	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 HEA EPORT CERTIFICATION AND SETTLEMENT SUMMARY	LTH CARE	Provider CCN: 315153	From 01/01/2022	Vorksheet S Parts I, II & III Date/Time Prepared: 5/27/2023 9:31 am
PART I - COST	REPORT STATUS				
Provi der use only	1. [X] Electronically prepared cost rep 2. [] Manually prepared cost report 3. [0] If this is an amended report ent 3.01 [] No Medicare Utilization. Enter '	ter the numbe		Date: 5/27/20 r resubmitted thi	
Contractor use only	 4. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 5. Date Received: 	8.[N] Last 9.NPR Date: 10.[0]IfI 11.Contracto 12.[F] Medi	No. t Cost Report for this Cost Report for this ine 4, column 1 is "4" r Vendor Code care Utilization. Ente no utilization.	Provider CCN : Enter number of _ <u>4</u>	

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 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Lau	ra Schilare	Ť	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	Laura Schilare			2
3	Signatory Title	VP FINANCE			3
4	Date	(Dated when report is electronica			4

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	Title XIX	
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	73, 886	4, 081	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	73, 886	4, 081	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.

I LLE	Financial Systems D NURSING FACILITY AND SKILLED NURSING FACILITY HEAL	THE MANOR TH CARE	Provi der M	No.: 315153	Peri od:		Workshe		2540-1 2
	X INDENTIFICATION DATA				From 01/01, To 12/31,		Part I Date/Ti		
	1.00	2.00		3.00			5/27/20	<u>JZ3 9:3</u>	
	Skilled Nursing Facility and Skilled Nursing Facili		ddress:	0100					
	Street: 689 WEST MAIN STREET PO Box:								1.0
00	City: FREEHOLD State:	NJ	Zip Code: (07728					2.0
00	County: MONMOUTH CBSA Co	ode: 35154	Urban/Rura	al:U					3.0
01	CBSA Co	ode:							3.0
		Compo	nent Name	Provi der		Payme	ent Syst		
				CCN	Certified		0, or N		4
						V	XVIII	-	
	CNE and CNE Deced Component I don't fire the		1.00	2.00	3.00	4.00) 5.00	6.00	-
	SNF and SNF-Based Component Identification:	THE MANOR		215152	02/10/1974	N	Р	P	1 1 0
		THE WANUK		315153	02/10/19/4		P	P	4.0
	Nursing Facility ICF/IID					-			6.0
	SNF-Based HHA								7.0
	SNF-Based RHC								8.0
	SNF-Based FQHC								9.0
	SNF-Based CMHC								10.0
	SNF-Based OLTC								11.0
	SNF-Based HOSPICE								12.0
	SNF-Based CORF								13.0
55				<u> </u>	From		То)·	13.1
					1.00		2.0		1
00	Cost Reporting Period (mm/dd/yyyy)				01/01/2		12/31		14.0
	Type of Control (See Instructions)						HEALTHC		15.0
							SYSTEM		
							Y/	'N	
							1. (00	1
	Type of Freestanding Skilled Nursing Facility								
00	Is this a distinct part skilled nursing facility that	at meets the	requi remen	ts set forth	in 42 CFR		Ν	1	16.
	section 483.5?								
00	Is this a composite distinct part skilled nursing fa	acility that	meets the	requirements	set forth	in	N	1	17.
	42 CFR section 483.5?								
	Are there any costs included in Worksheet A that res	sulted from ⁻					l Y	/	18. (
							1		10.
	organizations as defined in CMS Pub. 15-1, chapter 1						I		10.0
	Miscellaneous Cost Reporting Information	10? If yes,	complete W	orksheet A-8	-1.				
00	Miscellaneous Cost Reporting Information If this is a low Medicare utilization cost report, i	10? If yes, ndicate with	complete W	orksheet A-8 r yes, or "N	-1. " for no.		N	1	19.0
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Heal th	Financial Systems	THE MANOR		In Lie	u of Form CMS	-2540-10
	D NURSING FACILITY AND SKILLED NURSING	FACILITY HEALTH CARE	Provi der No.: 315153		Worksheet S-	2
COMPLE	X INDENTIFICATION DATA			From 01/01/2022 To 12/31/2022	Part I Date/Time Pr	epared:
					5/27/2023 9:	
					Y/N	
					1.00	
42.00	Are malpractice premiums and paid losse	es reported in other than	the Administrative a	nd General cost	N	42.00
	center? Enter Y or N. If yes, check box	k, and submit supporting s	schedule listing cost	centers and		
	amounts.					
	Are there any home office costs as defi				N	43.00
44.00	If line 43 is yes, enter the home offic	ce chain number and enter	the name and address	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 nam	e and address of the	home office on the	lines	
	bel ow.					
45.00	Name:	Contractor's Name:	Contrac	ctor's Number:		45.00
46.00	Street:	PO Box:				46.00
47.00	Ci ty:	State:	Zip Coo	le:		47.00

	ED NURSING FACILITY AND SKILLED NURSING FACILI	TY HEALTH CARE Pr	rovi der		Peri od:	Worksheet S-2	2
MPL	EX REIMBURSEMENT QUESTIONNALRE				From 01/01/2022 To 12/31/2022	Date/Time Pre	epareo
					Y/N	5/27/2023 9:3 Date	
					1.00	2.00	
	General Instruction: For all column 1 respons responses the format will be (mm/dd/yyyy) Completed by All Skilled Nursing Facilites Provider Organization and Operation	ses enter in column 1,	"Y" foi	r Yes or "N"	for No. For all	the date	-
00	Has the provider changed ownership immediatel reporting period? If column 1 is "Y", enter instructions)	y prior to the beginn the date of the change	ning of e in col	the cost umn 2. (see	N		1.
	· · · · · · · · · · · · · · · · · · ·			Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program?	2 I f	1.00 N	2.00	3.00	2.
00	column 1 is yes, enter in column 2 the date of						2.
00	3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or the relationships? (see instructions)	, chain home offices, d to the provider or i , or members of the b	drug ts poard	Ν			3.
				Y/N	Туре	Date	
	Cinematical Data and Demonstra			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepa Accountant? (Y/N) Column 2: If yes, enter "A" Compiled, or "R" for Reviewed. Submit complet available in column 3. (see instructions) If Are the cost report total expenses and total	' for Audited, "C" for te copy or enter date no, see instructions. revenues different fr	- -om	Y	A	04/17/2023	4.
	those on the filed financial statements? If a reconciliation.	column 1 is "Y", submi	t				
					Y/N	Legal Oper.	
					1.00	2.00	
0	Approved Educational Activities						
00	Column 1: Were costs claimed for Nursing Scho	ool? (Y/N) Column 2:	Is the	provider the	Ν	N	6.
00	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 instructi ng the cost reporting	ons.		N N N	N	7
00	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 instructi ng the cost reporting	ons.		N	N Y/N 1.00	6. 7. 8.
00	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 instructi ng the cost reporting se instructions.	ons. period	for Nursing	N	Y/N	7.8
00 00	Iegal 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) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt	s? (Y/N) see instructing the cost reporting e instructions.	ons. period	for Nursing	NN	Y/N 1.00	7.
00 00 00 00	I egal 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 Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy.	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch	ons. period	for Nursing ns. ring this cos	N N t reporting	Y/N 1.00 Y N	7. 8. 9. 10.
00 00 00 00	Iegal 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) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debt	s? (Y/N) see instructing the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch	ons. period	for Nursing ns. ring this cos	N N t reporting	Y/N 1.00 Y	7. 8. 9. 10.
	Iegal 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 bad If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and	s? (Y/N) see instructi ng the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru	N N N t reporting ructions.	Y/N 1.00 Y N N	7.
	I egal 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) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instructing the cost reporting e instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru ", see instru Pa	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 Y N N Part B	7. 8. 9. 10. 11.
	I egal 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) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instructi ng the cost reporting ee instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru	N N N t reporting ructions.	Y/N 1.00 Y N N	7. 8. 9. 10. 11.
0 0 00 00 00 00	I egal 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) set Bad Debts Is the provider seeking reimbursement for bac If line 9 is "Y", did the provider's bad debr period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement	s? (Y/N) see instructing the cost reporting e instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N	N N N N N N N N N N N N N N N N N N N	Y/N 1.00 Y N N Part B Y/N	7 8 9 10 11 12
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debinering? period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used	s? (Y/N) see instructing the cost reporting e instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00	N N N St reporting Suctions. Art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00	7 8 9 10 11 12 13
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used t	s? (Y/N) see instructing the cost reporting e instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru Pa Y/N 1.00 Y	N N N St reporting Suctions. Art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y	7 8 9 10 11 12 13 13
	Iegal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for bad If line 9 is "Y", did the provider's bad debiperiod? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report	s? (Y/N) see instructing the cost reporting e instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00 Y	N N N St reporting Suctions. Art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y N	7. 8. 9. 10. 11.
	I egal operator of the program? (Y/N) Were costs claimed for Allied Health Programs Were approvals and/or renewals obtained during School and/or Allied Health Program? (Y/N) set Bad Debts Is the provider seeking reimbursement for back If line 9 is "Y", did the provider's bad debric period? If "Y", submit copy. If line 9 is "Y", are patient deductibles and Bed Complement Have total beds available changed from prior PS&R Data Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.) Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4. If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions. If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	s? (Y/N) see instructing the cost reporting e instructions. d debts? (Y/N) see ins t collection policy ch d/or coinsurance waive cost reporting period Description	ons. period struction nange du	for Nursing ns. ring this cos Y", see instru ", see instru Pa Y/N 1.00 Y N	N N N St reporting Suctions. Art A Date 2.00	Y/N 1.00 Y N N Part B Y/N 3.00 Y N N	7 8 9 10 11 12 13 13 14

Health Financial Systems	THE MANOR		In Lie	u of Form CMS-	2540-10
SKILLED NURSING FACILITY AND SKILLED NURSING FACI	LITY HEALTH CARE	Provider No.: 315153	Period:	Worksheet S-2	
COMPLEX REIMBURSEMENT QUESTIONNAIRE			From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narod
			10 12/31/2022	5/27/2023 9:3	1 am
		1.00	2.0	00	
Cost Report Preparer Contact Information					
19.00 Enter the first name, last name and the ti		LA	CAI RNS		19.00
held by the cost report preparer in column	ns 1, 2, and 3,				
respecti vel y.					
20.00 Enter the employer/company name of the cos		RASTATE HEALTHCARE			20.00
preparer.	SYST				
21.00 Enter the telephone number and email addre		294-7017	SCAI RNS@CENTRAS	STATE. COM	21.00
report preparer in columns 1 and 2, respec	cti vel y.				

Heal th	Financial Systems	THE MA	NOR		In Lie	u of Form CMS-	2540-10
	D NURSING FACILITY AND SKILLED NURSING FACILI X REIMBURSEMENT QUESTIONNAIRE	TY HEALTH CARE	Pro	ovider No.: 315153	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/27/2023 9:3	epared:
		Part B					
		Date					
		4.00					
	PS&R Data						
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	07/07/2021					13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.						14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.						15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.						16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:						17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.						18.00
		_					
	Cont. Demont Deserves Contact Lafer 11			3.00			
19.00	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1		MANAGER REI MBURS	SR CARE BUDGET AND E)		19.00
20.00	respectively. Enter the employer/company name of the cost r preparer.	report					20.00
21.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						21.00

SKI LLE	Financial Systems ED NURSING FACILITY AND SKILLED NURSIN	THE MA IG FACI LI TY HEALTH CARE			Period:	u of Form CMS-2 Worksheet S-3	2540-10
COMPLE	EX STATI STI CAL DATA				rom 01/01/2022 To 12/31/2022	Part I Date/Time Prep 5/27/2023 9:31	
				l np	oatient Days/Vis		
	Component	Number of Beds	Bed Days Available	Title V	Title XVIII	Title XIX	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	SKILLED NURSING FACILITY	123	44, 895				1.00
2.00 3.00	NURSING FACILITY	0	0	(0	2.00 3.00
4.00	HOME HEALTH AGENCY COST		0	0	0	0	4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC						6.00
7.00 8.00	HOSPICE Total (Sum of lines 1-7)	0 123	0 44, 895			0 13, 535	7.00 8.00
0.00		Inpatient D			Di scharges	13, 555	0.00
	Comment	Others	- 	T: +1 - 1/			
	Component	0ther 6.00		Title V 8.00	Title XVIII 9.00	Title XIX 10.00	
1.00	SKILLED NURSING FACILITY	8, 156	29, 484	0.00			1.00
2.00	NURSING FACILITY	0	0	0		0	2.00
3.00	ICF/IID	0	0			0	3.00
4.00 5.00	HOME HEALTH AGENCY COST Other Long Term Care	0	0				4.00 5.00
5.00 6.00	SNF-Based CMHC	0	0				5.00 6.00
7.00	HOSPICE	0	0	0	0 0	0	7.00
8.00	Total (Sum of lines 1-7)	8, 156	29, 484	(278		8.00
		Di scha	arges	Ave	rage Length of	Stay	
	Component	Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00	SKILLED NURSING FACILITY NURSING FACILITY	158 0	460 0	0.00		563.96 0.00	1.00 2.00
2.00 3.00		0	0	0.00		0.00	3.00
4.00	HOME HEALTH AGENCY COST		-				4.00
5.00	Other Long Term Care	0	0				5.00
6.00	SNF-Based CMHC		0	0.00	0.00	0.00	6.00
7.00 8.00	HOSPICE Total (Sum of lines 1-7)	158	0 460	0.00			7.00 8.00
0.00		Average Length	100		ssi ons		0.00
	Component	of Stay Total	Title V	Title XVIII	Title XIX	Other	
	component	16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	64. 10	0	308	3 4	150	1.00
2.00	NURSING FACILITY	0.00	0		0	0	2.00
3.00 4.00	ICF/IID HOME HEALTH AGENCY COST	0.00			0	0	3.00 4.00
5.00	Other Long Term Care	0.00				0	5.00
6.00	SNF-Based CMHC						6.00
7.00	HOSPICE	0.00	0				7.00
8.00	Total (Sum of lines 1-7)	64.10 Admissions	O Full Time		3 4	150	8.00
					_		
	Component	Total	Employees on Payroll	Nonpaid Workers			
					-		
		21.00	22.00	23.00			
	SKILLED NURSING FACILITY	462	104.00				1.00
2.00	NURSING FACILITY	462 0	104.00 0.00	0.00 0.00)		2.00
2.00 3.00	NURSING FACILITY ICF/IID	462	104.00 0.00 0.00	0.00 0.00 0.00			2.00 3.00
2.00 3.00 4.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST	462 0 0	104.00 0.00 0.00 0.00	0.00 0.00 0.00 0.00			2.00 3.00 4.00
2.00 3.00 4.00 5.00	NURSING FACILITY ICF/IID	462 0	104.00 0.00 0.00	0.00 0.00 0.00 0.00 0.00			2.00 3.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	NURSING FACILITY ICF/IID HOME HEALTH AGENCY COST Other Long Term Care	462 0 0	104. 00 0. 00 0. 00 0. 00 0. 00	0.00 0.00 0.00 0.00 0.00 0.00 0.00			2.00 3.00 4.00 5.00

