	I Systems required by Law (42 USC 1395g; 42 CFR 413.: since the beginning of the cost reporting po			t in all interim	u of Form CMS-2540-10 FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
	G FACILITY AND SKILLED NURSING FACILITY HEAD PORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315153	Period: From 01/01/2021 To 12/31/2021	Vorksheet S Parts I, II & III Date/Time Prepared: 5/30/2022 5:03 pm
PART I - COST F	REPORT STATUS				
Provi der	1. [X]Electronically prepared cost rep	port		Date:	Ti me:
use only	2.[] Manually prepared cost report3.[0] If this is an amended report ent3. 01[] No Medicare Utilization. Enter '			r resubmitted thi	s cost report
Contractor	4.[1]Cost Report Status	6. Contractor	No		
use only	(1) As Submitted	7.[N] Firs	t Cost Report for this	Provider CCN	
	Settled without audit	8.[N]Last	Cost Report for this	Provider CCN	
	(3) Settled with audit	9. NPR Date:	·		
	(4) Reopened	10 [0] f	ine 4, column 1 is "4"	· Enter number of	times reopened
	(5) Amended		r Vendor Code		
	5. Date Received:	12.[F] Medi	care Utilization. Ente		'L" for low, or "N"

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

MISREPRESENTATION OF 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 THE MANOR (315153) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			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	51, 488	7, 575	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	51, 488	7, 575	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.

NILLE.	Financial Systems	THE MANOR	No . 015150		n Lieu	u of For		
OMPLE	D NURSING FACILITY AND SKILLED NURSING FACILITY HEAL X INDENTIFICATION DATA	TH CARE Provider	No.: 315153	Period: From 01/01/		Workshe Part I		
				To 12/31/	2021	Date/Ti 5/30/20		
	1.00	2.00	3.00					
	Skilled Nursing Facility and Skilled Nursing Facilit Street: 689 WEST MAIN STREET PO Box:							1.00
	City: FREEHOLD State:		e: 07728					2.00
	5	de: 35154 Urban/Ru	ıral: U					3.00
. 01	CBSA CC	de: Component Name	Provi der	Date	Daymo	ent Syst	om (D	3.01
		component Mame	CCN	Certified	Payine	0, or N		
					V	XVIII	XIX	
	CNE and CNE Deced Component I dentification.	1.00	2.00	3.00	4.00	5.00	6.00	
	SNF and SNF-Based Component Identification:	THE MANOR	315153	02/10/1974	N	Р	P	4.00
	Nursing Facility							5.00
	I CF/I I D							6.00
	SNF-Based HHA SNF-Based RHC						1	7.00
	SNF-Based FQHC						1	9.00
	SNF-Based CMHC						1	10.00
	SNF-Based OLTC							11.00
	SNF-Based HOSPICE SNF-Based CORF						1	12.00
3.00			I	From:		То	:	13.00
				1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy)			01/01/2	-	12/31/		14.00
5.00	Type of Control (See Instructions)					HEALTHCA SYSTEM	IKE	15.00
						Y/I	N	
						1.C	0	
	Type of Freestanding Skilled Nursing Facility Is this a distinct part skilled nursing facility tha	t meets the requireme	onts set forth	in 42 CER		N		16.00
	section 483.5?	t meets the requireme	ants set for th	1111 42 011		IN IN		10.00
	Is this a composite distinct part skilled nursing fa	cility that meets the	e requirements	s set forth	in	Ν		17.00
	42 CFR section 483.5?	ultad from transports	wo with color	tod		Y		18.00
	Are there any costs included in Worksheet A that res organizations as defined in CMS Pub. 15-1, chapter 1					ř		18.00
	Miscellaneous Cost Reporting Information	<i></i>						
	If this is a low Medicare utilization cost report, i					N		19.00
	If line 19 is yes, does this cost report meet your c utilization cost report, indicate with a "Y", for ye		for filing a	low Medicar	e	N		19.01
	Depreciation - Enter the amount of depreciation repo		the method i	ndicated on	Li nes	20 - 22		1
	Straight Line					2	188, 744	
	Declining Balance Sum of the Year's Digits						C	21.00
	Sum of line 20 through 22					4	488, 744	22.00
	If depreciation is funded, enter the balance as of	the end of the period	ł.				C	
5.00	Were there any disposal of capital assets during the					N		
	Was accelerated depreciation claimed on any assets i	n the current or any		anortina nor	iod?			
			prior cost re	sporting per	100.	N		
6. 00	(Y/N)	-				N		26.00
6. 00 7. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N)	at end of the period	to which thi	s cost repo	rt			26.00 27.00
6.00 7.00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance	at end of the period	to which thi	s cost repo	rt			26.00 27.00
5. 00 7. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N)	at end of the period	to which thi	s cost repo	rt	N		26.00 27.00
6. 00 7. 00 8. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N)	at end of the period	to which thi ble cost from	s cost repo n prior cost	rt Part 1.00	N N <u>A Part B</u> 2.00	0ther 3.00	26.00 27.00
6.00 7.00 8.00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	rt Part 1.00 ne app	N A Part B 2.00 I i cati on	0ther 3.00	26.00 27.00
6. 00 7. 00 8. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N)	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	rt Part 1.00 ne app	N A Part B 2.00 I i cati on	0ther 3.00	26.00 27.00
6. 00 7. 00 8. 00 9. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	rt Part 1.00 ne app	N A Part B 2.00 I i cati on	0ther 3.00	26. 00 27. 00 28. 00 -
6. 00 7. 00 8. 00 9. 00 0. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	rt Part 1.00 e app ïes f	N A Part B 2.00 Iication or the	0ther 3.00	26. 00 27. 00 28. 00 - - 29. 00 30. 00
5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	Part 1.00 ie app ies fo N	N A Part B 0 2.00 Iication or the N	Other 3.00	26. 00 27. 00 28. 00 28. 00 30. 00 31. 00
5. 00 7. 00 3. 00 3. 00 9. 00 0. 00 1. 00 2. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	rt Part 1.00 e app ïes f	N A Part B 2.00 Iication or the	Other 3.00	26. 00 27. 00 28. 00 28. 00 30. 00 31. 00 32. 00
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC	at end of the period proportion of allowa	d to which thi able cost from for an exemp	s cost repo n prior cost tion from th	Part 1.00 ie app ies fo N	N APart B 2.00 Lication or the N N N	Other 3.00	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
5.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based FQHC SNF-Based CMHC	at end of the period proportion of allowa	to which thi able cost from for an exemp	s cost repo n prior cost tion from th	Part 1.00 ie app ies fo N	N APart B 2.00 Lication or the N	Other 3.00	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
5.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC	at end of the period proportion of allowa	to which thi able cost from for an exemp	s cost repo n prior cost tion from th that qualif	Part 1.00 le app ies fo N N	N APart B 2.00 Lication or the N N N	Other 3.00	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
5.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based FQHC SNF-Based CMHC	at end of the period proportion of allowa	to which thi able cost from for an exemp	s cost repo n prior cost tion from th	Part 1.00 le app i es fo N N	N APart B 2.00 Lication or the N N N	Other 3.00 N	26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	<pre>(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based HHA SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state t</pre>	at end of the period proportion of allowation wider that qualifies each component and typ hat certifies the pro	d to which thi able cost from for an exemp be of service	s cost repo m prior cost tion from th that qualif	Part 1.00 le app i es fo N N	N A Part B 2.00 Lication or the N N N N	Other 3.00 N	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	<pre>(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state t regardless of the level of care given for Titles V 8</pre>	hat certifies the pro XIX patients? (Y/N)	d to which thi able cost from for an exemp be of service	s cost repo n prior cost tion from th that qualif	Part 1.00 le app i es fo N N	N A Part B 2.00 Lication or the N N N N	Other 3.00 N	26. 00 27. 00 28. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	<pre>(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state t regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insura</pre>	hat certifies the pro XIX patients? (Y/N) nce? (Y/N)	d to which thi able cost from for an exemp be of service	s cost repo m prior cost tion from th that qualif	Part 1.00 le app i es fo N N	N A Part B 2.00 Lication or the N N N N	Other 3.00 N	26.00 27.00 28.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	<pre>(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based RHC SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state t regardless of the level of care given for Titles V 8</pre>	hat certifies the proc XIX patients? (Y/N) olicy? If the policy	d to which thi able cost from for an exemp pe of service ovider as a Sf is	s cost repo n prior cost tion from th that qualif	Part 1.00 le app i es fi N N	N A Part B 0 2.00 Lication or the N N N N 2.0	0ther 3.00 N	26.00 27.00 28.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
29.00 29.00 30.00 11.00 32.00 33.00 44.00 35.00 36.00 37.00 38.00	(Y/N) Did you cease to participate in the Medicare program applies? (Y/N) Was there a substantial decrease in health insurance reports? (Y/N) If this facility contains a public or non-public pro of the lower of the costs or charges enter "Y" for e exemption. Skilled Nursing Facility Nursing Facility ICF/IID SNF-Based HHA SNF-Based HHA SNF-Based FQHC SNF-Based CMHC SNF-Based OLTC Is the skilled nursing facility located in a state t regardless of the level of care given for Titles V & Are you legally-required to carry malpractice insura Is the malpractice a "claims-made" or "occurrence" p	hat certifies the proc XIX patients? (Y/N) olicy? If the policy	d to which thi able cost from for an exemp be of service	s cost repo n prior cost tion from th that qualif	Part 1.00 le app i es fi N N	N A Part B 2.00 Lication or the N N N N	Other 3.00 N	25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 38.00 39.00

Heal th	Financial Systems	THE MANOR		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provider No.: 315		Worksheet S-2	2
COMPLE	X INDENTIFICATION DATA			From 01/01/2021 To 12/31/2021	Part Date/Time Pre	epared:
					5/30/2022 5:0	
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrativ	ve and General cost	N	42.00
	center? Enter Y or N. If yes, check box	x, and submit supporting s	schedule listing o	cost centers and		
	amounts.					
	Are there any home office costs as defi				N	43.00
	If line 43 is yes, enter the home offic	ce chain number and enter	the name and addr	ress of the home		44.00
	office on lines 45, 46 and 47.					
	1.00	2.00		3.00		
	If this facility is part of a chain or	ganization, enter the name	e and address of t	the home office on the	lines	
	bel ow.	1				
45.00	Name:	Contractor's Name:	Con	ntractor's Number:		45.00
46.00	Street:	PO Box:				46.00
47.00	Ci ty:	State:	Zi p	o Code:		47.00

	D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE	Provi der		Period:	Worksheet S-2	2
MPLE	X REIMBURSEMENT QUESTI ONNAI RE				From 01/01/2021 To 12/31/2021	Date/Time Pre	
					Y/N	5/30/2022 5:0 Date	<u>J3 pm</u>
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy)	ses enter in column	1, "Y" fo	r Yes or "N"	for No. For all	the date	
	Completed by All Skilled Nursing Facilites						
20	Provider Organization and Operation Has the provider changed ownership immediatel	w prior to the hea	inning of	the east	N		1 1.
00	reporting period? If column 1 is "Y", enter i	the date of the cha	nge in col	umn 2. (see	IN		'.
	instructions)						
				Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in			N	2.00	0.00	2.
	column 1 is yes, enter in column 2 the date of 3, "V" for voluntary or "I" for involuntary.	of termination and	in column				
00	Is the provider involved in business transact	tions, including ma	nagement	Ν			3
	contracts, with individuals or entities (e.g.						
	or medical supply companies) that are related officers, medical staff, management personnel						
	of directors through ownership, control, or 1						
	relationships? (see instructions)			Y/N	Туре	Date	
				1.00	2. 00	3.00	
0	Financial Data and Reports		D ! ! !				-
0	Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A'			Y	A	04/20/2022	4
	Compiled, or "R" for Reviewed. Submit complet						
~	available in column 3. (see instructions) If			N			5
0	Are the cost report total expenses and total those on the filed financial statements? If o			Ν))
	reconciliation.						
					Y/N 1.00	Legal Oper. 2.00	-
	Approved Educational Activities				1.00	2.00	
					-	1	-
00	Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2	: Is the	provider the	N	N	6
				provider the	N	N	
00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin	s? (Y/N) see instru ng the cost reporti	ctions.			N	7
00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs	s? (Y/N) see instru ng the cost reporti	ctions.		N	N Y/N	7
0	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	s? (Y/N) see instru ng the cost reporti	ctions.		N		7
00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se Bad Debts	s? (Y/N) see instru ng the cost reporti ee instructions.	ctions. ng period	for Nursing	N	<u>Y/N</u> 1.00	7 8
00 00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) se	s? (Y/N) see instru ng the cost reporti ee instructions.	ctions. ng period instructio	for Nursing	NN	Y/N	7 8
)0)0)0)0 00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) sc Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy.	s? (Y/N) see instru ng the cost reporti ee instructions. d debts? (Y/N) see t collection policy	ctions. ng period instructio change du	for Nursing ns. ring this cos	N N t reporting	Y/N 1.00 Y N	7 8 9 10
)0)0)0)0 00	Column 1: Were costs claimed for Nursing Scho legal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained durin School and/or Allied Health Program? (Y/N) so Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	s? (Y/N) see instru ng the cost reporti ee instructions. d debts? (Y/N) see t collection policy	ctions. ng period instructio change du	for Nursing ns. ring this cos	N N t reporting	Y/N 1.00 Y	7 8 9 10
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Health Financial Systems T	HE MANO	R	In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH	CARE	Provider No.: 315153	Peri od:	Worksheet S-2	
COMPLEX REIMBURSEMENT QUESTI ONNAI RE			From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	pared:
				5/30/2022 5:0	
		1.00	2.	00	
Cost Report Preparer Contact Information					
19.00 Enter the first name, last name and the title/position	SHI	ELLA	CAI RNS		19.00
held by the cost report preparer in columns 1, 2, and	3,				
respecti vel y.					
20.00 Enter the employer/company name of the cost report	CEI	NTRASTATE HEALTHCARE			20.00
preparer.	SYS	STEM			
21.00 Enter the telephone number and email address of the co	st 732	2-294-7017	SCAI RNS@CENTRAS	STATE. COM	21.00
report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	THE MAN	IOR	In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE	Provider No.: 315153	Peri od:	Worksheet S-2	
COMPLE	X REIMBURSEMENT QUESTIONNAIRE			From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared
				10 12/31/2021	5/30/2022 5:0	
		Part B				
		Date				
		4.00				
40.00	PS&R Data	05 (04 (0000				1 4 9 9 9
13.00	Was the cost report prepared using the PS&R	05/31/2022				13.00
	only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to					
	prepare this cost report in cols. 2 and					
	4. (see Instructions.)					
14.00	Was the cost report prepared using the PS&R					14.00
14.00	for total and the provider's records for					14.00
	allocation? If either col. 1 or 3 is "Y"					
	enter the paid through date of the PS&R used					
	to prepare this cost report in columns 2 and					
	4.					
15.00	If line 13 or 14 is "Y", were adjustments					15.00
	made to PS&R data for additional claims that					
	have been billed but are not included on the					
	PS&R used to file this cost report? If "Y",					
	see Instructions.					
16.00	If line 13 or 14 is "Y", then were					16.00
	adjustments made to PS&R data for					
	corrections of other PS&R Report					
	information? If yes, see instructions.					
17.00	If line 13 or 14 is "Y", then were					17.00
	adjustments made to PS&R data for Other?					
10.00	Describe the other adjustments:					10.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18.00
	provider silecords? It is see this tractions.					
		_	3.00			
	Cost Report Preparer Contact Information		0.00			
	Enter the first name, last name and the title	e/position Sl	UPERVI SOR, SENI OR CARE			19.00
	held by the cost report preparer in columns 1					
	respectively.					
20.00	Enter the employer/company name of the cost r	report				20.00
	preparer.					
21.00	Enter the telephone number and email address					21.00
	report preparer in columns 1 and 2, respectiv	/el y.				

