medical supply companies) that are relate					
	officers, medical staff, management personne	I, or members of the board				
	of directors through ownership, control, or relationships? (see instructions)	family and other similar				
		·	Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports				40.00.000	Ι.
00	Column 1: Were the financial statements prep. Accountant? (Y/N) Column 2: If yes, enter "A		Y	A	12/31/2023	4
	Compiled, or "R" for Reviewed. Submit comple					
_	available in column 3. (see instructions) If					_
00	Are the cost report total expenses and total those on the filed financial statements? If		Y			5
	reconciliation.					
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	-
00	Column 1: Were costs claimed for Nursing Sch	ool? (Y/N) Column 2: Is the	provider the	N	N	6
	legal operator of the program? (Y/N)					
00	Were costs claimed for Allied Health Program		for Nuroing	N		7
00	Were approvals and/or renewals obtained duri		for Nursing	N		8
	School and/or Allied Health Program? (Y/N) s	ee instructions.				
	School and/or Allied Health Program? (Y/N) s	ee instructions.			Y/N	
		ee instructions.			Y/N 1.00	
	School and/or Allied Health Program? (Y/N) s Bad Debts Is the provider seeking reimbursement for ba		ons.			9
00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb	d debts? (Y/N) see instructio		st reporting	1.00	
00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy.	d debts? (Y/N) see instruction t collection policy change du	uring this cos	1 5	1.00 Y N	10
00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb	d debts? (Y/N) see instruction t collection policy change du	uring this cos	1 5	1.00 Y	10
00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If '	Y", see instr	ructions.	1.00 Y N N	10
00 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If "Y	uring this cos 'Y", see instru (", see instru Pa	ructions.	1.00 Y N N Part B	10
00 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If '	uring this cos 'Y", see instru (", see instru Pa Y/N	ructions. art A Date	1.00 Y N N Part B Y/N	10
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos 'Y", see instru (", see instru Pa Y/N 1.00	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos 'Y", see instru (", see instru Pa Y/N	ructions. art A Date	1.00 Y N N Part B Y/N	10 11 12
00 00 00 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos 'Y", see instru (", see instru Pa Y/N 1.00	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos 'Y", see instru (", see instru Pa Y/N 1.00	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos <u>Y", see instru</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u>	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos 'Y", see instru (", see instru Pa Y/N 1.00	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If ' cost reporting period? If " Description	uring this cos <u>Y", see instru</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u>	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	uring this cos <u>Y", see instru</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u>	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13
0 00 00 00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	uring this cos <u>Y", see instru</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u>	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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.	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instru (", see instru (", see instru Y/N 1.00 Y	ructions.	1.00 Y N Part B Y/N 3.00 N	10 11 12 13 13 14
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	uring this cos <u>Y", see instru</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u>	ructions.	1.00 Y N N Part B Y/N 3.00	10 11 12 13 13 14
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instru (", see instru (", see instru Y/N 1.00 Y	ructions.	1.00 Y N Part B Y/N 3.00 N	10 11 12 13 13 14
000000000000000000000000000000000000000	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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",	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instru (", see instru (", see instru Y/N 1.00 Y	ructions.	1.00 Y N Part B Y/N 3.00 N	10 11 12 13 13 14
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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.	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instru (", see instru (", see instru Y/N 1.00 Y	ructions.	1.00 Y N Part B Y/N 3.00 N	10 11 12 13 13 14
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R data for	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instr (", see instru (", s	ructions.	1.00 Y N Part B Y/N 3.00 N N	10 11 12 13 13 14
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instr (", see instru (", s	ructions.	1.00 Y N Part B Y/N 3.00 N N	10 11 12 13 13 14
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instr (", see instr	ructions.	1.00 Y N Part B Y/N 3.00 N N N	10 11 12 13 13 14 15 16
	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions. If line 13 or 14 is "Y", then were	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instr (", see instru (", s	ructions.	1.00 Y N Part B Y/N 3.00 N N	10 11 12 13 13 14 15 16
00	Bad Debts Is the provider seeking reimbursement for ba If line 9 is "Y", did the provider's bad deb period? If "Y", submit copy. If line 9 is "Y", are patient deductibles an Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) 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. 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. If line 13 or 14 is "Y", then were adjustments made to PS&R Report information? If yes, see instructions.	d debts? (Y/N) see instruction t collection policy change du d/or coinsurance waived? If " cost reporting period? If " Description 0	I'Y", see instr (", see instr	ructions.	1.00 Y N Part B Y/N 3.00 N N N	9 10 11. 12 13 13 14 15 16 17. 18

Heal th	Financial Systems PITMA	MANC)R	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CAR	E	Provi der No.: 315427	Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNALRE			From 07/01/2022 To 06/30/2023		pared: 54 pm
			1.00	2.	00	
	Cost Report Preparer Contact Information					
19.00	Enter the first name, last name and the title/position	DEAN	IDRA	FALLON		19.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respectively.					
20.00	Enter the employer/company name of the cost report	BAKE	ER TILLY US, LLP			20.00
	preparer.					
21.00	Enter the telephone number and email address of the cost	570-	-820-0301	DEANDRA. FALLON	BAKERTI LLY. CO	21.00
	report preparer in columns 1 and 2, respectively.			М		

Heal th	Financial Systems	PI TMAN M	<i>I</i> ANOR	In Lie	u of Form CMS-:	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE		Provider No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Pre 11/30/2023 1:	pared:
		Part B				
		Date 4.00				
	PS&R Data	1.00				
13. 00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)					13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14.00
15. 00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15.00
16. 00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:					17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
		-	3.00			
	Cost Report Preparer Contact Information					
19. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		DIRECTOR			19.00
20. 00	Enter the employer/company name of the cost r	report				20. 00
21.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					21.00

	Financial Systems D NURSING FACILITY AND SKILLED NURSIN X STATISTICAL DATA	PITMAN M NG FACILITY HEALTH CARE		F	Period: From 07/01/2022 Fo 06/30/2023		pared:
				l np	oatient Days/Vis	si ts	
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	72	26, 280	(-/	9, 709	1.00
. 00 . 00	NURSING FACILITY	0	0	(0	2.0 3.0
. 00	HOME HEALTH AGENCY COST	0	0		o o	0	4.0
. 00	Other Long Term Care	178	64, 970				5.0
. 00	SNF-Based CMHC						6.0
. 00 . 00	HOSPICE Total (Sum of lines 1-7)	0 250	0 91, 250			0 9, 709	7.0 8.0
. 00		Inpatient D			Di scharges	9, 709	0.0
	Component	Other	Total	Title V	Title XVIII	Title XIX	
. 00	SKILLED NURSING FACILITY	<u> </u>	7.00	8.00	9.00	10.00	1.0
. 00	NURSING FACILITY	0, 290	20, 022			0	2.0
. 00	ICF/IID	0	0		-	0	3. C
. 00	HOME HEALTH AGENCY COST	0	0				4. C
. 00	Other Long Term Care	42, 613	42, 613				5.0
. 00 . 00	SNF-Based CMHC HOSPI CE	0	0		0	0	6. C 7. C
. 00	Total (Sum of lines 1-7)	50, 903	63, 235		98	10	8.0
		Discha			rage Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
. 00	SKILLED NURSING FACILITY	111	219	0.00		970. 90	1.0
. 00	NURSING FACILITY	0	0	0.00	D	0.00	2.0
. 00 . 00	HOME HEALTH AGENCY COST	0	0			0.00	3.C 4.C
. 00	Other Long Term Care	48	48				5. C
. 00	SNF-Based CMHC						6. C
. 00	HOSPICE	0	0			0.00	7.0
. 00	Total (Sum of lines 1-7)	159 Average Length	267	0.00 Admi	26.77 ssi ons	970.90	8. C
		of Stay					
	Component	Total	Title V	Title XVIII	Title XIX	Other	
. 00	SKILLED NURSING FACILITY	<u> </u>	17.00	18.00	19.00	20.00	1. (
. 00	NURSING FACILITY	0.00	0		0	0	2.0
. 00	ICF/IID	0.00			0	0	3.0
. 00	HOME HEALTH AGENCY COST						4.0
. 00 . 00	Other Long Term Care SNF-Based CMHC	887.77				54	5. C 6. C
. 00	HOSPICE	0.00	0		o o	0	7.0
. 00	Total (Sum of lines 1-7)	236.84	0				8. C
		Admi ssi ons	Full Time	Equi val ent			
	Component	Total	Employees on	Nonpai d	-		
			Payrol I	Workers			
00		21.00	22.00	23.00			4 0
. 00 . 00	SKILLED NURSING FACILITY NURSING FACILITY	240	40. 74 0. 00				1.0 2.0
. 00	ICF/IID	0	0.00				3.0
. 00	HOME HEALTH AGENCY COST		0.00				4.0
. 00	Other Long Term Care	54	36. 70				5.0
	SNF-Based CMHC		0.00	0.00			6. 0
. 00 . 00	HOSPICE	o	0.00				7.0

Heal th	Financial Systems	PI TMAN	MANOR		In Lie	u of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION				Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/30/2023 1:	pared: 54 pm
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6		3	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	PART II – DIRECT SALARIES						
	SALARI ES		1		1		
1.00	Total salaries (See Instructions)	8, 826, 364	0	8, 826, 36			
2.00	Physician salaries-Part A	0	0		0 0.00		2.00
3.00	Physician salaries-Part B	0	0		0 0.00		
4.00	Home office personnel	0	0		0 0.00		4.00
5.00	Sum of lines 2 through 4	0	0		0.00		
6.00	Revised wages (line 1 minus line 5)	8, 826, 364		8, 826, 36			
7.00	Other Long Term Care	2, 124, 898	0	2, 124, 89			
8.00	HOME HEALTH AGENCY COST	0	0		0 0.00		
9.00	CMHC	0	0		0 0.00		
10.00	HOSPI CE	0	0	24.40	0 0.00		
11.00	Other excluded areas	26, 482		26, 48			11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	2, 151, 380		2, 151, 38			12.00
13.00	Total Adjusted Salaries (line 6 minus line	6, 674, 984	0	6, 674, 98	4 238, 857.00	27.95	13.00
14.00	OTHER WAGES & RELATED COSTS	F01 110	0	F01 11	12 404 00	42.01	11.00
14.00	Contract Labor: Patient Related & Mgmt	591, 112		591, 11			14.00
15.00 16.00	Contract Labor: Physician services-Part A	21,006		21,00			
16.00	Home office salaries & wage related costs WAGE-RELATED COSTS	776, 843	0	776, 84	3 12,275.00	63.29	16.00
17.00	Wage-related costs core (See Part IV)	2,005,506	0	2,005,50	6		17.00
18.00	Wage-related costs other (See Part IV)	3, 801		3, 80			18.00
19.00	Wage related costs (excluded units)	489, 758		489, 75			19.00
20.00	Physician Part A - WRC	Δ <i>-</i> , 730		-07,75	0		20.00
21.00	Physician Part B - WRC	0	0		0		21.00
21.00	Total Adjusted Wage Related cost (see	1, 519, 549		1, 519, 54	9		21.00
22.00	instructions)	1, 517, 547		1, 517, 54			22.00

Heal th	Financial Systems	PI TMAN	MANOR		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period:	Worksheet S-3	
					From 07/01/2022 To 06/30/2023		pared [.]
						11/30/2023 1:	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			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		1	1		
1.00	Employee Benefits	0	0		0 0.00		1.00
2.00	Administrative & General	1, 289, 324		1, 289, 32			2.00
3.00	Plant Operation, Maintenance & Repairs	427, 252		427, 25			3.00
4.00	Laundry & Linen Service	110, 837	0	110, 83	7 5, 812. 00	19.07	4.00
5.00	Housekeepi ng	514, 975	0	514, 97	5 29, 086. 00	17.71	5.00
6.00	Dietary	883, 498	0	883, 49	8 53, 184. 00	16.61	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)	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0)	0.00	0.00	10.00
11.00	Social Service	43, 342	0	43, 34	2 1, 435. 00	30.20	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	268, 162	0	268, 16	2 10, 010. 00	26.79	13.00
14.00	Total (sum lines 1 thru 13)	3, 537, 390	0	3, 537, 39	0 144, 138. 00	24.54	14.00
	•						

Heal th	Financial Systems	PI TMAN MANOR		In Lie	u of Form CMS-	2540-1
SNF WA	AGE RELATED COSTS	Provider No	: 315427	Period: 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				1.00	
	Part A - Core List					1
	RETI REMENT COST					1
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contr	i buti on			0	2.00
3.00	Qualified and Non-Qualified Pension Plan C				140, 118	3.00
4.00	Prior Year Pension Service Cost				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to Externa	l Organization)				1
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension P	lan			0	6.00
7.00	Employee Managed Care Program Administrati	on Fees			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)			797, 184	8.00
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				9, 698	10.00
11.00	Life Insurance (If employee is owner or be				0	
12.00	Accident Insurance (If employee is owner o				0	
13.00	Disability Insurance (If employee is owner				4, 038	13.0
14.00	Long-Term Care Insurance (If employee is o	wner or beneficiary)			0	
15.00	Workers' Compensation Insurance				294, 258	15.0
16.00	Retirement Health Care Cost (Only current	year, not the extraordinary accrua	al require	d by FASB 106.	0	16.0
	Non cumulative portion)					
	TAXES					
					648, 310	
18.00					0	
19.00	Unemployment Insurance				107, 300	
20.00	State or Federal Unemployment Taxes				0	20.0
04 00	OTHER					1 0 1 0
21.00	Executive Deferred Compensation				0	
	Day Care Cost and Allowances				0	
23.00		22)			4,600	
24.00	Total Wage Related cost (Sum of lines 1 -	23)			2,005,506	24.00
					Amount Reported	
					1. 00	
	Part B - Other than Core Related Cost				1.00	
25 00	OTHER WAGE RELATED COST				2 001	25.00