SNF WAGE INDEX INFORMATION Provider No. : 315153 Period: Provider No. : 315153 Period: For 01/01/2022 Worksheet S-3 (Do 12/31/2022) Paid Hours (Nage Cell 2) Worksheet S-3 (Do 12/31/2022) PART II - DIRECT SALARIES Adjusted Adjusted Nelated to 32/37/2023 Paid Hours Average Hourly Salary in col. 3 Paid Hours Average Hourly Wage Cell 3 + col. 4) 1.00 1.00 2.00 3.00 4.00 5.00 SALARIES	Heal th	Financial Systems	THE M	ANOR		In Lie	eu of Form CMS-2	2540-10
Reported Salaries from Worksheet A-6 Salaries (col. 3) 1 ± col. 2) Related to Salary in col. Wage (col. 3) col. 4) 1.00 2.00 3.00 4.00 5.00 SALARIES	SNF WA	IGE INDEX INFORMATION				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre 5/27/2023 9:3	pared: <u>1 am</u>
PART 11 - DIRECT SALARIES SALARIES 1.00 2.00 3.00 4.00 5.00 SALARIES								
PART I I - DI RECT SALARI ES			Reported					
PART II - DI RECT SALARIES SALARIES SALARIES SALARIES SALARIES SALARIES 1.00 Total salaries (See Instructions) 6,078,037 0 6,078,037 195,698.00 31.06 1.00 2.00 Physician salaries-Part A 0 0 0 0 0.00 0.00 0.00 2.00 3.00 Physician salaries-Part B 0 0 0 0 0.00 0.00 0.00 2.00 4.00 Mome office personnel 0				Worksheet A-6	1 ± col. 2)	Salary in col. 3	col. 4)	
SALARIES 1.00 Total salaries (se Instructions) 6,078,037 0 6,078,037 195,698.00 31.06 1.00 3.00 Physician salaries-Part A 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 2.00 4.00 Home office personnel 0 0 0 0.00 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 6,078,037 0 6,078,037 195,698.00 31.06 6.00 7.00 Other Long Term Care 0 0 0 0.00 0.00 0.00 0.00 0.00 7.00 0 Differe excluded areas 0 0 0 0.00 0.00 0.00 10.00 11.00 10.00 Other excluded areas 0 0 0 0 0 0.00 0.00 11.00			1.00	2.00	3.00	4.00	5.00	
1.00 Total salaries (See Instructions) 6,078,037 0 6,078,037 195,698.00 31.06 1.00 2.00 Physician salaries-Part A 0 0 0 0.00 0								
2.00 Physician salaries-Part A 0 0 0 0.00 0.00 2.00 3.00 Physician salaries-Part B 0 0 0.00 0.00 0.00 3.00 4.00 Home office personnel 0 0 0.00			1			- 1		
3.00 Phýsician salaries-Part B 0 0 0 0.00 0.00 3.00 4.00 Home office personnel 0 0 0 0.00			6, 078, 037	C	6, 078, 03			
4.00 Home office personnel 0 0 0.00 0.00 0.00 4.00 5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 0.00 0.00 6.00 Revised wages (line 1 minus line 5) 6,078,037 0 6,078,037 195,698.00 31.06 6.00 7.00 Other Long Term Care 0 0 0.00 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.			0	C				
5.00 Sum of lines 2 through 4 0 0 0 0.00 0.00 5.00 6.00 Revised wages (line 1 minus line 5) 6,078,037 0 6,078,037 195,698.00 31.06 6.00 7.00 Other Long Term Care 0 0 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.00 8.00 10.00 HOSEPICE 0 0 0 0.00 0.00 9.00 11.00 Other excluded areas 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus line 6,078,037 0 6,078,037 195,698.00 31.06 13.06 15.00 Contract Labor: Physician services-Part A 0 0 0			0	C				
6.00 Revised wages (line 1 minus line 5) 6,078,037 0 6,078,037 195,698.00 31.06 6.00 7.00 Other Long Term Care 0 0 0 0.00 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 7.00 9.00 CMHC 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0.00 0.00 9.00 11.00 Other excluded areas 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of lines 7 0 0 0 0.00 10.00 12.00 13.00 Total Adjusted Salaries (line 6 minus line 12) 6,078,037 0 6,078,037 195,698.00 31.06 13.00 14.00 Contract Labor: Patient Related & Mgmt 5,275,568 0 5,275,568 66,878.00 78.88 14.00 16.00 Home office salaries & wage related costs 0 0 0 0 0 15.00 </td <td></td> <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td></td>			0	C				
7.00 Other Long Term Care 0 0 0.00 0.00 7.00 8.00 HOME HEALTH AGENCY COST 0 0 0.00 0.00 0.00 8.00 9.00 CMHC 0 0 0 0.00 0.00 9.00 9.00 CMHC 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 11.00 13.00 Total Adjusted Salaries (Line 6 minus Line 6, 078, 037 0 6, 078, 037 195, 698.00 31.06 13.00 12.0 Otheract Labor: Physician services-Part A 0 0 0 0.00 0.00 10.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 15.00 16.00 Wage-related costs core (See Part IV) 1, 988, 596 0<			0	C				
8.00 HOME HEALTH AGENCY COST 0 0 0 0.00 0.00 0.00 8.00 9.00 CMHC 0 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0 0.00 0.00 9.00 11.00 Other excluded areas 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 6,078,037 0 6,078,037 195,698.00 31.06 13.00 14.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0 0.00 16.00 18.00 Wage-rel ated costs core (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 19.00 Wage rel ated			6, 078, 037	C	6, 078, 03			
9.00 CMHC 0 0 0 0.00 0.00 9.00 10.00 HOSPICE 0 0 0 0.00 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 10.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 11.00 13.00 Total Adjusted Salaries (Line 6 minus Line 6.078.037 0 6.078.037 195.698.00 31.06 13.00 12.00 OTHER WAGES & RELATED COSTS			0	C				
10.00 HOSPICE 0 0 0 0.00 0.00 10.00 11.00 Other excluded areas 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 11.00 13.00 Total Adjusted Salaries (Line 6 minus Line 6.078.037 0 6.078.037 195.698.00 31.06 13.00 14.00 Contract Labor: Patient Related & Mgmt 5.275.568 0 5.275.568 66.878.00 78.88 14.00 15.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 15.00 16.00 Wage-related costs core (See Part IV) 1.988.596 0 1.988.596 1.988.596 18.00 19.00 Wage related costs (excluded units) 0 0 0 0 19.00 20.00 Physician Part A - WRC 0 0 0 0 20.00 19.00 22.00 Total Adjusted Wage Related cost (see 1.988.596 0 1.988.596 22.00			0	C				
11.00 Other excluded areas 0 0 0 0.00 0.00 11.00 12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 6,078,037 0 6,078,037 195,698.00 31.06 13.00 0 Other excluded salaries (Line 6 minus Line 6,078,037 0 6,078,037 195,698.00 31.06 13.00 0 Other excluded salaries (Line 6 minus Line 6,078,037 0 6,078,037 195,698.00 31.06 13.00 0 Other excluded salaries (Line 6 minus Line 6,078,037 0 0 0 0 0 0 13.00 0 Other excludes salaries (Line 6 minus Line 6,078,037 0 5,275,568 66,878.00 78.88 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0 0 0 0 0 0 0 16.00 WAGE-RELATED COSTS Tr.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 18.00 <tr< td=""><td></td><td></td><td>0</td><td>C</td><td></td><td></td><td></td><td></td></tr<>			0	C				
12.00 Subtotal Excluded salary (Sum of Lines 7 0 0 0 0.00 0.00 12.00 13.00 Total Adjusted Salaries (Line 6 minus Line 12) 6,078,037 0 6,078,037 195,698.00 31.06 13.00 OTHER WAGES & RELATED COSTS 14.00 O 0 0 0 0.00 0.00 15.00 IS Contract Labor: Physician services-Part A 0 0 0 0.00 16.00 WAGE-RELATED COSTS If NOW Wage-rel ated costs core (See Part IV) 1,988,596 0 1,988,596 16.00 INCO IT.00 Wage-rel ated costs other (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 Interviewed wage related costs 0 0 0 18.00 Interviewed wage Related costs (excluded units) 0			0	C				
through 11) Total Adjusted Salaries (line 6 minus line 6,078,037 0 6,078,037 195,698.00 31.06 13.00 11.00 OTHER WAGES & RELATED COSTS 0 5,275,568 0 5,275,568 66,878.00 78.88 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 16.00 WAGE-RELATED COSTS 11,988,596 0 1,988,596 17.00 16.00 Wage-rel ated costs core (See Part IV) 1,988,596 0 0 0 18.00 19.00 Wage related costs (excluded units) 0 0 0 19.00 19.00 20.00 Physician Part A - WRC 0 0 0 20.00 20.00 20.00 21.00 22.00			0	C				
12) Image: Contract Labor: Patient Related & Mgmt 5, 275, 568 0 5, 275, 568 66, 878.00 78.88 14.00 14.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office sal aries & wage related costs 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 18.00 Wage related costs other (See Part IV) 1,988,596 0 0 0 0 18.00 19.00 Wage related costs (excluded units) 0 0 0 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 22.00 10 stad Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00 22.00	12.00		0	C		0 0.00	0.00	12.00
14.00 Contract Labor: Patient Related & Mgmt 5,275,568 0 5,275,568 66,878.00 78.88 14.00 15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 Wage-related costs (excluded units) 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 21.00 21.00 22.00 Total Adjusted Wage Related cost (see 1, 988, 596 0 1, 988, 596 22.00	13.00		6, 078, 037	C	6, 078, 03	195, 698. 00	31.06	13.00
15.00 Contract Labor: Physician services-Part A 0 0 0 0.00 0.00 15.00 16.00 Home office salaries & wage related costs 0 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 Wage-related costs (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 20.00 20.00 21.00 21.00 21.00 22.00 17.988,596 0 1,988,596 22.00		OTHER WAGES & RELATED COSTS		•			•	
16.00 Home office salaries & wage related costs 0 0 0.00 0.00 16.00 WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 17.00 18.00 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 20.00 21.00 21.00 21.00 22.00 1,988,596 0 1,988,596 22.00 20.00 22.00	14.00	Contract Labor: Patient Related & Mgmt	5, 275, 568	C	5, 275, 56	66, 878. 00	78.88	14.00
WAGE-RELATED COSTS 17.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 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 20.00 20.00 21.00 Potal Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00	15.00	Contract Labor: Physician services-Part A	0	C		0 0.00	0.00	15.00
17.00 Wage-related costs core (See Part IV) 1,988,596 0 1,988,596 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 21.00 21.00 22.00 Total Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00	16.00	Home office salaries & wage related costs	0	C)	0 0.00	0.00	16.00
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 22.00 Total Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00					_			
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 22.00 Total Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00	17.00	Wage-related costs core (See Part IV)	1, 988, 596	C	1, 988, 59	96		17.00
20.00 Physician Part A - WRC 0 0 20.00 21.00 Physician Part B - WRC 0 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00	18.00	Wage-related costs other (See Part IV)	0	C)	0		18.00
21.00 Physician Part B - WRC 0 0 21.00 22.00 Total Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00	19.00	Wage related costs (excluded units)	0	C		0		19.00
22.00 Total Adjusted Wage Related cost (see 1,988,596 0 1,988,596 22.00	20.00	Physician Part A - WRC	0	C)	0		20.00
	21.00	Physician Part B - WRC	0	C		0		21.00
	22.00		1, 988, 596	C	1, 988, 59	96		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:	Worksheet S-3	
					From 01/01/2022 To 12/31/2022		pared:
						5/27/2023 9:3	
		Amount	Reclass. of	Adj usted		Average Hourly	
		Reported	Salaries from			Wage (col. 3 ÷	
			Worksheet A-6	1 ± col. 2)	Salary in col.	col. 4)	
		1.00	0.00		3	5.00	
		1.00	2.00	3.00	4.00	5.00	
	PART III - OVERHEAD COST - DIRECT SALARIES	ā				0.00	
1.00	Employee Benefits	0	0		0 0.00		
2.00	Administrative & General	688, 363		688, 36			2.00
3.00	Plant Operation, Maintenance & Repairs	164, 795	0	164, 79	5 5, 833. 00	28. 25	3.00
4.00	Laundry & Linen Service	70, 640	0	70, 64	0 4, 267. 00	16. 55	4.00
5.00	Housekeepi ng	352, 125	0	352, 12	5 18, 768. 00	18. 76	5.00
6.00	Dietary	832, 757	0	832, 75	7 37, 637. 00	22.13	6.00
7.00	Nursing Administration	825, 524	0	825, 52	4 18, 849. 00	43.80	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	Social Service	163, 694	0	163, 69	4, 733.00	34.59	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	249, 082	0	249, 08	2 10, 991. 00	22.66	13.00
14.00	Total (sum lines 1 thru 13)	3, 346, 980	0	3, 346, 98	0 113, 373. 00	29. 52	14.00

	Financial Systems	THE MANOR			u of Form CMS-2	
NF WA	GE RELATED COSTS	Pro	ovider No.: 315153	Period: From 01/01/2022	Worksheet S-3 Part IV	
				To 12/31/2022		pared
				10 12/01/2022	5/27/2023 9:3	
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					-
	Part A - Core List					-
	RETIREMENT COST				272.000	
. 00	401K Employer Contributions	hout the second			272, 000	
. 00	Tax Sheltered Annuity (TSA) Employer Contri				0	
. 00	Qualified and Non-Qualified Pension Plan Co	DST			0	
. 00	Prior Year Pension Service Cost PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati an)			0	4.
. 00	401K/TSA Plan Administration fees	organization)			0	15.
. 00	Legal /Accounting/Management Fees-Pension Pl	30			0	
. 00	Employee Managed Care Program Administration				0	
	HEALTH AND INSURANCE COST	on rees			0	· · ·
	Health Insurance (Purchased or Self Funded)	N			593, 195	8.
. 00	Prescription Drug Plan				309, 181	
	Dental, Hearing and Vision Plan				60, 803	
	Life Insurance (If employee is owner or ber	neficiary)			17,659	
	Accident Insurance (If employee is owner or				0	
	Disability Insurance (If employee is owner				72, 706	
	Long-Term Care Insurance (If employee is ov				0	
	Workers' Compensation Insurance				210, 621	
	Retirement Health Care Cost (Only current)	ear, not the extraordina	rv accrual require	ed by FASB 106.	0	
	Non cumulative portion)		J		-	
	TAXES					
7.00	FICA-Employers Portion Only				452, 431	17.
8.00	Medicare Taxes - Employers Portion Only				0	18.
9.00	Unemployment Insurance				0	19.
	State or Federal Unemployment Taxes				60, 812	20.
	OTHER					
	Executive Deferred Compensation				0	
	Day Care Cost and Allowances				0	1
	Tuition Reimbursement				0	
4.00	Total Wage Related cost (Sum of lines 1 - 2	23)			2, 049, 408	24.
					Amount	
					Reported	
	Dent D. Other then Core Delated Cost				1.00	
	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)					25.

Heal th	Financial Systems	THE MA	NOR		In Lie	eu of Form CMS-2	2540-10
	PORTING OF DIRECT CARE EXPENDITURES		Provi der	No.: 315153	Peri od:	Worksheet S-3	
					From 01/01/2022 To 12/31/2022	Part V Date/Time Pre	narod
					10 12/31/2022	5/27/2023 9:3	1 am
	Occupational Category	Amount	Fringe	Adj usted		Average Hourly	
		Reported	Benefits	Sal ari es (col		Wage (col. 3 ÷	
				1 + col. 2)	5	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Di rect Sal ari es	1.00	2.00	3.00	4.00	5.00	
	Nursing Occupations						
1.00	Registered Nurses (RNs)	586, 096	C	586, 09	6 11, 786. 00	49.73	1.00
2.00	Licensed Practical Nurses (LPNs)	777, 521	C	777, 52	21, 379. 00	36.37	2.00
3.00	Certified Nursing Assistant/Nursing	1, 266, 701	C	1, 266, 70	47, 255. 00	26.81	3.00
	Assi stants/Ai des						
4.00	Total Nursing (sum of lines 1 through 3)	2, 630, 318	C	2, 630, 31			4.00
5.00	Physical Therapists	0	(0 0.00		
6.00 7.00	Physical Therapy Assistants Physical Therapy Aides	0	(0 0.00		
7.00 8.00	Occupational Therapists	0			0 0.00		
8.00 9.00	Occupational Therapy Assistants	0			0 0.00		
10.00	Occupational Therapy Assistants	0			0 0.00		
11.00	Speech Therapi sts	0			0 0.00		
12.00	Respiratory Therapists	0	(0 0.00		
13.00	Other Medical Staff	0	C		0 0.00		
	Contract Labor			1	·		
	Nursing Occupations						
14.00	Registered Nurses (RNs)	417, 647		417, 64	7 3, 085. 00	135.38	
15.00	Licensed Practical Nurses (LPNs)	1, 417, 464		1, 417, 46			•
16.00	Certified Nursing Assistant/Nursing	2, 707, 969		2, 707, 96	9 36, 221. 00	74.76	16.00
17 00	Assistants/Aides	4 5 42 000		4 542 00		01 1/	17 00
17.00	Total Nursing (sum of lines 14 through 16)	4, 543, 080		4, 543, 08			
18. 00 19. 00	Physical Therapists Physical Therapy Assistants	308, 963		308, 96			18.00 19.00
20.00	Physical Therapy Aides	0			0 0.00		
20.00	Occupational Therapists	312, 773		312, 77			
21.00	Occupational Therapy Assistants	512,775		312,77	0 0.00		
23.00	Occupational Therapy Aides	0			0 0.00		
24.00	Speech Therapi sts	110, 752		110, 75			
25.00	Respiratory Therapists	0			0 0.00		
	Other Medical Staff	0		1	0 0.00		26.00

Health Financial Systems PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	THE MANOR Provider No.: 315153	Peri od:	u of Form CMS Worksheet S-	
		From 01/01/2022 To 12/31/2022		
		Group	5/27/2023 9: Days	31 am
		1.00	2.00	1.00
1.00 2.00		RUX RUL		1.00
3. 00		RVX		3.00
4.00		RVL		4.00
5.00 6.00		RHX RHL		5.00
7.00		RMX		7.00
8.00 9.00		RML		8.00 9.00
10.00		RLX RUC		10.00
11.00		RUB		11.00
12. 00 13. 00		RUA RVC		12.00
14.00		RVB		14.00
15. 00		RVA		15.00
16.00 17.00		RHC RHB		16.00
18.00		RHA		18.00
19.00		RMC		19.00
20.00		RMB		20.00
21. 00 22. 00		RMA RLB		21.00
23.00		RLA		23.00
24.00		ES3		24.00
25. 00 26. 00		ES2 ES1		25.00 26.00
27.00		HE2		27.00
28.00		HE1		28.00
29.00 30.00		HD2 HD1		29.00 30.00
31.00		HC2		31.00
32.00		HC1		32.00
33. 00 34. 00		HB2 HB1		33.00 34.00
35. 00		LE2		35.00
36.00		LE1		36.00
37. 00 38. 00		LD2 LD1		37.00
39.00		LC2		39.00
40.00		LC1		40.00
41.00 42.00		LB2 LB1		41.00
43.00		CE2		43.00
44.00		CE1		44.00
45.00 46.00		CD2 CD1		45.00 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 58.00		SSB SSA		57.00 58.00
59.00		I B2		59.00
60.00		I B1		60.00
61.00 62.00		I A2 I A1		61.00 62.00
63. 00		BB2		63.00
64. 00 65. 00		BB1		64.00
65. 00 66. 00		BA2 BA1		65.00 66.00
67.00		PE2		67.00
68.00		PE1		68.00
69. 00 70. 00		PD2 PD1		69.00 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		75.00