	Financial Systems ED NURSING FACILITY AND SKILLED NURSING EX STATISTICAL DATA	THE MA FACILITY HEALTH CARE			eriod: rom 01/01/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Prep 5/30/2022 5:03	bared:
				l npa	atient Days/Vis		5 pm
	Component	Number of Beds	Bed Days Avai I abl e	Title V	Title XVIII	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
. 00	SKILLED NURSING FACILITY	123	44, 895	0		11, 725	1.00
2.00 3.00	NURSING FACILITY	0	0	0		0	2.00 3.00
1.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
5.00	SNF-Based CMHC			_		-	6.00
7.00	HOSPICE	0	0	0	0	0	7.00
3.00	Total (Sum of lines 1-7)	123 Inpatient D	44, 895 avs/Vi si ts	0	4, 965 Di scharges	11, 725	8.00
	Component	Other	Total	Title V	Title XVIII	Title XIX	
1.00	SKILLED NURSING FACILITY	6.00	7.00	8.00	9.00	10.00	1.00
2.00	NURSING FACILITY	9,010	23,700	0	205	25	2.00
3.00	ICF/IID	0	0			0	3.00
1.00	HOME HEALTH AGENCY COST	0	0				4.00
5.00	Other Long Term Care	0	0				5.00
5.00 7.00	SNF-Based CMHC HOSPI CE	0	0	0	0	0	6.00 7.00
. 00 8. 00	Total (Sum of lines 1-7)	9, 010	25, 700	0	205	25	8.00
	· · ·	Di scha	arges	Aver	age 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	122	352	0.00		469.00	1.00
2.00	NURSING FACILITY	0	0	0.00		0.00	2.00
8.00 4.00	ICF/IID HOME HEALTH AGENCY COST	0	0			0.00	3.00 4.00
5.00	Other Long Term Care	0	0				5.00
. 00	SNF-Based CMHC						6.00
7.00	HOSPICE	0	0	0.00		0.00	7.00
3. 00	Total (Sum of lines 1-7)	122 Average Length	352	0.00 Admis	24.22 si ons	469.00	8.00
		of Stay			51 0115		
	Component	Total	Title V	Title XVIII	Title XIX	Other	
1.00	SKILLED NURSING FACILITY	16.00	17.00	18.00 240	19.00	20.00	1.00
2.00	NURSING FACILITY	0.00	0	240	0	0	2.00
	ICF/IID				-	-	
	1017118	0.00			0	0	3.00
. 00 . 00	HOME HEALTH AGENCY COST				0	-	4.00
3.00 4.00 5.00	HOME HEALTH AGENCY COST Other Long Term Care	0.00			0	0	4.00 5.00
8.00 4.00 5.00 5.00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC	0. 00	0	0	0	0	4.00 5.00 6.00
8.00 4.00 5.00 5.00 7.00	HOME HEALTH AGENCY COST Other Long Term Care		0			0	3.00 4.00 5.00 6.00 7.00 8.00
3.00 4.00 5.00 5.00 7.00 3.00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	0.00		240		0	4.00 5.00 6.00 7.00
8.00 4.00 5.00 5.00 7.00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of lines 1-7)	0.00 0.00 73.01 Admi ssi ons	O Full Time	240 Equi val ent		0	4.00 5.00 6.00 7.00
8.00 4.00 5.00 5.00 7.00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE	0.00 0.00 73.01 Admissions Total	0 Full Time Employees on Payroll	240 Equi val ent Nonpai d Workers		0	4.00 5.00 6.00 7.00
3.00 4.00 5.00 5.00 7.00 3.00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component	0.00 0.00 73.01 Admissions Total 21.00	0 Full Time Employees on Payroll 22.00	240 Equi val ent Nonpai d <u>Workers</u> 23.00	6	0	4.00 5.00 6.00 7.00 8.00
8.00 .00 .00 .00 .00 .00 .00 .00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component	0.00 0.00 73.01 Admissions Total 21.00 359	0 Full Time Employees on Payroll 22.00 89.00	240 Equi val ent Nonpai d Workers 23.00 0.00	6	0	4. 00 5. 00 6. 00 7. 00 8. 00 1. 00
8.00 .00 .00 .00 .00 .00 .00 .00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY	0.00 0.00 73.01 Admissions Total 21.00	0 Full Time Employees on Payrol I 22.00 89.00 0.00	240 Equi val ent Workers 23.00 0.00 0.00	6	0	4. 00 5. 00 6. 00 7. 00 8. 00 1. 00 2. 00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component	0.00 0.00 73.01 Admissions Total 21.00 359 0	0 Full Time Employees on Payroll 22.00 89.00	240 Equi val ent Workers 23.00 0.00 0.00 0.00 0.00	6	0	4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00
3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 7. 00 8. 00 9.	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	0.00 0.00 73.01 Admissions Total 21.00 359 0	0 Full Time Employees on Payroll 22.00 89.00 0.00 0.00 0.00 0.00	240 Equi val ent Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00	6	0	4.00 5.00 6.00 7.00 8.00 1.00 2.00 3.00 4.00 5.00
8.00 4.00 5.00 5.00 7.00	HOME HEALTH AGENCY COST Other Long Term Care SNF-Based CMHC HOSPICE Total (Sum of Lines 1-7) Component SKILLED NURSING FACILITY NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	0.00 0.00 73.01 Admi ssi ons Total 21.00 359 0 0	0 Full Time Employees on Payroll 22.00 89.00 0.00 0.00 0.00	240 Equi val ent Nonpai d Workers 23.00 0.00 0.00 0.00 0.00 0.00 0.00	6	0	4.00 5.00 6.00 7.00 8.00

SNF WAGE INDEX INFORMATION Provider No.: 315153 Period: From 01/01/20; To 12/31/202 Amount Reported Reclass. of Salaries from Worksheet A-6 Adjusted Salaries (col. 1 ± col. 2) Paid Hours Related to Salary in col 3 PART 11 - DI RECT SALARIES SALARIES	Pate/Time Preps/5/30/2022 5:00 Average Hourly Wage (col. 3 ÷ col. 4) 5.00 20 29.07	3 pm
PART II - DI RECT SALARI ES SALARI ES 1.00 2.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00	Wage (col . 3 ÷ col . 4) 5.00 29.07	
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$. col . 4) 5. 00 29. 07	
PART II - DI RECT SALARI ES SALARI ES 1.00 2.00 3.00 4.00 O Total salaries (See Instructions) 6,656,206 0 6,656,206 228,962.0 2.00 Physician salaries-Part A 0 0 0 0.0	5. 00 29. 07	
PART II DIRECT SALARIES SALARIES 1.00 Total salaries (See Instructions) 6,656,206 0 6,656,206 228,962.0 2.00 Physician salaries-Part A 0 0 0 0.0	29.07	
SALARI ES 1.00 Total salaries (See Instructions) 6,656,206 0 6,656,206 228,962.0 2.00 Physician salaries-Part A 0 0 0 0.0		
1.00 Total salaries (See Instructions) 6,656,206 0 6,656,206 228,962.0 2.00 Physician salaries-Part A 0 0 0 0.0		
2.00 Physician salaries-Part A 0 0 0.0		
		1.00
3.00 Physician salaries-Part B 0 0 0 0 0.0		2.00
		3.00
4.00 Home office personnel 0 0 0.0		4.00
5.00 Sum of Lines 2 through 4 0 0 0.0		5.00
6.00 Revised wages (line 1 minus line 5) 6,656,206 0 6,656,206 228,962.0		6.00
7.00 Other Long Term Care 0 0 0.0		7.00
8.00 HOME HEALTH AGENCY COST 0 0 0.0		8.00
9.00 CMHC 0 0 0.0		9.00
10. 00 HOSPICE 0 0 0. 0		10.00
11.00 Other excluded areas 0 0 0.0		11.00
12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0.0 through 11) 0 0 0.0	0.00	12.00
13.00 Total Adjusted Salaries (line 6 minus line 6,656,206 0 6,656,206 228,962.0	0 29.07	13.00
OTHER WAGES & RELATED COSTS		
14.00 Contract Labor: Patient Related & Mgmt 864,809 0 864,809 12,353.0		14.00
15.00 Contract Labor: Physician services-Part A 0 0 0 0.0		15.00
16.00 Home office salaries & wage related costs 0 0 0.0	0.00	16.00
WAGE-RELATED COSTS		
17.00 Wage-related costs core (See Part IV) 2,023,734 0 2,023,734		17.00
18.00 Wage-related costs other (See Part IV) 0 0 0		18.00
19.00 Wage related costs (excluded units) 0 0 0		19.00
20.00 Physician Part A - WRC 0 0 0		20.00
21.00 Physician Part B - WRC 0 0 0		21.00
22. 00Total Adjusted Wage Related cost (see2,023,73402,023,734i nstructions)00000		22.00

Heal th	Financial Systems	THE M	ANOR		In Lie	eu of Form CMS-2	2540-10
SNF WA	GE INDEX INFORMATION		Provi der		Period: From 01/01/2021	Worksheet S-3 Part III	
					To 12/31/2021		pared:
						5/30/2022 5:0	3 pm
		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		0.00		
2.00	Administrative & General	711, 978		711, 97			
3.00	Plant Operation, Maintenance & Repairs	181, 804		181, 80 [,]			
4.00	Laundry & Linen Service	93, 337	0	93, 33	7 6, 356. 75	14.68	4.00
5.00	Housekeepi ng	303, 729	0	303, 72	9 17, 638. 55	17.22	5.00
6.00	Dietary	745, 566	0	745, 56	5 38, 310. 88	19.46	6.00
7.00	Nursing Administration	807, 218	0	807, 21	3 15, 569. 04	51.85	7.00
8.00	Central Services and Supply	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	Soci al Servi ce	176, 068	0	176, 06	5, 853. 00	30. 08	11.00
12.00	Nursing and Allied Health Ed. Act.			1			12.00
13.00	Other General Service	185, 178	0	185, 17	8, 203. 40	22.57	13.00
14.00	Total (sum lines 1 thru 13)	3, 204, 878	0	3, 204, 87	3 117, 399. 86	27.30	14.00
	•						

	ancial Systems RELATED COSTS	THE MANOR	Provider No.: 315153	Period:	u of Form CMS-2 Worksheet S-3	
IN WAGE I				From 01/01/2021	Part IV	
				To 12/31/2021	Date/Time Pre	
					5/30/2022 5:0 Amount	3 pm
					Reported	
					1.00	
PAR	T IV - WAGE RELATED COSTS				1.00	
Par	t A - Core List					1
	I REMENT COST					1
. 00 401	K Employer Contributions				272, 004	1 1
.00 Tax	Sheltered Annuity (TSA) Employer Contribut	i on			0	2
.00 Qua	lified and Non-Qualified Pension Plan Cost				0	3
.00 Pri	or Year Pension Service Cost				0	4
PLA	N ADMINISTRATIVE COSTS (Paid to External Org	gani zati on)				
	K/TSA Plan Administration fees				0	5
	al/Accounting/Management Fees-Pension Plan				0	6
	loyee Managed Care Program Administration F	ees			0	7
	LTH AND INSURANCE COST					
	Ith Insurance (Purchased or Self Funded)				679, 358	
	scription Drug Plan				277, 671	
	tal, Hearing and Vision Plan				62, 908	
	e Insurance (If employee is owner or benefi				20, 904	
	ident Insurance (If employee is owner or be				0	
	ability Insurance (If employee is owner or				75, 768	
	g-Term Care Insurance (If employee is owner	or beneficiary)			0	
	kers' Compensation Insurance				155, 607	
	irement Health Care Cost (Only current year	, not the extraord	linary accrual require	d by FASB 106.	0	16
Non	cumulative portion)					
	A-Employers Portion Only				479, 514	1 17
	icare Taxes - Employers Portion Only				0	
	mployment Insurance				0	
	te or Federal Unemployment Taxes				0	
ОТН						1
	cutive Deferred Compensation				0	21
	Care Cost and Allowances				0	
	tion Reimbursement				0	23
4.00 Tot	al Wage Related cost (Sum of lines 1 - 23)				2, 023, 734	24
·					Amount	
					Reported	
					1.00	
	t B - Other than Core Related Cost					
. 00 OTH	ER WAGE RELATED COSTS (SPECIFY)				0	25