Heal th	Financial Systems	PI TMAN M	MANOR		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES		Provi der	No.: 315427	Period: From 07/01/2022	Worksheet S-3 Part V	
					To 06/30/2023	11/30/2023 1:	pared: 54 pm
	Occupational Category	Amount	Fringe	Adjusted		Average Hourly	
		Reported	Benefits	Salaries (col	. Related to Salary in col.	Wage (col. 3 ÷ col. 4)	
					3	COI. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es			•			
	Nursing Occupations	· · · · · ·					
1.00	Registered Nurses (RNs)	1, 245, 995	283, 588				1.00
2.00	Licensed Practical Nurses (LPNs)	186, 901	42, 539				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	965, 491	219, 746	1, 185, 23	7 40, 986. 00	28. 92	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2, 398, 387	545, 873				4.00
5.00	Physical Therapists	169, 620	38, 606				5.00
6.00	Physical Therapy Assistants	48, 283	10, 989	59, 27			6.00
7.00	Physical Therapy Aides	0	0		0 0.00		7.00
8.00	Occupational Therapists	102, 525	23, 335				8.00
9.00	Occupational Therapy Assistants	7, 894	1, 797	9, 69			9.00
10.00	Occupational Therapy Aides	0	0		0 0.00		
11.00	Speech Therapists	40, 295	9, 171				11.00
12.00	Respiratory Therapists	57, 981	13, 196				12.00
13.00	Other Medical Staff	312, 609	71, 150	383, 75	9 11, 640. 00	32.97	13.00
	Contract Labor						
14 00	Nursing Occupations	20.045		20.04	5 2/0 00	77.00	14.00
14.00	Registered Nurses (RNs)	28, 045		28, 04			14.00
15.00	Licensed Practical Nurses (LPNs)	95, 685		95, 68			15. 00 16. 00
16.00	Certi fi ed Nursi ng Assi stant/Nursi ng Assi stants/Ai des	467, 382		467, 38	2 11, 685. 00	40.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	591, 112		591, 11	2 13, 495. 00	43.80	17.00
18.00	Physical Therapists	0			0 0.00		
19.00	Physical Therapy Assistants	0			0 0.00	0.00	19.00
20.00	Physical Therapy Aides	0			0 0.00		20.00
21.00	Occupational Therapists	0			0 0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0			0 0.00	0.00	22.00
23.00	Occupational Therapy Aides	0			0.00	0.00	23.00
24.00	Speech Therapists	0			0 0.00	0.00	24.00
25.00	Respi ratory Therapi sts	0			0 0.00		25.00
26.00	Other Medical Staff	0			0 0.00	0.00	26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PITMAN MANOR Provider No.: 31542	7 Period:	u of Form CMS Worksheet S-	
		From 07/01/2022 To 06/30/2023		epared:
		Group	Days	
1.00		1.00 RUX	2.00	1.00
2.00		RUL		2.00
3.00		RVX		3.00
4.00		RVL		4.00
5. 00 6. 00		RHX RHL		5.00
7.00		RMX		7.00
8.00		RML		8.00
9.00		RLX		9.00
10.00 11.00		RUC RUB		10.00
12.00		RUA		12.00
13.00		RVC		13.00
14.00		RVB		14.00
15. 00 16. 00		RVA RHC		15.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21.00 22.00		RMA RLB		21.00
23. 00		RLA		23.00
24.00		ES3		24.00
25.00		ES2		25.00
26.00 27.00		ES1 HE2		26.00 27.00
28.00		HE2 HE1		27.00
29.00		HD2		29.00
30. 00		HD1		30.00
31.00		HC2		31.00
32. 00 33. 00		HC1 HB2		32.00 33.00
34.00		HB1		34.00
35. 00		LE2		35.00
36.00		LE1		36.00
37. 00 38. 00		LD2 LD1		37.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00		LB2		41.00
42.00		LB1		42.00
43.00 44.00		CE2 CE1		43.00
45.00		CD2		45.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00 49.00		CC1 CB2		48.00 49.00
50.00		CB2 CB1		50.00
51.00		CA2		51.00
52.00		CA1		52.00
53.00 54.00		SE3 SE2		53.00 54.00
54. 00 55. 00		SE2 SE1		54.00
56.00		SSC		56.00
57.00		SSB		57.00
58.00		SSA		58.00
59.00 60.00		I B2 I B1		59.00 60.00
61.00		I A2		61.00
62.00		I A1		62.00
63. 00		BB2		63.00
64.00 65.00		BB1 BA2		64.00 65.00
66. 00		BA2 BA1		66.00
67.00		PE2		67.00
68. 00		PE1		68.00
69.00		PD2		69.00
70. 00 71. 00		PD1 PC2		70.00
72.00		PC2 PC1		71.00
73.00		PB2		73.00
74.00		PB1	1	74.00

Health Financial Systems PITMAN MA	NOR		In Lie	u of Form CM	S-2540-10			
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315427	Peri od:	Worksheet S	-7			
			From 07/01/2022 To 06/30/2023					
			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 102.00 Recruitment 103.00 Retention of employees 104.00 Training 105.00 OTHER (SPECIFY) 106.00 Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)					101.00 102.00 103.00 104.00 105.00 106.00			

	Financial Systems	PI TMAN MA	NOR		In Lie	u of Form CMS-2	2540-10
RECLAS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 07/01/2022	Worksheet A	
					To 06/30/2023	Date/Time Pre 11/30/2023 1:	
	Cost Center Description	Sal ari es	Other		1 Reclassi ficati	Reclassi fi ed	
				+ col. 2)	ons I ncrease/Decre	Trial Balance (col. 3 +-	
					ase (Fr Wkst	col. 4)	
					A-6)	0011 1)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES		622, 264	622, 26		622, 264	1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0		2,009,30	0 0	0	2.00 3.00
3.00 4.00	00400 ADMINI STRATI VE & GENERAL	1, 289, 324	2, 009, 307 2, 733, 862	4, 023, 18	-	2, 009, 307 4, 023, 186	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	427, 252	1,047,681	1, 474, 93		1, 474, 933	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	110, 837	33, 858			144, 695	6.00
7.00	00700 HOUSEKEEPI NG	514, 975	115, 175			630, 150	7.00
8.00	00800 DI ETARY	883, 498	1, 223, 676	2, 107, 17	4 0	2, 107, 174	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	10.00
11.00 12.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	11.00 12.00
12.00	01300 SOCIAL SERVICE	43, 342	0	43, 34	2 0	43, 342	12.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	43, 342	0	-5, 54	0 0	43, 342	14.00
15.00	01500 ACTI VI TI ES	197, 588	52, 309	249, 89	7 0	249, 897	15.00
15.01	01501 CHAPLAI N	70, 574	359		3 0	70, 933	15.01
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 SKILLED NURSING FACILITY	2, 710, 996	964, 558			3, 675, 554	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00 33.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	2, 124, 898	0 127, 246	2, 252, 14	0 0 4 0	0 2, 252, 144	32.00 33.00
55.00	ANCI LLARY SERVICE COST CENTERS	2, 124, 070	127, 240	2,232,14	4 0	2,232,144	33.00
40.00	04000 RADI OLOGY	0	8, 607	8, 60	7 0	8, 607	40.00
41.00	04100 LABORATORY	0	9, 485	9, 48	5 0	9, 485	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	57, 981	4, 043			62, 024	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	217, 903 110, 419	93, 933 0	311, 83 110, 41		245, 412 164, 775	1
46.00	04600 SPEECH PATHOLOGY	40, 295	0	40, 29		52, 363	1
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	02,000	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 007	11, 00	7 0	11, 007	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	120, 129	120, 12	9 0	120, 129	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
60.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC		-				62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0		0 0	-	1
71.00	07100 AMBULANCE	0	0		0 0	0	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES		0		0 0	0	80.00
81.00	08100 I NTEREST EXPENSE		0		0 0	0	81.00
82.00	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	82.00
83.00	08300 HOSPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	8, 799, 882	9, 177, 499	17, 977, 38	1 0	17, 977, 381	89.00
00.00	NONREI MBURSABLE COST CENTERS	26,402	10.070	27.44	0 0	27.440	
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	26, 482	10, 978 0	37,46		37, 460 0	90.00 91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		o n	0	
93.00	09300 NONPAID WORKERS	0	0		0 0	0	1
94.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
100.00	TOTAL	8, 826, 364	9, 188, 477	18, 014, 84	1 0	18, 014, 841	100. 00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES Provider No.: 315427 Period: Work From 07/01/2022	Form CMS-2540-10 <sheet a<="" th=""></sheet>
	e/Time Prepared:
11/3	30/2023 1:54 pm
Cost Center Description Adjustments to Net Expenses Expenses (Fr For Allocation	
Wkst A-8) (col. 5 +-	
col. 6)	
6.00 7.00	
GENERAL SERVICE COST CENTERS	1.00
1.00 00100 CAP REL COSTS - BLDGS & FI XTURES 0 622, 264 2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT 0 0	1.00
3.00 00300 EMPLOYEE BENETITS -55, 567 1, 953, 740	3.00
4. 00 00400 ADMINI STRATI VE & GENERAL -897, 847 3, 125, 339	4.00
5. 00 00500 PLANT OPERATION, MAINT. & REPAIRS -25, 424 1, 449, 509	5.00
6. 00 00600 LAUNDRY & LI NEN SERVI CE -70 144, 625	6.00
7. 00 00700 HOUSEKEEPING -432 629, 718	7.00
8. 00 00800 DI ETARY 0 2, 107, 174 9. 00 00900 NURSI NG ADMI NI STRATI ON 0 0	8.00 9.00
10. 00 01000 CENTRAL SERVICES & SUPPLY 0 0	10.00
11.00 01100 PHARMACY 0 0	11.00
12.00 01200 MEDICAL RECORDS & LIBRARY 0 0	12.00
13.00 01300 SOCIAL SERVICE 0 43,342	13.00
14. 00 O1400 NURSI NG AND ALLI ED HEALTH EDUCATION 0 0	14.00
15. 00 01500 ACTIVITIES 0 249, 897 15. 01 01501 CHAPLAIN 0 70. 933	15.00
15. 01 01501 CHAPLAI N 0 70, 933	15. 01
30. 00 03000 SKI LLED NURSI NG FACI LI TY 0 3, 675, 554	30.00
31.00 03100 NURSING FACILITY 0 0 0	31.00
32.00 03200 I CF/I I D 0 0	32.00
33. 00 03300 OTHER LONG TERM CARE 0 2, 252, 144	33.00
ANCI LLARY SERVICE COST CENTERS	40.00
40. 00 04000 RADI OLOGY 0 8, 607 41. 00 04100 LABORATORY 0 9, 485	40.00
42. 00 04200 I NTRAVENOUS THERAPY 0 0	42.00
43. 00 04300 0XYGEN (INHALATION) THERAPY 0 62, 024	43.00
44. 00 04400 PHYSI CAL THERAPY 0 245, 412	44.00
45. 00 04500 OCCUPATI ONAL THERAPY 0 164, 775	45.00
46. 00 04600 SPEECH PATHOLOGY 0 52, 363	46.00
47. 00 04700 ELECTROCARDI OLOGY 0 0 48. 00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 11, 007	47.00 48.00
49. 00 04900 DRUGS CHARGED TO PATIENTS 0 120, 129	48.00
50. 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0	50.00
51.00 05100 SUPPORT SURFACES 0 0	51.00
OUTPATIENT SERVICE COST CENTERS	
60. 00 06000 CLINIC 0 0 61. 00 06100 RURAL HEALTH CLINIC 0 0	60.00 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 07100 AMBULANCE 0 0	71.00
73.00 07300 CMHC 0 0	73.00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0	80.00
81.00 081001 INTEREST EXPENSE 0 0	81.00
82.00 08200 UTILIZATION REVIEW - SNF 0 0	82.00
83. 00 08300 HOSPI CE 0 0	83.00
89. 00 SUBTOTALS (sum of lines 1-84) -979, 340 16, 998, 041	89.00
NONREI MBURSABLE COST CENTERS 90. 00 09000 GI FT, FLOWER, COFFEE SHOPS & CANTEEN 0 37, 460	90.00
90.00 09000 GFFT, FLOWER, COFFEE SHOPS & CANTEEN 0 37,400 91.00 09100 BARBER AND BEAUTY SHOP 0 0	90.00
92. 00 09200 PHYSI CI ANS PRI VATE OFFI CES 0 0	92.00
93. 00 09300 NONPAI D WORKERS 0 0	93.00
94.00 09400 PATIENTS LAUNDRY 0 0	94.00
100. 00 TOTAL -979, 340 17, 035, 501	100.00

Health Financial Systems	PITMAN MANOR In Lieu of Form CMS-254					2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315427	Period: From 07/01/2022	Worksheet A-6	
				To 06/30/2023	Date/Time Pre 11/30/2023 1:	
			Increases		117 007 2020 1.	
	Cost Cente	r	Line #	Sal ary	Non Salary	
	2.00		3.00	4.00	5.00	
(1) A - TO RECLASS OT AND ST						
1.00	OCCUPATIONAL THERAF	Υ	45.0	0 15, 815	38, 541	1.00
2.00	SPEECH PATHOLOGY		46.0	3, 511	8, 557	2.00
TOTALS						
100.00	Total Reclassificat	ions (Sum		19, 326	47, 098	100.00
	of columns 4 and 5	must				
	equal sum of column	s 8 and				
	9)					

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

Health Financial Systems	PI TMAN MANOF	R		In Lieu of Form CMS-25			
RECLASSI FI CATI ONS		Provi der	No.: 315427	Period: From 07/01/2022	Worksheet A-6		
				To 06/30/2023			
	Decreases						
	Cost Cente	r	Line #	Sal ary	Non Salary		
	6.00		7.00	8.00	9.00		
(1) A - TO RECLASS OT AND ST							
1.00	PHYSI CAL THERAPY		44. (0 19, 326	47, 098	1.00	
2.00			0. (0 0	0	2.00	
TOTALS							
100.00				19, 326	47, 098	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.

	Financial Systems	PI TMAN I	MANOR			In Lie	u of Form CMS-2	2540-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315427		i od:	Worksheet A-7	
					Fro To	m 07/01/2022 06/30/2023	Date/Time Prep	arad
					10	00/ 30/ 2023	11/30/2023 1:5	54 pm
				Acqui si ti on	s			
	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 BALA	ANCES						
1.00	Land	39, 437	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	14, 555, 117	328, 836		0	328, 836	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	2, 173, 072	124, 938		0	124, 938	0	5.00
6.00	Movable Equipment	171, 892	0		0	0	0	6.00
7.00	Subtotal (sum of lines 1-6)	16, 939, 518	453, 774		0	453, 774	0	7.00
8.00	Reconciling Items	0	0		0	0	0	8.00
9.00	Total (line 7 minus line 8)	16, 939, 518	453, 774		0	453, 774	0	9.00
	Description	Endi ng Bal ance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALA							
1.00	Land	39, 437	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	14, 883, 953	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	2, 298, 010	0					5.00
6.00	Movable Equipment	171, 892	0					6.00
7.00	Subtotal (sum of lines 1-6)	17, 393, 292	0					7.00
8.00	Reconciling Items	0	0					8.00
9.00	Total (line 7 minus line 8)	17, 393, 292	0					9.00

	MENTS TO EXPENSES		Drovi dor	No.: 315427	Peri od:	Worksheet A-8	2540
JJJ21	MENTS TO EXPENSES		Provi der	NO.: 315427	From 07/01/2022 To 06/30/2023	Date/Time Pre	
						11/30/2023 1:	
					lassification on		
				10/From Whic	ch the Amount is [.]	to be Adjusted	
	Description (1)	(2) Basis For Adjustment	Amount		t Center	Line No.	
00	Investment income on restricted funds	1.00	2.00		3.00	4.00	1.
0	(chapter 2)		0			0.00	· ·
00	Trade, quantity, and time discounts (chapter 8)		0			0.00	2
00	Refunds and rebates of expenses (chapter 8)		0			0.00	
00	Rental of provider space by suppliers (chapter 8)		0			0.00	4
00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	5
00	Television and radio service (chapter 21)	В		PLANT OPERAT REPAI RS	ION, MAINT. &	5.00	6
00	Parking lot (chapter 21)		0			0.00	7
00	Remuneration applicable to provider-based physician adjustment	A-8-2	0				6
0	Home office cost (chapter 21)		0			0.00	
00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
00	Nonallowable costs related to certain Capital expenditures (chapter 24)	A-8-1	0			0.00	
00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	-81, 718				12
00	Laundry and Linen service	В	-70	LAUNDRY & LI	NEN SERVICE	6.00	13
00	Revenue - Employee meals		0			0.00	
00	Cost of meals - Guests		0			0.00	
00	Sale of medical supplies to other than patients		0			0.00	
00	Sale of drugs to other than patients		0			0.00	
00	Sale of medical records and abstracts		0			0.00	
00 00	Vending machines Income from imposition of interest, finance		0			0.00	
	or penalty charges (chapter 21)		0				
00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21
00	Utilization reviewphysicians' compensation (chapter 21)		0	UTI LI ZATI ON	REVIEW - SNF	82.00	22
00	Depreciationbuildings and fixtures			CAP REL COST FIXTURES	S - BLDGS &	1.00	23
00	Depreciationmovable equipment			CAP REL COST EQUIPMENT	S - MOVABLE	2.00	24
00	MARKETING SAL/OTHER	A		ADMI NI STRATI		4.00	
01		A		EMPLOYEE BEN		3.00	
02	NON-ALLOWABLE EXPENSES	A		ADMI NI STRATI		4.00	
03 04	BED TAX ASSESSMENT ELECTRIC REVENUE	A B	-423	ADMI NI STRATI PLANT OPERAT REPAI RS	VE & GENERAL ION, MAINT. &	4.00 5.00	
05	HOUSEKEEPI NG SERVI CES	В		HOUSEKEEPI NG		7.00	25
	MAINTENANCE SERVICES	В	-450		ION, MAINT. &	5.00	
07	OTHER INCOME	В		ADMI NI STRATI	VE & GENERAL	4.00	25
			-979, 340				100

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

Health Financial Systems	PI TMAN	MANOR		In Lie	u of Form CMS	S-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ				Period: From 07/01/2022 To 06/30/2023	Date/Time P 11/30/2023	repared:
	Line No.	Cost (Center	Expense	e Items	
	1.00	2.	00	3.	00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:				ED ORGANIZATIONS	S OR	
1.00		ADMI NI STRATI VE	& GENERAL	HOME OFFICE ALL	LOCATION	1.00
2.00	0.00					2.00
3.00	0.00					3.00
4.00	0.00					4.00
5.00	0.00					5.00
6.00	0.00					6.00
7.00	0.00					7.00
8.00	0.00					8.00
9.00	0.00					9.00
10.00 TOTALS (sum of lines 1-9). Transfer column						10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						
	Amount	Amount	Adjustments			
	Allowable In	Included in	(col. 4 minu	s		
	Cost	Wkst. A, col.	col. 5)			
		5				
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:			-		S OR	
1.00	1, 015, 669	1, 097, 387	-81, 71	8		1.00
2.00	0	0		0		2.00
3.00	0	0		0		3.00
4.00	0	0		0		4.00
5.00	0	0		0		5.00
6.00	0	0		0		6.00
7.00	0	0		0		7.00
8.00	0	0		0		8.00
9.00	0	0		0		9.00
10.00 TOTALS (sum of lines 1-9). Transfer column	1, 015, 669	1, 097, 387	-81, 71	8		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						I

Health Financial Systems	PI TMAN M	ANOR	In Lie	u of Form CMS-2	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ	ATIONS AND HOME	Provider No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8- Parts I-II Date/Time Prep 11/30/2023 1:5	bared:
	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

1.00		G	UNI TED	METHODI ST	HOMES OF N	IJ 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 fv						1

(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.