Health Financial Systems THE MANOF	R		In Lie	eu of Form CM	S-2540-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	No.: 315153	Peri od:	Worksheet S	-7
			From 01/01/2022 To 12/31/2022		
			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 payments beginning 10/01/2003. Congress expected this increase expenses. For lines 101 through 106: Enter in column 1 the amo 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 with direct patient care and related expenses for each categor (See instructions)	to be used unt of the total SNF no if the s	I for direct expense for revenue from pending refl	patient care and each category. Er Worksheet G-2, F ects increases as	related hterin Partl, 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

RECLAS	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	THE MAN			Period:	u of Form CMS-2 Worksheet A	2340-10
					rom 01/01/2022 To 12/31/2022	Date/Time Pre 5/27/2023 9:3	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	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	1	444 505	444 505	440.040	(07, 400	1 1 00
	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT		464, 505	464, 505			1.00
2.00 3.00	00300 EMPLOYEE BENEFITS	0	1, 809, 790	1, 809, 790		157, 082 1, 809, 790	2.00
4.00	00400 ADMINI STRATI VE & GENERAL	688, 363	1, 367, 418	2, 055, 781		1, 719, 209	
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	164, 795	408, 140			572, 935	
6.00	00600 LAUNDRY & LINEN SERVICE	70, 640	47, 357	117, 997		114, 759	6.00
7.00	00700 HOUSEKEEPI NG	352, 125	93, 280			445, 054	7.00
	00800 DI ETARY	832, 757	496, 312	1, 329, 069	2, 124	1, 331, 193	8.00
9.00	00900 NURSING ADMINISTRATION	825, 524	151	825, 675	-209, 355	616, 320	9.00
	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0 0	0	10.00
	01100 PHARMACY	0	0	C	0 0	0	11.00
	01200 MEDICAL RECORDS & LIBRARY	0	431	431		34, 244	12.00
	01300 SOCIAL SERVICE	163, 694	44	163, 738		163, 738	
	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	240,000	0	201 012	-	0	14.00
	INPATIENT ROUTINE SERVICE COST CENTERS	249, 082	52, 730	301, 812	2 - 3, 185	298, 627	15.00
	03000 SKI LLED NURSING FACILITY	2, 623, 147	5, 425, 597	8, 048, 744	-526, 505	7, 522, 239	30.00
	03100 NURSING FACILITY	0	0	(0 0	0	31.00
	03200 CF/I D	0	0	C	0 0	0	32.00
	03300 OTHER LONG TERM CARE	0	0	C	0 0	0	33.00
	ANCILLARY SERVICE COST CENTERS	1 1			1		
	04000 RADI OLOGY	0	0	0		23, 834	
		0	0		7,731	7, 731	
	04200 INTRAVENOUS THERAPY	0	0		0 140, 915	140, 915	
	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	107, 910	736, 011	0 843, 921		107, 608 736, 313	
	04500 OCCUPATIONAL THERAPY	107, 910	/ 30, 011	043, 721	0	/30, 313	44.00
	04600 SPEECH PATHOLOGY	0	0	(0	0	46.00
	04700 ELECTROCARDI OLOGY	0	0	C	2, 081	2, 081	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	212, 128	212, 128	48.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	C	297, 659	297, 659	49.00
	05000 DENTAL CARE - TITLE XIX ONLY	0	0	C	-	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		34, 657	34, 657	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0	C	0 0	0	60.00
	06100 RURAL HEALTH CLINIC	0	0			0	61.00
	06200 FQHC	Ű	0		5	0	62.00
	OTHER REIMBURSABLE COST CENTERS						
	07000 HOME HEALTH AGENCY COST	0	0	(0 0	0	70.00
	07100 AMBULANCE	0	0				
	07300 CMHC	0	0	(0 0	0	73.00
	SPECIAL PURPOSE COST CENTERS		0			0	
	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE		0		-	0	80.00 81.00
	08200 UTI LI ZATI ON REVIEW - SNF	0	0			0	81.00
	08300 HOSPICE	0	0			0	83.00
89.00	SUBTOTALS (sum of lines 1-84)	6, 078, 037	10, 901, 766	16, 979, 803	-2, 759	16, 977, 044	89.00
	NONREI MBURSABLE COST CENTERS						
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	C	0 0	0	
90.00		0	0	C	2, 759	2, 759	
90. 00 91. 00	09100 BARBER AND BEAUTY SHOP		0	(0 0	0	92.00
90.00 91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0	-			
90.00 91.00 92.00 93.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	C	0 0	0	93.00
90.00 91.00 92.00 93.00 94.00	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	000000000000000000000000000000000000000	0	0		0	94.00
90.00 91.00 92.00 93.00 94.00 95.00	09200 PHYSI CLANS PRI VATE OFFI CES 09300 NONPALD WORKERS 09400 PATLENTS LAUNDRY 09500 MARKETI NG	0 0 0	000000000000000000000000000000000000000			0	94.00 95.00
90.00 91.00 92.00 93.00 94.00 95.00 95.01	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY	0 0 0 0	000000000000000000000000000000000000000			0	94.00 95.00 95.01

	Financial Systems SIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	THE M		No.: 315153	In Lieu Period:	u of Form CMS-2 Worksheet A	540-10
					From 01/01/2022 To 12/31/2022		ared:
	Cost Center Description	Adjustments to					Cim
		Wkst A-8)	For Allocation (col. 5 +-	1			
		into the of	col. 6)				
		6.00	7.00				
1 00	GENERAL SERVICE COST CENTERS	212 462	204.040	1			1 00
1.00 2.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT	-212, 463	394, 960 157, 082	1			1.00 2.00
3.00	00300 EMPLOYEE BENEFITS	-204, 650		1			3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	0	1, 719, 209				4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	572, 935	j			5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	114, 759	1			6.00
7.00	00700 HOUSEKEEPING	0	445,054	1			7.00
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	-31, 223	1, 299, 970 616, 320	1			8.00 9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	010, 320	1			10.00
11.00	01100 PHARMACY	0	0				11.00
	01200 MEDICAL RECORDS & LIBRARY	0	34, 244				12.00
	01300 SOCIAL SERVICE	0	163, 738				13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0				14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	298, 627				15.00
30.00	03000 SKILLED NURSING FACILITY	0	7, 522, 239				30.00
	03100 NURSING FACILITY	0	0	1			31.00
32.00	03200 CF/I D	0	C				32.00
33.00	03300 OTHER LONG TERM CARE	0	C				33.00
	ANCI LLARY SERVI CE COST CENTERS			1			
	04000 RADI OLOGY 04100 LABORATORY	0	23, 834				40. 00 41. 00
41.00 42.00	04200 I NTRAVENOUS THERAPY	0	7, 731 140, 915	1			41.00
	04300 OXYGEN (INHALATION) THERAPY	0	107, 608	1			43.00
44.00	04400 PHYSI CAL THERAPY	0	736, 313	1			44.00
	04500 OCCUPATI ONAL THERAPY	0	C	1			45.00
46.00	04600 SPEECH PATHOLOGY	0	0				46.00
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	2,081	1			47.00 48.00
48.00	04900 DRUGS CHARGED TO PATIENTS	0	212, 128 297, 659	1			48.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	277,037	1			50.00
51.00	05100 SUPPORT SURFACES	0	34, 657	1			51.00
	OUTPATIENT SERVICE COST CENTERS	T.	1	1			
60.00	06000 CLINIC	0					60.00
	06100 RURAL HEALTH CLINIC	0	C				61.00
02.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	C				70.00
71.00	07100 AMBULANCE	0	21, 505				71.00
73.00	07300 CMHC	0	0				73.00
00.00	SPECIAL PURPOSE COST CENTERS						~~ ~~
80.00 81.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES 08100 INTEREST EXPENSE	0					80. 00 81. 00
81.00	08200 UTILIZATION REVIEW - SNF	0		•			81.00
	08300 HOSPI CE	0					83.00
89.00	SUBTOTALS (sum of lines 1-84)	-448, 336	16, 528, 708	8			89.00
	NONREI MBURSABLE COST CENTERS			1			
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	•			90.00
	09100 BARBER AND BEAUTY SHOP	-2,676		1			91.00
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS						92.00 93.00
	09400 PATIENTS LAUNDRY	0					93.00 94.00
	09500 MARKETI NG	0		1			95.00
95.01	09501 CLI NI C	0	0				95.01
	09502 INDEPENDENT LIVING	0	0				95.02
100.00	TOTAL	-451, 012	16, 528, 791	I		ſ	100.00

Heal th	Financial Systems	THE MANOR			In Lie	u of Form CMS-	2540-10
RECLAS	SIFICATIONS		Provi der	No.: 315153	Peri od:	Worksheet A-6	,
					From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
						5/27/2023 9:3	
		Cost Costor		I ncreases	Calany	Nam Calami	
		Cost Center 2.00		<u>Line #</u> 3.00	Sal ary 4, 00	Non Salary 5.00	
	(1) A - MME DEPRECIATION RECLASS	2.00		3.00	4.00	5.00	-
1.00		CAP REL COSTS - MOVA EQUI PMENT	ABLE	2. (0 00	157, 082	1.00
	(1) B - LEASE EXPENSE						
2.00		CAP REL COSTS - BLDO FIXTURES	GS &	1. (0 00	300, 000	2.00
	(1) C - BARBER AND BEAUTY						
3.00		BARBER AND BEAUTY SH	HOP	91. (0 00	2, 759	3.00
	(1) D - MED SURG SUPPLIES		1				
4.00		MEDI CAL SUPPLI ES CHA PATI ENTS	ARGED TO	48.0		212, 128	
5.00				0.0		0	
6.00				0.0		0	
7.00	(1) E - DRUGS BILLABLE			0.0	0 00	0	7.00
8.00	(1) E - DRUGS DILLADLE	DRUGS CHARGED TO PAT		49.0	0 00	297, 659	8.00
9.00		I NTRAVENOUS THERAPY	IT ENTID	42. (140, 915	1
	(1) F - ENTERAL SUPPLIES					· · ·	
10.00		DI ETARY		8. (0 00	2, 124	10.00
	(1) G - SUPPORT SURFACES						1
11.00	(1) H - ANCILLARY	SUPPORT SURFACES		51.0	0 00	34, 657	11.00
12.00	(1) H - ANCILLART	RADI OLOGY		40.0	0	23 834	12.00
13.00		LABORATORY		41.0		7, 731	
14.00		ELECTROCARDI OLOGY		47.0	0 00	2, 081	14.00
15.00		AMBULANCE		71. (0 00	21, 505	15.00
	(1) K - REHAB SERVICES						
16.00		OXYGEN (INHALATION)	THERAPY	43. (00 107, 608	0	16.00
17.00	(1) N - NURSING ADMINISTRATION	SKILLED NURSING FACI		30.0	0 00	209, 355	1 17 00
17.00	(1) 0 - MEDI CAL RECORDS	SKI LLED NORSTING TACI		30.1		207, 333	17.00
18.00		MEDICAL RECORDS & LI	BRARY	12. (0 00	33, 813	18.00
	TOTALS						
100.00		Total Reclassificati			107, 608	1, 445, 643	100. 00
		of columns 4 and 5 r					
		equal sum of columns 9)	s 8 and				
	1	7)	I		1		1

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

Heal th	Financial Systems	THE MANOR			In Lie	u of Form CMS-:	2540-10
RECLAS	SSIFICATIONS		Provi der	No.: 315153	Period: From 01/01/2022	Worksheet A-6	
					To 12/31/2022	Date/Time Pre 5/27/2023 9:3	pared: 1 am
				Decreases			
		Cost Cente	r	Line #	Sal ary	Non Salary	
		6.00		7.00	8.00	9.00	
	(1) A - MME DEPRECIATION RECLASS						
1.00		CAP REL COSTS - BLE FLXTURES	GS &	1.0	0 00	157, 082	1.00
	(1) B - LEASE EXPENSE						
2.00		ADMINISTRATIVE & GE	ENERAL	4.	0 00	300, 000	2.00
	(1) C - BARBER AND BEAUTY						
3.00		ADMINISTRATIVE & GE	INERAL	4.	0 00	2, 759	3.00
	(1) D - MED SURG SUPPLIES			1			
4.00		LAUNDRY & LINEN SEF	RVICE	6.		3, 238	
5.00		ACTI VI TI ES		15.		3, 185	5.00
6.00		SKILLED NURSING FAC	CI LI TY	30.		205, 354	6.00
7.00		HOUSEKEEPI NG		7.	0 0	351	7.00
	(1) E - DRUGS BILLABLE			1			
8.00		SKILLED NURSING FAC	CI LI TY	30.		438, 574	8.00
9.00				0.	000	0	9.00
	(1) F - ENTERAL SUPPLIES			1			
10.00		SKILLED NURSING FAC	CLLITY	30.	0 0	2, 124	10.00
	(1) G - SUPPORT SURFACES			1			
11.00		SKILLED NURSING FAC	CILITY	30.	0 0	34, 657	11.00
	(1) H - ANCILLARY			1			
12.00		SKILLED NURSING FAC	CI LI TY	30.		55, 151	
13.00				0.		0	
14.00				0.		0	14.00
15.00				0.	0 0	0	15.00
	(1) K - REHAB SERVICES			1			
16.00		PHYSI CAL THERAPY		44.	00 107, 608	0	16.00
	(1) N - NURSING ADMINISTRATION			1			
17.00		NURSING ADMINISTRAT	T ON	9.	0 0	209, 355	17.00
	(1) 0 - MEDI CAL RECORDS			1			
18.00		ADMINISTRATIVE & GE	INERAL	4.	0 00	33, 813	18.00
	TOTALS			1			
100.00)			1	107, 608	1, 445, 643	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.

Heal th	Financial Systems	THE MA	ANOR		. In Lie	eu of Form CMS-2	2540-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	No.: 315153	Period: From 01/01/2022 To 12/31/2022		pared:
				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 BALANCE	S					
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	7, 926, 245	37, 101		0 37, 101	6, 566, 746	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	0	C)	0 0	0	4.00
5.00	Fixed Equipment	1, 604, 211	16, 015		0 16, 015		5.00
6.00	Movable Equipment	2, 205, 509	16, 875		0 16, 875		6.00
7.00	Subtotal (sum of lines 1-6)	11, 735, 965	69, 991		0 69, 991	9, 755, 452	7.00
8.00	Reconciling Items	0	0		0 0	0 0	8.00
9.00	Total (line 7 minus line 8)	11, 735, 965	69, 991		0 69, 991	9, 755, 452	9.00
	Description	Endi ng Bal ance					
			Depreci ated				
			Assets	4			
		6.00	7.00				
	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	5					
1.00	Land	0	0	0			1.00
2.00	Land Improvements	1, 396, 600	0)			2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	270, 158	0	2			5.00
6.00	Movable Equipment	383, 746	0				6.00
7.00	Subtotal (sum of lines 1-6)	2, 050, 504	0				7.00
8.00	Reconciling Items	0 050 504	0				8.00
9.00	Total (line 7 minus line 8)	2, 050, 504	C	2			9.00