Heal th	Financial Systems	THE MA	NOR		In Lie	eu of Form CMS-2	2540-10
SNF RE	PORTING OF DIRECT CARE EXPENDITURES			No.: 315153	Period: From 01/01/2021 To 12/31/2021	5/30/2022 5:0	pared:
	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col 1 + col. 2)	. Related to Salary in col. 3		
		1.00	2.00	3.00	4.00	5.00	
	Direct Salaries						
	Nursing Occupations						
1.00	Registered Nurses (RNs)	844, 858	C				1.00
2.00	Licensed Practical Nurses (LPNs)	1, 127, 444	C				2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1, 397, 476	C	1, 397, 4	63, 412. 00	22.04	3.00
4.00	Total Nursing (sum of lines 1 through 3)	3, 369, 778	C	3, 369, 7	78 112, 371. 00	29.99	4.00
5.00	Physical Therapists	0	C)	0 0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	C)	0 0.00		6.00
7.00	Physical Therapy Aides	0	C)	0 0.00	0.00	7.00
8.00	Occupational Therapists	0	C)	0 0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	C		0 0.00		9.00
10.00	Occupational Therapy Aides	0	C		0 0.00		10.00
11.00	Speech Therapists	0	C		0 0.00		11.00
12.00	Respi ratory Therapi sts	107, 992	C				12.00
13.00	Other Medical Staff	0	C)	0 0.00	0.00	13.00
	Contract Labor						
	Nursing Occupations	r		1	1	1	
14.00	Registered Nurses (RNs)	0			0 0.00		
15.00	Licensed Practical Nurses (LPNs)	0			0 0.00		15.00
16.00	Certified Nursing Assistant/Nursing	0			0 0.00	0.00	16.00
17.00	Assistants/Aides Total Nursing (sum of lines 14 through 16)	0			0 0.00	0.00	17.00
17.00	Physical Therapists	213, 860		213, 8			17.00
18.00	Physical Therapy Assistants	213, 600		213,00	0 3, 182.00		
20.00	Physical Therapy Aides	0			0 0.00		
20.00	Occupational Therapists	291, 969		291, 9			20.00
21.00	Occupational Therapy Assistants	291, 909		271,90	0 4, 343.00 0 0.00		21.00
22.00	Occupational Therapy Assistants	0			0 0.00		
23.00	Speech Therapi sts	79, 415		79, 4			
24.00	Respiratory Therapists	0		, , , 4	0 0.00		25.00
26.00	Other Medical Staff	0			0 0.00		26.00
20.00		9		1	- 0.00	5.00	

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	THE MANOR Provider No.: 315153	Peri od:	u of Form CMS Worksheet S-	
		From 01/01/2021 To 12/31/2021		
		Group	5/30/2022 5: 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		RMZ		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 16.00
17.00		RHB		17.00
18.00		RHA		18.00
19.00		RMC		19.00
20. 00 21. 00		RMB RMA		20.00 21.00
22.00		RLB		22.00
23.00		RLA		23.00
24.00		ES3		24.00
25. 00 26. 00		ES2 ES1		25.00 26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00		HD2		29.00
30. 00 31. 00		HD1 HC2		30.00 31.00
32.00		HC1		32.00
33. 00		HB2		33.00
34.00		HB1		34.00 35.00
35. 00 36. 00		LE2 LE1		35.00
37.00		LD2		37.00
38.00		LD1		38.00
39.00 40.00		LC2 LC1		39.00 40.00
40.00		LB2		40.00
42.00		LB1		42.00
43.00		CE2		43.00
44. 00 45. 00		CE1 CD2		44.00 45.00
46.00		CD1		46.00
47.00		CC2		47.00
48.00		CC1		48.00
49. 00 50. 00		CB2 CB1		49.00 50.00
51.00		CA2		51.00
52.00		CA1		52.00
53. 00 54. 00		SE3 SE2		53.00 54.00
55.00		SE1		55.00
56.00		SSC		56.00
57.00		SSB		57.00
58. 00 59. 00		SSA I B2		58.00 59.00
60.00		I B2		60.00
61. 00		I A2		61.00
62.00		I A1		62.00
63. 00 64. 00		BB2 BB1		63.00 64.00
65. 00		BA2		65.00
66.00		BA1		66.00
67.00		PE2		67.00
68. 00 69. 00		PE1 PD2		68.00 69.00
70.00		PD2 PD1		70.00
71.00		PC2		71.00
72.00		PC1		72.00
73. 00 74. 00		PB2 PB1		73.00 74.00
75.00		PA2		74.00

Health Financial Systems THE MANOR			In Lie	u of Form CMS	6-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315153	Period:	Worksheet S	-7
			From 01/01/2021 To 12/31/2021	Date/Time P 5/30/2022 5	
			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 An payments beginning 10/01/2003. Congress expected this increase expenses. For lines 101 through 106: Enter in column 1 the amoun column 2 the percentage of total expenses for each category to line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no with direct patient care and related expenses for each category (See instructions)	to be used nt of the total SNF o if the s	l for direct expense for revenue from pending refl	patient care and each category. Er Worksheet G-2, F ects increases as	related hter in Part I, ssociated	
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

LASS	SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	EXPENSES	Provi der	No.: 315153	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 5:0	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons Increase/Decre ase (Fr Wkst A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS - BLDGS & FIXTURES		488, 744	488, 74			
	00200 CAP REL COSTS - MOVABLE EQUIPMENT		0		0 140, 566		
	00300 EMPLOYEE BENEFITS	0	1,822,033			1, 822, 033	
	00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	711, 978 181, 804	752, 821 382, 908	1, 464, 79 564, 71		1, 123, 783	
	00600 LAUNDRY & LINEN SERVICE	93, 337	382, 908 20, 423	113, 76		564, 712 111, 051	
	00700 HOUSEKEEPI NG	303, 729	75, 200			378, 929	
	00800 DI ETARY	745, 566	406, 267	1, 151, 83		1, 156, 635	
	00900 NURSI NG ADMI NI STRATI ON	807, 218	305	807, 52		592, 478	
	01000 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
00	01100 PHARMACY	0	0		0 0	0	11
	01200 MEDI CAL RECORDS & LI BRARY	0	950	95	33, 230	34, 180	12
	01300 SOCIAL SERVICE	176, 068	460	176, 52	28 0	176, 528	
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
	01500 ACTIVITIES	185, 178	14, 811	199, 98	-1, 221	198, 768	15
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 SKILLED NURSING FACILITY	2 240 721	1 040 424	4 410 15	E 407 E09	3, 921, 557	30
	03100 NURSING FACILITY	3, 349, 721	1,069,434	4, 419, 15	55 -497, 598 0 0	3, 921, 557	
	03200 CF/I D	0	0		0 0	0	
	03300 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS				-1 -		
00	04000 RADI OLOGY	0	0		0 34, 927	34, 927	40
	04100 LABORATORY	0	0		0 21, 718		
	04200 I NTRAVENOUS THERAPY	0	0		0 97, 612	97, 612	
	04300 OXYGEN (INHALATION) THERAPY	0	0	(00.0)	0 101, 772	101, 772	
	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	101, 607	591, 438	693, 04	15 -101,937 0 0	591, 108 0	
	04600 SPEECH PATHOLOGY	0	0			0	
	04700 ELECTROCARDI OLOGY	0	0		0 13,756	13, 756	
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 204, 549	204, 549	
00	04900 DRUGS CHARGED TO PATIENTS	0	0		0 230, 779	230, 779	49
00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50
	05100 SUPPORT SURFACES	0	0		0 74, 716	74, 716	51
	OUTPATIENT SERVICE COST CENTERS				0		
	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0		0 0	0	
	06200 FQHC	0	0		0	0	62
	OTHER REIMBURSABLE COST CENTERS						
00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70
	07100 AMBULANCE	0	0		0 33, 879	33, 879	71
	07300 CMHC	0	0		0 0	0	73
	SPECIAL PURPOSE COST CENTERS	[0	0	
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE		0		0 0	0	
	08200 UTILIZATION REVIEW - SNF	0	0		0 0	0	
	08300 HOSPI CE	0	0			0	
00	SUBTOTALS (sum of lines 1-84)	6, 656, 206	5, 625, 794	12, 282, 00	-7, 786	12, 274, 214	
	NONREI MBURSABLE COST CENTERS	1					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90
	09100 BARBER AND BEAUTY SHOP	0	0		0 7, 786	7, 786	91
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
	09300 NONPALD WORKERS	0	0		0 0	0	
	09400 PATIENTS LAUNDRY	0	0		0 0	0	
	09500 MARKETI NG	0	0		0	0	
	09501 CLINIC 09502 INDEPENDENT LIVING	0	0			0	
02							

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	THE MA		No.: 315153		u of Form CMS-25 Worksheet A	540-1
101110					From 01/01/2021 To 12/31/2021	Date/Time Prepa	ared
						5/30/2022 5:03	pm
	Cost Center Description	Adjustments to	For Allocation				
		Wkst A-8)	(col . 5 +-				
			col. 6)	_			
		6.00	7.00				
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	240 610	307, 568				1.0
00	00200 CAP REL COSTS - BEDGS & FIXTORES	-340, 610	140, 566	1			2.0
00	00300 EMPLOYEE BENEFITS	-145, 934	1, 676, 099	1			3. C
00	00400 ADMI NI STRATI VE & GENERAL	0	1, 123, 783				4. C
00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	564, 712	2			5.0
00	00600 LAUNDRY & LINEN SERVICE	-844	110, 207	7			6.0
00	00700 HOUSEKEEPI NG	0	378, 929	1			7.0
00	00800 DI ETARY	-10, 991	1, 145, 644	1			8.0
00	00900 NURSI NG ADMI NI STRATI ON	0	592, 478	3			9.0
0.00	01000 CENTRAL SERVICES & SUPPLY	0	(10.0
	01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0	34, 180	-			11. (12. (
	01300 SOCIAL SERVICE	0	176, 528	1			13.0
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	(170,020	1			14. C
	01500 ACTI VI TI ES	0	198, 768	3			15. C
	INPATIENT ROUTINE SERVICE COST CENTERS	•					
). 00	03000 SKILLED NURSING FACILITY	0	3, 921, 557	7			30. C
	03100 NURSING FACILITY	0	(31. C
	03200 I CF/I I D	0	(32.0
8.00	O3300 OTHER LONG TERM CARE	0	(33.0
	ANCI LLARY SERVI CE COST CENTERS	0	24.02	7			10 0
	04000 RADI OLOGY 04100 LABORATORY	0	34, 927 21, 718	1			40. C
	04200 I NTRAVENOUS THERAPY	0	97, 612	1			42.0
	04300 OXYGEN (INHALATION) THERAPY	0	101, 772	1			43.0
	04400 PHYSI CAL THERAPY	0	591, 108	1			44. (
5.00	04500 OCCUPATI ONAL THERAPY	0	(D			45.0
o. 00	04600 SPEECH PATHOLOGY	0	(D			46. (
	04700 ELECTROCARDI OLOGY	0	13, 756	1			47. (
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	204, 549				48.0
	04900 DRUGS CHARGED TO PATIENTS	0	230, 779				49. (50. (
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	74, 716	-			50. 51.
. 00	OUTPATIENT SERVICE COST CENTERS	0	74,710	J			51.0
). 00	06000 CLINIC	0	(60. (
. 00	06100 RURAL HEALTH CLINIC	0	(61. (
2.00	06200 FQHC						62. (
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0)				70. (
	07100 AMBULANCE	0	33, 879	1			71.0
3.00	07300 CMHC	0	()			73.0
). 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES	0	(80. (
	08100 I NTEREST EXPENSE	0	(81.0
	08200 UTILIZATION REVIEW - SNF	0	(82.0
3.00	08300 HOSPI CE	0	(D			83. (
9.00	SUBTOTALS (sum of lines 1-84)	-498, 379	11, 775, 835	5			89. (
	NONREI MBURSABLE COST CENTERS	-	-	-1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	(1			90.0
	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	-7, 786	(1			91.0
	09200 PHYSICIANS PRIVATE OFFICES	0					92. (93. (
	09400 PATIENTS LAUNDRY		((5			93.0
	09500 MARKETI NG	0	(95.0
	09501 CLI NI C	0	(95.0
	09502 I NDEPENDENT LI VI NG	0	(b			95. C
	TOTAL	-506, 165	11, 775, 835	-		1	100. C

Heal th	Financial Systems	THE MANOR			In Lie	u of Form CMS-:	2540-10
	ISI FI CATI ONS		Provi der	No.: 315153	Peri od:	Worksheet A-6	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
					10 12/31/2021	5/30/2022 5:0	
				Increases			
		Cost Center		Line #	Salary	Non Salary	
	(1) A - MME DEPRECIATION RECLASS	2.00	3.00	4.00	5.00		
1.00	(1) A - WIME DEFRECTATION RECEASS	CAP REL COSTS - MOVA	ABLE	2.0		140, 566	1.00
		EQUI PMENT		2		110,000	
	(1) B - LEASE EXPENSE						
2.00		CAP REL COSTS - BLDO	GS &	1. (0 00	300, 000	2.00
	(1) C - BARBER AND BEAUTY	FIXTURES					-
3.00	(1) C - BARDER AND BEAUTY	BARBER AND BEAUTY SH	IOP	91.0		7, 786	3.00
5.00	(1) D - MED SURG SUPPLIES	BARBER AND BEAUTI SI		71.5		7,700	5.00
4.00		MEDICAL SUPPLIES CHA	ARGED TO	48.0	0 00	204, 549	4.00
		PATI ENTS					
5.00				0.0		0	5.00
6.00				0.0		0	6.00
7.00	(1) E - DRUGS BILLABLE			0.0	0 00	0	7.00
8.00	(1) L - DROGS BILLABLE	DRUGS CHARGED TO PA	LENTS	49.0	0 00	230, 779	8.00
9.00		I NTRAVENOUS THERAPY	IT ENTID	42.0		97, 612	9.00
	(1) F - ENTERAL SUPPLIES					· · · · · · · · · · · · · · · · · · ·	1
10.00		DI ETARY		8. (0 00	4, 802	10.00
	(1) G - SUPPORT SURFACES						
11.00	(1) H - ANCILLARY	SUPPORT SURFACES		51.0	0 00	74, 716	11.00
12.00	(T) H - ANGILLARY	RADI OLOGY		40.0		34, 927	12 00
12.00		LABORATORY		40.0		21, 718	
14.00		ELECTROCARDI OLOGY		47. (13, 756	
15.00		AMBULANCE		71. (0 00	33, 879	15.00
	(1) K - REHAB SERVICES						
16.00		OXYGEN (INHALATION)	THERAPY	43. (00 101, 607	165	16.00
17 00	(1) N - NURSING ADMINISTRATION			20.4		215 045	17.00
17.00	(1) 0 - MEDICAL RECORDS	SKILLED NURSING FAC	LIIY	30. (0 00	215, 045	17.00
18.00	(1) 0 - MEDICAL RECORDS	MEDI CAL RECORDS & LI	BRARY	12.0		33, 230	18 00
	TOTALS	PRESTONE RECORDO & EI		12.1		00,200	
100.00		Total Reclassificati	ons (Sum		101, 607	1, 413, 530	100.00
		of columns 4 and 5 r					
		equal sum of columns	s 8 and				
	I	9)	I		1		I