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					
	4.00	5.00	6.00				
PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. 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	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-financi	ial)	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.

 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.

Heal th	Financial Systems	PITMAN M	IANOR			In Lie	u of Form CMS-2	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315427		riod: om 07/01/2022 06/30/2023	Worksheet B Part I Date/Time Pre 11/30/2023 1:	
			CAPI TAL REL	ATED COSTS			11/00/2020 11	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT		EMPLOYEE BENEFI TS	Subtotal	
		0	1.00	2.00		3.00	3A	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	622.264	600 064					1 1 00
1.00 2.00	00200 CAP REL COSTS - BEDGS & FIXTORES	622, 264	622, 264		0			1.00
3.00	00300 EMPLOYEE BENEFITS	1, 953, 740	0		0	1, 953, 740		3.00
4.00	00400 ADMINISTRATIVE & GENERAL	3, 125, 339	26, 580		0	237, 945	3, 389, 864	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	1, 449, 509	6, 933		0	97, 263	1, 553, 705	5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG	144, 625 629, 718	8, 474 3, 852		0	25, 232 117, 233	178, 331 750, 803	6.00 7.00
8.00	00800 DI ETARY	2, 107, 174	16, 178		0	201, 127	2, 324, 479	8.00
9.00	00900 NURSING ADMINI STRATI ON	0	0		0	0	0	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		0	0	0	10.00
11.00		0	0		0	0	0	11.00
12.00 13.00	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	43, 342	0 1, 928		0	0 9, 867	0 55, 137	12.00 13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	43, 342	1, 720		0	7, 007 0	0,137	14.00
15.00	01500 ACTI VI TI ES	249, 897	9, 245		0	44, 981	304, 123	15.00
15.01	01501 CHAPLAI N	70, 933	0		0	16, 066	86, 999	15.01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	2 (75 554	00 (7)		0	(17.154	4 202 204	20.00
30.00 31.00	03100 NURSING FACILITY	3, 675, 554 0	99, 676 0		0	617, 154 0	4, 392, 384 0	30.00 31.00
32.00	03200 CF/I D	0	0		0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	2, 252, 144	446, 806		0	483, 729	3, 182, 679	33.00
10.00	ANCI LLARY SERVI CE COST CENTERS	0.(07	0				0. (07	10.00
40.00 41.00	04000 RADI OLOGY 04100 LABORATORY	8, 607 9, 485	0		0	0	8, 607 9, 485	40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0	, 405 0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	62, 024	0		0	13, 199	75, 223	43.00
44.00	04400 PHYSI CAL THERAPY	245, 412	1, 822		0	45, 206	292, 440	
45.00 46.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	164, 775	0		0	28, 737 9, 972	193, 512	
46.00	04700 ELECTROCARDI OLOGY	52, 363	0		0	9, 9/2	62, 335 0	46.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	11,007	0		0	0	11,007	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	120, 129	0		0	0	120, 129	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51.00	05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	51.00
60.00	06000 CLINIC	0	0		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62.00	06200 FQHC							62.00
70 00	OTHER REIMBURSABLE COST CENTERS		0		0	0	0	
70.00 71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0		0 0	0	0	70.00
	07300 CMHC	0	0		0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS							
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
81.00 82.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVIEW - SNF							81.00 82.00
82.00 83.00	08300 HOSPICE	0	0		0	0	0	82.00
89.00	SUBTOTALS (sum of lines 1-84)	16, 998, 041	621, 494		0	1, 947, 711	16, 991, 242	89.00
	NONREI MBURSABLE COST CENTERS	·	-	1	-			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	37,460	0 770		0	6, 029	43, 489	90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	//0		0	0	770 0	91.00 92.00
92.00 93.00	09300 NONPAID WORKERS	0	0		0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0		0	Ō	0	94.00
98.00	Cross Foot Adjustments	0	0		0	0	0	98.00
99.00	Negative Cost Centers		622 244		0	1 052 740	17 025 501	99.00
100.00	D TOTAL	17, 035, 501	622, 264	I	U	1, 953, 740	17, 035, 501	100.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 07/01/2022 o 06/30/2023	Worksheet B Part I Date/Time Pre 11/30/2023 1:	pared: 54 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1 1			i i		1
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	3, 389, 864 385, 973 44, 301 186, 515 577, 449 0 0 0	1, 939, 678 27, 919 12, 690 53, 300 0 0	250, 551 0 0	950, 008	2, 981, 891 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	13, 697	6, 351 0		3, 177 0	0	13.00
15.00	01500 ACTI VI TI ES	75, 551	30, 457	0	15, 236	0	15.00
15.01	01501 CHAPLAIN	21, 612	0	0	0	0	15.01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	1, 091, 164	328, 389	141, 943	164, 277	1,037,912	30.00
31.00	03100 NURSI NG FACI LI TY	0	020,007			0	31.00
32.00	03200 CF/I D	0	0	-	-	0	32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	790, 644	1, 472, 033	108, 608	736, 383	1, 943, 979	33.00
40, 00	04000 RADI OLOGY	2, 138	0	0	o	0	40.00
41.00	04100 LABORATORY	2, 356	0		0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	18, 687 72, 648	0 6, 001	0	0 3, 002	0	43.00
45.00	04500 OCCUPATI ONAL THERAPY	48,072	0,001	0	0,002	0	45.00
46.00	04600 SPEECH PATHOLOGY	15, 485	0	0	0	0	46.00
47.00 48.00	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 2, 734	0	0	0	0	47.00
48.00 49.00	04900 DRUGS CHARGED TO PATIENTS	2, 734	0		0	0	48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	Ő	Ő	0	50.00
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0			0	61.00
62.00	06200 FQHC						62.00
70 00	OTHER REIMBURSABLE COST CENTERS						70.00
70. 00 71. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0	0			0	70.00
	07300 CMHC	0	0	Ő	Ő	0	73.00
	SPECIAL PURPOSE COST CENTERS	1			т т		
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	3, 378, 869	1, 937, 140	250, 551	948, 738	2, 981, 891	89.00
90.00	NONREIMBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	10, 804	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	191	2, 538		-	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	94.00 98.00
98, 00	Cross Foot Adjustments						
98. 00 99. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	99.00

Heal th	Financial Systems	PI TMAN I	MANOR		In Li	eu of Form CMS-	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	No.: 315427	Period: From 07/01/202 To 06/30/202		pared: 54 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS					-	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 0 0 0 0	0 0 0 0 0		0 0 0	0 0 78, 362	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0 0	
15.00	01500 ACTI VI TI ES	0	0		0	0 0	15.00
15.01	01501 CHAPLAI N	0	0		0	0 0	15.01
	INPATIENT ROUTINE SERVICE COST CENTERS	-1		1	-		
30.00	03000 SKI LLED NURSI NG FACI LI TY	0	0		0	0 78, 362	30.00
31.00	03100 NURSING FACILITY 03200 I CF/I I D	0	0		0	0 0	31.00
32.00 33.00	03200 OTHER LONG TERM CARE	0	0		0	0 0	
33.00	ANCILLARY SERVICE COST CENTERS	0	0		0	0 0	33.00
40.00	04000 RADI OLOGY	0	0		0	0 0	40.00
41.00	04100 LABORATORY	0	0		0	0 0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0 0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0	0 0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0	0 0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0	0 0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0	0 0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0 0	47.00
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	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
51.00	OUTPATIENT SERVICE COST CENTERS	U	0		0	0 0	51.00
60.00	06000 CLINIC	0	0		0	0 0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0 0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			-			
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0 0	
	07100 AMBULANCE	0	0		0	0 0	
73.00	07300 CMHC	0	0		0	0 0	73.00
00.00	SPECIAL PURPOSE COST CENTERS			[
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0		0	0 0	
89.00	SUBTOTALS (sum of lines 1-84)	0	0		0	0 78, 362	
	NONREIMBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0 0	
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0 0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0 0	
93.00	09300 NONPALD WORKERS	0	0		0	0 0	
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0		0	0 0	94.00 98.00
98.00 99.00	Negative Cost Centers	0	0		0	0 0	
100.00	5	0	0		0		100.00
	1 1	1	-	•	1		

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	PI TMAN		No : 215427		u of Form CMS-2	2540-10
	LLUCATION - GENERAL SERVICE COSTS			No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/30/2023 1:	
			OTHER GENER	RAL SERVICE			
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Stepdown Adjustments	
	1	14.00	15.00	15.01	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT						1.00
2.00	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 01100 PHARMACY						10.00
11.00 12.00	01200 MEDICAL RECORDS & LIBRARY						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 ACTI VI TI ES	0	425, 367				15.00
15.01	01501 CHAPLAI N	0	0		11		15.01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	425, 367	35, 4	20 7, 695, 218	0	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 CF/I D	0	0		0 0	0	32.00
33.00	O3300 OTHER LONG TERM CARE	0	0	73, 1	8, 307, 517	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 10, 745	0	40.00
40.00	04100 LABORATORY	0	0		0 11, 841	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 93, 910	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 374, 091	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 241, 584	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 77, 820	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0	0	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0		0 13, 741	0	48.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 149, 972 0 0	0	49.00 50.00
51.00	05100 SUPPORT SURFACES	0	0		0 0	0	51.00
01.00	OUTPATIENT SERVICE COST CENTERS			1		0	01.00
60.00	06000 CLI NI C	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			1			
	07000 HOME HEALTH AGENCY COST	0	-		0 0	-	70.00
71.00	07100 AMBULANCE	0	0		0 0	0	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	73.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES			1			80.00
81.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	425, 367	108, 6	11 16, 976, 439	0	89.00
	NONREIMBURSABLE COST CENTERS				1		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 54, 293	0	
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 4, 769	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	
93.00	09300 NONPALD WORKERS	0	0		0 0	0	
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0			0	
98.00 99.00	Negative Cost Centers	0	0		0 0	0	
100.00		0	425, 367	108, 6	11 17, 035, 501		100.00
100.00		, Ч	725, 507	1 100, 0		0	1.00.00

	Financial Systems	PI TMAN MANO		In Lieu of Form CMS-	2540-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider No.: 315427	Period: Worksheet B From 07/01/2022 Part I	
				To 06/30/2023 Date/Time Pro	epared:
	Cost Center Description	Total		11/30/2023 1	54 pm
	obst center beschiption	18.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300 EMPLOYEE BENEFITS				3.00
4.00	00400 ADMINI STRATI VE & GENERAL				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00 7.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG				6.00 7.00
8.00	00800 DI ETARY				8.00
9.00	00900 NURSI NG ADMI NI STRATI ON				9.00
10.00	01000 CENTRAL SERVICES & SUPPLY				10.00
11.00	01100 PHARMACY				11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY				12.00
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				
30.00	03000 SKILLED NURSING FACILITY	7, 695, 218			30.00
31.00	03100 NURSING FACILITY	0			31.00
32.00	03200 I CF/I I D	0			32.00
33.00	03300 OTHER LONG TERM CARE	8, 307, 517			33.00
40.00	ANCI LLARY SERVICE COST CENTERS	10 745			40.00
40.00	04000 RADI OLOGY	10, 745 11, 841			40.00
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0			41.00 42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	93, 910			43.00
44.00	04400 PHYSI CAL THERAPY	374, 091			44.00
45.00	04500 OCCUPATI ONAL THERAPY	241, 584			45.00
46.00	04600 SPEECH PATHOLOGY	77, 820			46.00
47.00	04700 ELECTROCARDI OLOGY	0			47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 741			48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	149, 972			49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
51.00	05100 SUPPORT SURFACES	0			51.00
	OUTPATIENT SERVICE COST CENTERS				
60.00		0			60.00
61.00	06100 RURAL HEALTH CLINIC	0			61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS				62.00
70.00	07000 HOME HEALTH AGENCY COST	0			70.00
70.00	07100 AMBULANCE	0			71.00
73.00	07300 CMHC	Ő			73.00
	SPECIAL PURPOSE COST CENTERS	-			
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00	08100 INTEREST EXPENSE				81.00
82.00	08200 UTILIZATION REVIEW - SNF				82.00
83.00	08300 HOSPI CE	0			83.00
89.00	SUBTOTALS (sum of lines 1-84)	16, 976, 439			89.00
	NONREI MBURSABLE COST CENTERS	1			_
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	54, 293			90.00
91.00	09100 BARBER AND BEAUTY SHOP	4, 769			91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	0			92.00
93.00	09300 NONPALD WORKERS	0			93.00
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0			94.00 98.00
98.00 99.00	Negative Cost Centers	0			98.00
100.00	0	17,035,501			100.00
	1 1				1.227.00