ENTS TO EXPENSES			No.: 315153	Period: From 01/01/2022 To 12/31/2022		
					5/27/2023 9:3	
				lassification on		
			To/From Whic	h the Amount is	to be Adjusted	
Description (1)	(2) Basis For	Amount	Cos	Center	Line No.	
	Adjustment					
	1.00	2.00		3.00	4.00	
	В	-212, 463		S - BLDGS &	1.00	1.
		0			0.00	2.
b)		0			0.00	2.
Refunds and rebates of expenses (chapter 8)		0			0.00	3.
ental of provider space by suppliers		0			0.00	4
chapter 8)						
		0			0.00	5
		0			0.00	6
						7
	A-8-2	-			0.00	8
physician adjustment		0				Ĭ
lome office cost (chapter 21)		0			0.00	9
ale of scrap, waste, etc. (chapter 23)		0			0.00	10
lonallowable costs related to certain		0			0.00	11
	A O 1	0				10
	A-8-1	0				12
		0			0.00	13
Revenue - Employee meals		0			0.00	
Cost of meals - Guests		0			0.00	15
ale of medical supplies to other than	В	0	DI ETARY		8.00	16
	D	0				
	D					
		0			0.00	20
nterest expense on Medicare overpayments		0			0.00	21
nd borrowings to repay Medicare						
overpayments						
		0	UTILIZATION	REVIEW - SNF	82.00	22
		0	CAP REL COST	S - BLDGS &	1 00	22
oprocration-burrarings and friktures					1.00	23
epreciationmovable equipment			CAP REL COST	S - MOVABLE	2.00	24
		~			0.00	0.5
ntner adjustment (specify)		0				
DY DERATES	R	-204 450		FELTS		
				FAUTY SHOP		
	·	2,070			0.00	
otal (sum of lines 1 through 99) (Transfer		-451,012			2.00	100.
	<pre>tental of provider space by suppliers chapter 8) elephone services (pay stations excluded) chapter 21) elevision and radio service (chapter 21) arking lot (chapter 21) temuneration applicable to provider-based hysician adjustment lome office cost (chapter 21) ale of scrap, waste, etc. (chapter 23) onal lowable costs related to certain apital expenditures (chapter 24) djustment resulting from transactions with elated organizations (chapter 10) aundry and linen service tevenue - Employee meals ost of meals - Guests ale of medical supplies to other than atients ale of drugs to other than patients ale of medical records and abstracts ending machines ncome from imposition of interest, finance r penalty charges (chapter 21) nterest expense on Medicare overpayments nd borrowings to repay Medicare verpayments tilization reviewphysicians' compensation chapter 21) epreciationbuildings and fixtures eupreciationmovable equipment ther adjustment (specify) ex REBATES URCHASE DISCOUNT ARBER AND BEAUTY fotal (sum of lines 1 through 99) (Transfer o Worksheet A, col. 6, line 100)</pre>	chapter 2) rade, quantity, and time discounts (chapter) refunds and rebates of expenses (chapter 8) tental of provider space by suppliers chapter 8) elephone services (pay stations excluded) chapter 21) elevision and radio service (chapter 21) tarking lot (chapter 21) tarking lot (chapter 21) tarking lot (chapter 21) ale of scrap, waste, etc. (chapter 23) tonal lowable costs related to certain tapital expenditures (chapter 24) dj ustment resulting from transactions with el ated organizations (chapter 10) aundry and linen service tevenue - Employee meals tost of medical supplies to other than tatients ale of medical records and abstracts ending machines ncome from imposition of interest, finance r penalty charges (chapter 21) nterest expense on Medicare overpayments nt borrowings to repay Medicare verpayments tilizationmovable equipment ther adj ustment (specify) XX REBATES URCHASE DISCOUNT ARBER AND BEAUTY otal (sum of lines 1 through 99) (Transfer o Worksheet A, col. 6, line 100)	chapter 2) rade, quantity, and time discounts (chapter)0rade, quantity, and time discounts (chapter of equation of the provider space by suppliers (chapter 8)0ental of provider space by suppliers (chapter 21)0elephone services (pay stations excluded) (chapter 21)0elevision and radio service (chapter 21) (anking lot (chapter 21))0emuneration applicable to provider-based (hysician adjustment)A-8-2ome office cost (chapter 21) (ale of scrap, waste, etc. (chapter 23)) (onallowable costs related to certain (apital expenditures (chapter 10)) (aundry and linen service (evenue - Employee meals (ost of meals - Guests)0ale of drugs to other than patients (ale of medical supplies to other than (ale of medical records and abstracts) (ending machines)0ale of from imposition of interest, finance (r penalty charges (chapter 21)) (erpeciationbuildings and fixtures)0eperciation-movable equipment (ther adjustment (specify)) (X REBATES)0X REBATES (URCHASE DISCOUNT (ARER AND BEAUTY)0A RER AND BEAUTY0Otal (sum of lines 1 through 99) (Transfer-451,012	chapter 2) rade, quantity, and time discounts (chapter) defunds and rebates of expenses (chapter 8) ental of provider space by suppliers chapter 8) elephone services (pay stations excluded) chapter 21) elevision and radio service (chapter 21) arking lot (chapter 21) arking lot (chapter 21) ale of scrap, waste, etc. (chapter 23) onallowable costs related to certain apital expenditures (chapter 10) aundry and linen service evenue - Employee meals ole of medical supplies to other than atients ale of medical supplies to other than ale of medical recervers, finance r penalty charges (chapter 21) merest expense on Medicare overpayments nd borrowings to repay Medicare verpayments tillizationmovable equipment ther adj ustment (specify) X REBATES ARBER AND BEAUTY ABER AND BEAUTY	chapter 2) rade, quanti ty, and time discounts (chapter) efunds and rebates of expenses (chapter 8) ental of provider space by suppliers chapter 8) elephone services (pay stations excluded) chapter 21) elevision and radio service (chapter 21) arking lot (chapter 21) enumeration applicable to provider-based hysician adjustment ome office cost (chapter 21) and lowable costs related to certain applicable to chapter 20) and lowable costs related to certain applicable costs related to certain audry and linen service evenue - Enployee meals ost of medical supplies to other than atients ale of medical records and abstracts ending machines ncome from imposition of interest, finance r penalty charges (chapter 21) nterest expense on Medicare overpayments nd borrowings to repay Medicare verpayments tilization reviewphysicians' compensation chapter 21) epreciationbuildings and fixtures epreciationbuildings and fixtures eprecidings and fixtures epreciationbuildings a	chapter 2) rade, quantity, and time discounts (chapter) errade, quantity, and time discounts (chapter 8) elephone services (pay stations excluded) chapter 21) elevision and radio service (chapter 21) or arking lot (chapter 21) or arking lot (chapter 21) one offic costs (chapter 21) ale of scrap, waste, etc. (chapter 23) onal lowable costs related to certain apticate do costs related to certain obst of medical costs related to certain audry and linen service ost of medical supplies to other than atients ale of medical records and abstracts on come from imposition of interest, finance repensity chapter 21) on do rowings to repay Medicare werpayments thill zation reviewphysicians' compensation chapter 21) epreciationmovable equipment ther adjustment (specify) x REBATES NABEL ACOL REL COSTS - MICVABLE epreciationmovable equipment ther adjustment (specify) x REBATES NABEL ACOL REL COSTS - MICVABLE EQUIPMENT A -2, 676EARABER AND BEAUTY SHOP (com o Korksheet A, col 6, line 100) (Tansfer A -2, 676EARABER AND BEAUTY SHOP (com o Korksheet A, col 6, line 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 MA	ANOR		In Li	eu of Form C	MS-2540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME		No.: 315153	Period: From 01/01/202 To 12/31/202		Prepared:
	Line No.	Cost (Expen	se Items	
	1.00	2.	00	3	3. 00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIN CLAIMED HOME OFFICE COSTS:	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	FED ORGANI ZATI O	NS OR	
1.00		ADMI NI STRATI VE		CORPORATE DIR	ECT	1.00
2.00		ADMI NI STRATI VE		I NSURANCE		2.00
3.00	3.00	EMPLOYEE BENEF	I TS	EMPLOYEE BENE	FITS	3.00
4.00		CAP REL COSTS EQUI PMENT	- MOVABLE	COPI ER		4.00
5.00	4.00	ADMI NI STRATI VE	& GENERAL	PRI NTI NG		5.00
6.00	30.00	SKILLED NURSIN	G FACILITY	MEDI CAL SUPPL	IES	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	IS		
	Cost	Wkst. A, col.	col. 5)			
		5	· ·			
	4.00	5.00	6.00			
PART I. COSTS INCURRED AND ADJUSTMENTS REQUI	RED AS A RESULT	OF TRANSACTIO	NS WITH RELAT	TED ORGANI ZATI O	NS OR	
CLAIMED HOME OFFICE COSTS:	21/ 02/	21/ 02/		0		1 00
1.00	316, 836			0		1.00
2.00	116, 760			0		2.00
3.00	1, 587, 521			0		3.00
4.00	8, 847			0		4.00
5.00	105			0		5.00
6.00	2, 577	2, 577		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	2,032,646	2, 032, 646		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	540-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZ OFFICE COSTS	ATIONS AND HOME	Ξ	Provider No.: 315153	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8- Parts I-II Date/Time Prep 5/27/2023 9:31	bared:
	Symbol (1)		Name	Percentage of Ownership		
	1.00		2.00	3.00		

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

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

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

1.00	А	CENTRASTATE MEDICAL CENTER	0.00	1.00
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00 G. Other (financial or non-financial)			0.00	100.00
speci fy:				

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

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

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

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

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

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	1			
		Ownership	51				
	4.00	5.00	6.00	1			
PART II. INTERRELATIONSHIP TO RELATED ORGANIZ	ZATION(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	0.00	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.

COST A	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	THE MA			Peri od: From 01/01/2022 To 12/31/2022	u of Form CMS-: Worksheet B Part I Date/Time Pre	pared:
			CAPITAL RE	LATED COSTS		5/27/2023 9:3	1 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FI XTURES	MOVABLE EQUI PMENT	EMPLOYEE BENEFI TS	Subtotal	
		0	1.00	2.00	3.00	3A	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	204.0(0	394, 960				1 1 00
1.00 2.00	00200 CAP REL COSTS - BEDGS & FIXTURES	394, 960 157, 082	394, 900	157, 08	2		1.00
3.00	00300 EMPLOYEE BENEFITS	1, 605, 140	0		0 1, 605, 140		3.00
4.00	00400 ADMI NI STRATI VE & GENERAL	1, 719, 209	109, 974	43, 73		2, 054, 710	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	572, 935	17, 953			641, 549	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	114, 759	8, 014			144, 615	6.00
7.00	00700 HOUSEKEEPI NG	445, 054	3, 290			542, 644	
8.00	00800 DI ETARY	1, 299, 970	44, 934			1, 582, 697	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	616, 320	4, 523			840, 654	9.00
10.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0		0 0	0	
11.00 12.00	01200 MEDICAL RECORDS & LIBRARY	34, 244	2, 143		0 0	0 37, 239	11.00
13.00	01300 SOCIAL SERVICE	163, 738	2, 143			209, 988	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	103,730	2, 101		0 0	0	14.00
15.00	01500 ACTI VI TI ES	298, 627	19, 151			391, 175	•
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 SKILLED NURSING FACILITY	7, 522, 239	161, 565	64, 25	692, 741	8, 440, 804	30. 00
31.00	03100 NURSING FACILITY	0	0		0 0	0	31.00
32.00	03200 CF/I D	0	0		0 0	0	32.00
33.00	O3300 OTHER LONG TERM CARE	0	0		0 0	0	33.00
10.00	ANCI LLARY SERVI CE COST CENTERS	22.024				22,024	1 40 00
40.00	04000 RADI OLOGY 04100 LABORATORY	23, 834 7, 731	0		0 0	23, 834 7, 731	
42.00	04200 I NTRAVENOUS THERAPY	140, 915	0		0 0	140, 915	
43.00	04300 OXYGEN (INHALATION) THERAPY	107, 608	0		0 0	140, 913	
44.00	04400 PHYSI CAL THERAPY	736, 313	17, 253			788, 926	•
45.00	04500 OCCUPATI ONAL THERAPY	0	525			734	•
46.00	04600 SPEECH PATHOLOGY	0	665			929	•
47.00	04700 ELECTROCARDI OLOGY	2, 081	0		0 0	2, 081	47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	212, 128	1, 514	60	2 0	214, 244	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	297, 659	1, 295			299, 469	
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0 0	0	50.00
51.00	05100 SUPPORT SURFACES	34, 657	0		0 0	34, 657	51.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	60.00
50.00 51.00	06100 RURAL HEALTH CLINIC	0	0		0 0	0	61.00
62.00	06200 FQHC	Ű	0		0	0	62.00
	OTHER REIMBURSABLE COST CENTERS	· · ·					1
70.00	07000 HOME HEALTH AGENCY COST	0	0		0 0	0	70.00
71.00	07100 AMBULANCE	21, 505	0		0 0	21, 505	
73.00	07300 CMHC	0	0		0 0	0	73.00
00 00	SPECIAL PURPOSE COST CENTERS	1					
80.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES						80.00
81.00 82.00	08100 I NTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00 82.00
83.00	08300 HOSPI CE	0	0		0 0	0	
89.00	SUBTOTALS (sum of lines 1-84)	16, 528, 708	394, 960	157, 08	1, 605, 140	16, 528, 708	
	NONREI MBURSABLE COST CENTERS						
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	1	0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	83	0		0 0	83	
92.00	09200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	
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
5.00	09500 MARKETI NG	0	0		0 0	0	95.00
95.01	09501 CLINIC	0	0		0 0	0	•
95.02	09502 I NDEPENDENT LI VI NG	0	0		0 0	0	
98.00	Cross Foot Adjustments Negative Cost Centers	0	0		0 0	0	98.00 99.00
00 00		i ()	0	1	0 0		1 99 11
9.00 00.00		16, 528, 791	394, 960	157, 08	1, 605, 140		

OST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	THE MA		No.: 315153 Pe	eriod: rom 01/01/2022 o 12/31/2022	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/27/2023 9:3	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
~~	GENERAL SERVICE COST CENTERS						1
. 00 . 00 . 00 . 00 . 00 . 00 . 00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING	2, 054, 710 91, 073 20, 529 77, 033	732, 622 21, 987 9, 025	187, 131	628, 702		1.00 2.00 3.00 4.00 5.00 6.00 7.00
. 00	00800 DI ETARY	224, 677	123, 280		110, 469	2, 041, 123	8.00
. 00	00900 NURSING ADMINISTRATION	119, 338	12, 410	0	11, 120	0	9.00
0.00	01000 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	10.00
1.00	01100 PHARMACY	0	0	0	0	0	11.00
	01200 MEDICAL RECORDS & LIBRARY	5, 286	5, 881		5, 270	0	12.00
	01300 SOCIAL SERVICE	29, 809	5, 929		5, 313	0	13.00
	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
5.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	55, 530	52, 543	0	47, 083	0	15.00
0. 00	03000 SKILLED NURSING FACILITY	1, 198, 239	443, 264	187, 131	397, 202	2, 041, 123	30.00
	03100 NURSI NG FACILITY	1, 190, 239	445, 204		0	2,041,123	31.00
	03200 CF/I D	0	0	-	0	0	
	03300 OTHER LONG TERM CARE	0	0		0	0	33.00
	ANCILLARY SERVICE COST CENTERS	- I I					1
0.00	04000 RADI OLOGY	3, 383	0	0	0	0	40.00
1.00	04100 LABORATORY	1, 097	0	0	0	0	41.00
	04200 I NTRAVENOUS THERAPY	20, 004	0		0	0	42.00
3.00	04300 OXYGEN (INHALATION) THERAPY	15, 276	0		0	0	43.00
	04400 PHYSI CAL THERAPY	111, 994	47, 334	1	42, 415	0	44.00
5.00 6.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY	104 132	1, 440 1, 824		1, 291 1, 635	0	45.00 46.00
	04700 ELECTROCARDI OLOGY	295	1, 024		1,035	0	47.00
	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 414	4, 153	-	3, 721	0	48.00
9.00	04900 DRUGS CHARGED TO PATIENTS	42, 512	3, 552	0	3, 183	0	49.00
0.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
1.00	05100 SUPPORT SURFACES	4, 920	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS			-	_		
	06000 CLINIC	0	0		0	0	60.00
	06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	0	0	0	61.00 62.00
2.00	OTHER REIMBURSABLE COST CENTERS						02.00
0. 00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	3, 053	0		0	0	
3.00	07300 CMHC	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 I NTEREST EXPENSE						81.00
	08200 UTI LI ZATI ON REVI EW - SNF		-		_	-	82.00
	08300 HOSPICE		0	0		0	
9. 00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	2, 054, 698	732, 622		628, 702	2, 041, 123	
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0		0	0	90.00
	09100 BARBER AND BEAUTY SHOP	12	0	-	0	0	91.00
	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS	0	0	0	0	0	92.00
	09400 PATIENTS LAUNDRY	0	0		0	0	93.00
	09500 MARKETI NG	0	0		0	0	94.00
	09501 CLI NI C	0	0	0	0	0	95.0
	09502 I NDEPENDENT LI VI NG	0	0	0	0	0	95.0
8.00	Cross Foot Adjustments	0	0	0	Ő	0	98.00
	5		0		0	0	99.00
9.00	Negative Cost Centers	0	0	0	0	2, 041, 123	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	THE MA		No.: 315153	Pe	eri od:	u of Form CMS-2 Worksheet B	2010 10
						om 01/01/2022	Part I	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
	1	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 HOUSEKEEPI NG							7.00
8.00	00800 DI ETARY							8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	983, 522						9.00
10.00	01000 CENTRAL SERVICES & SUPPLY	0	C					10.00
11.00	01100 PHARMACY	0	C		0			11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	0	0		0	53, 676		12.00
	01300 SOCIAL SERVICE	0	C		0	0	251, 039	
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0		0	0	0	
15.00		0	C		0	0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	002 522			0	E2 (7(251 020	20.00
30.00 31.00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY	983, 522	0		0	53, 676	251, 039 0	30.00 31.00
32.00	03200 I CF/I I D	0	0		0	0	0	32.00
	03300 OTHER LONG TERM CARE	0	0		0	0	0	
55.00	ANCI LLARY SERVICE COST CENTERS	<u>ч</u>	0	1		0	0	55.00
40.00	04000 RADI OLOGY	0	0		0	0	0	40.00
41.00	04100 LABORATORY	0	C)	0	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	0		0	0	0	44.00
	04500 OCCUPATI ONAL THERAPY	0	C		0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	0		0	0	0	46.00
	04700 ELECTROCARDI OLOGY	0	0		0	0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	48.00 49.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0		0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0	0		0	0	0	51.00
01.00	OUTPATIENT SERVICE COST CENTERS							01.00
60.00	06000 CLINIC	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	1 1		1				
70.00	07000 HOME HEALTH AGENCY COST	0	0		0	0	0	
71.00	07100 AMBULANCE	0	0		0	0	0	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	U	1	0	0	0	73.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES			1				80.00
81.00	08100 I NTEREST EXPENSE							81.00
82.00	08200 UTILIZATION REVIEW - SNF							82.00
83.00	08300 H0SPI CE	0	C)	0	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	983, 522	0)	0	53, 676	251, 039	89.00
	NONREI MBURSABLE COST CENTERS							
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0	0	0	
	09100 BARBER AND BEAUTY SHOP	0	0		0	0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	0		0	0	0	92.00
	09300 NONPALD WORKERS	0	U		0	0	0	93.00
	09400 PATIENTS LAUNDRY	0	0		0	0	0	
94.00		. UI	U	1	U	0	0	95.00
94. 00 95. 00	09500 MARKETING	0	0		0		(1)	
94. 00 95. 00 95. 01	09501 CLI NI C	0	0		0	0	0	95.01 95.02
94.00 95.00 95.01 95.02	09501 CLINIC 09502 INDEPENDENT LIVING	0	0 0 0		0	0	0	95.02
94. 00 95. 00 95. 01	09501 CLI NI C	000000000000000000000000000000000000000	0 0 0 0		0 0 0	0 0 0	-	95. 02 98. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	THE M		No.: 315153	Period: From 01/01/2022 To 12/31/2022	u of Form CMS-: Worksheet B Part I Date/Time Pre	
						5/27/2023 9:3	
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Stepdown Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS		[1			1 1 00
12.00 13.00 14.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0					$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00 \end{array}$
15.00	01500 ACTIVITIES	0	546, 331				15.00
31.00 32.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 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	0 0 0 0			31 0 0 0 0 0 0 0 0 0	14, 542, 331 0 0 0	32.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	C	27, 2	17 0	27, 217	40.00
41.00 42.00 43.00	04100 LABORATORY 04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY			8, 8 160, 9 122, 8	28 0 19 0 84 0	8, 828 160, 919 122, 884 990, 669	41.00 42.00 43.00
46.00 47.00	04500 OCCUPATIONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDIOLOGY	000000000000000000000000000000000000000		3, 50 4, 52 2, 3	20 0 76 0	3, 569 4, 520 2, 376	46.00 47.00
49. 00 50. 00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0 0 0		348, 7	16 0 0 0	252, 532 348, 716 0 39, 577	49.00 50.00
60.00	OUTPATIENT SERVICE COST CENTERS	0	C	1	0 0	0	60.00
61.00	06100 RURAL HEALTH CLINIC 06200 FOHC OTHER REIMBURSABLE COST CENTERS	0			0 0 0 0	0	1
70.00	07000 HOME HEALTH AGENCY COST	0	C	þ	0 0	0	70.00
	07100 AMBULANCE 07300 CMHC	0	, s		58 0 0 0	24, 558 0	71.00 73.00
80.00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100 INTEREST EXPENSE 08200 UTI LI ZATI ON REVI EW - SNF						81.00 82.00
	08300 HOLLATION LEVIEW - SMI 08300 HOSPICE SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0		16, 528, 6	0 0 96 0	0 16, 528, 696	83.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	C		0 0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSICIANS PRIVATE OFFICES	0	0		95 O	95 0	1
93.00	09300 NONPAI D WORKERS	0	0		0 0	0	93.00
	09400 PATIENTS LAUNDRY 09500 MARKETING	0	0		0 0	0	
	09501 CLINIC	0			0 0	0	
95.02	09502 INDEPENDENT LIVING	0	C		0 0	0	95.02
98.00 99.00	Cross Foot Adjustments Negative Cost Centers	0			0 0	0	
	TOTAL	0			-		