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	THE MANOR			In Lie	u of Form CMS-:	2540-10
RECLASSI FI CATI ONS		Provi der	No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Pre	
					5/30/2022 5:0	<u>3 pm</u>
			Decreases			
	Cost Cente	r	Line #	Sal ary	Non Salary	
	6.00		7.00	8.00	9.00	
(1) A - MME DEPRECIATION RECLASS			1 .		440 544	
1.00	CAP REL COSTS - BLD FIXTURES	IGS &	1. (00 0	140, 566	1.00
(1) B - LEASE EXPENSE						
2.00	ADMINISTRATIVE & GE	NERAL	4. (00 0	300, 000	2.00
(1) C - BARBER AND BEAUTY			1			
3.00	ADMINISTRATIVE & GE	NERAL	4. (0 0	7, 786	3.00
(1) D - MED SURG SUPPLIES			1		0.700	
4.00	LAUNDRY & LINEN SER ACTIVITIES	VICE	6. (
5. 00 6. 00	SKILLED NURSING FAC		15.0		1, 221	5.00 6.00
7.00	PHYSICAL THERAPY	ILIIY			200, 454 165	
(1) E - DRUGS BILLABLE	PHYSI CAL THERAPY 44.00 0					
8.00	SKILLED NURSING FAC	TTTT	30.0	0 00	328, 391	8.00
9,00	SKI EEED NORSTNO TAC		0.0		0	9,00
(1) F - ENTERAL SUPPLIES			0.0	0	Ŭ	7.00
10.00	SKILLED NURSING FAC	I LI TY	30.0	0 00	4, 802	10.00
(1) G - SUPPORT SURFACES						
11.00	SKILLED NURSING FAC	I LI TY	30. (0 00	74, 716	11.00
(1) H - ANCILLARY						
12.00	SKILLED NURSING FAC	I LI TY	30.0		104, 280	
13.00			0.0		0	
14.00			0.0		0	14.00
15.00			0.0	0 0	0	15.00
(1) K - REHAB SERVICES			T		· · -	
16.00	PHYSICAL THERAPY		44.0	00 101, 607	165	16.00
(1) N - NURSING ADMINISTRATION					015 045	17.00
17.00 (1) 0 - MEDI CAL RECORDS	NURSING ADMINISTRAT	TUN	9. (0 0	215, 045	17.00
18.00	ADMI NI STRATI VE & GE		4.0	0 00	33, 230	18.00
TOTALS	ADIVITIVI STRATIVE & GE		4.0		33, 230	10.00
100.00				101, 607	1, 413, 530	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.

	n Financial Systems	THE MA				u of Form CMS-2	2540-1
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Date/Time Prep 5/30/2022 5:03	bared: 3 pm
				Acqui si ti on			
	Description	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	ANALYSIS OF CHANGES IN CAPITAL ASSET BAL	ANCES					
1.00	Land	0	0		0 0	0	1.0
2.00	Land Improvements	7, 839, 292	86, 953		0 86, 953	0	2.0
3.00	Buildings and Fixtures	0	0		0 0	0	3.0
4.00	Building Improvements	0	0		0 0	0	4.C
5.00	Fixed Equipment	1, 555, 650	44, 580		0 44, 580	0	5.C
5.00	Movable Equipment	2, 126, 894	83, 565		0 83, 565		6. C
7.00	Subtotal (sum of lines 1-6)	11, 521, 836	215, 098		0 215, 098	0	7.C
8.00	Reconciling Items	0	0		0 0	0	8.0
9.00	Total (line 7 minus line 8)	11, 521, 836	215, 098		0 215, 098	0	9.0
	Description	Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BAL	ANCES	-				
1.00	Land	0	0				1.0
2.00	Land Improvements	7, 926, 245	0				2. C
3.00	Buildings and Fixtures	0	0				3. C
4.00	Building Improvements	0	0				4.0
5.00	Fixed Equipment	1, 600, 230	0				5.C
6.00	Movable Equipment	2, 210, 459	0				6.0
7.00	Subtotal (sum of lines 1-6)	11, 736, 934	0				7.0
8.00	Reconciling Items	0	0				8.0
9.00	Total (line 7 minus line 8)	11, 736, 934	0				9.0

	Financial Systems WENTS TO EXPENSES	THE MAN		No.: 315153	Peri od:	eu of Form CMS-2 Worksheet A-8	
11021	VIEINIS IU ENPENSES		Provider	110.: 313133	From 01/01/2021	worksneet A-8	
					To 12/31/2021	Date/Time Pre 5/30/2022 5:0	
					lassification on	Worksheet A	
				To/From Whic	ch the Amount is	to be Adjusted	
	Description (1)	(2) Basis For	Amount	Cos	t Center	Line No.	
		Adjustment				1.00	
00	Investment income on restricted funds	1.00 B	2.00	CAP REL COST	3.00	4.00	1.
00	(chapter 2)	В	-340, 610	FI XTURES	S - BLDGS &	1.00	1.
00	Trade, quantity, and time discounts (chapter		0			0.00	2
	8)						
00	Refunds and rebates of expenses (chapter 8)		0			0.00	3
00	Rental of provider space by suppliers		0			0.00	4
~~	(chapter 8)						
00	Telephone services (pay stations excluded)		0			0.00	5
00	(chapter 21) Television and radio service (chapter 21)		0			0.00	6
00	Parking lot (chapter 21)		0			0.00	
00	Remuneration applicable to provider-based	A-8-2	0			0.00	8
	physician adjustment						
00	Home office cost (chapter 21)		0			0.00	9
. 00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	
00	Nonallowable costs related to certain		0			0.00	11
~~	Capital expenditures (chapter 24)						1 4 0
. 00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	0				12
00	Laundry and Linen service		0			0.00	13
. 00	Revenue - Employee meals		0			0.00	
. 00	Cost of meals - Guests		0			0.00	
00	Sale of medical supplies to other than	В	-	DI ETARY		8.00	
	patients	_	-				
. 00	Sale of drugs to other than patients		0			0.00	17
00	Sale of medical records and abstracts		0			0.00	
. 00	Vending machines	В	-19	DI ETARY		8.00	
. 00	Income from imposition of interest, finance		0			0.00	20
00	or penal ty charges (chapter 21)		0			0.00	0.1
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare		0			0.00	21
	overpayments						
. 00	Utilization reviewphysicians' compensation		0	UTILIZATION	REVIEW - SNE	82.00	22
	(chapter 21)		0		din on	02100	
. 00	Depreciationbuildings and fixtures		0	CAP REL COST	S - BLDGS &	1.00	23
				FI XTURES			
00	Depreciationmovable equipment		0	CAP REL COST	S – MOVABLE	2.00	24
				EQUI PMENT		_	
	Other adjustment (specify)		0			0.00	
. 02	RX REBATES	В		EMPLOYEE BEN	EFIIS	3.00	
. 04	PURCHASE DI SCOUNT	B		DI ETARY		8.00	
. 05	BARBER AND BEAUTY	A		BARBER AND B		91.00	
	LAUNDRY Total (sum of lines 1 through 99) (Transfor	В		LAUNDRY & LI	NEN SERVICE	6.00	31 100
0.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-506, 165				100

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

Health Financial Systems	THE M	ANOR		In Lie	u of Form CMS	-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOMI	E Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet A- Parts I-II Date/Time Pr 5/30/2022 5:	epared:
	Line No.	Cost (Center	Expense	e Items	
	1.00	2.	00	3.		
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIF CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	ED ORGANI ZATI ONS	6 OR	
1.00	4.00	ADMI NI STRATI VE	& GENERAL	CORPORATE DI REC	CT	1.00
2.00	4.00	ADMI NI STRATI VE	& GENERAL	I NSURANCE		2.00
3.00	3.00	EMPLOYEE BENEF	ITS	EMPLOYEE BENEFI	I TS	3.00
4.00	4.00	ADMI NI STRATI VE	& GENERAL	PRINT SHOP		4.00
5.00	30.00	SKILLED NURSIN	G FACILITY	MED SURG SUPPLI	ES	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:			-	ED ORGANI ZATI ONS	5 OR	
1.00	336, 960			0		1.00
2.00	113, 412			0		2.00
3.00	1, 349, 295	1, 349, 295		0		3.00
4.00	150			0		4.00
5.00	8, 991	8, 991		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, 808, 808	1, 808, 808		0		10.00
6, line 100 to Worksheet A-8, column 3, line						
12.						

Health Financial Systems	THE MA	ANOR		In Lie	u of Form CMS-2	2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	E	Provider No.: 315153	From 01/01/2021	Worksheet A-8 Parts I-II Date/Time Prep 5/30/2022 5:03	pared:
	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 A CENTRASTATE MEDICAL CENTER 100.00 2.00	
3.00 4.00 5.00	1.00
4.00 5.00 0.00	2.00
5.00 0.00	3.00
	4.00
	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	10.00
100.00 G. Other (financial or non-financial) 0.00	100.00
speci fy:	

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in

related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Rel ated Organi	zation(s) and/	or Home Office						
	Name	Percentage of	Type of Business						
		Ownership							
	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	PARENT COMPANY	100.00 ACUTE CARE HOSPITAL	1.00
2.00		0.00	2.00
3.00		0.00	3.00
4.00		0.00	4.00
5.00		0.00	5.00
6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00 G. Other (financial or non-financial)		0.00	100.00
speci fy:			

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 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.

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	THE MAN		No.: 315153	Period: From 01/01/2021	u of Form CMS-: Worksheet B Part I	2040 10
					To 12/31/2021	Date/Time Pre 5/30/2022 5:0	
			CAPI TAL REL	ATED COSTS			
	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	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	207 5 (0	207 540	[1 1 00
. 00 . 00	00200 CAP REL COSTS - BEDGS & FIXTORES	307, 568 140, 566	307, 568	140, 56	56		1.00 2.00
. 00	00300 EMPLOYEE BENEFITS	1, 676, 099	0		0 1, 676, 099		3.00
. 00	00400 ADMINISTRATIVE & GENERAL	1, 123, 783	85, 640	39, 14	40 179, 283	1, 427, 846	4.00
. 00	00500 PLANT OPERATION, MAINT. & REPAIRS	564, 712	13, 980				
. 00	00600 LAUNDRY & LINEN SERVICE	110, 207	6, 241	2, 85			
. 00	00700 HOUSEKEEPING	378, 929	2, 562	1, 17			
. 00		1, 145, 644	34, 992			1, 384, 369 800, 876	
. 00 0. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	592, 478	3, 522 0	1, 61	10 203, 266 0 0	800,878 0	
1.00	01100 PHARMACY	0	0		0 0		
	01200 MEDICAL RECORDS & LIBRARY	34, 180	1, 669	76	63 0	36, 612	
3.00	01300 SOCI AL SERVICE	176, 528	1, 683		69 44, 336		
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0 0	0	
	01500 ACTIVITIES	198, 768	14, 914	6, 81	16 46, 630	267, 128	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	11		r			
0.00	03000 SKILLED NURSING FACILITY	3, 921, 557	125, 816	57, 50			
1.00	03100 NURSING FACILITY	0	0		0 0		
	03200 I CF/I I D	0	0		0 0	0	
3.00	03300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
0. 00	ANCI LLARY SERVI CE COST CENTERS 04000 RADI OLOGY	34, 927	0		0 0	34, 927	40.00
1.00	04100 LABORATORY	21, 718	0		0 0	21, 718	
2.00	04200 I NTRAVENOUS THERAPY	97, 612	0		0 0	97,612	
3.00	04300 OXYGEN (INHALATION) THERAPY	101, 772	0		0 0	101, 772	
4.00	04400 PHYSI CAL THERAPY	591, 108	13, 435	6, 14	40 25, 586	636, 269	44.00
5.00	04500 OCCUPATI ONAL THERAPY	0	409	18		596	
6. 00	04600 SPEECH PATHOLOGY	0	518	23	37 0	755	
7.00	04700 ELECTROCARDI OLOGY	13, 756	0		0 0	13, 756	
8.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	204, 549	1, 179		39 0	206, 267	
9.00 0.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	230, 779	1, 008 0	40	61 0 0 0	232, 248	1
	05100 SUPPORT SURFACES	74, 716	0		0 0		
1.00	OUTPATIENT SERVICE COST CENTERS	,,,,,,			0 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 01.0
0. 00	06000 CLI NI C	0	0		0 0	0	60. 0
1.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.0
2.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS						1 70 0
0.00	07000 HOME HEALTH AGENCY COST	0	0		0 0		
	07100 AMBULANCE 07300 CMHC	33, 879 0	0		0 0		1
5.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0 0	0	/ 3. 0
0. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80. 0
1.00	08100 INTEREST EXPENSE						81.00
2.00	08200 UTILIZATION REVIEW - SNF						82.00
3.00	08300 HOSPI CE	0	0		0 0	0	83.0
9.00	SUBTOTALS (sum of lines 1-84)	11, 775, 835	307, 568	140, 56	66 1, 676, 099	11, 775, 835	89.00
	NONREI MBURSABLE COST CENTERS	-	-		-		
0.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0		
1.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0		
	09200 PHYSI CLANS PRI VATE OFFI CES	0	0			0	
2.00		0	0			0	
2.00 3.00	09300 NONPALD WORKERS				- U	0	1 /4.0
2.00 3.00 4.00	09400 PATIENTS LAUNDRY	0	0		0 0	0	95 0
2.00 3.00	09400 PATI ENTS LAUNDRY 09500 MARKETI NG	0	0		0 0 0 0	0	95.00 95.0
2.00 3.00 4.00 5.00	09400 PATIENTS LAUNDRY	0 0 0	0 0 0		0 0 0 0 0 0	-	95. O
2.00 3.00 4.00 5.00 5.01	09400 PATI ENTS LAUNDRY 09500 MARKETI NG 09501 CLI NI C		0 0 0 0		0 0 0 0 0 0 0 0 0 0	0	95.0 [°] 95.02
2.00 3.00 4.00 5.00 5.01 5.02	09400 PATIENTS LAUNDRY 09500 MARKETING 09501 CLINIC 09502 INDEPENDENT LIVING Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 11, 775, 835	0 0 0 0 307, 568	140, 56	0 0 0 0 0 0 0 0 0 0 0 0 56 1, 676, 099	0 0 0 0	95.01 95.02 98.00 99.00