Heal th	Financial Systems	PI TMAN M	MANOR			In Lie	u of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315427		riod: om 07/01/2022 06/30/2023	Worksheet B Part II Date/Time Pre 11/30/2023 1:5	pared:
			CAPI TAL REL	LATED COSTS			117 307 2023 1.	<u>54 piii</u>
	Cost Center Description	Di rectl y Assigned New Capital	BLDGS & FI XTURES	MOVABLE EQUI PMENT		Subtotal	EMPLOYEE BENEFI TS	
		Related Costs 0	1.00	2.00		2A	3.00	
	GENERAL SERVICE COST CENTERS	· · · · ·		2100		2.1	0100	
1.00 2.00 3.00 4.00 5.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	0	0 26, 580 6, 933		0	0 26, 580 6, 933	0 0 0	1.00 2.00 3.00 4.00 5.00
6.00 7.00	00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	0	8, 474 3, 852		0	8, 474 3, 852	0	6.00 7.00
8.00 9.00 10.00 11.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	0 0 0	16, 178 0 0 0		0 0 0	16, 178 0 0 0	0 0 0 0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 0 0	0 1, 928 0 9, 245		0 0 0 0	0 1, 928 0 9, 245	0 0 0 0	12.00 13.00 14.00 15.00
15. 01	01501 CHAPLAIN I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0		0	0	0	15.01
30. 00 31. 00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY	0	99, 676 0		0 0	99, 676 0	0 0	30. 00 31. 00
32. 00 33. 00	03200 I CF/I I D 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0 446, 806		0 0	0 446, 806	0	32.00 33.00
40.00	04000 RADI OLOGY	0	0		0	0	0	40.00
41.00 42.00 43.00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0	0 0 0		0 0 0	0 0 0	0 0 0	41.00 42.00 43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	1, 822 0		0	1, 822 0	0	44.00 45.00
46.00 47.00 48.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0 0	0 0 0	46.00 47.00 48.00
48.00 49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	48.00 49.00 50.00
51.00	05100 SUPPORT SURFACES OUTPATI ENT SERVI CE COST CENTERS	0	0		0	0	0	51.00
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	0		0 0	0 0	0 0	60.00 61.00 62.00
70.00	OTHER REIMBURSABLE COST CENTERS 07000 HOME HEALTH AGENCY COST	0	0		0	ol	0	70.00
70.00 71.00 73.00	07100 AMBULANCE 07300 CMHC	0	0		0	0	0	70.00 71.00 73.00
	SPECIAL PURPOSE COST CENTERS	-		1	-			
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE							80.00 81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF		0		~			82.00
83. 00 89. 00	08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	621, 494		0 0	0 621, 494	0 0	83. 00 89. 00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	770 0		0	770	0	91.00 92.00
93.00	09300 NONPAI D WORKERS	0	0		0	0	0	93.00
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0		0	0	0	94.00 98.00
99.00	Negative Cost Centers		0		0	0	0	99.00
100.00	TOTAL	0	622, 264		0	622, 264	0	100. 00

Heal th	Financial Systems	PI TMAN M	IANOR		In Lie	u of Form CMS-:	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/30/2023 1:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG E	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS	1		1			1 1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 01\\ \end{array}$	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES 01501 CHAPLAIN	26, 580 3, 027 347 1, 463 4, 528 0 0 0 0 0 0 0 107 0 592 169	9, 960 143 65 274 0 0 0 0 33 0 156 0	8, 9(54 0 5, 380 0 151 0 0 0 0 0 0 0 0 0 18 0 0 0 86 0 0 0 0	21, 131 0 0 0 0 0 0 0 0 0 0	9.00 10.00 11.00 12.00 13.00 14.00 15.00
10.01	INPATIENT ROUTINE SERVICE COST CENTERS	107			0 0	0	10.01
30. 00 31. 00 32. 00 33. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	8, 556 0 0 6, 200	1, 686 C C 7, 559		0 0 0 0	7, 355 0 0 13, 776	31.00 32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	17	0	1	0 0	0	40.00
40.00	04100 LABORATORY	18	0		0 0	0	
42.00	04200 I NTRAVENOUS THERAPY	0	C		0 0	0	1
43.00	04300 OXYGEN (INHALATION) THERAPY	147	0		0 0	0	1
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	570 377	31 0	1	0 17 0 0	0	44.00 45.00
46.00	04600 SPEECH PATHOLOGY	121	0		0 0	0	1
47.00	04700 ELECTROCARDI OLOGY	0	C		0 0	0	1
48.00	04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS	21	C		0 0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	234	0		0 0	0	
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0 0	0	1
01100	OUTPATIENT SERVICE COST CENTERS				0 0		
60.00	06000 CLI NI C	0	C		0 0	0	
61.00	06100 RURAL HEALTH CLINIC	0	C)	0 0	0	
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0)	0 0	0	70.00
	07100 AMBULANCE	0	0		0 0	-	
73.00	07300 CMHC	0	0		0 0	0	73.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00	08100 I NTEREST EXPENSE						81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	26, 494	9, 947	8,90	54 5, 373	21, 131	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	85	C		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	1	13		0 7	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	
93.00 94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY	0	0			0	1
94.00 98.00	Cross Foot Adjustments		U		0 0	0	1
99.00	Negative Cost Centers	0	C		0 0	0	99.00
100.00	TOTAL	26, 580	9, 960	8,90	5, 380	21, 131	100. 00

Heal th	Financial Systems	PI TMAN M	MANOR		In Li	eu of Form CMS-2	2540-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	No.: 315427	Period: From 07/01/202 To 06/30/202		
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 3.00 4.00 5.00 6.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00	00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	0 0 0	0 0		0		7.00 8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 15.01	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES 01501 CHAPLAIN		0 0 0 0 0		0 0 0 0 0	0 0 2,086 0 0 0 0 0 0 0 0	12.00 13.00 14.00 15.00 15.01
30.00 31.00 32.00 33.00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0 0 0 0	0 0 0 0		0 0 0 0	0 2,086 0 0 0 0 0 0 0 0	31.00
40.00	ANCI LLARY SERVICE COST CENTERS	0	0		0	0 0	40.00
41.00	04100 LABORATORY	0	0		0	0 0	41.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0	0 0	42.00 43.00
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0	0		0	0 0	43.00
45.00	04500 OCCUPATIONAL THERAPY	0	0)	0	0 0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0	0 0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0	0 0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	48.00 49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0 0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0 0	51.00
	OUTPATIENT SERVICE COST CENTERS						
60.00 61.00 62.00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FOHC	0	0		0	0 0 0 0	60.00 61.00 62.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	0		0	0 0	70.00
71.00	07100 AMBULANCE 07300 CMHC	0	0		0	0 0	
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES			1			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	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	0	1	0	0 2,086	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0)	0	0 0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0	0 0	
92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0		0	0 0	
93.00 94.00	09400 PATIENTS LAUNDRY	0	0		0	0 0	
98.00	Cross Foot Adjustments	0	0		0	-	98.00
99.00	Negative Cost Centers	0	0		0	0 0	
100.00	D TOTAL	0	0	1	0	0 2,086	100.00

Heal th	Financial Systems	PI TMAN I	MANOR		In Lie	eu of Form CMS-2	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS			No.: 315427	Period: From 07/01/2022 To 06/30/2023		
			OTHER GENER	RAL SERVICE			
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	ACTI VI TI ES	CHAPLAI N	Subtotal	Post Step-Down Adjustments	
	1	14.00	15.00	15.01	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS	1		1		[1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUI PMENT						1.00 2.00
3.00	00300 EMPLOYEE BENEFITS						3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600 LAUNDRY & LINEN SERVICE						6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00 12.00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY						11. 00 12. 00
12.00	01300 SOCIAL SERVICE						13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES	0	10, 079				15.00
15.01	01501 CHAPLAI N	0	0		69		15.01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	10, 079		55 135, 501	0	30.00
31.00	03100 NURSING FACILITY	0	0		0 0		31.00
32.00	03200 I CF/I I D	0	0		0 0	0	32.00
33.00	O3300 OTHER LONG TERM CARE	0	0	1	14 482, 512	0	33.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 17	0	40.00
40.00	04100 LABORATORY	0	0		0 18		40.00
42.00	04200 I NTRAVENOUS THERAPY	0	0		0 0		42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0		0 147	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	0		0 2,440	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	0		0 377	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0 121	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	0		0 0		47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 21	0	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 234	0	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0		0 0 0 0		50.00 51.00
51.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	51.00
60.00	06000 CLINIC	0	0		0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0		61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			1			
	07000 HOME HEALTH AGENCY COST	0	-		0 0	-	70.00
	07100 AMBULANCE	0	0		0 0		
73.00	O7300 CMHC	0	0		0 0	0	73.00
80.00	SPECIAL PURPOSE COST CENTERS 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	10, 079	1	69 621, 388	0	89.00
	NONREI MBURSABLE COST CENTERS			1			
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 85		90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 791	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
93.00	09300 NONPALD WORKERS	0	0		0 0	0	93.00
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0			0	94.00 98.00
98.00 99.00	Negative Cost Centers	0	0		0 0		
100.00		0	10, 079	1	69 622, 264		100.00
	н н Н	1					

	Financial Systems	PI TMAN MANO			u of Form CMS-2540-1
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Prepared: 11/30/2023 1:54 pm
	Cost Center Description	Total 18.00			
	GENERAL SERVICE COST CENTERS	10100		· · · · · · · · · · · · · · · · · · ·	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES 01501 CHAPLAIN				11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	135, 501			30.00
31.00	03100 NURSING FACILITY	0			31.00
32.00	03200 CF/I D	0			32.00
33.00	03300 OTHER LONG TERM CARE	482, 512			33. 00
40.00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	17			40.00
41.00	04100 LABORATORY	18			41.00
42.00	04200 I NTRAVENOUS THERAPY	0			42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	147			43.00
44.00	04400 PHYSI CAL THERAPY	2, 440			44.00
45.00	04500 OCCUPATI ONAL THERAPY	377			45.00
46.00	04600 SPEECH PATHOLOGY	121			46.00
47.00	04700 ELECTROCARDI OLOGY	0			47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	21			48.00
	04900 DRUGS CHARGED TO PATIENTS	234			49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			50.00
51.00	05100 SUPPORT SURFACES	0			51.00
60, 00	OUTPATIENT SERVICE COST CENTERS	0			60.00
61.00	06100 RURAL HEALTH CLINIC	0			61.00
62.00	06200 FQHC	0			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				
	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			83.00
89.00	SUBTOTALS (sum of lines 1-84)	621, 388			89.00
00.00	NONREI MBURSABLE COST CENTERS	05			
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	85			90.00 91.00
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	0			91.00
92.00 93.00	09300 NONPALD WORKERS	0			92.00
93.00 94.00	09400 PATIENTS LAUNDRY	0			93.00
	ULCOSS FOOT ADJUSTMENTS	()			
94.00 98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0			98.00 99.00