	Financial Systems TION OF CAPITAL RELATED COSTS	THE MA		No.: 315153 P	In Lie eriod:	u of Form CMS-: Worksheet B	2540-10
ALLOUP	TION OF CALLINE RELATED COSTS		Trovider	F	rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre 5/27/2023 9:3	
			CAPI TAL RE	LATED COSTS			
	Cost Center Description	Di rectly Assigned New Capital	BLDGS & FI XTURES	MOVABLE EQUI PMENT	Subtotal	EMPLOYEE BENEFI TS	
		Related Costs 0	1.00	2.00	2A	3.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	25	3.00	
1.00	00100 CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS	0	0		0	0	2.00
3.00 4.00	00400 ADMINISTRATIVE & GENERAL	0	109, 974	43.738	153, 712	0	4.00
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS	0	17, 953			0	5.00
6.00	00600 LAUNDRY & LINEN SERVICE	0	8, 014			0	6.00
7.00	00700 HOUSEKEEPI NG	0	3, 290			0	7.00
8.00	00800 DI ETARY	0	44, 934			0	8.00
9.00	00900 NURSI NG ADMI NI STRATI ON	0	4, 523	1, 799	6, 322	0	9.00
10.00 11.00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY	0	0		0	0	10.00
12.00	01200 MEDI CAL RECORDS & LI BRARY	0	2, 143	852	2, 995	0	12.00
13.00	01300 SOCIAL SERVICE	0	2, 161			0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	C	0	0	14.00
15.00	01500 ACTIVITIES	0	19, 151	7, 617	26, 768	0	15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY		1/1 5/5	(4.250	225 024	0	
30.00 31.00	03100 NURSING FACILITY	0	161, 565 0		225, 824 0	0	30.00
32.00	03200 I CF/I I D	0	0	-	-	0	32.00
33.00	03300 OTHER LONG TERM CARE	0	0		-	0	•
	ANCI LLARY SERVI CE COST CENTERS						
40.00	04000 RADI OLOGY	0	0			0	40.00
41.00		0	0	C	0	0	41.00
42.00 43.00	04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATION) THERAPY	0			0	0	42.00
44.00	04400 PHYSI CAL THERAPY	0	17, 253	6, 862	24, 115	0	44.00
45.00	04500 OCCUPATI ONAL THERAPY	0	525			0	45.00
46.00	04600 SPEECH PATHOLOGY	0	665			0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	1 514			0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0	1, 514 1, 295			0	48.00 49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	1, 275			0	50.00
51.00	05100 SUPPORT SURFACES	0	0		-	0	51.00
	OUTPATIENT SERVICE COST CENTERS						1
60.00	06000 CLINIC	0	0			0	60.00
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FQHC	0	C	C	0	0	61.00 62.00
02.00	OTHER REIMBURSABLE COST CENTERS						02.00
70.00	07000 HOME HEALTH AGENCY COST	0	C	C	0	0	70.00
71.00	07100 AMBULANCE	0	C	C	0	0	71.00
73.00	07300 CMHC	0	0	C	0	0	73.00
00.00	SPECIAL PURPOSE COST CENTERS	1 1		1	1		
80.00 81.00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE						80.00 81.00
82.00	08200 UTILIZATION REVIEW - SNF						82.00
83.00	08300 HOSPI CE	0	0	c	0	0	
89.00	SUBTOTALS (sum of lines 1-84)	0	394, 960	157, 082	552, 042	0	89.00
00.00	NONREI MBURSABLE COST CENTERS			-		-	00.07
90.00 91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0			0	•
91.00 92.00	09200 PHYSICIANS PRIVATE OFFICES	0			0	0	
93.00	09300 NONPALD WORKERS	0	0		0	0	
94.00	09400 PATIENTS LAUNDRY	0	C	d d	0	0	
95.00	09500 MARKETI NG	0	C	C	0	0	•
95.01	09501 CLINIC	0	C	C	0	0	
95.02	09502 INDEPENDENT LIVING	0	C	۲ (C	0	0	
98.00 99.00	Cross Foot Adjustments Negative Cost Centers		0		0	0	98.00 99.00
100.00		0	394, 960	157, 082	552, 042		100.00
		, U	574, 700	1 107,002	552, 542	0	1.00.00

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	THE MA	Provi der	F	eriod: rom 01/01/2022 o 12/31/2022	5/27/2023 9:3	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES	1					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	153, 712 6, 813 1, 536	31, 906 958	13, 695			2.00 3.00 4.00 5.00 6.00
7.00	00700 HOUSEKEEPING	5, 763	393			0/ 070	7.00
3.00		16, 808	5, 369			86, 872	8.00
7.00 10.00	00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY	8, 928 0	540 0		190 0	0	9.00 10.00
11.00	01100 PHARMACY	0	0		0	0	11.00
12.00	01200 MEDICAL RECORDS & LIBRARY	395	256	0	90	0	12.00
13.00	01300 SOCIAL SERVICE	2, 230	258		91	0	13.00
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500 ACTI VI TI ES	4, 154	2, 288	0	805	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 SKI LLED NURSI NG FACI LI TY	89, 640	19, 305			86, 872	30.00
	03100 NURSING FACILITY 03200 ICF/IID	0	0	0	0	0	31.00 32.00
32.00 33.00	03300 OTHER LONG TERM CARE	0	0			0	32.00
55.00	ANCI LLARY SERVI CE COST CENTERS	Y	0	0	U	0	33.00
40.00	04000 RADI OLOGY	253	0	0	0	0	40.00
41.00	04100 LABORATORY	82	0	0	0	0	41.00
42.00	04200 I NTRAVENOUS THERAPY	1, 497	0	0	0	0	42.00
43.00	04300 OXYGEN (INHALATION) THERAPY	1, 143	0	0	0	0	43.00
44.00	04400 PHYSI CAL THERAPY	8, 378	2,061	0	726	0	44.00
45.00	04500 OCCUPATIONAL THERAPY	8	63		22 28	0	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	10 22	79 0		28	0	46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 275	181		64	0	47.00
49.00	04900 DRUGS CHARGED TO PATIENTS	3, 180	155	0	54	0	49.00
50.00	05000 DENTAL CARE - TITLE XIX ONLY	0	0			0	50.00
51.00	05100 SUPPORT SURFACES	368	0	0	0	0	51.00
	OUTPATIENT SERVICE COST CENTERS	1 1			1		
50.00	06000 CLINIC	0	0			0	60.00
51.00	06100 RURAL HEALTH CLINIC	0	0	0	0	0	61.00
52.00	06200 FQHC OTHER REIMBURSABLE COST CENTERS						62.00
70.00	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	228	0			0	
73.00	07300 СМНС	0	0	0	0	0	73.00
	SPECIAL PURPOSE COST CENTERS						
30.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
31.00	08100 INTEREST EXPENSE 08200 UTILIZATION REVIEW - SNF						81.00
32.00 33.00	08200 HOSPICE	0	0	0	0	0	82.00 83.00
39.00 39.00	SUBTOTALS (sum of lines 1-84)	153, 711	31, 906	13, 695	10, 754	86, 872	89.00
57.00	NONREI MBURSABLE COST CENTERS	100,711	01,700	10,070	10,701	00,072	07.00
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100 BARBER AND BEAUTY SHOP	1	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 95.01	09500 MARKETI NG	0	0		0	0	95.00
95.01 95.02	09501 CLINIC 09502 INDEPENDENT LIVING	0	0		0	0	95.01 95.02
93.02 98.00	Cross Foot Adjustments		0		0	0	95.02
		0	0		0	0	99.00
99.00	Negative Cost Centers	UI UI	0	0	U1	0	99.00

	Financial Systems TION OF CAPITAL RELATED COSTS		Provi der	No.: 315153		riod: om 01/01/2022		pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY		RECORDS & LI BRARY	SOCIAL SERVICE	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS			1				1
1.00 2.00 3.00 4.00 5.00 6.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE							1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00	00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY	15, 980 0 0	C		0			7.00 8.00 9.00 10.00 11.00
12.00 13.00 14.00	01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION	0 0 0			0 0 0	3, 736 0 0	5, 599 0	12.00 13.00
15.00	01500 ACTI VI TI ES	0	C		0	0	0	15.00
00 55	INPATIENT ROUTINE SERVICE COST CENTERS			N.	_		= == : :	00.00
30.00	03000 SKI LLED NURSI NG FACI LI TY	15, 980	C		0	3, 736	5, 599	
31.00 32.00	03100 NURSING FACILITY 03200 ICF/IID	0	C		0	0	0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE	0	C		0	0	0	1
55.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>		4	0	0	0	55.00
40.00	04000 RADI OLOGY	0	C		0	0	0	40.00
41.00	04100 LABORATORY	0	C		0	0	0	41.00
42.00	04200 INTRAVENOUS 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	D	0	0	0	45.00
46.00	04600 SPEECH PATHOLOGY	0	C		0	0	0	46.00
47.00	04700 ELECTROCARDI OLOGY	0	C		0	0	0	47.00
48.00 49.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS 04900 DRUGS CHARGED TO PATIENTS	0			0	0	0	48.00 49.00
49.00 50.00	05000 DENTAL CARE - TITLE XIX ONLY	0			0	0	0	50.00
51.00	05100 SUPPORT SURFACES	0			0	0	0	51.00
51.00	OUTPATIENT SERVICE COST CENTERS	U	- C	4	0	0	0	51.00
60.00	06000 CLINIC	0	C	b	0	0	0	60.00
61. 00 62. 00	06100 RURAL HEALTH CLINIC 06200 FOHC	0	C		0	0	0	61.00 62.00
70.00	OTHER REIMBURSABLE COST CENTERS	0	C	1	0	0	0	70.00
71.00	07100 AMBULANCE	0	C	1	0	0		71.00
	07300 CMHC	0	C	1	0	0	0	73.00
/0.00	SPECIAL PURPOSE COST CENTERS			1				/ 01 00
80.00	08000 MALPRACTICE PREMIUMS & PAID LOSSES							80.00
81.00	08100 INTEREST EXPENSE							81.00
82.00	08200 UTILIZATION REVIEW - SNF							82.00
83.00	08300 HOSPI CE	0	C		0	0	0	
89.00 90.00	SUBTOTALS (sum of lines 1-84) NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	15, 980	C	1	0	3, 736		
	09100 BARBER AND BEAUTY SHOP	0	C		0	0	0	
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0	C		0	0	0	
93.00	09300 NONPAID WORKERS	0	C		0	0	0	
94.00	09400 PATIENTS LAUNDRY	0	C		0	0	0	
95.00	09500 MARKETI NG	0	C		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		0			98.00
99.00	Negative Cost Centers	0 15, 980	C		0	0	0	99.00 100.00
100.00) TOTAL			11	0	3, 736	5 500	

Heal th	Financial Systems	THE M	ANOR		In Lie	u of Form CMS-:	2540-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/27/2023 9:3	
	Cost Center Description	NURSI NG AND ALLI ED HEALTH EDUCATI ON	OTHER GENERAL SERVI CE ACTI VI TI ES	Subtotal	Post Step-Down Adjustments	Total	
		14.00	15.00	16.00	17.00	18.00	
1 00	GENERAL SERVICE COST CENTERS		1	1			1 00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\end{array}$	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DI ETARY 00900 NURSING ADMINISTRATION 01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY 01300 SOCIAL SERVICE						$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00 \end{array}$
14.00	01400 NURSING AND ALLIED HEALTH EDUCATION	0					14.00
15.00	01500 ACTIVITIES INPATIENT ROUTINE SERVICE COST CENTERS	0	34, 015				15.00
30.00	03000 SKILLED NURSING FACILITY	0	34, 015	501, 460	0 0	501, 460	30.00
31.00	03100 NURSING FACILITY	0	0	0		0	31.00
32.00 33.00	03200 I CF/IID 03300 OTHER LONG TERM CARE	0				0	32.00 33.00
33.00	ANCI LLARY SERVICE COST CENTERS	0	0	1		0	33.00
40.00	04000 RADI OLOGY	0				253	40.00
41.00 42.00	04100 LABORATORY	0	0	-		82	41.00
42.00	04200 INTRAVENOUS THERAPY 04300 OXYGEN (INHALATION) THERAPY	0		1, 497 1, 143		1, 497 1, 143	42.00 43.00
44.00	04400 PHYSI CAL THERAPY	0	0	35, 280		35, 280	44.00
45.00	04500 OCCUPATIONAL THERAPY	0	0	827		827	45.00
46.00 47.00	04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY	0	0	1,046		1, 046 22	46.00 47.00
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4, 636		4, 636	48.00
49.00	04900 DRUGS CHARGED TO PATIENTS	0	0	5, 199		5, 199	49.00
50.00 51.00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES	0	0			0 368	50.00 51.00
51.00	OUTPATIENT SERVICE COST CENTERS	0	0				51.00
60.00	06000 CLI NI C	0				0	60.00
61.00	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	0					71.00
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	73.00
80. 00	08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
	08100 INTEREST EXPENSE						81.00
82.00 83.00	08200 UTI LI ZATI ON REVI EW - SNF 08300 HOSPI CE	0	0) 0	0	82.00 83.00
89.00	SUBTOTALS (sum of lines 1-84)	0		552, 041		552, 041	89.00
	NONREI MBURSABLE COST CENTERS	-					
	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0				0	90.00
91.00 92.00	09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0	0	1		1 0	91.00 92.00
	09300 NONPAI D WORKERS	0	0	0	0 0	0	93.00
94.00	09400 PATIENTS LAUNDRY	0	0	(0 0	0	94.00
95. 00 95. 01	09500 MARKETI NG 09501 CLI NI C					0	95.00 95.01
95. 01 95. 02	09502 I NDEPENDENT LI VI NG	0	0			0	95.01
98.00	Cross Foot Adjustments	0	0	C	0 0	0	98.00
99.00	Negative Cost Centers	0		552 042	-	0 552 042	99.00
100.00	TOTAL	1 0	34, 015	552, 042	<u>-</u> U	552, 042	100.00