Heal th	Financial Systems	THE MA	ANOR		In Lie	u of Form CMS-:	2540-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 5:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1 1		1			1 1 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINI STRATI VE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY	1, 427, 846 87, 048 19, 704 63, 354 191, 019	717, 909 21, 545 8, 844 120, 804	184, 05	2 0 531, 342 0 93, 362	1, 789, 554	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00	00900 NURSING ADMINISTRATION	110, 507	12, 160		9, 398	0	9.00
10.00 11.00 12.00 13.00 14.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE	0 0 5, 052 30, 814	0 0 5, 763 5, 810		0 0 0 0 0 4,454 0 4,490	0 0 0	10.00 11.00 12.00 13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 36, 859	0 51, 488		0 0 0 39, 792	0	14.00 15.00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	30, 039	51,400	1	57, 192	0	15.00
30.00	03000 SKILLED NURSING FACILITY	682, 791	434, 363	184, 05	2 335, 691	1, 789, 554	30.00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 I CF/I I D	0	0		0 0	0	1
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	33.00
40.00	04000 RADI OLOGY	4,819	0		0 0	0	40.00
41.00	04100 LABORATORY	2, 997	0		0 0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	13, 469	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	14, 043	0		0 0	0	43.00
44.00	04400 PHYSI CAL THERAPY	87, 794	46, 383		0 35, 847	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	82	1, 411		0 1, 091	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	104 1, 898	1, 788		0 1, 382	0	46.00
47.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 461	4, 069		0 3,145	0	47.00
49.00	04900 DRUGS CHARGED TO PATIENTS	32,046	3, 481		0 2, 690	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	10, 310	0		0 0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	T. T		T			
60.00	06000 CLINIC	0	0		0 0	0	
	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
	07100 AMBULANCE	4, 675	0		0 0	0	1
73.00	07300 CMHC	0	0)	0 0	0	73.00
~~ ~~	SPECIAL PURPOSE COST CENTERS						
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						81.00
82.00 83.00	08300 HOSPI CE	0	0		0	0	82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	1, 427, 846	717, 909	184, 05	2 531, 342	1, 789, 554	
	NONREI MBURSABLE COST CENTERS	.,,		1		.,	
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	0	92.00
	09300 NONPAID WORKERS	0	0			0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 MARKETING	0	0			0	94.00 95.00
95.00 95.01	09501 CLINIC	0	0			0	95.00
95.02	09502 I NDEPENDENT LI VI NG	0	0		0 0	0	95.02
98.00	Cross Foot Adjustments	0	0		o o	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	99.00
100.00	TOTAL	1, 427, 846	717, 909	184, 05	2 531, 342	1, 789, 554	100.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	THE MA		No.: 315153		eri od:	u of Form CMS-2 Worksheet B	_
					Fr Tc	rom 01/01/2021 0 12/31/2021	Part I Date/Time Pre 5/30/2022 5:0	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS			1				
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT							2.00
3.00	00300 EMPLOYEE BENEFITS							3.00
4.00	00400 ADMI NI STRATI VE & GENERAL							4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE							5.00 6.00
7.00	00700 HOUSEKEEPING							7.00
8.00	00800 DI ETARY							8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	932, 941						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	0					10.00
11.00	01100 PHARMACY	0	0		0			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	51, 881		12.00
13.00	01300 SOCI AL SERVI CE	0	C)	0	0	264, 430	1
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0	0	0	
15.00	01500 ACTI VI TI ES	0	C)	0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•				
30. 00	03000 SKILLED NURSING FACILITY	932, 941	C)	0	51, 881	264, 430	30.00
31.00	03100 NURSING FACILITY	0	C		0	0	0	31.00
32.00	03200 I CF/I I D	0	C		0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADI OLOGY	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	U		0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0		0	0	0	44.00
45.00 46.00	04600 SPEECH PATHOLOGY	0	0		0	0	0	45.00 46.00
40.00	04700 ELECTROCARDI OLOGY	0	0		0	0	0	40.00
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	C		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS			1	-	-		
60.00	06000 CLI NI C	0	C		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0	0	0	61.00
62.00	06200 FQHC							62.00
	OTHER REIMBURSABLE COST CENTERS			-				
70.00	07000 HOME HEALTH AGENCY COST	0	C	1	0	0		
71.00	07100 AMBULANCE	0	C		0	0		71.00
73.00	07300 CMHC	0	0	1	0	0	0	73.00
00 00	SPECIAL PURPOSE COST CENTERS	1		1				
	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES							80.00
81.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF							81.00
82.00 83.00	08300 HOSPI CE	0	C		0	0	0	82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	932, 941	0		0	51, 881	264, 430	1
07.00	NONREI MBURSABLE COST CENTERS	752, 741	0	1	0	51,001	204, 430	09.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	Ő		0	0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		Ō	0	0	
	09300 NONPALD WORKERS	0	C		0	0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	C		0	0	0	
95.00	09500 MARKETI NG	0	0		0	0	0	
95.01	09501 CLI NI C	0	C		0	0	0	95.01
95.02	09502 INDEPENDENT LIVING	0	C		0	0	0	95.02
98.00	Cross Foot Adjustments	0	C					98.00
99.00	Negative Cost Centers	0	C		0	0	0	
77.00			C	1	0	51, 881	264, 430	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	THE M.		No.: 315153	In Lie Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 5:0	pared:
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON 14. 00	OTHER GENERAL SERVI CE ACTI VI TI ES 15. 00	Subtotal	Post Stepdown Adjustments	Total 18.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	10.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00 4.00 5.00 6.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE						2.00 3.00 4.00 5.00 6.00
7.00	00700 HOUSEKEEPI NG						7.00
8.00	00800 DI ETARY						8.00
9.00	00900 NURSI NG ADMI NI STRATI ON						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY						10.00
11.00	01100 PHARMACY						11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY						12.00
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	395, 267				15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	0	395, 267	10, 019, 33	5 0	10, 019, 335	30.00
31.00	03100 NURSING FACILITY	0			0 0	0	31.00
32.00	03200 I CF/I I D	0			0 0		32.00
33.00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
	ANCI LLARY SERVICE COST CENTERS	I		1	-	1	-
40.00	04000 RADI OLOGY	0					1
41.00	04100 LABORATORY	0					1
42.00	04200 INTRAVENOUS THERAPY	0	0			111, 081	1
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY	0	0			115, 815 806, 293	
44.00	04400 PHISICAL THERAPY	0				3, 180	1
46.00	04600 SPEECH PATHOLOGY	0		4, 02		4, 029	
47.00	04700 ELECTROCARDI OLOGY	0	0	15, 65		15, 654	
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			241, 942	
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0				
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0		50.00
51.00	05100 SUPPORT SURFACES	0	0	85, 02	.6 0	85, 026	51.00
	OUTPATIENT SERVICE COST CENTERS		-				
60.00	06000 CLI NI C	0			0 0		60.00
61.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC						62.00
	OTHER REIMBURSABLE COST CENTERS			1	-		1
	07000 HOME HEALTH AGENCY COST				0 0 64 0		
	07100 AMBULANCE 07300 CMHC				0 0		71.00
73.00	SPECIAL PURPOSE COST CENTERS		0	1	0 0	0	73.00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
80.00	08100 INTEREST EXPENSE						81.00
82.00	08200 UTI LI ZATI ON REVIEW - SNF						82.00
83.00	08300 H0SPI CE	0	0		0 0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	0	395, 267	11, 775, 83	5 0	11, 775, 835	89.00
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
92.00	09200 PHYSICIANS PRIVATE OFFICES	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
95.00	09500 MARKETI NG				0	0	95.00
95.01					0 0	0	95.01
95.02 98.00	09502 INDEPENDENT LIVING Cross Foot Adjustments					0	95.02 98.00
98.00 99.00	Negative Cost Centers					0	98.00
100. OC	5	0		11, 775, 83	5 0		
			1 070,207	1, // 0, 00	-	1, , , 0, 000	1.00.00

82.00 08200 UTILIZATION REVIEW - SNF 82.00 83.00 08300 HOSPICE 0 0 0 0 83.00 89.00 SUBTOTALS (sum of lines 1-84) 0 307,568 140,566 448,134 0 89.00 NONREL MBURSABLE COST CENTERS 90.00 0 0 0 0 0 90.00 91.00 91.00 8ABRE AND BEAUTY SHOP 0 0 0 91.00 92.00 PHYSICIANS PRIVATE OFFICES 0 0 0 91.00 92.00 93.00 00 0 0 92.00 93.00 93.00 0 0 0 92.00 92.00 94.00 92.00 92.00 94.00 92.00 92.00 94.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00	Heal th	Financial Systems	THE MA	ANOR		In Lie	u of Form CMS-:	2540-10
Cost Canter Description Cantal Related Costs Cantal Related Costs Related Costs <threlated costs<="" t<="" td=""><td>ALLOCA</td><td>TION OF CAPITAL RELATED COSTS</td><td></td><td>Provi der</td><td>Fi</td><td>rom 01/01/2021</td><td>Part II Date/Time Pre</td><td></td></threlated>	ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	Fi	rom 01/01/2021	Part II Date/Time Pre	
Residence from the set of the se				CAPI TAL REL	ATED COSTS			
OPERAL SERVICE COST CENTERS I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I<		Cost Center Description	Assigned New Capital			Subtotal		
1.00 00100 (ZAP REL COSTS - BLICS & FLATURES 1.00 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 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 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 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 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 0.00 0.00 0.00 <td></td> <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>2A</td> <td>3.00</td> <td></td>				1.00	2.00	2A	3.00	
2:00 DO200 CAP R.L. COSTS - MOVABLE CON PRENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td>1 1</td> <td></td> <td></td> <td></td> <td></td> <td></td>			1 1					
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	TION OF CAPITAL RELATED COSTS		Provi der	1	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 5:03	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1		1	1 1		1.00
2.00 3.00 4.00 5.00 6.00 7.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	124, 780 7, 607 1, 722 5, 536	27, 976 840 345	11, 65!	9, 614		2.00 3.00 4.00 5.00 6.00 7.00
8.00	00800 DI ETARY	16, 693	4, 708	(1, 689	74, 074	8.00
9. 00 10. 00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	9,657	474 0		0 170 0 0	0	9.00 10.00
	01100 PHARMACY	0	0			0	11.00
	01200 MEDI CAL RECORDS & LI BRARY	441	225		81	0	12.00
	01300 SOCI AL SERVI CE	2, 693	226	(D 81	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		J	0	14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	3, 221	2,006		720	0	15.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	59,672	16, 924	11, 65	6,073	74,074	30.00
	03100 NURSING FACILITY	0	0	(0	31.00
	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
40.00	ANCI LLARY SERVI CE COST CENTERS	421	0		l o	0	40.00
	04100 LABORATORY	262	0			0	40.00
	04200 INTRAVENOUS THERAPY	1, 177	0		0 0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1, 227	0		0 0	0	43.00
	04400 PHYSI CAL THERAPY	7,672	1, 808		649	0	44.00
	04500 OCCUPATI ONAL THERAPY	7	55 70		20 25	0	45.00
	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	166	/0		25	0	46.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 487	159		57	0	48.00
	04900 DRUGS CHARGED TO PATIENTS	2, 800	136			0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	901	0	(0 0	0	51.00
60, 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0			0	61.00
	06200 FQHC		0				62.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	
	07100 AMBULANCE 07300 CMHC	409	0			0	71.00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1	<u>v</u>	0	/3.00
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
	08300 HOSPI CE	104 700	0	(0	
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	124, 780	27, 976	11, 65	5 9, 614	74, 074	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0		0 0	0	91.00
	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	92.00
	09300 NONPAI D WORKERS	0	0	(0 0	0	93.00
	09400 PATIENTS LAUNDRY	0	0		0	0	94.00
	09500 MARKETI NG 09501 CLI NI C	0	0			0	95.00 95.01
	09502 INDEPENDENT LIVING	0	0			0	95.01
95.02		0	0			-	
95. 02 98. 00	Cross Foot Adjustments			(J 01	0	98.00
	Cross Foot Adjustments Negative Cost Centers	0	0 27, 976	11, 65		0 0 74, 074	99.00