CBST ALLOCATION - STATISTICAL BASIS Provider Not: 315427	Health Financial Systems	PI TMAN				u of Form CMS-2	2540-10
Cost Center Description EAPLOS & EQUOS 1 at EFE (SDUARE FEE) EAPLOS & (SDUARE	COST ALLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1	
Cost Center Description PAPTAL RELATE 0557 PLATURES FARTURES BUIL YEAR BOWDINGT FARTURES FARTURES BUIL YEAR Construct Hatton Wath N STRUTUR (ACOW 005T) 1.00 CONTO CAR PIL CENTS - NUDSS & FLATURES 00000 (APACTE LEDIS - NUDSS & FLATURES 000000 (APACTE LEDIS - NUDSS & FLATURES 0000000 (APACTE LEDIS - NUDSS & FLATURES 0000000 (APACTE LEDIS - NUDSS & FLATURES 0000000 (APACTE LEDIS - NUDSS & FLATURES 00000000 (APACTE LEDIS - NUDSS & FLATURES 00000000 (APACTE LEDIS - NUDSS & FLATURES 00000000 (APACTE LEDIS - NUDSS & FLATURES 000000000 (APACTE LEDIS - NUDSS & FLATURES 000000000 (APACTE LEDIS - NUDSS & FLATURES 00000000000 (APACTE LEDIS - NUDSS & FLATURES 000000000000000000000000000000000000							
Dock Center Description BLOGS & DUPENI EXAMPLES BLPDOYES (SUMME FLEE) Record Flatter (SUMME FLEE) Record Flatter (SUMME FLEE) Record Flatter (SUMME FLEE) 100 2.00 3.03 4A 4.00 100 0.00 0.00 0.00 0.00 0.00 2.00 2.00 1.00 0.00 0.00 1.01.05.22 -3.39 84 13.645,637 4.00 0.00		CAPITAL REI	ATED COSTS			11/30/2023 1:	54 pm
Instrument Instruments A GREWALL A GREWALL COMPART SCAMPUSS A GREWALL A GREWALL 1:00 CONTO GAR PEL COST - ENTERS 1:00 3:00 4:4 4:00 1:00 CONTO GAR PEL COST - ENTERS 1:00 3:00 4:00 2:00 0:0000 GAR PEL COST - ENTERS 1:00 0:00000 0:00000 0:000							
SOUMAPT FITT) CORRANT FITT) CORRANT FITT) CORRANT SOURCE CACUM (CBT) 1.00 2.00 3.00 4A 4.00 1.00 00000 (CAP BLL 00ST - BLUDGS + LAURES) 1.00 2.00 3.00 1.00 3.00 0.00 00000 (CAP BLL 00ST - BLUDGS + LAURES) 1.00 3.00 3.00 3.00 0.00 00000 (CAP BLL 00ST - BLUDGS + LAURES) 1.01 3.02 3.00 3.00 0.00 00000 (CAP BLL 00ST - BLUDGS + LAURES) 1.01 3.00	Cost Center Description				Reconci I i ati on		
Image: Control Control Control Controls Indian Control Controls Indian Control Co							
IDENTIFY 1.00 2.00 3.00 4A 4.00 1.00 GOTOQ CAP REL COSTS - BLOGS A FUTURES 000000 ADM MISTRATULE & CENERAL ADD DATE ADD D		(SQUARE FEET)	(SQUARE FEET)			(ACCUM CUST)	
1.00 DOTOD CAP REL COSTS - BLICS & FLYTURES 163,969 1 100 2.00 3.00 DOSOC DEPLEX COSTS - MUNALE FOULTWENT 0 8,062,2772 -3,389,864 13,245,637,505 500 3.00 DOSOC DEPLEX COSTS - MUNALE FOULTWENT 0 100,722,222 -3,389,864 13,245,637,505 500 0.00 DOSOC LAURDEY & LINEN STRVICE 2,223 0 174,833 6,00 0.00 DOSOC MUNESKEEN ING 1,1015 0 514,457,705 70,700,803 7.00 0.00 DOSOC MUSSKEEN ING 4,223 0 883,498 0 2,224,479 8.00 0.00 DOSOC MUSSKEEN ING 51,1114 100,110 101,000 101,000 101,000 101,000 101,000 12,000 0 0 0 12,000 10.00 DISON SOCIAL SERVICE 4,1120 508 0 43,342 0 14,000 10.00 DISON SOCIAL SERVICE 4,1120 10,000 0 0 0 0 0 0 0		1.00	2.00		4A	4.00	
2.00 DOX200 CAP EDC DSTS - MOVABLE EDUIFMENT 0 2.00 4.00 DOX200 APPLYCEE EBVERTS 0 0 8, 582, 272 .3, 389, 964 13, 645, 637 4, 00 4.00 DOX200 AMURT DEPARTING, MM MT, & A EFAIRS 1, 227 0 1, 153, 645, 637 4, 00 0.00 DOX200 HART DEPARTING, MM MT, & A EFAIRS 1, 227 0 1, 154, 707 0 1, 563, 503 5, 00 1, 563, 647 8, 00 0.00 DOX200 HART DEPARTING, MM MT, & A EFAIRS 1, 207 0 1, 00, 11, 00 1, 349, 79, 80 0 1, 300 1, 00, 11, 00 1, 00, 01, 00 0 0 0 0 0 0 0 0 0 0 1, 00 1, 100			1	T		1	
3.00 002000 FAPLE TYPE TARKET ITS 0 0 6, 560, 222 -3, 389, 664 3, 4, 650, 222 -3, 389, 664 3, 4, 650, 223 -3, 689, 664 3, 4, 650, 223 -3, 389, 664 1, 553, 706 5, 00 00000 17, 553, 706 5, 00 00000 17, 553, 706 5, 00 00000 17, 553, 706 5, 00 17, 553, 706 5, 00 17, 553, 706 5, 00 00000 17, 553, 706 5, 00 0, 0000 17, 553, 706 5, 00 17, 553, 706 5, 00 17, 553, 706 5, 00 0, 17, 153, 16 00 17, 553, 706 5, 00 0, 00 17, 00, 00 17, 553, 706 5, 00 17, 753 0 1, 753, 706 5, 00 1, 753, 13, 00 10, 00 10, 00 10, 00 10, 00 10, 150, 00 11, 00 10, 150, 00, 00 1, 10, 00 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,		163, 969	-				
4.00 ODOROD ADMINI NT STATI VE & CENERAL 7.004 0 1.045,232 -3.289,864 13.465,637 4.00 6.00 ODOROD LANNOR * A LINEN SERVICE 2.233 0 110,837 0 17.83,331 6.00 0.00000 LETAR* 4.263 0 883,498 0 2.224,477 8.00 0.00000 DETAR* 4.263 0 883,498 0 2.244,477 8.00 0.00000 DETAR* 0 0 0 0 0 0 10.00 0.00000 DETAR* 4.263 0 883,498 0 2.24,477 8.00 0.00000 DETAR* 0 0 0 0 0 0 10.00 1.000 D1300 SOCIAL SERVICE 1.1884 0 0 0 0 0 0 14.00 0.00000 MINISING ADMAINING SEXPLICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	-				
5.00 00500 PLANT OPERATION. MAINT. & LEPAIRS 1, 227 0 427, 252 0 17, 553, 708 5, 00 7.00 00700 HASTERFETINK 1, 1015 0 514, 975 0 7780, 630 7.00 7.00 00700 HASTERFETINK 1, 1015 0 614, 975 0 7780, 630 7.00 7.00 00700 HASTERFETINK 1, 1015 0 614, 975 0 7780, 630 7.00 7.00 00700 HASTERFETINK 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>13 645 637</td><td></td></t<>						13 645 637	
6.00 DOUCOL LUMINEY LINEN SERVICE 2,233 0 110,837 0 178,831 6.00 0.00 DOUCOL DUSCENEEP IN 0.00 0							
8.00 00000 DI ETARY 4, 2c3 0 B83, 498 0 2, 324, 479 8, 00 9, 00							
9.00 00700 NURSING ADMINISTRATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 00700 HOUSEKEEPI NG	1, 015	C	514, 975	5 0	750, 803	7.00
10. 00 01000 CENTRAL SERVICES & SUPPLY 0 0 <		4, 263	0	883, 498	3 0		
11 DO DO D <thd< th=""> D <thd< th=""></thd<></thd<>		0			0		
12 00 01200 WEDICAL RECORDS & LIBRARY 0 0 0 0 12.00 01300 13 00 01300 SOLIAL SERVICE 508 0 4.3,342 0 51.137 13.00 14 00 01400 NURSING AND ALLED HALLTH EDUCATION 0 0 70.574 0 80.013 51.137 13.00 15 00 15500 (CHAPLAIN 0 0 70.574 0 80.013.000 80.014.135<		0					
13:00 01300 SOCIAL SERVICE 508 0 43,342 0 55,13 13.00 14.00 15:00 01500 ACTIVITIES 2,436 0 197,586 0 304,123 15.00 10:01 01500 CENPLAIN RAPLENT ROUTINE SERVICE COST CENTERS 0 <		0					
15.00 00 01500 ACTI VITES 2,436 0 70,588 0 304,123 15.00 IMPATLENT ROUTINE SERVICE COST CENTERS -		508	0	43, 342	2 0		
15. 01 01 01 01 00 70, 574 00 86, 999 15. 01 INPATE TOR NOUTINE SERVICE COST CENTERS 0 0, 00	14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0) (0 0	0	14.00
IMPATIENT ROUTINE SERVICE COST CENTERS INPATIENT ROUTINE SERVICE COST CENTERS 01 00 03100 NURSING FACILITY 0 0 0 0 0.0		2, 436					
30. 00 03000 SKILLED NURSING FACILITY 26, 265 0 2, 710, 996 0 4, 392, 384 30. 00 31.00 03100 URSING FACILITY 0		0	C	0 70, 574	4 0	86, 999	15.01
31.00 03100 NURSI NG FACILITY 0<		26 265	0	2 710 00/	5 0	1 302 381	30.00
32.00 03200 01200 014PE 014PE 0							•
ANCILLARY SERVICE COST CENTERS 0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>							
04000 RADILOGY 0		117, 735	0	2, 124, 898	3 0	3, 182, 679	33.00
41:00 04100 LABORATORY 0 0 0 9,485 41.00 42:00 04200 INTRAVENDIS THERAPY 0 0 57,981 0 75,223 43.00 44:00 04400 PHYSICAL THERAPY 0 0 57,981 0 75,223 43.00 44:00 04500 OCUPATIONAL THERAPY 0 0 126,234 0 193,512 45.00 04:00 04600 SPECH PATHOLOCY 0 0 147.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 0 0 120,129 49.00 50.00 50.00 50.00 50.00 51.00		1	[1			
42.00 04200 INTRAVENUES THERAPY 0 0 0 0 42.00 43.00 04300 OXYGEN INTRALATION) THERAPY 0 0 757.951 0 292.440 44.00 44.00 O4400 PHSI CAL THERAPY 480 0 198.577 0 292.440 44.00 45.00 O4600 SPECH PATHOLOGY 0 0 126.234 0 193.512 45.00 46.00 O4600 SPECH PATHOLOGY 0 0 0 0 17.00 49.00 04700 DENTAL CARGED TO PATIENTS 0 0 0 11.00 48.00 04900 DENTAL CARGED TO PATIENTS 0 0 0 0 120.12 49.00 051.00 SUPARCE COST CENTERS 0							•
43. 00 04300 0VSCRN () INHALATION) THERAPY 0 0 57, 961 0 75, 223 43. 00 44.00 04400 PHYSICAL THERAPY 0 0 126, 234 0 193, 512 45. 00 46.00 04600 SPECH, PATHOLOGY 0 0 43. 00 46. 00 47. 00 0 0 11, 001 48. 00 48. 00 0 0 0 11, 001 48. 00 11, 001 48. 00 0 0 0 0 0 126, 234 0 00 126, 234 0 0 126, 234 0 170. 00 126, 234 0 126, 234 0 126, 234 0 126, 234 0 126, 234 0 126, 234 0 126, 236 0							
44.00 04400 PHYSICAL THERAPY 480 0 198, 577 0 292, 440 44.00 65.00 04600 SPECCH PATHOLOCY 0 0 126, 224 0 193, 512 45.00 46.00 Oddol SPECCH PATHOLOCY 0 <td< td=""><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></td<>		-					
46.00 04600 SPECH PATHOLOGY 0 43.806 0 62.335 46.00 47.00 04700 ELECTRCARDIOLOGY 0 0 0 0 110.077 48.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 110.077 48.00 0.00 DEVISAL CARCE - TITLEX IX ONLY 0		480	0				
47. 00 04700 ELECTROCARDIOLOGY 0 </td <td></td> <td>0</td> <td>0</td> <td>126, 234</td> <td>4 O</td> <td>193, 512</td> <td>45.00</td>		0	0	126, 234	4 O	193, 512	45.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 11,007 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 0 0 0 120,129 49.00 00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 50.00 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 60.00 06100 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 0 0 60.00 61.00 60.00 61.00 60.00 61.00 60.00 61.00 60.00 61.00 61.00 62.00 71.00<		0	0	43, 806	5 0		
49:00 04900 DRUSS CHARGED TO PATIENTS 0 0 0 120,129 49.00 50:00 05000 DENTAL CARE - TITLE XIX ONLY 0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
50.00 OSDOO DENTAL CARE - TITLE XIX ONLY O							
51.00 OSIOO SUPPORT SURFACES O </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
60.00 CEINIC 0		0	0				
61.00 06100 RURAL HEALTH CLINIC 0 0 0 0 61.00 042.00 06200 FOHC 0 0 0 62.00				1			
62.00 COND COND <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
OTHER REI MBURSABLE COST CENTERS 70.00 OTOOD HOME HEALTH AGENCY OST O <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></td<>		0	C		0 0	0	
70.00 07000 HOME HEALTH AGENCY COST 0							62.00
71.00 07100 AMBULANCE 0 0 0 0 0 0 0 71.00		0	C		0 10	0	70.00
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 80.00 81.00 91.00 92.00		0	0) (0 0	0	
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 80.00 81.00 08100 INTEREST EXPENSE 81.00 82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08000 HOSPICE 0 0 83.00 83.00 08000 HOSPICE 0 0 0 83.00 83.00 08000 ISBTOTALS (sum of lines 1-84) 163.766 0 8,555,790 -3,389,864 13,601,378 89.00 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 26,482 0 43,489 90.00 91.00 09200 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 92.00 92.00 09200 BARBER AND BEAUTY SHOP 203 0 0 0 92.00 93.00 NONPAID WORKERS 0 0 0 92.00 93.00 94.00 94.00 94.00 94.00 98.00 98.00 99.00 98.00 98.00 98.00	73.00 07300 CMHC	0	0) (0 0	0	73.00
81.00 08100 INTEREST EXPENSE 81.00 81.00 82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 82.00 83.00 08300 HOSPICE 0 0 0 0 83.00 90.00 SUBTALS (sum of lines 1-84) 163,766 0 8,555,790 -3,389,864 13,601,378 89.00 90.00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 770 91.00 91.00 O9000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 0 0 0 92.00 92.00 O9200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 92.00 93.00 O9300 NONPAI D WORKERS 0 0 0 0 93.00 94.00 94.00 94.00 94.00 98.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 <t< td=""><td></td><td>I</td><td>ſ</td><td>1</td><td>T</td><td>ſ</td><td></td></t<>		I	ſ	1	T	ſ	
82.00 08200 UTILIZATION REVIEW - SNF 0 0 0 0 0 0 0 0 0 0 82.00 82.00 82.00 82.00 82.00 82.00 83.00 0 0 0 0 0 0 0 0 0 0 83.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 92.00 93.00 90.00 93.00 90.00 93.00 90.00 93.00 90.00 93.00 93.00							
83.00 08300 HOSPICE 0 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 163,766 0 8,555,790 -3,389,864 13,601,378 89.00 MONREL MBURSABLE COST CENTERS							
89.00 SUBTOTALS (sum of lines 1-84) 163,766 0 8,555,790 -3,389,864 13,601,378 89.00 NONREI MBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 26,482 0 43,489 90.00 91.00 09100 BARBER AND BEAUTY SHOP 203 0 0 0 770 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 92.00 94.00 09400 PATI ENTS LAUNDRY 0 0 0 93.00 99.00 Negative Cost Centers 0 0 0 0 98.00 99.00 Negative Cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 104.00 Part II)		0	o		o o	0	
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 0 26, 482 0 43, 489 90.00 91.00 91.00 91.00 92.00 0 0 0 0 0 0 0 770 91.00 92.00 0 0 0 0 0 0 0 0 0 0 0 0 91.00 92.00 0 0 0 0 0 0 0 0 0 0 0 0 0 92.00 0 93.00 0 0 0 0 0 0 0 0 92.00 0 93.00 0 0 0 0 94.00 94.00 94.00 0 0 0 0 0 0 94.00 94.00 98.00 0 0 0 0 0 98.00 99.00 0 0 0 0 0 98.00 99.00 0 0 0 0 0	89.00 SUBTOTALS (sum of lines 1-84)	163, 766	0	8, 555, 790	-3, 389, 864	13, 601, 378	89.00
91.00 09100 BARBER AND BEAUTY SHOP 203 0 0 0 770 91.00 92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 92.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 93.00 98.00 Cross Foot Adjustments 0 0 0 0 94.00 99.00 Negative Cost Centers 99.00 1,953,740 3,389,864 102.00 102.00 Cost to be allocated (per Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 103.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 105.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.001948 105.00		1	[1			
92.00 09200 PHYSICIANS PRIVATE OFFICES 0 0 0 92.00 93.00 09300 NONPAID WORKERS 0 0 0 0 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 99.00 Negative Cost Centers - - - 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 0.26,580 104.00 105.00 Unit cost multiplier (Wkst. B, Part - 0.000000 0.000000 0.001948 105.00				26, 482	2 0		
93.00 09300 NONPAID WORKERS 0 0 0 93.00 93.00 94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0 94.00 98.00 Cross Foot Adjustments 0 0 0 0 98.00 98.00 99.00 Negative Cost Centers 622,264 0 1,953,740 3,389,864 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 104.00 Cost to be allocated (per Wkst. B, Part I) 3.795010 0.000000 0.227648 0.246,580 104.00 97.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.207648 0.246,580 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0 0.000000 0.001948 105.00		203					
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 94.00 94.00 94.00 94.00 94.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 99.00 102.00 Cost to be allocated (per Wkst. B, Part I) 3795010 0.000000 0.227648 0 3, 389, 864 102.00 26, 580 104.00 26, 580 104.00 26, 580 104.00 105.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.000000 0.248421 103.00 26, 580 104.00 105.00 Unit cost multiplier (Wkst. B, Part Image: Cost multiplier (Wkst. B, Part <		0					
98.00 Cross Foot Adjustments 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 99.00		0	0		o o		
102.00 Cost to be allocated (per Wkst. B, Part I) 622,264 0 1,953,740 3,389,864 102.00 103.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0 26,580 104.00 104.00 Cost to be allocated (per Wkst. B, Part II) 3.795010 0.000000 0.227648 0 26,580 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0 0.000000 0.001948 105.00							
Part I) Part I) 103.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 3.795010 0.000000 0.227648 0.248421 103.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.001948 105.00	5						
103.00 Unit cost multiplier (Wkst. B, Part I) 3.795010 0.000000 0.227648 0.248421 103.00 104.00 Cost to be allocated (per Wkst. B, Part II) 3.795010 0.000000 0.227648 0.248421 103.00 105.00 Unit cost multiplier (Wkst. B, Part 0 0.000000 0.000000 0.001948 105.00		622, 264	0	1, 953, 740	נ	3, 389, 864	102.00
104.00 Cost to be allocated (per Wkst. B, Part II) 0 26,580 104.00 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.001948 105.00		3 795010	0 00000	0 227645	3	0 248421	103 00
Part II) 0.000000 0.001948 105.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.001948		0.770010		(Ď		
				0.00000	ס	0. 001948	105.00
	11)	I	l	I	1	I	I

Heal th	Financial Systems	PI TMAN	MANOR		In Lie	eu of Form CMS-	2540-10
	LLOCATION - STATISTICAL BASIS				eri od:	Worksheet B-1	
					rom 07/01/2022 0 06/30/2023	Date/Time Pre	pared:
	Cost Conton Decorintion	DLANT				11/30/2023 1:	54 pm
	Cost Center Description	PLANT OPERATI ON,	LAUNDRY &	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSING ADMINISTRATION	
		MAINT. &	(POUNDS OF	(**************************************	(
		REPAI RS	LAUNDRY)			(DI RECT	
		(SQUARE FEET) 5.00	6.00	7.00	8.00	NURSI NG) 9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS						2.00 3.00
4.00	00400 ADMINI STRATI VE & GENERAL						4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	155, 138					5.00
6.00	00600 LAUNDRY & LINEN SERVICE	2, 233					6.00
7.00 8.00	00700 HOUSEKEEPI NG 00800 DI ETARY	1,015					7.00
8.00 9.00	00900 NURSI NG ADMI NI STRATI ON	4, 263		4, 263	_		
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0		-	-	•
11.00	01100 PHARMACY	0	-	0	0	0	
12.00	01200 MEDICAL RECORDS & LIBRARY	0	-	0	-	0	
13.00 14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	508		508		0	
15.00	01500 ACTI VI TI ES	2,436	0	-	-	-	
15.01	01501 CHAPLAI N	0				0	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		04.550		51 7/0		
30. 00 31. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	26, 265					1
31.00	03200 I CF/I I D	0	-		-	0	
33.00	03300 OTHER LONG TERM CARE	117, 735	-	-	-		1
	ANCI LLARY SERVI CE COST CENTERS		1	i	1		
40.00	04000 RADI OLOGY	0					
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	-	-	-		
43.00	04300 OXYGEN (INHALATION) THERAPY	0	-		-	0	
44.00	04400 PHYSI CAL THERAPY	480	0		-	-	•
45.00	04500 OCCUPATI ONAL THERAPY	0	0	s s	-	-	
46.00		0	0	0	0	0	
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0			0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	-	•
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	-		-		
51.00	05100 SUPPORT SURFACES	0	0	0	0	0	51.00
60, 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	1	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0					1
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS	-	-	-	-	-	
	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE	0		í í	-	-	
71.00 73.00	07300 CMHC	0					
	SPECIAL PURPOSE COST CENTERS		-			-	
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 82.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00 82.00
82.00	08200 HOSPICE	0	0	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	154, 935	-		-		1
	NONREI MBURSABLE COST CENTERS		I	1	1		
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	-				
91. 00 92. 00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	203		203		0	
92.00 93.00	09300 NONPALD WORKERS	0	-		-	0	1
94.00	09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00	Cross Foot Adjustments						98.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 939, 678	250, 551	950, 008	2, 981, 891	_	99.00 102.00
102.00	Part I)	1, 737, 0/8	200,001	750,008	2,701,091		102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	12. 502920		6. 254579	20. 052392		
104.00		9, 960	8, 964	5, 380	21, 131	0	104.00
105.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 064201	0. 062271	0.035420	0. 142100	0. 000000	105 00
. 55. 50		3.001201		3.000 120	0.112100		