	Financial Systems LLOCATION - STATISTICAL BASIS	THE MA		No.: 315153 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2022 o 12/31/2022		pared:
		CAPI TAL REL	ATED COSTS			372172023 7.3	
	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	
1.00 2.00 3.00 4.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL	45, 144 0 12, 570	45, 144 C	6, 078, 037		14, 474, 081	1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00	00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING 00800 DIETARY 00900 NURSING ADMINISTRATION	2, 052 916 376 5, 136 517	2, 052 916 376	164, 795 70, 640 352, 125 832, 757	0 0 0 0	641, 549 144, 615 542, 644 1, 582, 697 840, 654	5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00	01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY 01300 SOCI AL SERVI CE	0 0 245 247	245 247	0 0 0		0 0 37, 239 209, 988	10.00 11.00 12.00 13.00
14. 00 15. 00	01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	2, 189	2, 189	249, 082	0	0 391, 175	14.00 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	18, 467 0 0 0	18, 467 C C C	0	0	8, 440, 804 0 0 0	30.00 31.00 32.00 33.00
	ANCILLARY SERVICE COST CENTERS			-			1
40.00 41.00 42.00 43.00 44.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY 04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0 0 0 0 1,972	0 0 0 0 1, 972	000000000000000000000000000000000000000	000000000000000000000000000000000000000	23, 834 7, 731 140, 915 107, 608 788, 926	40.00 41.00 42.00 43.00 44.00
44.00 45.00 46.00 47.00 48.00	04500 OCCUPATI ONAL THERAPY 04600 SPEECH PATHOLOGY 04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	60 76 0 173	60 76 0	0 0 0	0	734 734 929 2, 081 214, 244	45.00 46.00 47.00
49. 00 50. 00 51. 00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES 0UTPATIENT SERVICE COST CENTERS	148 0 0	148 0	0		299, 469 0	49.00 50.00 51.00
60. 00 61. 00 62. 00	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC 0THER REIMBURSABLE COST CENTERS	0	C C			0	60.00 61.00 62.00
71.00 73.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC SPECIAL PURPOSE COST CENTERS	000000		0	0	21, 505	71.00
80.00 81.00 82.00 83.00 89.00	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	0 6, 078, 037	0 -2, 054, 710	0 14, 473, 998	80.00 81.00 82.00 83.00 89.00
	NONREI MBURSABLE COST CENTERS 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP	0	0 0	0	0	L	90. 00 91. 00
93.00 94.00 95.00 95.01	09200 PHYSICIANS PRIVATE OFFICES 09300 NONPAID WORKERS 09400 PATIENTS LAUNDRY 09500 MARKETING 09501 CLINIC	0 0 0 0		0 0 0 0 0	0 0 0 0	0 0 0 0	92.00 93.00 94.00 95.00 95.01
95.02 98.00 99.00 102.00		0 394, 960	0 157, 082	0 1, 605, 140	0	0 2, 054, 710	95.02 98.00 99.00 102.00
103.00 104.00		8. 748892	3. 479576	0. 264089 0	9	0. 141958 153, 712	1
105.00				0. 000000)	0. 010620	105. 00

	Financial Systems	THE M		N 045450 D		u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2022	Worksheet B-1	
				T	o 12/31/2022	Date/Time Pre 5/27/2023 9:3	
	Cost Center Description	PLANT OPERATI ON, MAI NT. & REPAI RS	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSI NG	
		(SQUARE FEET)	,			YS)	
	OFNEDAL CEDILLOE COCT OFNITEDO	5.00	6.00	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS - BLDGS & FIXTURES			1			1.00
2.00 3.00 4.00 5.00	00200 CAP REL COSTS - MOVABLE EQUI PMENT 00300 EMPLOYEE BENEFITS 00400 ADMINI STRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS	30, 522					2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 LAUNDRY & LI NEN SERVI CE 00700 HOUSEKEEPI NG 00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON	916 376 5, 136 517	0	29, 230		29, 484	6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00	01000 CENTRAL SERVICES & SUPPLY 01100 PHARMACY 01200 MEDICAL RECORDS & LIBRARY	0 0 245	0	0 0 245	0	0 0 0	11.00
13.00 14.00 15.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	247 0 2, 189	-	0	0 0 0	0 0 0	14.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 31. 00 32. 00	03000 SKILLED NURSING FACILITY 03100 NURSING FACILITY 03200 ICF/IID	18, 467 0 0	0	0	0	29, 484 0 0	31.00 32.00
33.00	03300 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	33.00
40. 00 41. 00	04000 RADI OLOGY 041001 LABORATORY	0	0			0	
42.00	04200 I NTRAVENOUS THERAPY	0	0	0	0	0	
43.00 44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSICAL THERAPY	0 1, 972		0 1, 972	0	0	
		60		60	0	0	
46.00	04600 SPEECH PATHOLOGY	76		76	0	0	
47.00 48.00	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 173	-	0 173	0	0	
49.00	04900 DRUGS CHARGED TO PATIENTS	148				0	
50. 00 51. 00	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0				0	
60.00	06000 CLI NI C	0				0	•
61.00 62.00	06100 RURAL HEALTH CLINIC 06200 FOHC OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	61.00 62.00
	07000 HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
	07100 AMBULANCE	0	-	-	-	0	
73.00	07300 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	73.00
80. 00 81. 00	08000 MALPRACTI CE PREMI UMS & PAI D LOSSES 08100 I NTEREST EXPENSE						80. 00 81. 00
82.00 83.00 89.00	08200 UTILIZATION REVIEW - SNF 08300 HOSPICE SUBTOTALS (sum of lines 1-84)	0 30, 522	0 29, 484	-	-	0 29, 484	
00.05	NONREI MBURSABLE COST CENTERS						
90.00 91.00 92.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0		0	0	0 0 0	91.00
93.00	09300 NONPAI D WORKERS	0	0	0	0	0	93.00
94.00 95.00	09400 PATIENTS LAUNDRY 09500 MARKETING	0	0	0		0	
95.00 95.01	09500 MARKETTING 09501 CLINIC	0	0	-	-	0	
95.02	09502 I NDEPENDENT LI VI NG	0	0	0	Ő	0	95.02
98.00	Cross Foot Adjustments						98.00
99.00 102.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	732, 622	187, 131	628, 702	2, 041, 123	983, 522	99.00 102.00
103.00 104.00	Unit cost multiplier (Wkst. B, Part I)	24. 003080 31, 906				33. 357821 15, 980	103. 00 104. 00
105.00		1. 045344	0. 464489	0. 367910	0. 998678	0. 541989	105. 00

	Financial Systems NLLOCATION - STATISTICAL BASIS	THE MA		No.: 315153 Pe	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
0001 /	LECONTION STATISTICAL DASIS				rom 01/01/2022	Date/Time Pre	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	5/27/2023 9:3 NURSI NG AND	<u>1 am</u>
		SERVICES & SUPPLY (COSTED	(COSTED REQ UIS)	RECORDS & LI BRARY (PATI ENT DA	(PATI ENT DA YS)	ALLI ED HEALTH EDUCATI ON (ASSI GNED	
		REQUIS.) 10.00	11.00	YS) 12.00	13.00	TIME) 14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	11.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00	00100 CAP REL COSTS - BLDGS & FIXTURES 00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS 00400 ADMINISTRATIVE & GENERAL 00500 PLANT OPERATION, MAINT. & REPAIRS 00600 LAUNDRY & LINEN SERVICE 00700 HOUSEKEEPING						1.00 2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON 01000 CENTRAL SERVI CES & SUPPLY 01100 PHARMACY 01200 MEDI CAL RECORDS & LI BRARY	0 0 0	0 0	29, 484			8.00 9.00 10.00 11.00 12.00
14.00	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION 01500 ACTIVITIES	0 0 0	0 0 0	0 0 0	29, 484 0 0	0	1
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 SKI LLED NURSI NG FACI LI TY	o	0	29, 484	29, 484	0	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
10.00	ANCI LLARY SERVICE COST CENTERS		0				
41.00	04000 RADI OLOGY 04100 LABORATORY 04200 I NTRAVENOUS THERAPY	0 0 0	0 0 0		0 0 0	0 0 0	40.00 41.00 42.00
44.00	04300 OXYGEN (INHALATION) THERAPY 04400 PHYSI CAL THERAPY 04500 OCCUPATIONAL THERAPY	0	0 0 0	0 0 0	0 0 0	0 0 0	43.00 44.00 45.00
	04600 SPEECH PATHOLOGY	0	0	0	0	0	46.00
	04700 ELECTROCARDI OLOGY 04800 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	47.00
	04900 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
	05000 DENTAL CARE - TITLE XIX ONLY 05100 SUPPORT SURFACES OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	50.00 51.00
	06000 CLINIC 06100 RURAL HEALTH CLINIC 06200 FQHC	0	0	0	0 0	0 0	60.00 61.00 62.00
70.00	OTHER REIMBURSABLE COST CENTERS		0				1 70 00
71.00	07000 HOME HEALTH AGENCY COST 07100 AMBULANCE 07300 CMHC	0 0 0	0 0 0		0 0 0	0 0 0	71.00
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81. 00 82. 00	08100 INTEREST EXPENSE	0	0		0	0	81.00 82.00
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	0	0		29, 484	0	89.00
91.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 09100 BARBER AND BEAUTY SHOP 09200 PHYSI CLANS PRI VATE OFFI CES	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	90.00 91.00 92.00
94.00	09300 NONPAI D WORKERS 09400 PATI ENTS LAUNDRY 09500 MARKETI NG	0	0 0	0	0 0	0 0 0	93.00 94.00 95.00
95.01	09501 CLINIC 09502 INDEPENDENT LIVING Cross Foot Adjustments Negative Cost Centers	0	0	0	0 0	0	95.00 95.01 95.02 98.00 99.00
102.00 103.00	Cost to be allocated (per Wkst. B, Part I)	0. 000000	0. 000000	53, 676 1. 820513	251, 039 8. 514415	0. 000000	102.00
104.00	Cost to be allocated (per Wkst. B, Part II)	0	0	3, 736	5, 599	0	104.00
105.00) Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 126713	0. 189900	0.00000	105.00

	Financial Systems LLOCATION - STATISTICAL BASIS	THE MANOR	Provider No.: 315153	Peri od:	ı of Form CMS-2540- Worksheet B-1
				From 01/01/2022 To 12/31/2022	Date/Time Prepared
					5/27/2023 9:31 am
		OTHER GENERAL SERVI CE			
	Cost Center Description	ACTI VI TI ES			
		(PATI ENT DA YS)			
		15.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS - BLDGS & FLXTURES				1.
2.00 3.00	00200 CAP REL COSTS - MOVABLE EQUIPMENT 00300 EMPLOYEE BENEFITS				2.
4.00	00400 ADMI NI STRATI VE & GENERAL				4.
5.00	00500 PLANT OPERATION, MAINT. & REPAIRS				5.
6.00	00600 LAUNDRY & LINEN SERVICE				6.
7.00	00700 HOUSEKEEPING				7.
8.00 9.00	00800 DI ETARY 00900 NURSI NG ADMI NI STRATI ON				8.
10.00	01000 CENTRAL SERVICES & SUPPLY				10.
	01100 PHARMACY				11.
12.00	01200 MEDI CAL RECORDS & LI BRARY				12.
	01300 SOCIAL SERVICE 01400 NURSING AND ALLIED HEALTH EDUCATION				13.
	01500 ACTIVITIES	29, 484			14.
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	27,101			10.1
30. 00	03000 SKI LLED NURSI NG FACI LI TY	29, 484			30.
	03100 NURSING FACILITY	0			31.
32.00 33.00	03200 ICF/IID 03300 OTHER LONG TERM CARE	0			32. 33.
55.00	ANCI LLARY SERVICE COST CENTERS	0			
40.00	04000 RADI OLOGY	0			40.
	04100 LABORATORY	0			41.
42.00	04200 I NTRAVENOUS THERAPY	0			42.
43.00 44.00	04300 OXYGEN (I NHALATI ON) THERAPY 04400 PHYSI CAL THERAPY	0			43. 44.
	04500 OCCUPATI ONAL THERAPY	0			45.
46.00	04600 SPEECH PATHOLOGY	0			46.
	04700 ELECTROCARDI OLOGY	0			47.
48.00	04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			48.
49.00 50.00	04900 DRUGS CHARGED TO PATIENTS 05000 DENTAL CARE - TITLE XIX ONLY	0			49. 50.
51.00	05100 SUPPORT SURFACES	Ö			51.
	OUTPATIENT SERVICE COST CENTERS				
60.00	06000 CLINIC	0			60.
	06100 RURAL HEALTH CLINIC 06200 FQHC	0			61. 62.
02.00	OTHER REIMBURSABLE COST CENTERS				02.
70.00	07000 HOME HEALTH AGENCY COST	0			70.
	07100 AMBULANCE	0			71.
73.00	07300 CMHC	0			73.
80. 00	SPECIAL PURPOSE COST CENTERS 08000 MALPRACTICE PREMIUMS & PAID LOSSES				80.
81.00	08100 I NTEREST EXPENSE				81.
82.00	08200 UTILIZATION REVIEW - SNF				82.
83.00	08300 HOSPI CE	0			83.
89.00	SUBTOTALS (sum of lines 1-84) NONREIMBURSABLE COST CENTERS	29, 484			89.
90.00	09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0			90.
91.00	09100 BARBER AND BEAUTY SHOP	0			91.
92.00	09200 PHYSI CLANS PRI VATE OFFI CES	0			92.
	09300 NONPALD WORKERS	0			93.
94.00 95.00	09400 PATIENTS LAUNDRY 09500 MARKETING	0			94. 95.
95.00	09501 CLI NI C	0			95.
95.02	09502 INDEPENDENT LIVING	0			95.
98.00	Cross Foot Adjustments				98.
99.00	Negative Cost Centers	F/4 221			99. 102.
102.00	Cost to be allocated (per Wkst. B, Part I)	546, 331			102.
103.00		18. 529745			103.
104.00	Cost to be allocated (per Wkst. B,	34, 015			104.
	Part II)				
105.00	Unit cost multiplier (Wkst. B, Part	1. 153677			105.