	Financial Systems TION OF CAPITAL RELATED COSTS	THE MA		No.: 315153	Pe	eri od:	u of Form CMS-2 Worksheet B	
, ILLOO,						om 01/01/2021	Part II	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		RECORDS & LI BRARY	SOCI AL SERVI CE	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS	1		1	_			
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES							1.00
2.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT							2.00
3.00	00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL							3.00
4.00 5.00	00500 PLANT OPERATION, MAINT. & REPAIRS							4.00 5.00
6.00	00600 LAUNDRY & LINEN SERVICE							6.00
7.00	00700 HOUSEKEEPING							7.00
8.00	00800 DI ETARY							8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	15, 433						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	C					10.00
11.00	01100 PHARMACY	0	C		0			11.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	C		0	3, 179		12.00
13.00	01300 SOCIAL SERVICE	0	C		0	0		13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	C		0	0	0	14.00
15.00	01500 ACTI VI TI ES	0	C		0	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 SKILLED NURSING FACILITY	15, 433	C)	0	3, 179	5, 452	30.00
31.00	03100 NURSING FACILITY	0	C)	0	0	0	31.00
32.00	03200 I CF/I I D	0	C		0	0	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	C)	0	0	0	33.00
	ANCILLARY SERVICE COST CENTERS							
40.00	04000 RADI OLOGY	0	C		0	0		40.00
41.00	04100 LABORATORY	0	C)	0	0		41.00
42.00	04200 I NTRAVENOUS THERAPY	0	C)	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	0	C)	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	0	C)	0	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	C		0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0			0	0	0	46.00
47.00 48.00	04700 ELECTROCARDI OLOGY	0			0	0	0	47.00 48.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			0	0	0	48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	C		0	0	-	50.00
51.00	05100 SUPPORT SURFACES	0		,	0	0		51.00
51.00	OUTPATIENT SERVICE COST CENTERS	Y	- C	/	0	0	0	51.00
60.00	06000 CLINIC	0	C		0	0	0	60.00
61.00	06100 RURAL HEALTH CLINIC	0	C		0	0		61.00
62.00	06200 FQHC		-		-	-	-	62.00
	OTHER REIMBURSABLE COST CENTERS	1 1						
70.00	07000 HOME HEALTH AGENCY COST	0	C)	0	0	0	70.00
71.00	07100 AMBULANCE	0	C)	0	0	0	71.00
73.00	07300 CMHC	0	C)	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS							
	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	C		0	0	0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	15, 433	C)	0	3, 179	5, 452	89.00
00.00	NONREI MBURSABLE COST CENTERS			1	0		0	00.00
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	C		0	0		90.00
91.00	09200 PHYSICIANS PRIVATE OFFICES	0	C		0	0	0	91.00
	09300 NONPALD WORKERS				0	0	0	92.00 93.00
93.00	09400 PATIENTS LAUNDRY				0	0	0	93.00
95.00	09500 MARKETI NG	0			0	0	0	95.00
95.00 95.01	09501 CLI NI C				0	0	0	95.00
95.01	09502 I NDEPENDENT LI VI NG				0	0	0	95.01
98.00 98.00	Cross Foot Adjustments		c c		n	0	0	98.00
99.00 99.00	Negative Cost Centers		c r		0	Ο	0	99.00
100.00		15, 433	C		0	3, 179		100.00
	1 1	10, 100	C	1	-	5, 177	5, 152	5. 00

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	THE M.		No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/30/2022 5:0	pared:
	Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	18.00	
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
	00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	27, 677				14.00 15.00
	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	0	27, 677			403, 455	30.00
31.00 32.00 33.00	03100 NURSING FACILITY 03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0 0 0		0 0 0 0 0 0	0 0 0	31.00 32.00 33.00
55.00	ANCI LLARY SERVICE COST CENTERS			1	0 0	0	33.00
	04000 RADI OLOGY	0	0	1		421	40.00
41.00 42.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0	0			262 1, 177	
43.00	04300 OXYGEN (INHALATION) THERAPY	0	0	.,		1, 227	43.00
44.00 45.00	04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY	0	0			29, 704 678	44.00
46.00	04600 SPEECH PATHOLOGY	0	0	85		859	
47.00	04700 ELECTROCARDI OLOGY	0	0	16		166	
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0	., .=		4, 421	1
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	.,	0 0	4, 454 0	50.00
51.00	05100 SUPPORT SURFACES	0	0	1		901	
60. 00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC	1					62.00
70 00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	70.00
	07100 AMBULANCE	0					71.00
	07300 СМНС	0	0		0 0	0	73.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTILIZATION REVIEW - SNF						82.00
83.00 89.00	08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	0 27,677	448, 13	0 0	0 448, 134	
07.00	NONREI MBURSABLE COST CENTERS		21,011	1 440, 10	0	440, 134	09.00
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0 0	0	
	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	1	0 0	0	91.00 92.00
	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
	09400 PATIENTS LAUNDRY	0	0		0 0	0	94.00
	09500 MARKETI NG 09501 CLI NI C	0	0		0 0	0	95.00 95.01
	09501 CLINIC 09502 INDEPENDENT LIVING				0 0	0	1
98.00	Cross Foot Adjustments	0	0		0 0	0	98.00
99.00	Negative Cost Centers	0	0		0 0	0	
100.00	TOTAL	0	27, 677	448, 13	4 0	448, 134	1100.00

	Financial Systems LLOCATION - STATISTICAL BASIS	THE M			eriod:	worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/30/2022 5:0	
		CAPI TAL REI	ATED COSTS			0,00,2022 0.0	
	Cost Center Description	BLDGS & FI XTURES (SQUARE FEET)	MOVABLE EQUI PMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM COST)	
		1.00	2.00	3. 00	4A	4.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	45, 144		1			1 1.
00 00 00 00 00 00 00	00200 CAP REL COSTS - DEDGS & TEXTORES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	43, 144 0 12, 570 2, 052 916 376	45, 144 0 12, 570 2, 052 916	6, 656, 206 711, 978 181, 804 93, 337	-1, 427, 846 0 0	10, 347, 989 630, 861 142, 803 459, 144	2. 3. 4. 5. 6.
00 00 0.00 .00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	5, 136 517 0 0	5, 136 517 0 0	745, 566 807, 218 C	0	1, 384, 369 800, 876 0 0	8. 9. 10. 11.
3.00 1.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	245 247 0 2, 189	247 0	176, 068 C	0	36, 612 223, 316 0 267, 128	14.
. 00 2. 00	03000 SKI LLED NURSI NG FACI LI TY 03100 NURSI NG FACI LI TY 03200 I CF/I I D 03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	18, 467 0 0 0	18, 467 C C C	C C	0 0 0	4, 948, 365 0 0 0	30. 31. 32. 33.
0. 00	04000 RADI OLOGY	0	C	C	0	34, 927	40.
2.00 3.00	04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0 0 1, 972	0 0 0 1, 972		0 0 0 0	21, 718 97, 612 101, 772 636, 269	41. 42. 43.
5.00 7.00 8.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	60 76 0 173	76 0 173		0 0 0 0	596 755 13, 756 206, 267	46 47 48
. 00 . 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	148 0 0					50 51
. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC OTHER REIMBURSABLE COST CENTERS	000	C		000	0	60 61 62
. 00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	000000000000000000000000000000000000000	0 0 0	C	0		71
. 00 . 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 45, 144	C 45, 144	C 6, 656, 206	0 -1, 427, 846	0 10, 347, 989	80 81 82 83 83
	NONREI MBURSABLE COST CENTERS	· ·		1			
. 00 . 00 . 00 . 00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0 0 0 0 0	-			0 0 0 0	91 92 93 94
. 01 . 02 . 00 . 00	09500 MARKETING 09501 CLINIC 09502 INDEPENDENT LIVING Cross Foot Adjustments Negative Cost Centers	0			0	0 0 0	95 95 95 98 98
02.00 03.00 04.00	Part I) Unit cost multiplier (Wkst. B, Part I)	307, 568 6. 813043				1, 427, 846 0. 137983 124, 780	103
)5. 00	Part II)			0. 000000		0. 012058	

Heal th	Financial Systems	THE M	ANOR		In Lie	u of Form CMS-2	2540-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2021	Worksheet B-1	
					o 12/31/2021	Date/Time Pre	
	Cost Center Description	PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/30/2022 5:0 NURSI NG	3 pm
		OPERATI ON,	LINEN SERVICE		(MEALS SERVED)	ADMI NI STRATI ON	
		MAINT. & REPAIRS	(PATIENT DA YS)			(PATI ENT DA	
		(SQUARE FEET)	13)			YS)	
		5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES		1	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	20 522					4.00
5.00 6.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE	30, 522 916					5.00 6.00
7.00	00700 HOUSEKEEPI NG	376		29, 230			7.00
8.00	00800 DI ETARY	5, 136		5, 136	77, 100		8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	517		517	0	25, 700	9.00
10. 00 11. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0	0	0	0	10.00 11.00
	01200 MEDICAL RECORDS & LIBRARY	245	0	245	Ő	0	12.00
	01300 SOCIAL SERVICE	247	0	247	0	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0	0	, i i i i i i i i i i i i i i i i i i i	0	0	14.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	2, 189	0	2, 189	0	0	15.00
30.00	03000 SKILLED NURSING FACILITY	18, 467	25, 700	18, 467	77, 100	25, 700	30.00
	03100 NURSI NG FACI LI TY	0	0	0	0	0	31.00
32.00 33.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0	0		0	0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	0		<u> </u>	<u> </u>	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 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY	0	0	0	0	0	42.00 43.00
44.00	04400 PHYSI CAL THERAPY	1, 972	0	1, 972	0	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	60		60	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	76		76	0	0	46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 173	-	0 173	0	0	47.00 48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	148		148	0	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	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	61.00
62.00							62.00
70 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	70.00
	07100 AMBULANCE	0				0	
	07300 CMHC	0	0	0	0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1					
80. 00 81. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	0	-	0	83.00
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	30, 522	25, 700	29, 230	77, 100	25, 700	89.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
	09100 BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	92.00
93.00 94.00	09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0	0	0	0	0	93.00 94.00
	09500 MARKETI NG	0	0	0	0	0	95.00
95.01	09501 CLI NI C	0	0	0	0	0	95. 01
	09502 I NDEPENDENT LI VI NG	0	0	0	0	0	95.02
98.00 99.00	Cross Foot Adjustments Negative Cost Centers						98.00 99.00
102.00	5	717, 909	184, 052	531, 342	1, 789, 554	932, 941	
	Part I)						
103.00		23. 521034				36. 301206	
104.00	Cost to be allocated (per Wkst. B, Part II)	27,976	11, 655	9, 614	74, 074	15, 433	104.00
105.00		0. 916585	0. 453502	0. 328909	0. 960752	0. 600506	105.00
	11)	I	I	I			I

	Financial Systems LLOCATION - STATISTICAL BASIS	THE MA		No.: 315153 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
CUSTA	ALLOCATION - STATISTICAL DASIS		Provider		rom 01/01/2021	Date/Time Pre	
		051175.4				5/30/2022 5:0	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQ UIS)	RECORDS & LI BRARY (PATI ENT DA YS)	SOCIAL SERVICE (PATIENT DA YS)	ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
		10.00	11.00	12.00	13.00	14.00	
13.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS - BLDGS & FIXTURES O0200 CAP REL COSTS - MOVABLE EQUIPMENT O0300 EMPLOYEE BENEFITS O0400 ADMINISTRATIVE & GENERAL O0500 PLANT OPERATION, MAINT. & REPAIRS O0600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0 0 0 0 0 0 0 0	0 0 0 0 0	25, 700 0 0	25, 700 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	01500 ACTI VI TI ES	0	0	0	0	0	15.00
30. 00 31. 00 32. 00 33. 00	INPATIENT 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	25, 700 0 0 0	25, 700 0 0 0	0 0 0 0	31.00 32.00
	ANCILLARY SERVICE COST CENTERS	1		1			
48.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 04900 DRUGS CHARGED TO PATI ENTS 05000 DENTAL CARE - TI TLE XI X ONLY 05100 SUPPORT SUFFACES 0UTPATI ENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41.00 42.00 43.00 44.00 45.00 46.00 47.00 48.00 49.00 50.00
60.00 61.00	06000 CLINIC 06100 RURAL HEALTH CLINIC	0	0	0	0	0	
	06200 FQHC	0	0	0	0	0	62.00
	OTHER REIMBURSABLE COST CENTERS						
71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0 0 0	0	0 0 0		70.00 71.00 73.00
80. 00 81. 00 82. 00 83. 00 89. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0	0 0		0 25, 700	0	
91.00 92.00 93.00 94.00 95.00 95.01	09400 PATIENTS LAUNDRY 09500 MARKETING 09501 CLINIC 09502 INDEPENDENT LIVING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 264, 430	0 0 0 0 0 0 0 0 0 0	91.00 92.00 93.00 94.00 95.00 95.01
103.00 104.00		0. 000000 0	0. 000000 0	2. 018716 3, 179	10. 289105 5, 452	0. 000000 0	103. 00 104. 00
105.00		0. 000000	0. 000000	0. 123696	0. 212140	0. 000000	105.00