Health Financial Systems	PI TMAN M	IANOR		In Lie	u of Form CMS-	2540-10
COST ALLOCATION - STATISTICAL BASIS				eri od:	Worksheet B-1	
				rom 07/01/2022 o 06/30/2023	Date/Time Pre	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11/30/2023 1: NURSI NG AND	54 pm
cost center bescription	SERVICES &	(COSTED	RECORDS &	SUCIAL SERVICE	ALLI ED HEALTH	
	SUPPLY	REQUI S)	LI BRARY	(PATIENT DAYS)	EDUCATI ON	
	(COSTED		(TIME SPENT)		(ASSI GNED	
	REQUI S) 10.00	11.00	12.00	13.00	TIME) 14.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 CAP REL COSTS - BLDGS & FLXTURES						1.00
2.00 00200 CAP REL COSTS - MOVABLE EQUI PMENT 3.00 00300 EMPLOYEE BENEFITS						2.00 3.00
4.00 00400 ADMI NI STRATI VE & GENERAL						4.00
5.00 00500 PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00 00600 LAUNDRY & LINEN SERVICE						6.00
7. 00 00700 HOUSEKEEPI NG 8. 00 00800 DI ETARY						7.00 8.00
9. 00 00900 NURSI NG ADMI NI STRATI ON						9.00
10.00 01000 CENTRAL SERVICES & SUPPLY	0					10.00
	0	0				11.00
12. 00 01200 MEDI CAL RECORDS & LI BRARY 13. 00 01300 SOCI AL SERVI CE	0	0	0	20, 622		12.00 13.00
14.00 01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	20, 022	0	14.00
15. 00 01500 ACTI VI TI ES	0	0	0	0	0	15.00
15. 01 01501 CHAPLAI N	0	0	0	0	0	15.01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	20 (22	0	20.00
30. 00 03000 SKI LLED NURSI NG FACI LI TY 31. 00 03100 NURSI NG FACI LI TY	0	0		20, 622	0	30.00 31.00
32. 00 03200 I CF/I I D	0	0	0	0	0	32.00
33.00 03300 OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCI LLARY SERVI CE COST CENTERS		0			0	1 40 00
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY	0	0 0			0	40.00
41.00 04100 LABORATORY 42.00 04200 INTRAVENOUS THERAPY	0	0	0 0		0	41.00
43.00 04300 OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44. 00 04400 PHYSI CAL THERAPY	0	0	0	0	0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	0	0	0	0	0	45.00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	0	0		0	0	46.00 47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0		0	50.00
51.00 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	51.00
60. 00 06000 CLINIC	0		0	0	0	60.00
61.00 06100 RURAL HEALTH CLINIC	0	0			0	61.00
62.00 06200 FQHC						62.00
OTHER REI MBURSABLE COST CENTERS 70. 00 07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
70.00 07100 AMBULANCE	0	0	0	0	0	10.00
73.00 07300 CMHC	0	0			0	
SPECIAL PURPOSE COST CENTERS	I		1			
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 81.00 08100 INTEREST EXPENSE						80.00
81.00 08100 INTEREST EXPENSE 82.00 08200 UTILIZATION REVIEW - SNF						81.00 82.00
83. 00 08300 HOSPI CE	0	0	0	0	0	83.00
89.00 SUBTOTALS (sum of lines 1-84)	0	0	0	20, 622	0	89.00
NONREI MBURSABLE COST CENTERS					2	
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 91.00 09100 BARBER AND BEAUTY SHOP	0	0			0	90.00 91.00
92. 00 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93. 00 09300 NONPAI D WORKERS	0	0	0	0	0	93.00
94.00 09400 PATIENTS LAUNDRY	0	0	0	0	0	94.00
98.00Cross Foot Adjustments99.00Negative Cost Centers						98.00 99.00
102.00 Cost to be allocated (per Wkst. B,	0	0	0	78, 362	0	102.00
Part I)	0	0		, 0, 002		
103.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000		0. 000000	1
104.00 Cost to be allocated (per Wkst. B,	0	0	0	2, 086	0	104.00
Part II) 105.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 101154	0. 000000	105.00

	Financial Systems	PI TMAN		No 1 215 427		eu of Form CMS-	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der	No.: 315427	Period: From 07/01/2022 To 06/30/2023	Date/Time Pre	epared:
		OTHER GENER	RAL SERVICE			11/30/2023 1:	<u>54 pili</u>
	Cost Center Description	ACTI VI TI ES	CHAPLAI N	-			
	cost center bescription	(PATIENT DAYS)					
		15.00	15.01				
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES						1 1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT						2.00
3.00	00300 EMPLOYEE BENEFITS		- -				3.00
4.00	00400 ADMI NI STRATI VE & GENERAL						4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						5.00
7.00	00700 HOUSEKEEPING						7.00
	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
	01000 CENTRAL SERVICES & SUPPLY						10.00
	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY						11.00
	01300 SOCIAL SERVICE						13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION						14.00
15.00	01500 ACTI VI TI ES	20, 622					15.00
15. 01	01501 CHAPLAI N	0	63, 235				15.01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	20, 622	20, 622	1			30.00
	03100 NURSING FACILITY	20, 822	20, 822	1			31.00
	03200 I CF/I I D	0	0				32.00
33.00	03300 OTHER LONG TERM CARE	0	42, 613				33.00
	ANCI LLARY SERVICE COST CENTERS	-	-	1			1
	04000 RADI OLOGY	0	0				40.00
	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0				41.00
	04300 OXYGEN (INHALATION) THERAPY	0	0				43.00
	04400 PHYSI CAL THERAPY	0	0				44.00
	04500 OCCUPATI ONAL THERAPY	0	0				45.00
		0	0				46.00
	04700 ELECTROCARDIOLOGY 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					47.00
	04900 DRUGS CHARGED TO PATIENTS	0	0				49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0				50.00
51.00	05100 SUPPORT SURFACES	0	0				51.00
(0.00			0	1			
	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	1			60.00
	06200 FQHC	0					62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0		1			70.00
	07100 AMBULANCE 07300 CMHC	0	0	1			71.00
73.00	SPECIAL PURPOSE COST CENTERS	0	0	1			73.00
80. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 00
81.00	08100 INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPICE	0	0				83.00
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	20, 622	63, 235				89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0				90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0	1			91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0				92.00
	09300 NONPALD WORKERS	0	0				93.00
94.00 98.00	09400 PATIENTS LAUNDRY Cross Foot Adjustments	0	0				94.00
98.00 99.00	Negative Cost Centers						99.00
102.00		425, 367	108, 611				102.00
	Part I)						
103.00			1. 717577				103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	10, 079	169				104.00
105.00		0. 488750	0. 002673				105.00

Health Financial Systems PIT	MAN MANOR		In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CEN	NTERS Provider		Period:	Worksheet C	
			From 07/01/2022 To 06/30/2023	Date/Time Pre	pared [.]
				11/30/2023 1:	
Cost Center Description		Total (from	Total Charges		
		Wkst. B, Pt I	r	di vi ded by	
		col. 18)	0.00	<u>col. 2</u>	
		1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS		40.74		1 0 10 100	40.00
40. 00 04000 RADI OLOGY		10, 74		1.248402	
		11, 84	1 9, 857	1.201278	
42. 00 04200 I NTRAVENOUS THERAPY			0	0.000000	
43. 00 04300 0XYGEN (INHALATION) THERAPY		93, 91		1.514091	43.00
44. 00 O4400 PHYSI CAL THERAPY		374, 09		1. 266877	
45. 00 04500 OCCUPATI ONAL THERAPY		241, 58		0.994517	
46. 00 04600 SPEECH PATHOLOGY		77, 82	53, 912		
47. 00 04700 ELECTROCARDI OLOGY		40.74	0	0.000000	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		13, 74		5. 256695	
49. 00 04900 DRUGS CHARGED TO PATIENTS		149, 97	2 116, 106		49.00
50.00 OS000 DENTAL CARE - TITLE XIX ONLY			0	0.00000	•
51. 00 OS100 SUPPORT SURFACES			J0	0. 000000	51.00
		1		0.00000	(0.00
			J 0	0. 000000	
61.00 06100 RURAL HEALTH CLINIC					61.00
62. 00 06200 FQHC 71. 00 07100 AMBULANCE				0,00000	62.00
		07.270	J J U	0. 000000	
100. 00 Total		973, 70	4 791, 322		100. 00