Health Financial Systems	THE MANOR		In Lie	u of Form CMS-	2540-10
RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST	CENTERS Provi de		Period:	Worksheet C	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/27/2023 9:3	pared: <u>1 am</u>
Cost Center Description		Total (from			
		Wkst. B, Pt I	r	di vi ded by	
		col . 18)		col. 2	
		1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS				0.075/00	
40. 00 04000 RADI OLOGY		27, 21			•
41.00 04100 LABORATORY		8, 82			•
42. 00 04200 I NTRAVENOUS THERAPY		160, 91			
43.00 04300 OXYGEN (INHALATION) THERAPY		122, 88			•
44. 00 04400 PHYSI CAL THERAPY		990, 66			•
45.00 04500 OCCUPATI ONAL THERAPY		3, 56			•
46.00 04600 SPEECH PATHOLOGY		4, 52			•
47.00 04700 ELECTROCARDI OLOGY		2, 37			•
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS		252, 53			•
49.00 04900 DRUGS CHARGED TO PATIENTS		348, 71	6 167, 191		•
50.00 05000 DENTAL CARE - TITLE XIX ONLY			0 0	0.000000	•
51.00 05100 SUPPORT SURFACES		39, 57	7 40, 080	0. 987450	51.00
OUTPATI ENT SERVICE COST CENTERS		I			
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		24, 55			•
100. 00 Total		1, 986, 36	5 6, 088, 248		100.00

Health Financial Systems	THE MA	ANOR		In Lie	u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Period:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narod
				10 12/31/2022	5/27/2023 9:3	
		Title	XVIII (1)	Skilled Nursing		<u> </u>
				Facility		
		Health Care Pr	rogram Charges	Heal th Care	Program Cost	
	Ratio of Cost	Part A	Part B	Part A (col. 1		
	to Charges			x col. 2)	x col. 3)	
	(Fr. Wkst. C					
	Column 3)					
	1.00	2.00	3.00	4.00	5.00	
PART I - CALCULATION OF ANCILLARY AND OUTPAT	ITENT COST					+
ANCI LLARY SERVI CE COST CENTERS 40. 00 04000 RADI OLOGY	0. 875680	29, 676		0 25, 987	0	40.00
40. 00 104000 RADI OLOGY 41. 00 04100 LABORATORY	0. 875880					
41. 00 04100 LABORATORY 42. 00 04200 I NTRAVENOUS THERAPY	0. 987439			0 7, 295	0	
43. 00 04300 OXYGEN (INHALATION) THERAPY	0. 987439			0 0	0	
43. 00 04400 PHYSI CAL THERAPY	0. 555159			0 990, 670	0	•
45. 00 04500 OCCUPATI ONAL THERAPY	0. 001930			0 990, 870		
45. 00 04500 OCCUPATIONAL THERAPT 46. 00 04600 SPEECH PATHOLOGY	0. 001930			0 3, 319		
47. 00 04700 ELECTROCARDI OLOGY	0. 987121	287		0 4, 320	0	
48. 00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 991033			203	0	
49. 00 04900 DRUGS CHARGED TO PATIENTS	2. 085734			0 348, 716	0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0. 000000			0 340, 710	0	50.00
51. 00 05100 SUPPORT SURFACES	0. 987450			0 0	0	
OUTPATIENT SERVICE COST CENTERS	0. 707430	0		0 0	0	51.00
60. 00 06000 CLINIC	0. 000000	0		0 0	0	60.00
61. 00 06100 RURAL HEALTH CLINIC	51 000000				Ū	61.00
62. 00 06200 FQHC						62.00
71.00 07100 AMBULANCE (2)	0. 987455			o	0	
100.00 Total (Sum of lines 40 - 71)		5, 288, 682		0 1, 380, 790	-	100.00
					-	

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

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

Health Financial Systems	THE MA				u of Form CMS-	2540-10
APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provi der		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Parts II-III Date/Time Pre 5/27/2023 9:3	pared: 1 am
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		·			1.00	
PART II - APPORTIONMENT OF VACCINE COST					1.00	
1.00 Drugs charged to patients - ratio of c	ost to charges (From Workshee	t C, column 3	, line 49)	2.085734	1.00
2.00 Program vacci ne charges (From your rec					0	2.00
3.00 Program costs (Line 1 x line 2) (Title	XVIII, PPS prov	iders, transf	er this amoun	t to Worksheet	0	3.00
E, Part I, line 18)						
Cost Center Description	Total Cost	Nursing &	Ratio of	Program Part A		
	(From Wkst. B,			Cost (From	& Allied	
	Part I, Col.				Health Costs	
	18		Costs to Tota		for Pass	
		14)	Costs - Part		Through (Col.	
			(Col. 2 / Col 1)		3 x Col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - CALCULATION OF PASS THROUGH COSTS	FOR NURSING &	ALLIED HEALTH				
ANCILLARY SERVICE COST CENTERS						
40. 00 04000 RADI OLOGY	27, 217	0	0.0000	0 25, 987	0	40.00
41. 00 04100 LABORATORY	8, 828	0	0.0000	0 7, 295	0	41.00
42.00 04200 INTRAVENOUS THERAPY	160, 919	0	0.00000		0	42.00
43.00 04300 OXYGEN (INHALATION) THERAPY	122, 884	0	0.00000		0	43.00
44. 00 04400 PHYSI CAL THERAPY	990, 669	0	0.00000		0	44.00
45. 00 04500 OCCUPATI ONAL THERAPY	3, 569	0	0.00000		0	45.00
46.00 04600 SPEECH PATHOLOGY	4, 520	0	0.00000		0	46.00
47.00 04700 ELECTROCARDI OLOGY	2, 376	0	0.00000		0	
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATIENTS	252, 532	0	0.00000		0	
49.00 04900 DRUGS CHARGED TO PATIENTS	348, 716	0	0.0000		0	
50. 00 05000 DENTAL CARE - TITLE XIX ONLY	0	0	0.0000		0	
51.00 05100 SUPPORT SURFACES	39, 577	0	0.00000		0	
100.00 Total (Sum of Lines 40 - 52)	1, 961, 807	0	1	1, 380, 790	0	100.00

Health Financial Systems THE MANOR COMPUTATION OF INPATIENT ROUTINE COSTS THE MANOR		Provider No.: 315153	Period: From 01/01/2022 To 12/31/2022		pare
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				-
	INPATIENT DAYS Inpatient days including private room days			29, 484	1 1.
	Private room days			27,404	2.
	Inpatient days including private room days applicable to the P	Program		7, 793	
	Medically necessary private room days applicable to the Progra			0,1,1	4
	Total general inpatient routine service cost			14, 542, 331	5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges			11, 546, 477	6
00	General inpatient routine service cost/charge ratio (Line 5 d	livided by line 6)		1. 259460	7
	Enter private room charges from your records			0	-
00	Average private room per diem charge (Private room charges lin	ne 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-private room	charges line 10, divide	d by	0.00	11
	semi-private room days)	C .	2		
2.00	Average per diem private room charge differential (Line 9 minu	ıs line 11)		0.00	12
	Average per diem private room cost differential (Line 7 times			0.00	
	Private room cost differential adjustment (Line 2 times line 1			0	14
	General inpatient routine service cost net of private room cos	t differential (Line 5	minus line 14)	14, 542, 331	15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS	ided by line 1)		402.22	1.
	Adjusted general inpatient service cost per diem (Line 15 div Program routine service cost (Line 3 times line 16)	rided by Tine T)		493.23	
	Medically necessary private room cost applicable to program (ling 4 times ling 12)		3, 843, 741	
	Total program general inpatient routine service cost (Line 17			3, 843, 741	
	Capital related cost allocated to inpatient routine service cost		t II column 18	501, 460	
	line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)			001, 100	20
	Per diem capital related costs (Line 20 divided by line 1)			17.01	21
	Program capital related cost (Line 3 times line 21)			132, 559	22
	Inpatient routine service cost (Line 19 minus line 22)			3, 711, 182	
	Aggregate charges to beneficiaries for excess costs (From pro			0	24
	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	3, 711, 182	
	Enter the per diem limitation (1)				26
7 00	Inpatient routine service cost limitation (Line 3 times the pe	er diem limitation line	26) (1)		27
	Reimbursable inpatient routine service costs (Line 22 plus th				28

(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	29, 484	1.00
2.00	Program inpatient days (see instructions)	7, 793	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. 264313	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

	Financial Systems THE MANOR			u of Form CMS-2	
COMPUTATION OF INPATIENT ROUTINE COSTS		Provider No.: 315153	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/27/2023 9:3	pare
		Title XIX	Skilled Nursing Facility	PPS	
		÷			
	DADT I CALCULATION OF INDATIENT DOUTINE COSTS			1.00	
	PART I CALCULATION OF INPATIENT ROUTINE COSTS				+
1.00	Inpatient days including private room days			29, 484	1 1.
2.00	Private room days			27,404	
3.00	Inpatient days including private room days applicable to the Pr	rogram		13, 535	
1.00	Medically necessary private room days applicable to the Program	5		15, 555	4
5.00	Total general inpatient routine service cost			14, 542, 331	
. 00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			11, 012, 001	ľ
. 00	General inpatient routine service charges			11, 546, 477	1 6
. 00	General inpatient routine service cost/charge ratio (Line 5 di	vided by line 6)		1. 259460	
8. 00	Enter private room charges from your records	5		0	8
. 00	Average private room per diem charge (Private room charges line 2)	e 8 divided by private	room days, line	0.00	9
0.00	Enter semi-private room charges from your records			0	10
11.00	Average semi-private room per diem charge (Semi-private room o semi-private room days)	charges line 10, divide	ed by	0.00	
12.00	Average per diem private room charge differential (Line 9 minus	line 11)		0.00	12
3.00	Average per diem private room cost differential (Line 7 times I			0.00	
4.00	Private room cost differential adjustment (Line 2 times line 13			0.00	
15.00	General inpatient routine service cost net of private room cost		minus line 14)	14, 542, 331	
	PROGRAM INPATIENT ROUTINE SERVICE COSTS			11/012/001	1
6.00		ded by line 1)		493.23	1 16
7.00	Program routine service cost (Line 3 times line 16)	<u> </u>		6, 675, 868	17
8.00	Medically necessary private room cost applicable to program (I	ine 4 times line 13)		0	18
9.00	Total program general inpatient routine service cost (Line 17	plus line 18)		6, 675, 868	19
20.00	Capital related cost allocated to inpatient routine service cost line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	sts (From Wkst. B, Par	rt II column 18,	501, 460	20
1. 00	Per diem capital related costs (Line 20 divided by line 1)			17.01	21
22.00	Program capital related cost (Line 3 times line 21)			230, 230	22
23.00	Inpatient routine service cost (Line 19 minus line 22)			6, 445, 638	23
24.00	Aggregate charges to beneficiaries for excess costs (From prov	/ider records)		0	24
25.00	Total program routine service costs for comparison to the cost	limitation (Line 23 mi	nus line 24)	6, 445, 638	25
26.00	Enter the per diem limitation (1)			0.00	26
27.00	Inpatient routine service cost limitation (Line 3 times the per	diem limitation line	26) (1)	0	27
28.00	Reimbursable inpatient routine service costs (Line 22 plus the		line 27)	6, 675, 868	28
	(Transfor to Workshoot E. Part II. Line 4) (Soo instructions)				1

27.00	Inpatient routine service cost rhinitation (Line 3 times the per drein rhinitation rine 20) (1)	0	4
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)	6, 675, 868	2
	(Transfer to Worksheet E, Part II, line 4) (See instructions)		
(1) Li	nes 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	29, 484	1.00
2.00 Program inpatient days (see instructions)	13, 535	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. 459063	4.00
5.00 Program nursing & allied health costs for pass-through. (line 3 times line 4)	0	5.00

Heal th	Financial Systems	THE MANOR		In Lie	u of Form CMS-2	2540-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	Pr	ovider No.: 315153	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part I Date/Time Prep 5/27/2023 9:3	
			Title XVIII	Skilled Nursing Facility	PPS	
				-	1.00	
	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION O		NT		1.00	
1.00	Inpatient PPS amount (See Instructions)				4, 921, 438	1.00
2.00	Nursing and Allied Health Education Activities (pass	through payme	nts)		0	2.00
3.00	Subtotal (Sum of Lines 1 and 2)				4, 921, 438	
4.00	Primary payor amounts				0	4.00
5.00	Coinsurance				719, 067	5.00
6.00	Allowable bad debts (From your records)				115, 154	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructi	ons)		0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)				74, 850	8.00
9.00	Recovery of bad debts - for statistical records only				0	9.00
10.00	Utilization review				0	10.00
11.00	Subtotal (See instructions)				4, 277, 221	11.00
12.00	Interim payments (See instructions)				4, 145, 925	12.00
13.00	Tentati ve adjustment				0	13.00
14.00	OTHER adjustment (See instructions)				0	14.00
14.50	Demonstration payment adjustment amount before seques	stration			0	14.50
14.55	Demonstration payment adjustment amount after sequest	ration			0	14.55
14.75	Sequestration for non-claims based amounts (see instr	ructions)			943	14.75
14.99	Sequestration amount (see instructions)				56, 467	14.99
15.00	Balance due provider/program (see Instructions)				73, 886	15.00
16.00					0	16.00
	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEME	NT LESSER OF	COST OR CHARGES - T	ITLE XVIII ONLY		
	Ancillary services Part B				0	
18.00					0	
19.00					0	
20.00	, , , , , , , , , , , , , , , , , , ,				0	
21.00		20)			0	
22.00	515				0	
23.00					0	
	Allowable bad debts (From your records)				6, 359	
	Allowable Bad debts for dual eligible beneficiaries (see instructi	ons)		0	
	Adjusted reimbursable bad debts (see instructions)	00			4, 133	
	Subtotal (Sum of lines 21 and 24, minus lines 22 and	23)			4, 133	
	Interim payments (See instructions)				0	
27.00	5				0	
28.00	Other Adjustments (See instructions) Specify	tration			0	
28.50 28.55	Demonstration payment adjustment amount before seques				0	
28.55 28.99	Demonstration payment adjustment amount after sequest Sequestration amount (see instructions)	liation			52	
28.99 29.00	Balance due provider/program (see instructions)				52 4, 081	
	Protested amounts (Nonallowable cost report items) in	accordance "	ith CMS Dub 15 2 o	ection 115 2	4,081	
30.00	Frotested amounts (nonarrowable cost report filens) if	i accoruance w	1 th GWS PUD. 10-2, S		0	30.00

- 28.55 Demonstration payment adjustment amount ofter sequestration
 28.55 Demonstration amount (see instructions)
 29.00 Balance due provider/program (see instructions)
 30.00 Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2

Health Financial Systems	THE MANOR	In Lieu	u of Form CMS-2540-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	T TITLE V and TITLE XIX ONLY Prov	From 01/01/2022	Worksheet E Part II Date/Time Prepared:

Facility 1.00 COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient ancillary services (see Instructions) 1.00 2.00 Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) 0.00 0.00 Outpatient services 6,67 4.00 Inpatient routine services (see instructions) 6,67 5.00 Utilization reviewphysicians' compensation (from provider records) 6,67 6.00 Cost of covered services (Sum of lines 1 - 5) 6,67 7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6,67 8.00 SUBTOTAL (Line 6 minus line 7) 6,67 9.00 Primary payor amounts 6,67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6,67 7.00 Inpatient ancillary service charges 1 11.00 Inpatient service charges 1 12.00 Outpatient service charges 1 13.00 Inpatient routine service charges 1 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 <td< th=""><th>0 1.00 0 2.00 0 3.00 368 4.00 0 5.00</th></td<>	0 1.00 0 2.00 0 3.00 368 4.00 0 5.00
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.00 Inpatient ancillary services (see Instructions) 1.00 2.00 Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) 6.67 3.00 Outpatient services (see instructions) 6.67 5.00 Utilization reviewphysic lans' compensation (from provider records) 6.67 6.00 Cost of covered services (Sum of lines 1 - 5) 6.67 7.00 Differential in charges between semi private accommodations and less than semi private accommodations 6.67 8.00 SUBTOTAL (Line 6 minus line 7) 6.67 9.00 Primary payor amounts 6.67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6.67 REASONABLE CHARGES 6.67 11.00 Inpatient routine service charges 6.67 12.00 Uptatient service charges 6.67 13.00 Inpatient routine service charges 6.67 14.00 Inpatient accollarges between semiprivate accommodations and less than semiprivate accommodations 16.67 15.00 Total reasonable charges 6.67 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge b	0 2.00 0 3.00 368 4.00 0 5.00 368 6.00
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient ancillary services (see Instructions) 2.00 Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) 3.00 Outpatient services 4.00 Inpatient routine services (see instructions) 5.00 Utilization review-physicians' compensation (from provider records) 6.00 Cost of covered services (Sum of lines 1 - 5) 7.00 Differential in charges between semi private accommodations and less than semi private accommodations 8.00 SUBTOTAL (Line 6 minus line 7) 9.00 Primary payor amounts 10.00 Inpatient ancillary service charges 11.00 Inpatient ancillary service charges 12.00 Outpatient service charges 13.00 Inpatient actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.00000) 0.0 19.00 Ratio of REIMBURSEMENT SETLEMENT Cost of covered services (see Instructions) 20.00 Cost of covered services (see Instructions) 0.0 <th>0 2.00 0 3.00 368 4.00 0 5.00 368 6.00</th>	0 2.00 0 3.00 368 4.00 0 5.00 368 6.00
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient ancillary services (see Instructions) 2.00 Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) 3.00 Outpatient services 4.00 Inpatient routine services (see instructions) 5.00 Utilization review-physicians' compensation (from provider records) 6.00 Cost of covered services (Sum of lines 1 - 5) 7.00 Differential in charges between semi private accommodations and less than semi private accommodations 8.00 SUBTOTAL (Line 6 minus line 7) 9.00 Primary payor amounts 10.00 Inpatient ancillary service charges 11.00 Inpatient ancillary service charges 12.00 Outpatient service charges 13.00 Inpatient actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.00000) 0.0 19.00 Ratio of REIMBURSEMENT SETLEMENT Cost of covered services (see Instructions) 20.00 Cost of covered services (see Instructions) 0.0 <th>0 2.00 0 3.00 368 4.00 0 5.00 368 6.00</th>	0 2.00 0 3.00 368 4.00 0 5.00 368 6.00
1.00 Inpatient ancillary services (see Instructions) 2.00 Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) 0.00 Outpatient services 4.00 Inpatient routine services (see instructions) 5.00 Utilization reviewphysicians' compensation (from provider records) 6.00 Cost of covered services (Sum of Lines 1 - 5) 6.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 8.00 SUBTOTAL (Line 6 minus line 7) 9.00 Primary payor amounts 10.00 Total Reasonable Cost (Line 8 minus line 9) REASONABLE CHARGES 6,67 11.00 Inpatient routine service charges 12.00 Outpatient service charges 13.00 Inpatient routine service charges 14.00 Ifferential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Inpatient routine service charges 14.00 Ifferential in charges between semiprivate accommodations and less than semi private accommodations 15.00 Inpatient routine service charges 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance	0 2.00 0 3.00 368 4.00 0 5.00 368 6.00
2.00 Nursing & Allied Health Cost (From Worksheet D-1, Pt. II, line 5) 0 3.00 Outpatient services 6.67 4.00 Inpatient routine services (Sum of lines 1 - 5) 6.67 5.00 Utilization reviewphysicians' compensation (from provider records) 6.67 6.00 Cost of covered services (Sum of lines 1 - 5) 6.67 7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6.67 8.00 SUBTOTAL (Line 6 minus line 7) 6.67 9.00 Primary payor amounts 6.67 10.00 Inpatient ancillary service charges 6.67 11.00 Inpatient ancillary service charges 6.67 12.00 Outpatient service charges 6.67 13.00 Inpatient routine service charges 6.67 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6.67 15.00 Utpatient routine service charges 0 0 10.01 Inpatient notillary service charges 0 0 10.02 Sugregate amount actually collected from patients liable for payment for services on a charge basis ha such payment been made in accordance with 42	0 2.00 0 3.00 368 4.00 0 5.00 368 6.00
3.00 Outpatient services 6.67 4.00 Inpatient routine services (see instructions) 6.67 5.00 Utilization reviewphysicians' compensation (from provider records) 6.67 6.00 Cost of covered services (Sum of lines 1 - 5) 6.67 7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6.67 8.00 SUBTOTAL (Line 6 minus line 7) 6.67 9.00 Primary payor amounts 6.67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6.67 REASONABLE CHARGES 6.67 11.00 Inpatient routine service charges 6.67 12.00 Outpatient routine service charges 6.67 13.00 Inpatient routine service charges 6.67 14.00 Differential in charges between semi private accommodations and less than semi private accommodations 6.67 15.00 Total reasonable charges 6.67 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 6.67 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0 3.00 368 4.00 0 5.00 368 6.00
4.00 Inpatient routine services (see instructions) 6,67 5.00 Utilization reviewphysicians' compensation (from provider records) 6,67 6.00 Cost of covered services (Sum of lines 1 - 5) 6,67 7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6,67 8.00 SUBTOTAL (Line 6 minus line 7) 6,67 9.00 Primary payor amounts 6,67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6,67 REASONABLE CHARGES 6,67 11.00 Inpatient ancillary service charges 6,67 12.00 Outpatient service charges 6,67 13.00 Inpatient routine service charges 6,67 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 7 15.00 Total reasonable charges 0 0 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 7 15.00 Total reasonable charges 0 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accor	3684.0005.003686.00
5.00 Utilization reviewphysicians' compensation (from provider records) 6.0 6.00 Cost of covered services (Sum of lines 1 - 5) 6.67 7.00 Differential in charges between semi private accommodations and less than semi private accommodations 6.67 8.00 SUBTOTAL (Line 6 minus line 7) 6.67 9.00 Primary payor amounts 6.67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6.67 8.200 Nutpatient service charges 6.67 11.00 Inpatient ancillary service charges 6.67 12.00 Outpatient service charges 6.67 13.00 Inpatient routine service charges 6.67 14.00 Differential in charges between semi private accommodations and less than semi private accommodations 6.67 15.00 Total reasonable charges 6.67 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 6.67 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see Instructions) 0.0 0.00 Cost of covered services (see Instructions)	0 5.00 368 6.00
6.00 Cost of covered services (Sum of Lines 1 - 5) 6,67 7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6,67 8.00 SUBTOTAL (Line 6 minus line 7) 6,67 9.00 Primary payor amounts 6,67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6,67 REASONABLE CHARGES 6,67 11.00 Inpatient ancillary service charges 6,67 12.00 Outpatient service charges 6,67 13.00 Inpatient ancillary service charges 6,67 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6 15.00 Total reasonable charges 6 67 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 6 17.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0 COMPUTATION OF RELIMBURSEMENT SETLEMENT 7 20.00 Cost of covered services (see Instructions) 0 0.01 0	6. 00
7.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 8.00 SUBTOTAL (Line 6 minus line 7) 6,67 9.00 Primary payor amounts 6,67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6,67 REASONABLE CHARGES 6,67 11.00 Inpatient ancillary service charges 6,67 12.00 Outpatient service charges 6,67 13.00 Inpatient routine service charges 6,67 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6,67 15.00 Total reasonable charges 6,67 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 6,67 15.00 Total reasonable charges 6,67 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 6,67 17.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 0.0 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 0.0 19.00 Cost of covered services (see Instructions) 0 0.0	
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9.00 Primary payor amounts 6,67 10.00 Total Reasonable Cost (Line 8 minus line 9) 6,67 REASONABLE CHARGES 0 11.00 Inpatient ancillary service charges 0 12.00 Outpatient service charges 0 13.00 Inpatient routine service charges 0 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 0 15.00 Total reasonable charges 0 CUSTOMARY CHARGES 0 4 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 0 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0 20.00 Cost of covered services (see Instructions) 21.00 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 0 0	
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REASONABLE CHARGES 11.00 Inpatient ancillary service charges 12.00 Outpatient service charges 13.00 Inpatient routine service charges 14.00 Differential in charges between semi private accommodations and less than semi private accommodations 15.00 Total reasonable charges CUSTOMARY CHARGES Customary CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 20.00 Cost of covered services (see Instructions) 21.00 21.00 Deductibles 22.00 22.00 Subtotal (Line 20 minus line 21) 23.00 23.00 Coinsurance 10	368 10.00
11.00 Inpatient ancillary service charges 12.00 Outpatient service charges 13.00 Inpatient routine service charges 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Total reasonable charges CUSTOMARY CHARGES Clastomary charges (customary charges determine the patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	10100
12.00 Outpatient service charges 13.00 Inpatient routine service charges 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Total reasonable charges CUSTOMARY CHARGES CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 10 10	0 11.00
13.00 Inpatient routine service charges 14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Total reasonable charges CUSTOMARY CHARGES CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 1000000 0.0	0 12.00
14.00 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15.00 Total reasonable charges CUSTOMARY CHARGES CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 1000 1000	0 13.00
15.00 Total reasonable charges CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 10 10	0 14.00
CUSTOMARY CHARGES 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 19.00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	0 15.00
17.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 0.0 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 20.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance 1000000	
had such payment been made in accordance with 42 CFR 413.13(e) 0 18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF RELINBURSEMENT SETTLEMENT 0 20.00 Cost of covered services (see Instructions) 0 21.00 Deductibles 22.00 22.00 Subtotal (Line 20 minus line 21) 0 23.00 Coinsurance 0	0 16.00
18.00 Ratio of line 16 to line 17 (not to exceed 1.000000) 0.0 19.00 Total customary charges (see instructions) 0.0 COMPUTATION OF RELINBURSEMENT SETTLEMENT 0 20.00 Cost of covered services (see Instructions) 0 21.00 Deductibles 0 22.00 Subtotal (Line 20 minus line 21) 0 23.00 Coinsurance 0	0 17.00
19.00 Total customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	000 18.00
20.00 Cost of covered services (see Instructions) 21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	0 19.00
21.00 Deductibles 22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	
22.00 Subtotal (Line 20 minus line 21) 23.00 Coinsurance	0 20.00
23.00 Coinsurance	0 21.00
	0 22.00
24.00 Subtotal (Line 22 minus line 23)	0 23.00
	0 24.00
25.00 Allowable bad debts (from your records)	0 25.00
26.00 Subtotal (sum of lines 24 and 25)	0 26.00
27.00 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit	0 27.00
28.00 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization	0 28.00
29.00 Other Adjustments (see instructions) Specify	0 29.00
30.00 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (0 30.00
if minus, enter amount in parentheses)	0 01 00
31.00 Subtotal (Line 26 plus or minus lines 29, and 30, minus lines 27 and 28)	0 31.00
32.00 Interim payments	0 32.00
33.00 Balance due provider/program (Line 31 minus line 32) (indicate overpayments in parentheses) (see Instructions)	0 33.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	No.: 315153	Period: From 01/01/202 To 12/31/202		pare
		Ti tl	e XVIII	Skilled Nursin Facility		
		I npati en	it Part A		nrt 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		4, 145, 9	0 0	0	1
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	
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program		1			
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53				0	0	
54				0	0	
99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50			0	0	3
00	- 3.98)		4 145 0	25	0	4
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)		4, 145, 9	/25		4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
)3	Drovidor to Drogram		I	0	0	5
50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
50 51				0	0	
52				0	0	
99 99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50			0	0	
	- 5. 98)			-		Ĭ
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	PROGRAM TO PROVIDER		73, 8	86	4, 081	
02	PROVIDER TO PROGRAM			0	0	-
00	Total Medicare program liability (see instructions)		4, 219, 8		4, 081	7
			Contr	actor Name	Contractor	
				1 00	Number	
				1.00	2.00	1

 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.

NCE SHEET (If you are nonproprietary and do not maintain -type accounting records, complete the "General Fund" column	Provi der	No.: 315153	Period: From 01/01/2022	Worksheet G	
)			To 12/31/2022	Date/Time Pre 5/27/2023 9:3	
	General Fund	Specific Purpose Func	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
Assets CURRENT ASSETS					1
Cash on hand and in banks	1, 665, 000		0 0	0	1 1
Temporary investments	6, 065, 000		0 0	0	
Notes recei vabl e Accounts recei vabl e	0 965, 000		0 0	0	
Other receivables	905,000		0 0	0	
Less: allowances for uncollectible notes and accounts	0		0 0	0	1 1
recei vabl e					
Inventory	0		0 0	0	1
Prepaid expenses Other current assets	203, 000		0 0	0	
0 Due from other funds	203,000		0 0	0	
0 TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	8, 898, 000		0 0	0	
FI XED ASSETS	Γ				
	0		0 0	0	
0 Land improvements 0 Less: Accumulated depreciation			0 0	0	
0 Buildings	0		0 0	0	
0 Less Accumulated depreciation	0		0 0	0	
0 Leasehold improvements	1, 586, 000		0 0	0	
0 Less: Accumulated Amortization	0		0 0	0	
0 Fixed equipment 0 Less: Accumulated depreciation	0		0 0	0	
0 Less: Accumulated depreciation 0 Automobiles and trucks				0	
0 Less: Accumulated depreciation	0		0 0	0	
0 Major movable equipment	0		0 0	0	
0 Less: Accumulated depreciation	0		0 0	0	
0 Minor equipment - Depreciable	0		0 0	0	
0 Minor equipment nondepreciable 0 Other fixed assets	0			0	
0 TOTAL FIXED ASSETS (Sum of Lines 12 - 27)	1, 586, 000		0 0	0	
OTHER ASSETS					
0 Investments	0		0 0	0	
0 Deposits on Leases	0		0 0	0	-
0 Due from owners/officers 0 Other assets	88, 000		0 0	0	
0 TOTAL OTHER ASSETS (Sum of Lines 29 - 32)	88,000		0 0	0	
0 TOTAL ASSETS (Sum of lines 11, 28, and 33)	10, 572, 000		0 0	0	34
Liabilities and Fund Balances					
CURRENT LIABILITIES 0 Accounts payable	1 020 000		0 0	0	1 2
0 Accounts payable 0 Salaries, wages, and fees payable	1, 930, 000		0 0	0	-
0 Payroll taxes payable	0		0 0		
0 Notes & Loans payable (Short term)	0		0 0	0	
0 Deferred income	0		0 0	0	-
0 Accel erated payments	0		0		40
0 Due to other funds 0 Other current liabilities	3, 084, 000		0 0	0	
0 TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5, 014, 000		0 0	0	
LONG TERM LI ABI LI TI ES		·			1 ``
0 Mortgage payable	0		0 0		44
0 Notes payable	0		0 0	0	
0 Unsecured Loans	0		0 0	0	
0 Loans from owners: 0 Other long term liabilities				0	
0 OTHER (SPECIFY)	0		0 0	0	
0 TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	0		0 0	0	
0 TOTAL LIABILITIES (Sum of lines 43 and 50)	5, 014, 000		0 0	0	51
CAPITAL ACCOUNTS	E 550 000				
0 General fund balance 0 Specific purpose fund	5, 558, 000		0		52
0 Specific purpose rund 0 Donor created - endowment fund balance - restricted			0		54
0 Donor created - endowment fund balance - restricted			0		5!
0 Governing body created - endowment fund balance			0		56
0 Plant fund balance - invested in plant				0	
0 Plant fund balance - reserve for plant improvement,				0	58
replacement, and expansion 0 TOTAL FUND BALANCES (Sum of lines 52 thru 58)	5, 558, 000		0 0	0	59
	ບບບ	1	0	0	1 2,
0 TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and	10, 572, 000		0 0	0	6

Heal th	Financial Systems	THE MAN	OR		In Lie	eu of Form CMS-2	2540-10
	IENT OF CHANGES IN FUND BALANCES		Provi der	No.: 315153	Period: From 01/01/2022 To 12/31/2022	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments) Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance		2, 094, 803 -6, 736, 803 5, 558, 000 5, 558, 000 5, 558, 000 0 5, 558, 000	3.00			$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$
	sheet (Line 11 - line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00	_		
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 31) Total (sum of line 1 and line 2) Additions (credit adjustments)	0	0	0.00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 5 - 9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) Total deductions (sum of lines 13 - 17) Fund balance at end of period per balance sheet (Line 11 - line 18)	0 0 0 0	0 0 0 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 01/01/2022	Worksheet G-2 Parts I-II Date/Time Pre 5/27/2023 9:3	bared:
	Cost Center Description			I npati ent		Outpati ent	Total	
	•			1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Care Services							
1.00	SKILLED NURSING FACILITY			10, 899, 00			10, 899, 000	1.00
				10, 699, 00				
2.00	NURSING FACILITY				0		0	2.00
3.00	ICF/IID				0		0	3.00
4.00	OTHER LONG TERM CARE				0		0	4.00
5.00	Total general inpatient care services (Sum of Li	nes 1 - 4)		10, 899, 00	00		10, 899, 000	5.00
	All Other Care Services							
6.00	ANCI LLARY SERVI CES				0	0	0	6.00
7.00	CLINIC					o	0	7.00
8,00	HOME HEALTH AGENCY COST					0	0	8.00
9.00	AMBULANCE					0	0	9.00
10.00	RURAL HEALTH CLINIC					0	0	10.00
10.00	FQHC					0	0	10. 00
	CMHC					0	0	11.00
						0	-	
	HOSPI CE				0	0	0	12.00
	OTHER (SPECIFY)				0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Tr Worksheet G-3, Line 1)	ansfer column 3	to	10, 899, 00	00	0	10, 899, 000	14.00
	Cost Center Description							
					ŀ	1.00	2.00	
	PART II - OPERATING EXPENSES					1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Lin	o 100)			Т		16, 979, 803	1.00
2.00		e 100)				0	10, 979, 003	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						o		10.00
11.00						0		11.00
12.00						n		12.00
12.00						0		13.00
	Total Deductions (Sum of lines 9 - 13)					0	0	14.00
	Total Operating Expenses (Sum of Lines 1 and 8,	minus lino 14)					16, 979, 803	
15.00	Total operating expenses (sum of fines 1 and 8,	minus inne 14)				I	10, 979, 803	10.00

Heal th	Financial Systems	THE MANOR			In Lie	u of Form CMS-2	2540-10
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider No.	: 315153	Peri od:	Worksheet G-3	
					From 01/01/2022	Date/Time Pre	
	To 12/31/2022						
						5/27/2023 9: 3	
						1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I,					10, 899, 000	1.00
2.00	Less: contractual allowances and discounts on pat	tients accounts				0	2.00
3.00	Net patient revenues (Line 1 minus line 2)					10, 899, 000	3.00
4.00	Less: total operating expenses (From Worksheet G-		ne 15)			16, 979, 803	4.00
5.00	Net income from service to patients (Line 3 minus	s 4)				-6, 080, 803	5.00
	Other income:						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					-989, 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
	Revenue from laundry and linen service					0	13.00
	Revenue from meals sold to employees and guests					0	14.00
	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical supplie		n patients			0	16.00
17.00	Revenue from sale of drugs to other than patients					0	17.00
18.00	Revenue from sale of medical records and abstract					0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)					0	19.00
	Revenue from gifts, flower, coffee shops, canteer	ו				0	20.00
	Rental of vending machines					0	21.00
	Rental of skilled nursing space					0	22.00
23.00	Governmental appropriations					0	23.00
24.00	PURCHASE DISC, B&B, RX REBATES					333, 000	24.00
24.50	COVI D-19 PHE Fundi ng					0	24.50
25.00	Total other income (Sum of lines 6 - 24)					-656, 000	25.00
26.00	Total (Line 5 plus line 25)					-6, 736, 803	26.00
27.00	Other expenses (specify)					0	27.00
28.00						0	28.00
29.00						0	29.00
	Total other expenses (Sum of lines 27 - 29)					0	30.00
31.00	Net income (or loss) for the period (Line 26 minu	us line 30)				-6, 736, 803	31.00