51 AI	Financial Systems LLOCATION - STATISTICAL BASIS	THE MANO	Provi der No. : 315153	Peri od:	u of Form CMS-254 Worksheet B-1
				From 01/01/2021 To 12/31/2021	Date/Time Prepar
				10 12/31/2021	5/30/2022 5:03 p
		OTHER GENERAL			
	Cost Center Description	SERVI CE ACTI VI TI ES			
	COST CENTER DESCRIPTION	(PATIENT DA			
		YS)			
		15.00			
	GENERAL SERVICE COST CENTERS				
	00100 CAP REL COSTS - BLDGS & FIXTURES				
	00200 CAP REL COSTS - MOVABLE EQUIPMENT				
	00300 EMPLOYEE BENEFITS				
	00400 ADMINI STRATI VE & GENERAL				
	00500 PLANT OPERATION, MAINT. & REPAIRS				
	00600 LAUNDRY & LINEN SERVICE				
	00700 HOUSEKEEPI NG				
	00900 NURSI NG ADMI NI STRATI ON				
	01000 CENTRAL SERVICES & SUPPLY				10
					1
	01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE				12
	01400 NURSING AND ALLIED HEALTH EDUCATION				1
	01500 ACTIVITIES	25, 700			1
00	INPATIENT ROUTINE SERVICE COST CENTERS	25,700			
00	03000 SKILLED NURSING FACILITY	25, 700			30
	03100 NURSI NG FACILITY	20, 700			3
	03200 CF/I D	Ö			3
	03300 OTHER LONG TERM CARE	0			3
	ANCI LLARY SERVI CE COST CENTERS				
	04000 RADI OLOGY	0			40
00	04100 LABORATORY	0			4
00	04200 I NTRAVENOUS THERAPY	O			42
	04300 OXYGEN (INHALATION) THERAPY	0			4
	04400 PHYSI CAL THERAPY	0			4.
	04500 OCCUPATI ONAL THERAPY	0			4
	04600 SPEECH PATHOLOGY	0			4
	04700 ELECTROCARDI OLOGY	0			4
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			4
	04900 DRUGS CHARGED TO PATIENTS	0			4
	05000 DENTAL CARE - TITLE XIX ONLY	0			50
	05100 SUPPORT_SURFACES OUTPATI ENT_SERVI CE_COST_CENTERS	0			
	06000 CLINIC	0			60
	06100 RURAL HEALTH CLINIC	0			6
	06200 FQHC	Ŭ			6
	OTHER REIMBURSABLE COST CENTERS				
	07000 HOME HEALTH AGENCY COST	0			70
	07100 AMBULANCE	0			7
	07300 CMHC	0			7
	SPECIAL PURPOSE COST CENTERS				
00	08000 MALPRACTICE PREMIUMS & PAID LOSSES				8
	08100 INTEREST EXPENSE				8
	08200 UTILIZATION REVIEW - SNF				8
	08300 HOSPI CE	0			8
00	SUBTOTALS (sum of lines 1-84)	25, 700			
	NONREI MBURSABLE COST CENTERS				
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90
	09100 BARBER AND BEAUTY SHOP	0			9
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	o			92
	09400 PATIENTS LAUNDRY	0			9
	09500 MARKETI NG	0			9
	09501 CLINIC	0			9
	09502 INDEPENDENT LIVING	0			9
00	Cross Foot Adjustments	ő			9
00	Negative Cost Centers				9
2.00	Cost to be allocated (per Wkst. B,	395, 267			10:
	Part I)				
	Unit cost multiplier (Wkst. B, Part I)	15. 380039			10
3.00					
3.00 4.00	Cost to be allocated (per Wkst. B,	27, 677			10
	Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part	27, 677			10

Health Financial Systems THE MANOR		In Lie	u of Form CMS-2	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS		Period:	Worksheet C	
		rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/30/2022 5:0	pared: 3_pm
Cost Center Description	Total (from	Total Charges		
	Wkst. B, Pt I,		di vi ded by	
	col. 18)	0.00	<u>col. 2</u>	
	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS	20.74	10.0(/	0.000705	10.00
40. 00 04000 RADI OLOGY	39, 746			
	24, 715		0.070013	
42.00 04200 I NTRAVENOUS THERAPY	111, 08			
43.00 O4300 OXYGEN (INHALATION) THERAPY	115, 815		0.00000	
44. 00 04400 PHYSI CAL THERAPY	806, 293		0. 422923	
45. 00 04500 OCCUPATI ONAL THERAPY	3, 180			
46.00 O4600 SPEECH PATHOLOGY	4, 029			
47.00 04700 ELECTROCARDI OLOGY	15, 654			
48. 00 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	241, 942		1.000182	
49.00 04900 DRUGS CHARGED TO PATIENTS	270, 465	5 141, 065	1.917308	
50.00 05000 DENTAL CARE - TITLE XIX ONLY		0 0	0.00000	
51.00 O5100 SUPPORT SURFACES	85, 026	0	0.00000	51.00
OUTPATIENT SERVICE COST CENTERS				
60. 00 06000 CLINIC	(0 0	0.00000	
61.00 06100 RURAL HEALTH CLINIC				61.00
62. 00 06200 FQHC				62.00
71. 00 07100 AMBULANCE	38, 554		0.00000	
100. 00 Total	1, 756, 500	6, 274, 720		100. 00

Health Financial Systems	THE M			In Lie	u of Form CMS-2	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period:	Worksheet D	
				From 01/01/2021 To 12/31/2021		narod
				10 12/31/2021	5/30/2022 5:0	
		Title	XVIII (1)	Skilled Nursing	PPS	
			. ,	Facility		
		Health Care Pr	rogram Charges	Health Care	Program Cost	
Cost Center Description	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	<u>Column 3)</u> 1.00	2.00	3.00	4,00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT		2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	TENT COST					
40. 00 04000 RADI OLOGY	2. 000705	16, 915		0 33, 842	0	40.00
41. 00 04100 LABORATORY	0. 070013			0 24, 715		
42.00 04200 I NTRAVENOUS THERAPY	3, 332963			0 21,710	0	
43.00 04300 0XYGEN (INHALATION) THERAPY	0. 000000			0 0	0	
44. 00 04400 PHYSI CAL THERAPY	0. 422923			482, 995	0	
45.00 04500 OCCUPATI ONAL THERAPY	0.001273			0 1,770		45.00
46.00 04600 SPEECH PATHOLOGY	0.003730	703, 666		0 2,625	0	46.00
47.00 04700 ELECTROCARDI OLOGY	73. 492958			0 15, 654	0	47.00
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.000182	0		0 0	0	48.00
49.00 04900 DRUGS CHARGED TO PATIENTS	1. 917308	125, 914		0 241, 416	0	49.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000	0		0		50.00
51.00 05100 SUPPORT SURFACES	0. 000000	0		0 0	0	51.00
OUTPATIENT SERVICE COST CENTERS						
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61.00 06100 RURAL HEALTH CLINIC						61.00
62.00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 000000			0		71.00
100.00 Total (Sum of lines 40 - 71)		3, 732, 306		0 803, 017	0	100. 00
(1) For title V and VIV upp columns 1 2 and 4 and						

(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	THE MA				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der	No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet D Parts II-III Date/Time Pre 5/30/2022 5:0	
		Titl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of c	ost to charges	(From Workshee	t C, column 3	, line 49)	1.917308	1.00
2.00 Program vaccine charges (From your rec	ords, or the PS&	&R)			0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	viders, transf	er this amour	t to Worksheet	0	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,			Cost (From	& Allied	
		(From Wkst. B,				
	18	Part I, Col. 14)	Costs to Tot Costs - Part		for Pass Through (Col.	
		14)	(Col. 2 / Co		3 x Col. 4)	
					3 X COI. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLI ED HEALTH				
ANCILLARY SERVICE COST CENTERS	1					
40. 00 04000 RADI OLOGY	39, 746	C				
41. 00 04100 LABORATORY	24, 715	C	0.0000			
42. 00 04200 I NTRAVENOUS THERAPY	111, 081	C	0.0000		0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	115, 815	C	0.0000		0	
44. 00 04400 PHYSI CAL THERAPY	806, 293		0.0000			
45. 00 04500 OCCUPATI ONAL THERAPY	3, 180		0.0000			45.00
46. 00 04600 SPEECH PATHOLOGY 47. 00 04700 ELECTROCARDI OLOGY	4,029		0.0000			
47. 00 104700 ELECTROCARDIOLOGY 48. 00 104800 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 654 241, 942		0.0000		0	
48. 00 104800 MEDICAL SUPPLIES CHARGED TO PATIENTS 49. 00 104900 DRUGS CHARGED TO PATIENTS	241, 942		0.0000		-	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	270,405		0.0000		0	
51. 00 105000 DENTAL CARE - TITLE XIX ONET	85, 026		0.0000		0	
100.00 Total (Sum of Lines 40 - 52)	1, 717, 946		0.0000	803, 017	e e e e e e e e e e e e e e e e e e e	
	1,717,740	C	1	000,017	0	1.00.00

OMPUT	ATION OF INPATIENT ROUTINE COSTS	Provider No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Parts I-II Date/Time Pre 5/30/2022 5:0	pare
		Title XVIII	Skilled Nursing Facility	PPS	is pili
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				
	I NPATI ENT DAYS				
. 00	Inpatient days including private room days			25, 700	
. 00	Private room days			0	2.
. 00	Inpatient days including private room days applicable to the F			4, 965	
. 00 . 00	Medically necessary private room days applicable to the Progra	am		10 010 225	4
. 00	Total general inpatient routine service cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			10, 019, 335	+ °
. 00	General inpatient routine service charges			9, 682, 653	6
00	General inpatient routine service cost/charge ratio (Line 5 d	divided by line 6)		1.034772	
00	Enter private room charges from your records	a n aba by 1116 b)		0	
00	Average private room per diem charge (Private room charges lir	ne 8 divided by private	room days, line	0.00	
	2)	51	<u> </u>		
	Enter semi-private room charges from your records			0	
1.00	Average semi-private room per diem charge (Semi-private room	charges line 10, divide	d by	0.00	11
	semi-private room days)			0.00	1 4 0
	Average per diem private room charge differential (Line 9 minu			0.00	
3.00 4.00	Average per diem private room cost differential (Line 7 times Private room cost differential adjustment (Line 2 times line 7			0.00	14
	General inpatient routine service cost net of private room cost		minus line 14)	10, 019, 335	
5.00	PROGRAM INPATIENT ROUTINE SERVICE COSTS			10, 017, 333	1 '
6.00	Adjusted general inpatient service cost per diem (Line 15 div	vided by line 1)		389, 86	1 16
	Program routine service cost (Line 3 times line 16)			1, 935, 655	17
B. 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 (Line 17	7 plus line 18)		1, 935, 655	19
0. 00	Capital related cost allocated to inpatient routine service co line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	osts (From Wkst. B, Par	t II column 18,	403, 455	20
1.00	Per diem capital related costs (Line 20 divided by line 1)			15.70	21
2. 00	Program capital related cost (Line 3 times line 21)			77, 951	22
3. 00				1, 857, 704	
	Aggregate charges to beneficiaries for excess costs (From pro			0	24
	1 5	t limitation (Line 23 mi	nus line 24)	1, 857, 704	
6.00	Enter the per diem limitation (1)				26
7.00					27
8.00	Reimbursable inpatient routine service costs (Line 22 plus th				

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

		1.00	
	PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00	Total SNF inpatient days	25, 700	1.00
2.00	Program inpatient days (see instructions)	4, 965	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. 193191	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

	Financial Systems TI ATION OF INPATIENT ROUTINE COSTS	HE MANOR Provider No.: 315153	Peri od:	u of Form CMS-2 Worksheet D-1	
COMION	COSTS	11001dei 110 313133	From 01/01/2021	Parts I-II	
			To 12/31/2021	Date/Time Prep 5/30/2022 5:03	
		Title XIX	Skilled Nursing Facility	PPS	0 pm
			Facility		
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				-
	Inpatient days including private room days			25, 700	1 1.
	Private room days			0	2
	Inpatient days including private room days applicable 1	o the Program		11, 725	
. 00	Medically necessary private room days applicable to the	e Program		0	4.
	Total general inpatient routine service cost	-		10, 019, 335	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges			9, 682, 653	
	General inpatient routine service cost/charge ratio (L	ine 5 divided by line 6).		1.034772	
	Enter private room charges from your records			0	8
. 00	Average private room per diem charge (Private room char	ges line 8 divided by private	room days, line	0.00	9
0. 00	2) Enter semi-private room charges from your records			0	10
	Average semi-private room per diem charge (Semi-privat	e room charges line 10, divide	ed by	0.00	
	semi-private room days)	5			
2.00	Average per diem private room charge differential (Line	e 9 minus line 11)		0.00	12
	Average per diem private room cost differential (Line 7			0.00	13
	Private room cost differential adjustment (Line 2 times			0	14
	General inpatient routine service cost net of private r	room cost differential (Line 5	minus line 14)	10, 019, 335	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS			200.04	
	Adjusted general inpatient service cost per diem (Line	15 divided by line 1)		389.86	
	Program routine service cost (Line 3 times line 16) Medically necessary private room cost applicable to pro	area (line (times line 12)		4, 571, 109	17
	Total program general inpatient routine service cost (0 4, 571, 109	
	Capital related cost allocated to inpatient routine service cost		t II column 18	4, 371, 109	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/III		t II cordinii Io,	403, 433	
	Per diem capital related costs (Line 20 divided by lir			15.70	21
2.00	Program capital related cost (Line 3 times line 21)			184, 083	22
	Inpatient routine service cost (Line 19 minus line 22)			4, 387, 026	23
	Aggregate charges to beneficiaries for excess costs (F			0	24
	Total program routine service costs for comparison to t	the cost limitation (Line 23 mi	nus line 24)	4, 387, 026	
	Enter the per diem limitation (1)			0.00	
	Inpatient routine service cost limitation (Line 3 times			0	27
	Reimbursable inpatient routine service costs (Line 22 p		line 27)	4, 571, 109	28
	(Transfer to Worksheet E, Part II, line 4) (See instructions 26 and 27 are not applicable for title XVIII, but more				1

(Transfer to Worksheet E, Part II, line 4) (See instructions) (1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