PAPPORTI ONMENT OF ANCILLARY AND OUTPATIENT COSTS Provider No.: 315427 Period: From 07/01/2022 Worksheet D From 07/01/2022 Worksheet D Date/Time Prepared: 1/3/2023 1:54 pm Image: Control of the	Health Financial Systems	PI TMAN	MANOR		In Lie	u of Form CMS-2	2540-10
PART I - CALCULATION OF ANCI LLARY AND OUTPATIENT Construction Part A Col. Part B Col.	APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der				
PART I - CALCULATION OF ANCI LLARY AND OUTPATI ENT COST Part A Part B Part A (col. 1 Part B (col. 1 x col. 2) Part B (col. 3) 40.00 04000 RADI OLOCY 1.248402 3.918 0 4.891 0 40.00 41.00 04000 RADI OLOCY 1.248402 3.918 0 4.891 0 42.00 40.00 04000 RADI OLOCY 1.248402 3.918 0 4.891 0 42.00 40.00 04000 RADI OLOCY 1.248402 3.918 0 4.891 0 42.00 41.00 04100 LABORATORY 1.201278 9.857 0 11.841 0 41.00 42.00 04200 INTRAVENUS THERAPY 0.000000 0 0 0 42.00 43.00 04500 OCCUNTRAVENTION THERAPY 1.266877 192.986 0 244.490 0 44.00 40.00 04000 SPECH PATHORY 0.994517 190.621 189.576 0 45.00 40.00 04000 SPECH PATHOLOGY 1.443463 46.980 0 6							
PART I - CALCULATION OF ANCI LLARY AND OUTPATI ENT COST Part A Part A Part B Part A (col. 1) Part B (col. 1) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 1.248402 3.918 0 4.891 0 42.00 44.00 04200 INTRAVENOUS THERAPY 1.248402 3.918 0 4.891 0 41.00 42.00 04200 INTRAVENOUS THERAPY 1.248402 3.918 0 4.891 0 41.00 43.00 04300 0XYGEN (INHALATION) THERAPY 1.514091 0 0 0 42.00 44.00 04000 PHYSI CAL THERAPY 1.56677 192.986 244,490 44.00 44.00 45.00 045000 SPECH PATHOLOGY 1.443463 46,980 0 67,814 0 45.00 49.00 04000 DRUGS CHARGED TO PATI ENTS 5.256695 0 0 0 0 44.00 44.00 44.00 44.00 44.00 50.00 51.00 51.00 </td <td></td> <td></td> <td></td> <td></td> <td>10 06/30/2023</td> <td></td> <td></td>					10 06/30/2023		
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT Contracts Part A Part A Part B Part A Col. 1 Part B Col. 3 40.00 04000 Ratio of Cost (Fr. Wkst. C) 0 <td< td=""><td></td><td></td><td>Title</td><td>XVIII (1)</td><td>Skilled Nursing</td><td></td><td></td></td<>			Title	XVIII (1)	Skilled Nursing		
PART I - CALCULATION OF ANCI LLARY AND OUTPATIENT 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) 40.00 40.00 5.00 1.00 2.00 3.00 4.00 5.00 40.00 40.00 ANCI LLARY SERVICE COST CENTERS 0 4.891 0 4.891 0 41.00 41.00 04100 LABORATORY 1.248402 3.918 0 4.891 0 41.00 41.00 42.00 04300 INTRAVENOUS THERAPY 0.000000 0 0 0 42.00 43.00 04500 OCCUPATI ONAL THERAPY 1.266877 192.986 0 244.490 0 44.00 45.00 04500 OCCUPATI ONAL THERAPY 0.994517 190.621 189.576 0 45.00 46.00 04600 SPEECH PATHOLOGY 1.443463 46.980 0 67.814 0 46.00 48.00 04600 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 0 47.00 48.00 46.00 49.00			in the			110	
Image: bit is a constraint of the constratene constraint of the constraint of the constraint of t			Heal th Care Pr	rogram Charges	Heal th Care	Program Cost	
Image: bit is a constraint of the constratene constraint of the constraint of the constraint of t							
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PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS 40.00 00 000000 RADIOLOGY 1.248402 3.918 0 4.891 0 40.00 41.00 04000 RADIOLOGY 1.248402 3.918 0 4.891 0 40.00 41.00 04000 RADIOLOGY 1.248402 3.918 0 4.891 0 42.00 41.00 04000 RADIOLOGY 1.264877 9.857 0 11.841 0 41.00 42.00 04300 DXYGEN (INHALATION) THERAPY 0.000000 0 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 1.266877 192.986 0 244.490 0 44.00 45.00 04500 OXCUPATIONAL THERAPY 0.994517 190.621 0 189,576 0 45.00 46.00 VATOR ELECTROCARDIOLOGY 1.443463 46,980 0 67.814 0 46.00 49.00 04000 DRUGS CHARGED TO PATIENTS 5.256695 0 0 0 <td< td=""><td></td><td></td><td>Part A</td><td>Part B</td><td></td><td></td><td></td></td<>			Part A	Part B			
Col umn 3) Col umn					x col. 2)	x col. 3)	
PART I CALCULATION OF ANCI LLARY AND OUTPATIENT COST ANCI LLARY SERVICE COST CENTERS							
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST ANCILLARY SERVICE COST CENTERS			2.00	2.00	4.00	E 00	
ANCI LLARY SERVICE COST CENTERS 40.00 04000 RADI OLOGY 1. 248402 3, 918 0 4, 891 0 40.00 41.00 O4100 LABORATORY 1. 201278 9, 857 0 11, 841 0 41.00 42.00 O4200 INTRAVENOUS THERAPY 0. 000000 0 0 0 42.00 0.43.00 OV300 DV30EN (1 INHALATION) THERAPY 1. 514091 0 0 0 43.00 44.00 04500 OCUPATI ONAL THERAPY 1. 266877 192, 986 0 244, 490 0 44.00 45.00 O4500 OCUPATI ONAL THERAPY 0. 994517 190, 621 0 189, 576 0 45.00 46.00 04500 SPEECH PATHOLOGY 1. 443463 46, 980 0 67, 814 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0. 000000 0 0 0 47.00 48.00 04900 DRUGS CHARGED TO PATI ENTS 1. 291682 116, 106			2.00	3.00	4.00	5.00	
40.00 04000 RADI OLOGY 1.248402 3.918 0 4.891 0 40.00 41.00 04100 LABDRATORY 1.201278 9.857 0 11.841 0 41.00 42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 42.00 43.00 04300 0XYGEN (IHALATI ON) THERAPY 1.514091 0 0 0 43.00 44.00 04500 0CUPATI ONAL THERAPY 1.266877 192.986 0 244,490 0 44.00 45.00 04500 0CUPATI ONAL THERAPY 0.994517 190,621 189,576 0 45.00 46.00 0400 SPECH PATHOLOGY 1.443463 46,980 0 67,814 0 46.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 5.256695 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATI ENTS 1.291682 116,106 149,972 0 49.00 50.00 51.00 000000 0 0 0 0							
41.00 04100 LABORATORY 1.201278 9,857 0 11,841 0 41.00 42.00 04200 INTRAVENOUS THERAPY 0.000000 0 0 0 42.00 43.00 04300 OXYGEN (INHALATION) THERAPY 1.514091 0 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 1.266877 192,986 0 244,490 0 44.00 45.00 04500 OCUPATI ONAL THERAPY 0.994517 190,621 0 189,576 0 45.00 46.00 V400 PEECH PATHOLOGY 1.443463 46,980 0 67,814 0 46.00 47.00 04900 DENTAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 48.00 49.00 O4900 DENTAL CARE - TITLE XI X ONLY 0.000000 0 0 49.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 60.00 60.00 </td <td></td> <td>1, 248402</td> <td>3, 918</td> <td></td> <td>0 4, 891</td> <td>0</td> <td>40.00</td>		1, 248402	3, 918		0 4, 891	0	40.00
43.00 04300 OXYGEN (I NHALATION) THERAPY 1.514091 0 0 0 43.00 44.00 04400 PHYSI CAL THERAPY 1.266877 192,986 0 244,490 0 44.00 45.00 04500 OCCUPATIONAL THERAPY 0.994517 190,621 0 189,576 0 45.00 46.00 04600 SPEECH PATHOLOGY 1.443463 46,980 0 67,814 0 46.00 47.00 04700 ELECTROCARDIOLOGY 0.000000 0 0 0 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 1.291682 116,106 0 149,972 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 0 50.00 05100 SUPPORT SURFACES 0.000000 0 0 0 0 51.00 04100 RURAL HEALTH CLINIC 0.000000 0 0 0 62.00	41. 00 04100 LABORATORY				0 11, 841	0	41.00
44.00 04400 PHYSI CAL THERAPY 1. 266877 192, 986 0 244, 490 0 44.00 45.00 04500 OCCUPATI ONAL THERAPY 0. 994517 190, 621 0 189, 576 0 45.00 46.00 04600 SPECH PATHOLOGY 1. 443463 46, 980 0 67, 814 0 46.00 47.00 04700 ELECTROCARDI OLOGY 0.000000 0 0 0 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 5.256695 0 0 0 48.00 9.00 04900 DRUGS CHARGED TO PATI ENTS 1. 291682 116, 106 0 149, 072 0 49.00 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 0.000000 0 0 0 50.00 51.00 OS100 SUPPORT SURFACES 0.000000 0 0 0 51.00 04100 RURAL HEALTH CLINIC 0.000000 0 0 0 60.00 61.00 62.00 61.00 06100 RURAL HEALTH CLINIC 0.000000 0	42.00 04200 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	42.00
45.00 04500 OCCUPATIONAL THERAPY 0.994517 190,621 0 189,576 0 45.00 46.00 04600 SPEECH PATHOLOGY 1.443463 46,980 0 67,814 0 46.00 47.00 04700 ELECTROCARDIOLOGY 0.000000 0 0 0 47.00 48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 48.00 49.00 04900 DEUGS CHARGED TO PATIENTS 1.291682 116,106 0 149,972 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0.000000 0 0 0 51.00 00TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 60.00 61.00 61.00 06100 RURAL HEALTH CLINIC 0.000000 0 0 62.00 62.00 62.00 71.00 07100 AMBULANCE (2) 0.000000 0 0 68.584	43.00 04300 0XYGEN (INHALATION) THERAPY	1. 514091	0		0 0	0	43.00
46.00 04600 SPEECH PATHOLOGY 1.443463 46,980 0 67,814 0 46.00 47.00 04700 ELECTROCARDIOLOGY 0.000000 0 0 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 1.291682 116,106 0 149,972 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 0 50.00 51.00 SUPPORT SURFACES 0.000000 0 0 0 0 50.00 61.00 06000 CLINIC 0.000000 0 0 0 61.00 62.00 0100 RURAL HEALTH CLINIC 0.000000 0 0 61.00 62.00 62.00 FOHC 0.1000000 0.000000 0 0 71.00 71.00 100.00 Total (Sum of Lines 40 - 71) 560,468 0 668,584 0 100.00	44.00 04400 PHYSI CAL THERAPY	1. 266877	192, 986		0 244, 490	0	44.00
47.00 04700 ELECTROCARDIOLOGY 0.000000 0 0 0 47.00 48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 1.291682 116,106 0 149,972 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0.000000 0 0 0 51.00 04000 CLINIC 0.000000 0 0 0 0 60.00 61.00 06400 CLINIC 0.000000 0 0 0 61.00 62.00 06200 FOHC 0.000000 0 0 0 61.00 62.00 07100 AMBULANCE (2) 0.000000 0 0 71.00 100.00 Total (Sum of Lines 40 - 71) 560,468 0 668,584 0 100.00	45.00 04500 OCCUPATI ONAL THERAPY	0. 994517	190, 621		0 189, 576	0	45.00
48.00 04800 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5.256695 0 0 0 48.00 49.00 04900 DRUGS CHARGED TO PATIENTS 1.291682 116,106 0 149,972 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 0 50.00 51.00 SUPPORT SURFACES 0.000000 0 0 0 51.00 00100 CUTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 51.00 00100 CLINIC 0.000000 0 0 0 0 60.00 61.00 06400 RURAL HEALTH CLINIC 0.000000 0 0 61.00 62.00 62.00 07100 AMBULANCE (2) 0.000000 0 0 62.00 71.00 100.00 Total (Sum of Lines 40 - 71) 560,468 0 668,584 0 100.00	46.00 04600 SPEECH PATHOLOGY	1. 443463	46, 980		0 67, 814	0	46.00
49.00 04900 DRUGS CHARGED TO PATIENTS 1.291682 116,106 0 149,972 0 49.00 50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.000000 0 0 0 50.00 51.00 05100 SUPPORT SURFACES 0.000000 0 0 0 0 51.00 00107 DUTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 60.00 60.00 06000 CLINIC 0.000000 0 0 0 60.00 61.00 62.00 06200 FOHC 0.000000 0 0 0 62.00 71.00 07100 AMBULANCE (2) 0.000000 0 0 68,584 0 100.00	47. 00 04700 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0.00000 0 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 51.00 50.00 51.00 50.00	48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	5. 256695	0		0 0	0	48.00
51.00 05100 SUPPORT SURFACES 0.00000 0 <th< td=""><td>49.00 04900 DRUGS CHARGED TO PATIENTS</td><td>1. 291682</td><td>116, 106</td><td></td><td>0 149, 972</td><td>0</td><td>49.00</td></th<>	49.00 04900 DRUGS CHARGED TO PATIENTS	1. 291682	116, 106		0 149, 972	0	49.00
OUTPATI ENT SERVICE COST CENTERS 60. 00 06000 CLINIC 0.000000 0 0 0 60. 00 61. 00 06100 RURAL HEALTH CLINIC 0.000000 0 0 61. 00 61. 00 62. 00 06200 FOHC 0 0 62. 00 62. 00 71. 00 07100 AMBULANCE (2) 0. 000000 0 0 71. 00 100. 00 Total (Sum of Lines 40 - 71) 560, 468 0 668, 584 0 100. 00	50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
60.00 06000 CLINIC 0.00000 0 0 0 60.00 61.00 06100 RURAL HEALTH CLINIC 0.00000 0 61.00 61.00 61.00 62.00 06200 FOHC 0.000000 0 0 62.00 62.00 71.00 07100 AMBULANCE (2) 0.000000 0 668,584 0 100.00	51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
61.00 06100 RURAL HEALTH CLINIC 61.00 62.00 06200 FOHC 62.00 71.00 07100 AMBULANCE (2) 0.000000 100.00 Total (Sum of lines 40 - 71) 560,468 0 668,584 0 100.00							
62.00 06200 FQHC 62.00 62.00 62.00 71.00 07100 AMBULANCE (2) 0.000000 0 71.00 0 71.00 0 71.00 0 100.00 0 100.00 0 100.00 0 100.00 100.00 0 100.00 100.00 0 100.00	60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
71.00 07100 AMBULANCE (2) 0.000000 0 0 71.00 100.00 Total (Sum of Lines 40 - 71) 560,468 0 668,584 0 100.00							
100.00 Total (Sum of Lines 40 - 71) 560, 468 0 668, 584 0 100.00							
		0. 000000			0		
			560, 468		0 668, 584	0	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.

Health Financial Systems	PI TMAN	MANOR		In Lie	u of Form CMS-:	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315427	Period: 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	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00Drugs charged to patients - ratio of co2.00Program vaccine charges (From your reco	ords, or the PS&	&R)			1. 291682 0	1.00 2.00
3.00 Program costs (Line 1 x line 2) (Title E, Part I, line 18)					0	3.00
Cost Center Description	Total Cost (From Wkst. B, Part I, Col. 18	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)		al I, Col. 4) A	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
ANCI LLARY SERVICE COST CENTERS			Т	- 1		
40. 00 04000 RADI OLOGY 41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY	10, 745 11, 841 0		0.0000 0.0000 0.0000	00 11, 841 00 0	0 0 0	41.00 42.00
43.00 04300 0XYGEN (I NHALATI ON) THERAPY 44.00 04400 PHYSI CAL THERAPY	93, 910 374, 091	C	0.0000	244, 490		43.00
45. 00 04500 OCCUPATI ONAL THERAPY 46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	241, 584 77, 820 0		0.0000 0.0000 0.0000	67, 814		45.00 46.00 47.00
48.00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 49.00 04900 DRUGS CHARGED TO PATI ENTS 50.00 05000 DENTAL CARE - TI TLE XI X ONLY 51.00 05100 SUPPORT SURFACES -	13, 741 149, 972 0 0		0.0000 0.0000 0.0000 0.0000 0.0000	00 0 00 149, 972 00 0	0 0 0 0	
100.00 Total (Sum of Lines 40 - 52)	973, 704	0		668, 584	0	100.00

ealth Financial Systems	PI TMAN MANOR	In Lie	u of Form CMS-2	2540-
OMPUTATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Parts I-II Date/Time Pre 11/30/2023 1:	pared
	Title XVIII	Skilled Nursing Facility	PPS	
			1.00	
PART I CALCULATION OF INPATIENT ROUTINE	COSTS		1.00	
I NPATI ENT DAYS				
.00 Inpatient days including private room of	lays		20, 622	1.0
.00 Private room days			0	2.0
.00 Inpatient days including private room of			2, 623	3.0
.00 Medically necessary private room days a	pplicable to the Program		0	4. C
.00 Total general inpatient routine service	e cost		7, 695, 218	5.0
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
.00 General inpatient routine service charge			9, 925, 160	
	charge ratio (Line 5 divided by line 6)		0.775324	7.0
.00 Enter private room charges from your re			0	8.
.00 Average private room per diem charge (F 2)	rivate room charges line 8 divided by private	room days, line	0.00	9.
0.00 Enter semi-private room charges from yo	our records		9, 925, 160	10.
1.00 Average semi-private room per diem char semi-private room days)	rge (Semi-private room charges line 10, divide	d by	481.29	11.
2.00 Average per diem private room charge di	fferential (Line 9 minus line 11)		0.00	12.0
3.00 Average per diem private room cost diff			0.00	13.
4.00 Private room cost differential adjustme	ent (Line 2 times line 13)		0	14.
5.00 General inpatient routine service cost PROGRAM INPATIENT ROUTINE SERVICE COSTS	net of private room cost differential (Line 5	minus line 14)	7, 695, 218	15.
6.00 Adjusted general inpatient service cost	per diem (Line 15 divided by line 1)		373.16	16.
7.00 Program routine service cost (Line 3 t			978, 799	17.
8.00 Medically necessary private room cost a	pplicable to program (line 4 times line 13)		0	18.
9.00 Total program general inpatient routine	service cost (Line 17 plus line 18)		978, 799	19.
0.00 Capital related cost allocated to inpat line 30 for SNF; line 31 for NF, or lin	ient routine service costs (From Wkst. B, Par e 32 for ICF/IID)	t II column 18,	135, 501	20.
1.00 Per diem capital related costs (Line 2			6.57	21.
2.00 Program capital related cost (Line 3 t	3		17, 233	
3.00 Inpatient routine service cost (Line 1	9 minus line 22)		961, 566	23.
4.00 Aggregate charges to beneficiaries for			0	24.
5.00 Total program routine service costs for	comparison to the cost limitation (Line 23 mi	nus line 24)	961, 566	25.
6.00 Enter the per diem limitation (1)	· · ·			26.
7.00 Inpatient routine service cost limitati	on (Line 3 times the per diem limitation line	26) (1)		27.
8.00 Reimbursable inpatient routine service (Transfer to Worksheet E, Part II, line	costs (Line 22 plus the lesser of line 25 or 4) (See instructions)	line 27)		28.
1) Lines 26 and 27 are not applicable for tit	, , , , , , , , , , , , , , , , , , , ,			•

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	20, 622	1.00
2.00	Program inpatient days (see instructions)	2, 623	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0. 127194	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00
2.00 3.00 4.00	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)	2, 623 0	2.00 3.00 4.00

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	· · · · J · · · ·	PI TMAN MANOR		u of Form CMS-2	
COMPUT	ATION OF INPATIENT ROUTINE COSTS	Provi der No.: 315427	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-1 Parts I-II Date/Time Pre 11/30/2023 1:	pared:
		Title XIX	Skilled Nursing Facility	Cost	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS			1.00	
	INPATIENT DAYS				İ
1.00	Inpatient days including private room days			20, 622	1.0
2.00	Private room days			0	2.0
3.00	Inpatient days including private room days applicabl	e to the Program		9, 709	3.0
4.00	Medically necessary private room days applicable to	the Program		0	4.0
5.00	Total general inpatient routine service cost			7, 695, 218	5. C
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
o. 00	General inpatient routine service charges			9, 925, 160	6.0
. 00	General inpatient routine service cost/charge ratio	(Line 5 divided by line 6)		0.775324	7.0
3.00	Enter private room charges from your records			0	8. (
. 00	Average private room per diem charge (Private room c 2)	charges line 8 divided by private	room days, line	0.00	9.1
0.00	Enter semi-private room charges from your records			9, 925, 160	10.
1. 00	Average semi-private room per diem charge (Semi-pri semi-private room days)	vate room charges line 10, divid	ed by	481.29	11.0
2.00	Average per diem private room charge differential (L	ine 9 minus line 11)		0.00	12.
3.00	Average per diem private room cost differential (Lin	ne 7 times line 12)		0.00	13.
4.00	Private room cost differential adjustment (Line 2 ti	mes line 13)		0	14.
5.00	General inpatient routine service cost net of privat PROGRAM INPATIENT ROUTINE SERVICE COSTS	e room cost differential (Line 5	minus line 14)	7, 695, 218	15.
6.00	Adjusted general inpatient service cost per diem (Li	ne 15 divided by line 1)		373.16	16.0
7.00	Program routine service cost (Line 3 times line 16)			3, 623, 010	17.
8.00	Medically necessary private room cost applicable to	program (line 4 times line 13)		0	18.
9.00	Total program general inpatient routine service cost			3, 623, 010	19.
0. 00	Capital related cost allocated to inpatient routine line 30 for SNF; line 31 for NF, or line 32 for ICF/		rt II column 18,	135, 501	20.
1.00	Per diem capital related costs (Line 20 divided by	line 1)		6.57	21.
	Program capital related cost (Line 3 times line 21)			63, 788	
3.00	Inpatient routine service cost (Line 19 minus line	22)		3, 559, 222	23.
	Aggregate charges to beneficiaries for excess costs			0	24.
	Total program routine service costs for comparison t	to the cost limitation (Line 23 m	inus line 24)	3, 559, 222	
	Enter the per diem limitation (1)			0.00	
	Inpatient routine service cost limitation (Line 3 ti			0	27.
28.00	Reimbursable inpatient routine service costs (Line 2 (Transfer to Worksheet E, Part II, line 4) (See inst		line 27)	3, 623, 010	28.