	1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1.00 Total SNF inpatient days	25, 700	1.00
2.00 Program inpatient days (see instructions)	11, 725	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. 456226	4.00
5.00 Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Health Financial Systems	THE MANOR		In Lie	u of Form CMS-2	2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE X	/111	Provider No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part I Date/Time Pre 5/30/2022 5:03	
		Title XVIII	Skilled Nursing Facility	PPS	5 pm
				1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPU	TATION OF RELMBURS	EMENT		1.00	
1.00 Inpatient PPS amount (See Instructions)	TATION OF REIMBORS			3, 420, 935	1.00
2.00 Nursing and Allied Health Education Activitie	es (pass through pa	vments)		0, 120, 700	
3.00 Subtotal (Sum of Lines 1 and 2)	- (p=== 1 ==9 p=	J		3, 420, 935	
4.00 Primary payor amounts				0	4.00
5.00 Coi nsurance				359, 870	
6.00 Allowable bad debts (From your records)				79, 213	
7.00 Allowable Bad debts for dual eligible benefic	iaries (See instru	ctions)		0	
8.00 Adjusted reimbursable bad debts. (See instru	•			51, 488	8.00
9.00 Recovery of bad debts - for statistical recor				0	
10.00 Utilization review	J			0	10.00
11.00 Subtotal (See instructions)				3, 112, 553	
12.00 Interim payments (See instructions)				3, 061, 065	
13.00 Tentative adjustment				0	
14.00 OTHER adjustment (See instructions)				0	14.00
14.50 Demonstration payment adjustment amount befor	e sequestration			0	14.50
14.55 Demonstration payment adjustment amount after	sequestration			0	14.55
14.75 Sequestration for non-claims based amounts (s	ee instructions)			0	14.75
14.99 Sequestration amount (see instructions)				0	14.99
15.00 Balance due provider/program (see Instruction	ıs)			51, 488	15.00
16.00 Protested amounts (Nonallowable cost report i	tems in accordance	with CMS Pub. 15-2, s	ection 115.2)	0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REI	MBURSEMENT LESSER	OF COST OR CHARGES - T	ITLE XVIII ONLY		
17.00 Ancillary services Part B				0	17.00
18.00 Vaccine cost (From Wkst D, Part II, line 3)				0	18.00
19.00 Total reasonable costs (Sum of lines 17 and 1	8)			0	19.00
20.00 Medicare Part B ancillary charges (See instru				0	
21.00 Cost of covered services (Lesser of line 19 o	r line 20)			0	
22.00 Primary payor amounts				0	
23.00 Coinsurance and deductibles				0	
24.00 Allowable bad debts (From your records)				11, 654	
24.01 Allowable Bad debts for dual eligible benefic		ctions)		0	
24.02 Adjusted reimbursable bad debts (see instruc				7, 575	
25.00 Subtotal (Sum of lines 21 and 24, minus lines	; 22 and 23)			7, 575	
26.00 Interim payments (See instructions)				0	
27.00 Tentative adjustment				0	
28.00 Other Adjustments (See instructions) Specify				0	
28.50 Demonstration payment adjustment amount befor	•			0	
28.55 Demonstration payment adjustment amount after	sequestrati on			0	
28.99 Sequestration amount (see instructions)				0	
29.00 Balance due provider/program (see instruction				7, 575	
30.00 Protested amounts (Nonallowable cost report i	tems) in accordanc	e with CMS Pub.15-2, s	section 115.2	0	30.00

Health Financial Systems	THE MANOR		In Lie	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	TITLE V and TITLE XIX ONLY	Provider No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part II Date/Time Prepared: 5/30/2022 5:03 pm

				5/30/2022 5:0	3 pm
		Title XIX	Skilled Nursing Facility	PPS	
			Facility		
				1.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient ancillary services (see Instructions)		0	1.00	
2.00	Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line	5)		0	2.00
3.00	Outpatient services			0	3.00
4.00	Inpatient routine services (see instructions)			4, 571, 109	4.00
5.00	Utilization reviewphysicians' compensation (from provider rec	ords)		0	5.00
6.00	Cost of covered services (Sum of lines 1 - 5)			4, 571, 109	6.00
7.00	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
8.00	SUBTOTAL (Line 6 minus line 7)			4, 571, 109	8.00
9.00	Primary payor amounts			0	9.00
	Total Reasonable Cost (Line 8 minus line 9)			4, 571, 109	10.00
	REASONABLE CHARGES				
	Inpatient ancillary service charges			0	11.00
	Outpatient service charges			0	
	Inpatient routine service charges			0	
	Differential in charges between semiprivate accommodations and	less than semiprivate	accommodations	0	
	Total reasonable charges			0	15.00
	CUSTOMARY CHARGES		1		
	Aggregate amount actually collected from patients liable for pay			0	
17.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	17.00
10.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	10.00
	Ratio of line 16 to line 17 (not to exceed 1.000000)			0.00000	
19.00	Total customary charges (see instructions)			0	19.00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20 00
20. 00 21. 00	Cost of covered services (see Instructions) Deductibles			0	
				0	
	Subtotal (Line 20 minus line 21) Coinsurance			0	
	Subtotal (Line 22 minus line 23)			0	
	Allowable bad debts (from your records)			0	
26.00	Subtotal (sum of lines 24 and 25)			0	
	Unrefunded charges to beneficiaries for excess costs erroneously	v collected based on c	orrection of	0	
27.00	cost limit	y confected based on c		0	27.00
28.00	Recovery of excess depreciation resulting from provider termina	tion or a decrease in	program	0	28.00
20.00	utilization		pi ogi alli	0	20.00
29.00	Other Adjustments (see instructions) Specify			0	29.00
	Amounts applicable to prior cost reporting periods resulting fro	om disposition of depr	eciable assets (0	
	if minus, enter amount in parentheses)			-	
31.00	Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 1	27 and 28)		0	31.00
32.00	Interim payments			0	32.00
	Balance due provider/program (Line 31 minus line 32) (indicate	overpayments in parent	heses) (see	0	33.00
33.00					

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No.: 315153		Period: From 01/01/2021 To 12/31/2021		pare
		Ti tl	e XVIII	Skilled Nursing Facility		<u>o piii</u>
		I npati en	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 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		3, 061, C	0 0	0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program		1	-	-	
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
52 53				0	0	
53 54				0	0	
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50			0	0	3
,,				0	Ĭ	
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)		3, 061, C	165	0	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
01	Program to Provider TENTATIVE TO PROVIDER		1	0	0	5
)2	ILIVIALIVE TO PROVIDER			0	0	
)2)3				0		
	Provider to Program		1	-		1
0	TENTATI VE TO PROGRAM			0	0] 5
51				0	0	
52				0	0	
99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	5
00	- 5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	PROGRAM TO PROVIDER		51, 4	88	7, 575	6
)2	PROVIDER TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		3, 112, 5		7, 575	7
			Contr	actor Name	Contractor	
				1 00	Number	
				1.00	2.00	

 8.00
 Name of Contractor

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

nd-ty	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the "General Fund" column	Provi der		Period: From 01/01/2021 To 12/31/2021	Worksheet G Date/Time Pre	nar
y)		General Fund	Speci fi c	Endowment Fund	5/30/2022 5:0	13 p
			Purpose Fund			
	Assets	1.00	2.00	3.00	4.00	-
ł	CURRENT ASSETS	1	[1
00	Cash on hand and in banks	2, 715, 000		0 0	0	
00	Temporary investments Notes receivable	8, 867, 000		0 0	0	
0	Accounts receivable	1, 090, 000			0	
	Other receivables	0		0 0	0	
00	Less: allowances for uncollectible notes and accounts	0		0 0	0	
	recei vabl e					
00	Inventory Prepaid expenses	0			0	
	Other current assets	113,000			0	
	Due from other funds	0		0 0	0	
00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	12, 785, 000		0 0	0	1
	FIXED ASSETS	1				4
	Land	0		0 0	0	
	Land improvements Less: Accumulated depreciation	0		0 0	0	
	Buildings	0		0 0	0	
00	Less Accumulated depreciation	0		0 0	0	
	Leasehold improvements	2, 566, 000		0 0	0	1
	Less: Accumulated Amortization	0		0 0	0	
	Fixed equipment	0		0 0	0	
	Less: Accumulated depreciation Automobiles and trucks	0			0	
	Less: Accumulated depreciation	0			0	
	Major movable equipment	0		0 0	0	
	Less: Accumulated depreciation	0		0 0	0	2
	Minor equipment - Depreciable	0		0 0	0	
	Minor equipment nondepreciable	0		0 0	0	
	Other fixed assets TOTAL FIXED ASSETS (Sum of lines 12 - 27)	2, 566, 000		0 0 0 0	0	
	OTHER ASSETS	2, 300, 000		<u> </u>	0	- 2'
	Investments	0		0 0	0	2
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets TOTAL OTHER ASSETS (Sum of lines 29 - 32)	87,000 87,000		0 0	0	-
	TOTAL ASSETS (Sum of Lines 11, 28, and 33)	15, 438, 000		0 0	0	
	Liabilities and Fund Balances	10, 100, 000		<u> </u>		ľ
	CURRENT LI ABI LI TI ES					
	Accounts payable	1, 606, 000		0 0	0	
	Salaries, wages, and fees payable	0		0 0	0	
	Payroll taxes payable Notes & loans payable (Short term)	0		0 0 0 0	0	1 ×
	Deferred income	0		0 0	0	
	Accelerated payments	0			-	4
00	Due to other funds	0		0 0	0	
	Other current liabilities	1, 537, 000		0 0	0	
00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42) LONG TERM LIABILITIES	3, 143, 000		0 0	0	4
00	Mortgage payable	0		0 0	0	4
	Notes payable	0		0 0	0	
	Unsecured Loans	0		0 0	0	4
	Loans from owners:	0		0 0	0	
	Other long term liabilities	0		0 0	0	
	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0			0	
	TOTAL LIABILITIES (Sum of Lines 43 and 50)	3, 143, 000		0 0	0	
+	CAPI TAL ACCOUNTS		I	-1 -1	-	1
	General fund balance	12, 295, 000				5
	Specific purpose fund			0		5
	Donor created - endowment fund balance - restricted			0		5
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		5
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				-	
	TOTAL FUND BALANCES (Sum of Lines 52 thru 58)	12, 295, 000		0 0	0	
00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	15, 438, 000		0 0	0	60

Health Financial Systems	THE MAN	THE MANOR In Lieu of				
STATEMENT OF CHANGES IN FUND BALANCES	_		No.: 315153	Period: From 01/01/2021 To 12/31/2021	Worksheet G-1 Date/Time Pre 5/30/2022 5:0	pared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	2 00	4.00	E 00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 33.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments)5.00.006.00.007.00.008.00.009.0010.0010.00Total additions (sum of line 5 - 9)11.00Subtotal (line 3 plus line 10)Deductions (debit adjustments)13.0014.0015.0016.0017.0018.00Total deductions (sum of lines 13 - 17)19.00Fund balance at end of period per balance	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 14,312,000 -2,017,000 12,295,000 12,295,000 12,295,000 12,295,000	3.00	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	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
sheet (Line 11 - Line 18)						17.00
	Endowment Fund	Pl ant				
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 3 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) 5.00 6.00 7.00 8.00 9.00	-	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 10.00 Total additions (sum of line 5 - 9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 13 - 17) 19.00 Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0	0 0 0 0 0		0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems	THE MANOR				In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315153		eriod: com 01/01/2021	Worksheet G-2 Parts I-II Date/Time Prep 5/30/2022 5:00	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			9,045,00	20		9, 045, 000	1.00
2.00	NURSING FACILITY			7,043,00	0		9, 043, 000	2.00
2.00	ICF/IID				0		0	3.00
	OTHER LONG TERM CARE				0		-	
4.00				0.045.0	0		0	4.00
5.00	Total general inpatient care services (Sum of	lines 1 - 4)		9, 045, 00	00		9, 045, 000	5.00
	All Other Care Services			1				
6.00	ANCI LLARY SERVI CES				0	0	0	6.00
7.00	CLINIC					0	0	7.00
8.00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9.00
10.00	RURAL HEALTH CLINIC					0	0	10.00
10. 10	FQHC					0	0	10. 10
11.00	СМНС					0	0	11.00
12.00	HOSPICE				0	0	0	12.00
13.00	OTHER (SPECI FY)				0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3	to	9, 045, 00	20	0	9, 045, 000	
14.00	Worksheet G-3, Line 1)		10	9,045,00	50	0	9,045,000	14.00
	Cost Center Description							
	obst ochter beschiption				F	1.00	2.00	
	PART II - OPERATING EXPENSES					1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, L	ing 100)			1		12, 282, 000	1.00
2.00		The TOO)				0	12, 202, 000	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
13.00						0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)					0	0	14.00
14.00	Total Operating Expenses (Sum of Lines 1 and 8	minus lino 14)					12, 282, 000	
13.00	The starting expenses (sum of times I dilu o	, minus inte 14)			I	I	12, 202, 000	15.00

Heal th	Financial Systems	THE MANOR			In Lie	u of Form CMS-2	2540-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provi der	No.: 315153	Period: From 01/01/2021	Worksheet G-3	
					To 12/31/2021	Date/Time Pre 5/30/2022 5:03	
						1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,	col. 3, line 1	4)			9,045,000	1.00
2.00	Less: contractual allowances and discounts on pat	ients accounts				0	2.00
3.00	Net patient revenues (Line 1 minus line 2)					9,045,000	3.00
4.00	Less: total operating expenses (From Worksheet G-	2, Part II, li	ne 15)			12, 282, 000	4.00
5.00	Net income from service to patients (Line 3 minus	5 4)				-3, 237, 000	5.00
	Other income:						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					885, 000	7.00
8.00	Revenues from communications (Telephone and Inte	ernet service)				0	8.00
9.00	Revenue from television and radio service					0	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					0	13.00
14.00	Revenue from meals sold to employees and guests					0	14.00
15.00	Revenue from rental of living quarters					0	15.00
16.00	Revenue from sale of medical and surgical supplie	es to other tha	n patients	5		0	16.00
17.00	Revenue from sale of drugs to other than patients	5				0	17.00
18.00	Revenue from sale of medical records and abstract	S				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)					0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	1				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	Other miscellaneous revenue (specify)					335, 000	24.00
24.50	COVI D-19 PHE Funding					0	24.50
25.00	Total other income (Sum of lines 6 - 24)					1, 220, 000	25.00
26.00	Total (Line 5 plus line 25)					-2,017,000	26.00
27.00	Other expenses (specify)					0	27.00
28.00						0	28.00
29.00						0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)					0	30.00
31.00	Net income (or loss) for the period (Line 26 minu	ıs line 30)				-2, 017, 000	31.00