	1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00 Total SNF inpatient days	20, 622	2 1.00
2.00 Program inpatient days (see instructions)	9, 709	2.00
3.00 Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)	(3.00
4.00 Nursing & allied health ratio. (line 2 divided by line 1)	0. 470808	3 4.00
5.00 Program nursing & allied health costs for pass-through. (line 3 times line 4)	(5.00
		•

Heal th	Financial Systems PITMAN MAN	IOR	In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Provider No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part I Date/Time Pre 11/30/2023 1:5	
		Title XVIII	Skilled Nursing Facility		
				1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBUR	SEMENT		4 (70 0)7	
1.00	Inpatient PPS amount (See Instructions)	(a) (manta)		1, 670, 067 0	1.00
2.00 3.00	Nursing and Allied Health Education Activities (pass through p	bayments)		-	2.00 3.00
3.00 4.00	Subtotal (Sum of lines 1 and 2) Primary payor amounts			1, 670, 067 0	3.00 4.00
4.00 5.00	Coinsurance			219, 364	4.00 5.00
6.00	Allowable bad debts (From your records)			31, 509	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instr	ructions)		15, 085	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)			20, 481	8.00
9.00	Recovery of bad debts - for statistical records only			20, 101	9.00
10.00	Utilization review			0	10.00
11.00	Subtotal (See instructions)			1, 471, 184	11.00
12.00	Interim payments (See instructions)			1, 421, 689	12.00
13.00	Tentati ve adjustment			0	13.00
14.00	OTHER adjustment (See instructions)			0	14.00
14.50	Demonstration payment adjustment amount before sequestration			0	14.50
14.55	Demonstration payment adjustment amount after sequestration			0	14.55
14.75	Sequestration for non-claims based amounts (see instructions)			410	14.75
14.99	Sequestration amount (see instructions)			29, 014	14.99
15.00	Balance due provider/program (see Instructions)			20, 071	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance			0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER	OF COST OR CHARGES - T	ITLE XVIII ONLY	-	
	Ancillary services Part B			0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)			0	18.00
19.00	Total reasonable costs (Sum of Lines 17 and 18)			0	19.00
20.00 21.00	Medicare Part B ancillary charges (See instructions) Cost of covered services (Lesser of line 19 or line 20)			0	20. 00 21. 00
21.00	Primary payor amounts			0	21.00
22.00	Coinsurance and deductibles			0	23.00
23.00	Allowable bad debts (From your records)			0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instr	ructions)		0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)			0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)			0	25.00
	Interim payments (See instructions)			0	26.00
27.00	Tentati ve adjustment			0	27.00
28.00	Other Adjustments (See instructions) Specify			0	28.00
28.50	Demonstration payment adjustment amount before sequestration			0	28.50
28.55	Demonstration payment adjustment amount after sequestration			0	28. 55
28.99	Sequestration amount (see instructions)			0	28.99
29.00	Balance due provider/program (see instructions)			0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordan	nce with CMS Pub.15-2, s	ection 115.2	0	30.00

	Financial Systems	PI TMAN MANO			u of Form CMS-2	2540-1
CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE V and TITLE XI			Provider No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part II Date/Time Pre 11/30/2023 1:	
			Title XIX	Skilled Nursing Facility	Cost	
				Tacifity		
				·	1.00	
С	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00 🗍	Inpatient ancillary services (see Instructions)				0	1.0
2.00	Nursing & Allied Health Cost (From Worksheet D-1	l, Pt. II, lin	e 5)		0	2.0
3.00 0	Outpatient services				0	3.0
4.00 I	Inpatient routine services (see instructions)				3, 623, 010	4. C
5.00 L	Jtilization reviewphysicians' compensation (fro	om provider re	cords)		0	5.0
6.00 0	Cost of covered services (Sum of lines 1 - 5)				3, 623, 010	6.0
	Differential in charges between semiprivate accom	nmodations and	less than semiprivate	accommodations	0	7.0
	SUBTOTAL (Line 6 minus line 7)				3, 623, 010	
	Primary payor amounts				0	9.0
	Total Reasonable Cost (Line 8 minus line 9)				3, 623, 010	10.0
	REASONABLE CHARGES					
	Inpatient ancillary service charges				0	
	Outpatient service charges				0	
	Inpatient routine service charges				0	
	Differential in charges between semiprivate accom	nmodations and	less than semiprivate	accommodations	0	14.0
	Total reasonable charges				0	15.0
	CUSTOMARY CHARGES					
	Aggregate amount actually collected from patients				0	16.
	Amounts that would have been realized from patier		payment for services o	n a charge basis	0	17.0
	had such payment been made in accordance with 42	• • •			0,000000	10
	Ratio of line 16 to line 17 (not to exceed 1.0000)00)			0.000000	
	Total customary charges (see instructions)				0	1 19.1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				0	1 20 /
	Cost of covered services (see Instructions) Deductibles				0	20.
	Subtotal (Line 20 minus line 21)				0	21.
	Coinsurance				0	
	Subtotal (Line 22 minus line 23)				0	
	Allowable bad debts (from your records)				0	
	Subtotal (sum of lines 24 and 25)				0	
	Jnrefunded charges to beneficiaries for excess co	oste orronooue	ly collected based on c	orroction of	0	20.
	cost limit		Ty corrected based on c		0	27.
	Recovery of excess depreciation resulting from pr	rovider termin	ation or a decrease in	program	0	28.
	utilization			p. cgi din	0	20.
-	Other Adjustments (see instructions) Specify				0	29.0
30.00 A	Amounts applicable to prior cost reporting period if minus, enter amount in parentheses)	ds resulting f	rom disposition of depr	eciable assets (0	30. (
	Subtotal (Line 26 plus or minus lines 29, and 30) minus lines	27 and 28)		0	31.
	Interim payments		2, 414 20)		0	
	Balance due provider/program (Line 31 minus line	32) (indicate	overpayments in parent	heses) (see	0	
	Instructions)	sz, (marcate	stal payments in parent		0	1 00.0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provi der	No.: 315427	Period: From 07/01/20: To 06/30/20:		epare
		Ti tl	e XVIII	Skilled Nursin Facility	ng PPS	
		I npati en	t Part A		Part B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy		
00	Total interim poymente peid te provider	1.00	2.00 1,421,6	3.00	4.00) 1.
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero List separately each retroactive lump sum adjustment		1, 421, 0	0	C	
00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	C	3.
02				0	0	
03				0	0	
)4				0	0	
)5				0	0) 3
0	Provider to Program ADJUSTMENTS TO PROGRAM			0	0) 3
50 51	ADJUSTMENTS TO PROGRAM			0		
52				0		
53				0		
54				0	0) 3
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50			0	0) 3
	- 3.98)				_	
00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		1, 421, 6	589	C) 4
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1)2	TENTATI VE TO PROVI DER			0	0	
)2)3				0	0	
	Provider to Program		1	~		4
0	TENTATI VE TO PROGRAM			0	0	5 5
51				0	0	
2				0	0	
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0	0) 5
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER		20, 0	071	C	6 10
)2	PROVI DER TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		1, 441, 7	/60	0) 7
			Contr	actor Name	Contractor	
				1 00	Number	
				1.00	2.00	

d-t	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der	F	eriod: rom 07/01/2022	Worksheet G	
y)		Canaral Fund		o 06/30/2023 Endowment Fund	Date/Time Pre 11/30/2023 1:	
		General Fund	Specific Purpose Fund		Plant Fund	
	Assets	1.00	2.00	3.00	4.00	-
	CURRENT ASSETS	-	-			
C	Cash on hand and in banks	83, 831	C		0	
2	Temporary investments	0	C		0	
))	Notes recei vabl e Accounts recei vabl e	1, 534, 703			0	
5	Other receivables	1, 334, 703		0	0	
5	Less: allowances for uncollectible notes and accounts	-573, 700	C	0	0	
	recei vabl e					
2	Inventory	115, 387		0	0	
))	Prepaid expenses Other current assets	121, 561			0	
00	Due from other funds	0		0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	1, 281, 782			0	
	FIXED ASSETS	-				
00	Land	39, 437	C		0	
00 00	Land improvements Less: Accumulated depreciation	0			0	
00 00	Buildings	14, 883, 953		-	0	
00	Less Accumulated depreciation	-12, 603, 966	-	-	0	
00	Leasehold improvements	0	C	0	0	1
00	Less: Accumulated Amortization	0	C		0	
	Fixed equipment	2, 298, 010			0	
00 00	Less: Accumulated depreciation Automobiles and trucks	-1, 630, 466 171, 892			0	
)0)0	Less: Accumulated depreciation	-171, 892			0	-
	Major movable equipment	0			0	
00	Less: Accumulated depreciation	0	C	0	0	24
	Minor equipment - Depreciable	0	C		0	
	Minor equipment nondepreciable	0	C		0	-
00 00	Other fixed assets	2, 986, 968			0	
00	TOTAL FIXED ASSETS (Sum of lines 12 - 27) OTHER ASSETS	2,900,900		0	0	2
00	Investments	0	C	0	0	2
00	Deposits on Leases	0	C	-	0	
00	Due from owners/officers	0	C	-	0	-
00 00	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	946, 340 946, 340		-	0	
00 00	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	5, 215, 090			0	
	Liabilities and Fund Balances	0,210,070				
	CURRENT LIABILITIES	1	1	1		
	Accounts payable	949, 961	0		0	
00	Salaries, wages, and fees payable Payroll taxes payable	1, 313, 285	0	0	0	
00 00	Notes & Loans payable (Short term)			0	0	
00	Deferred income	12, 500		0	0	
00	Accelerated payments	0				4
00	Due to other funds	0	C	0	0	
00	Other current liabilities	0	C		0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) LONG TERM LIABILITIES	2, 275, 746	C	0	0	4:
00	Mortgage payable	0	C	0	0	4
	Notes payable	0	C	0	0	
00	Unsecured Loans	0	C	0	0	4
00	Loans from owners:	0	C	0	0	
00	Other long term liabilities	3, 583, 771		0	0	
00 00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	3, 583, 771		0	0	
	TOTAL LIABILITIES (Sum of lines 43 and 50)	5, 859, 517		-	0	
	CAPITAL ACCOUNTS	, ,,,,,,,,			-	
00	General fund balance	-644, 427				52
00	Specific purpose fund		C			5
00	Donor created - endowment fund balance - restricted			0		5
00 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		5
00 00	Plant fund balance - invested in plant			0	0	
	Plant fund balance - reserve for plant improvement,				0	
0C					Ũ	
	replacement, and expansion					
00	TOTAL FUND BALANCES (Sum of lines 52 thru 58) TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	-644, 427 5, 215, 090		0	0	5º

Heal th	Financial Systems	PI TMAN M	IANOR		In Lie	eu of Form CMS-2	2540-10
	ENT OF CHANGES IN FUND BALANCES			No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet G-1 Date/Time Pre 11/30/2023 1:	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY RECONCILIATION Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance		2.00 2,132,512 -2,776,939 -644,427 0 -644,427		4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
19.00	sheet (Line 11 - Line 18)						19.00
		Endowment Fund	Prant	Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY RECONCILIATION	0			0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) ROUNDING Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0			0 0 0 0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems	PI TMAN MANOF	2		In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315427	Period: From 07/01/2022 To 06/30/2023	Worksheet G-2 Parts I-II	bared:
	Cost Center Description			Inpati ent	Outpati ent	Total	
	'			1.00	2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Care Services						
1.00	SKILLED NURSING FACILITY			9, 925, 16		9, 925, 160	1.00
				9, 920, 10			
2.00	NURSING FACILITY				0	0	2.00
3.00	ICF/IID				0	0	3.00
4.00	OTHER LONG TERM CARE			8, 518, 59		8, 518, 590	4.00
5.00	Total general inpatient care services (Sum of lin	es 1 - 4)		18, 443, 75	50	18, 443, 750	5.00
	All Other Care Services						
6.00	ANCI LLARY SERVI CES			701, 48	31 0	701, 481	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
10.00	FQHC				0	0	10. 00
					0	-	
11.00	CMHC				0	0	11.00
12.00	HOSPI CE				0 0	0	12.00
13.00	OTHER (SPECIFY)				0 0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Tra Worksheet G-3, Line 1)	nsfer column 3	to	19, 145, 23	31 0	19, 145, 231	14.00
	Cost Center Description						
					1.00	2.00	
	PART II - OPERATING EXPENSES				1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line	100)				18, 014, 841	1.00
2.00	Add (Specify)	100)			0	10, 014, 041	2.00
	Add (Specify)				0		
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
12.00							12.00
	Tatal Daduations (Sum of Lines 0, 12)				0		
14.00	Total Deductions (Sum of Lines 9 - 13)	1				0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, m	inus line 14)				18, 014, 841	15.00

Heal th	Financial Systems	PI TMAN MANOR		In Lie	u of Form CMS-2	2540-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES		No.: 315427	Peri od:	Worksheet G-3	
				From 07/01/2022		
				To 06/30/2023	Date/Time Pre 11/30/2023 1:	
	· · · · · · · · · · · · · · · · · · ·				11/30/2023 1.	<u>54 piii</u>
					1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col. 3, line 14)			19, 145, 231	1.00
2.00	Less: contractual allowances and discounts on pat				4,051,317	2.00
3.00	Net patient revenues (Line 1 minus line 2)				15, 093, 914	3.00
4.00	Less: total operating expenses (From Worksheet G-	2, Part II, line 15)			18, 014, 841	4.00
5.00	Net income from service to patients (Line 3 minus	4)			-2, 920, 927	5.00
	Other income:					
6.00	Contributions, donations, bequests, etc				45, 733	6.00
7.00	Income from investments				716	7.00
8.00	Revenues from communications (Telephone and Inte	rnet service)			0	8.00
9.00	Revenue from television and radio service				24, 551	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				70	13.00
14.00	Revenue from meals sold to employees and guests				-482	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical supplies	s 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 abstract	5			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	GRANT REVENUE				0	24.00
24.01	CATERING / COUNTRY STORE				48, 783	24.01
24.02	TRANS - RESIDENTIAL				3, 364	24.02
24.03					423	24.03
24.04	MI SCELLANEOUS I NCOME				20, 398	24.04
24.06	HOUSEKEEPING				432	24.06
24.50	COVI D-19 PHE Funding				0	24.50
25.00	Total other income (Sum of lines 6 - 24)				143, 988	
26.00	Total (Line 5 plus line 25)				-2, 776, 939	
27.00	MI SCELLANEOUS				0	27.00
28.00					0	28. 00 29. 00
29.00 30.00	Total other expenses (Sum of lines 27 - 29)				0	29.00 30.00
	Net income (or loss) for the period (Line 26 minu:	a lino 20)			-2, 776, 939	
31.00	Incernation (or ross) for the period (Effie 20 million	5 TTHE 30 <i>j</i>		I	-2, 110, 939	51.00